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Abortion as a Social Justice Issue in Contemporary Canada

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Abstract

Twenty-five years after the legal decision that decriminalized abortion in Canada, significant barriers and issues continue to impact the ability of women to exercise their right to bodily integrity. Provinces have abdicated their responsibility to provide adequate abortion access; Members of Parliament continue to introduce and entertain anti-abortion motions and bills; Crisis Pregnancy Centres and anti-abortion advocates perpetuate myths; and women continue to face judgment for controlling their reproduction. The Canadian Association of Social Workers articulates that social workers have an ethical obligation to work towards social justice for all. This paper serves to explain why abortion is still a critical social justice issue, and compels readers to take action against the reproductive oppression of women.

Keywords: abortion, Canada, reproductive oppression, social justice, women

The right not to reproduce means the entitlement not to be compelled to beget or bear children against one's will... Women do not owe their reproductive products or labour to any person or institution, including male partners or the state (Overall, 1992, p. 241).

January 28, 2013 marked the 25th anniversary of the Morgentaler decision, a legal decision that effectively decriminalized abortion in Canada (R v. Morgentaler, 1988). Despite this, major issues continue to plague women's reproductive rights. Canadian social workers, and other activists, must be aware of why abortion remains a critical social justice issue for the women of our country. This paper is intended to serve as a call to action for all people concerned about women's rights.

Social justice is based on compassion for people, and can be defined as the goal of all persons having full and equitable access to opportunities and services in a society (Long, Tice, & Morrison, 2006; Mullaly, 2010). Social justice is about ensuring that members of a society feel physically and psychologically secure (Bell, 2010; Long et al., 2006), and are able to be both self-determining in their choices, and interdependent in their reliance on other members for support (Bell, 2010). Miller (2001) succinctly states that social justice is "how the good and bad things in life should be distributed among members of a human society" (p. 1). More specifically, he argues that when "we attack some policy or some state of affairs as socially unjust, we are claiming that a person, or more usually a category of persons, enjoys fewer advantages than that person or group of persons ought to enjoy... given how other members of the society in question are faring" (Miller, 2001, p. 1). Based on this definition, social justice is a way of re-distributing resources and facilitating opportunity so that people can live in a more equitable way.

In addition to working towards equity between social groups (such as women and men), social justice is about achieving equity within what are traditionally viewed as homogenous groups (Mullaly, 2010). 'Women' as defined categorically are not homogenous. Women have different intersecting identities that impact their ability to access abortion services in different ways (Ross, 2006; Yee, Apale, & Deleary, 2011). Barriers to abortion access most drastically affect marginalized women, "particularly those who are low-income, women-of-colour, immigrant or refugee women and those who do not speak English or French" (Patton, 2009, p. 29). Social determinants of health, or how living conditions and identities affect one's health, have been established as critical to understanding healthcare access discrepancies (Mikkonen & Raphael, 2010). Specifically, the link between high levels of poverty and low access to sexual and reproductive healthcare has been made clear (International Planned Parenthood Federation, 2006). Women who cannot afford contraception are more likely to require abortion care and women who live in Aboriginal and rural communities are less likely to have an abortion provider nearby (Shaw, 2006; Yee et al., 2011). The lack of access to abortion services, especially for marginalized women, entrenches abortion as a social justice issue.

Working towards a more socially just society is one of the core values of the Canadian Association of Social Workers (CASW) (2005). Part of the opening sentence in the preamble for the Canadian Association of Social Workers Code of Ethics states, "The social work profession is dedicated to... the achievement of social justice for all" (CASW, 2005, p. 3). Acknowledging and honouring this value is an ethical obligation. In particular, the Code of Ethics highlights that

social workers “promote social fairness... and act to reduce barriers *and expand choice* [emphasis added] for all persons” (CASW, 2005, p. 5). To support the expansion of women’s reproductive choices, social workers must advocate for an increase in the accessibility of abortion services, and a decrease in the stigmatization of abortion care. Additionally, with reference to the social work principle of advocating for social justice “with special regard for those who are marginalized, disadvantaged, vulnerable, and/or have exceptional needs” (CASW, 2005, p. 5), social workers must acknowledge the marginalization of abortion providers, and work to alleviate the impact that it has.

Despite all legal restrictions on abortion in Canada having been removed in 1988 (Richer, 2008), there are significant barriers that prevent women from being able to access abortion services. Some of these barriers include regional differences in abortion availability, time and travel expenses, a shortage of abortion providers, severe judgement and misinformation about abortion, and the introduction of anti-abortion legislation (Palley, 2006; Patton, 2009; Sethna & Doull, 2012; Shaw, 2006). The prevalence of these barriers leads to women experiencing reproductive oppression. Reproductive oppression is defined as “the control and exploitation of women, girls, and individuals through our bodies, sexuality, labour, and reproduction” (Ross, 2006, p. 2). In order to emancipate all women from reproductive oppression, social workers (and others) need to work towards recognizing and fighting for abortion as a social justice issue.

Fundamentally, abortion is about bodily integrity and the right to self-determination. This value-statement encompasses complex moral, political, and religious claims, and is one that I strongly believe in. This paper first describes why abortion is a social justice issue in relation to achieving parity between women and men. It will then highlight how abortion has been established as a human right within Canadian law, and identify why its current legal status is precarious. Finally, it will discuss some of the barriers to abortion care that women in Canada face, and identify how these barriers create social injustice between different groups of women.

Abortion is Emancipatory

In order to escape male domination, a feminist perspective on fertility and childrearing posits that reproduction is the single most important aspect of life that women must be able to control (Elliot & Mandell, 2001). All social and economic equity measures (e.g., pay equity, full access to non-traditional jobs, and access to benefits) rely on women being able to control if, when, and how many children they will have (Kelly, 1992; Woliver, 2002). When women are unable to control their fertility, and are forced to bear and raise children, they become reliant on other people for support. Even in communities where whole families and neighbourhoods take on the responsibility of raising community children, the actual labour of childrearing falls predominantly to the responsibility of women (Mandell, 2001; Woliver, 2002).

Being pregnant and raising children reduces women’s capacity for political, social, and economic participation and immediately places them in a lower socioeconomic status (Kelly, 1992; Woliver, 2002). Some women have abortions in order to avoid becoming single mothers, for whom poverty rates are the highest of all family types in Canada (47.1% compared to the national average of 15.5%) (Kaposy, 2010, p. 22). Women play a central role in many families as both primary caregivers and income earners. When a woman becomes pregnant, her ability to

work outside of the home or to continue her education is often impeded. When teenage women become pregnant, they may drop out of school, thus lowering their chances of being able to work at a job with a decent income. This impacts their ability to provide for their families and to escape poverty (Kelly, 1992). Abortion is therefore an important reproductive service that women must be able to access in order to protect the health and safety of their families, and of themselves. It is critical that women are able to decide whether to have children only when they feel that they are able to meet their personal requirements of what is needed to raise a healthy and happy family.

Patriarchy and capitalism keep women reliant on men, and keep men in positions of power. This extends beyond the confines of the family home. When women are reliant on men's money, men are expected and encouraged to enter the workforce in order to support their families. Men being involved in the public sphere, that is, the realm of life that exists outside of the private home, allows them to more fully participate in public decision-making and the control of finances (Mandell, 2001). Thus, governmental and social policies have traditionally been created by men, and with men's interests at the centre. Perhaps then, the reason that supporters (and participants) of patriarchy dislike the idea of abortion so much, is because it is the ultimate denial of male authority. Reagan (1997) wrote, "Abortion, like contraception, means that women can separate sex and procreation – still a controversial issue" (p. 14). In a world where so much is controlled by men, including the sexual availability of women in the form of rape, abortion is one of the only aspects of life under the control of women. To choose not to have a child is to choose not to become intricately and forever linked to a man. As a way to assert their independence from men, women must be able to choose abortion.

Life, Liberty, and Security of the Fetus?

The evidence establishes convincingly that it is the law itself, which in many ways prevents [emphasis original] access to local therapeutic abortion facilities. The enormous emotional and financial burden placed upon women who must travel long distances from home to obtain an abortion is a burden created in many instances by Parliament (R v. Morgentaler, 1988, p. 71).

The Canada Health Act outlines five essential criteria that all healthcare services in Canada must meet; they are public administration, comprehensiveness, universality, portability, and accessibility (Madore, 2005). Despite abortion being recognized by all provinces as a medically necessary procedure (Arthur, 2005), its provision is routinely in contradiction of these five essential criteria. Furthermore, rather than working to correct this grievance, governments continue to entertain motions and bills that would further exclude abortion as a public health service.

Under the Canada Health Act, public administration refers to the requirement that provincial healthcare must be administered on a not-for-profit basis (Madore, 2005). Since "abortion clinics fall under the category of 'hospitals' in the Canada Health Act because they deliver a medically-required hospital service" (Arthur, 2005, p. 1), this means that all abortions must be publicly funded, regardless of whether they are performed in hospitals or clinics. Yet Prince Edward Island does not have any abortion services, and New Brunswick refuses to cover

the cost of abortions done in clinics (Kaposy, 2010). In New Brunswick, there is an ongoing legal battle against this policy, with at least one court challenge that has been awaiting trial since 2003 (McMahon, 2012). Until the provinces of Prince Edward Island and New Brunswick address the systemic inequalities that impact the women of their provinces, it appears they will continue to be allowed to abdicate their responsibilities to their residents.

“Comprehensiveness” under the Canada Health Act refers to the obligation of provinces to fund all services that are deemed medically necessary (Madore, 2005, p. 7). Abortion is medically necessary because women’s lives and health are at stake when it is unavailable, as they are forced to self-induce labour or obtain illegal abortions (Arthur, 2011). To date, all provinces recognize abortion as a medically necessary procedure (Arthur, 2005), but this could change as provincial governments have the right to determine and change which services it defines as medically necessary (Madore, 2005).

The criterion of universality demands that “all residents in the province have access to public health care insurance and insured services on uniform terms and conditions” (Madore, 2005, p. 7). Despite this, immigrant, refugee, and Aboriginal women disproportionately denied abortion care, even when other healthcare services are available to them (Patton, 2009; Yee et al., 2011).

Portability refers to people being able to access healthcare when they are outside their home province (Madore, 2005). Through reciprocal billing agreements, a person does not have to pay out-of-pocket if they require medical care while travelling, while at a post-secondary institution, or if a medical service is more accessible in another province (as is the case for many people who live on provincial borders). Yet abortion is routinely excluded from reciprocal billing agreements (Palley, 2006), which discriminates against women based on their feelings about their pregnancy. If a woman chooses to carry a fetus to term and give birth in another province, she would be covered; if she chooses to end her pregnancy, she would not be.

The accessibility criterion of the Canada Health Act exists to ensure that people “have reasonable and uniform access to insured health services, free of financial or other barriers” (Madore, 2005, p. 7). The inaccessibility of abortion services is perhaps the most convincing reason why abortion remains a social justice issue in Canada today. In recognition of this, the next section of this paper will be devoted to the discussion of abortion access issues.

Considering that all five criteria of the Canada Health Act are violated when it comes to abortion care, even though abortion is recognized as a medical service to be covered by the Act, it is clear that advocating for abortion in Canada is a social justice issue. Canada’s healthcare program is primarily funded by governments through taxpayer, including *female* taxpayer, dollars. Women must be able to access the public healthcare services that we pay for. Given that our healthcare system is built on the principle of people being able to access services equally (Madore, 2005), when there are discrepancies in care, the government must step-up to ensure that people’s rights are being protected.

Section 7 of the Canadian Charter of Rights and Freedoms states that, “everyone has the right to life, liberty, and security of the person” (Canada Act, 1982, para. 1). When a woman is

unable to access abortion care, her right to life, liberty, and security of the person is threatened. According to the judicial decision of 1988 that decriminalized abortion in Canada, “forcing a woman... to carry a fetus to term... is a profound interference with a woman’s body and thus a violation of security of the person” (R v. Morgentaler, 1988, p. 32-33). Legal precedents establish the link between abortion access and women’s rights, and enshrine abortion as a medically necessary service to be protected by the Canada Health Act (Kondro, 2001). However, since 1988, there have been numerous attempts to change the legal status of abortion in Canada. Perhaps the most notable judicial decision since abortion was decriminalized is Tremblay v. Daigle (1989). This case was based on the former sexual partner of a woman obtaining an injunction from the Québec Superior Court to prevent her from having an abortion. The woman appealed the injunction, but it was upheld by a majority of the Québec Court of Appeal (Richer, 2008). Ultimately, the woman travelled to the United States and terminated her pregnancy against the injunction ruling, and her case was appealed to the Supreme Court of Canada. It was declared that a fetus has no rights until it is born alive and has “proceeded completely [from the] body of its mother” (Browne & Sullivan, 2005, p. 288). Furthermore, it was established that in Canada, it is not accepted that “the potential father’s contribution to the act of conception gives him an equal say in what happens to the fetus” (Tremblay v. Daigle, 1989, III(3), para. 1). In addition to the Daigle case, there have been several other judicial decisions (see for example Borowski v. Canada, 1989; R v. Sullivan, 1991; Winnipeg Child and Family Services (Northwest Area) v. G. (D.F.), 1997; Dobson (Litigation Guardian of) v. Dobson, 1999) that have upheld the Canadian position that a fetus does not have any rights until it is born (Richer, 2008). Based on all of these cases, abortion is legally recognized as a woman’s prerogative, along with the acknowledgement that her rights are paramount to any potential rights of the fetus.

Although the idea that the rights of women supersede the rights of fetuses has been established in Canadian courts multiple times, anti-abortion politicians seem determined to change this. In many instances since abortion has been decriminalized in Canada, attacks on abortion access have been introduced to Parliament as private Member’s bills. Since 1987, and at the time of the writing of this article, there have been forty-four anti-abortion private Member’s bills or motions introduced to Canadian Parliament, and one government bill (Abortion Rights Coalition of Canada, 2012). Thus far, all of the motions and bills have failed to pass, yet some anti-abortion politicians are still determined to recriminalize abortion (see for example Warawa, 2012; Woodworth, 2012).

Typically, anti-abortion bills or motions are disguised with emotional language that appeals to the general population, and are created with the intention of recognizing fetuses as human beings. While many people do recognize fetuses as human beings, and still justify abortion as moral because of a woman’s right to bodily integrity, anti-abortion government bills are dangerous because of how they would change the legal, not moral, definition of human being. Such bills have the potential to make abortion illegal in Canada (Johnson, 2012, August 23). If a fetus is assigned personhood because it is legally designated a human being, then abortion becomes an act that kills a person, making it murder. In addition to making abortion illegal, such rulings would have implications for the rights of pregnant women. In Canada, law through the Canadian Charter of Rights and Freedoms (Canada Act, 1982) protects persons, and their right to life. If a pregnant woman carries a person in her womb, that person could have

rights that conflict with the woman's rights. For instance, if a woman takes drugs or consumes alcohol while pregnant, she could be charged with endangering the life of another person. Additionally, in cases where women have miscarriages, investigations could be launched into whether the death of the baby is the fault of the woman. Unfortunately, such cases exist, and women serve jail time every year in the United States, and other countries, where the limitations of fetal personhood are unclear (Centre for Reproductive Rights, 2012; Woliver, 2002).

Abortion opponents will also disguise the anti-abortion stance of bills through the use of obfuscation. For instance, Warawa (2012), used the language of ending "discrimination against females" to push for restrictions on abortion (para. 1). Warawa's M-408 sought to have the House of Commons condemn sex-selective abortions, a practice where a fetus is aborted based on its gender, and typically, because it is female. In Canada, to date, there are no definitive studies that confirm the rate at which sex-selective abortions are occurring. Even the most frequently cited report on sex-ratio discrepancies focuses on births (rather than abortions), did not conduct research with any abortion facilities, and poses sex-selective preimplantation of male eggs in fertility treatments as a possible explanation for birth ratio differences (Ray, Henry & Urquia, 2012). Despite the lack of evidence of the prevalence of sex-selective abortion, the media frenzy surrounding the introduction of M-408 would have Canadians believe that sex-selective abortions are an endemic in this country. The necessity for debate around sex-selective abortion is moot. However, to entertain Warawa's question of, is sex-selective abortion morally agreeable or not? One also has to entertain the more relevant question of, why do some women feel they need to have an abortion if their fetus is female? As stated by Mercer, (2013), "What should concern us about sex-selective abortion, is not the abortion part, but [rather] the beliefs and tastes behind the preference for a boy" (p. 2). The fact that sex-selective abortions might occur is not as related to abortion, as it is to women's status in society. Collectively, the status of women in society needs to be enhanced so that all people are equally valued, regardless of gender. Having the House condemn sex-selective abortions would not raise the status of women; it would only create the opportunity for the House to impose further restrictions on abortion.

The fact that there have been, and continue to be, attempts to recriminalize abortion in Canada sustains it as a social justice issue. Until abortion becomes an unchallenged event in Canadian society, women and allies will have to continue to fight for its legality and acceptance. Social workers must not fall for the clever ways that anti-abortion activists re-frame the abortion debate. We must recognize the use of emotional language and obfuscation as a ruse, which is strategically used by anti-abortion advocates to gain our support of their anti-woman goals.

Access Denied

Even though abortion has been legal in Canada for twenty-five years, women continue to face incredible barriers that prevent it from being an accessible health service. The inconsistent and complete lack of abortion care in different parts of Canada is what makes abortion a major social justice issue. In recent years, we have seen a decrease in the number of facilities that offer accessible abortion services (Shaw, 2006), and in the number of physicians who are willing to perform abortions (Sethna & Doull, 2007). Some provinces refuse to cover abortion in reciprocal billing agreements, and others continue to withhold funding for clinics (Palley, 2006; Patton, 2009). If a woman has to travel outside of her home community in order obtain an abortion,

taking time off of school or work, travel costs, and arranging for childcare and/or eldercare can make this task extremely difficult (Shaw, 2006). Also, anti-abortion healthcare professionals and crisis pregnancy centre volunteers continue to act as gatekeepers to abortion care (Shaw, 2006). By refusing to provide information about how to obtain an abortion and by spouting myths about the effects of abortion on women and society, they contribute to the perpetuation of abortion stigma. Until access to abortion services is universal and equitable, abortion will remain a critical social justice issue.

Abortion Tourism: Save up your Holiday Time

In 2010, the most recent year with national abortion statistics, 64,641 abortions were provided in Canada (Canadian Institute for Health Information, 2012). This number can be considered a low approximate because data are incomplete for British Columbia, and statistics were not collected for the province of Québec (Canadian Institute for Health Information, 2012). Furthermore, the national survey does not account for medical drug-induced abortions, self-procured abortions, or abortions done in the United States for Canadian women (Flaherty, 2003). In the previous national report, where Québec abortions were included, the national abortion rate was 96,815 (Statistics Canada, 2008). This is likely closer to the actual number of abortions performed in Canada.

Currently, only 15.9% of hospitals in Canada offer abortion services, despite the fact that any hospital with an obstetrics ward is capable of doing abortions (Shaw, 2006). There are also 33 abortion clinics across the country (Wu & Arthur, 2010). Access to abortion varies greatly depending on geographical location, and is more available in major urban centres (Shaw, 2006). On Prince Edward Island, there are currently no abortion services, and in New Brunswick, a woman requires written referrals to a hospital from two physicians in order for her abortion to be covered by the provincial healthcare plan (Sethna & Doull, 2007; Shaw, 2006). Nearly all of Canada's abortion facilities are located in major urban centres, generally within one-hundred-fifty kilometres of the United States border (Shaw, 2006).

When women are unable to access abortion services in their home regions, they may have to pay to travel to access abortion care, or in some cases, resort to attempts of self-induction (Shaw, 2006). To access abortion services, women may have to travel to another community, to another province, or even to another country (Sethna & Doull, 2012). Such travel requires significant amounts of money, the ability to take time off from school or work, and the ability to arrange for childcare or eldercare (Shaw, 2006). Even though costs related to travel for medical care are often covered by travel grants (Ontario Ministry of Health and Long-Term Care, 2012), or in interprovincial reciprocal billing agreements in the case of out-of-province care, reimbursement still necessitates being able to pay for costs up front, and not all provinces recognize abortion as eligible for reciprocal billing (Sethna & Doull, 2007).

Although over two decades old, estimates suggest that between 3,000 and 6,000 Canadian women travel to the United States for abortions every year (Thobani, 1992). Presently, we have no way of knowing how many women travel out of country in order to access abortion care, but studies suggest that abortion tourism is a widespread transnational phenomenon based on extra-legal impediments to abortion access (Sethna & Doull, 2012).

The shortage of abortion facilities leads to long wait-times in regions where abortion is provided. In some cases, the wait for an abortion can be as long as six weeks (Shaw, 2006). While legal abortion is safer than childbirth (Raymond & Grimes, 2012), the risks associated with it increase the further into pregnancy a woman is (Bartlett et al., 2004). Especially because abortion becomes almost impossible to access in Canada after twenty-four weeks gestation, it is critical that wait-times are reduced to facilitate the needs of women (Shaw, 2006). If a woman is unable to access abortion in her home region, or if the wait for abortion in her region would make accessing it nearly impossible, she may resort to extreme measures.

Within the first three months of running a national information and referral line related to abortion in Canada, I spoke with two women who had attempted to self-induce. The first said she tried to self-induce because she lived in a rural region of the Maritimes where abortion was not accessible, and the other said it was because she feared the judgement of her parents if she told them she was pregnant. Unfortunately, attempting to self-induce abortion is not as rare as it ought to be in a country where abortion is legal. This past year, the preliminary findings of a research report out of the University of Prince Edward Island revealed that women on Prince Edward Island were resorting to severe forms of self-injury in their attempts to terminate their pregnancies (Wright, 2011, November 10). One fourteen year old woman was reported to have ingested chemicals to try to induce abortion. When that did not work, she got drunk and threw herself down the stairs. It is unlikely that there are any statistics regarding the number of women who die from self-induced abortions in Canada. In reports, ‘abortion related deaths’ tend to refer to those that occurred in medical facilities, and do not account for suicide or self-induction.

Worldwide, unsafe abortions account for between 12% - 30% of all direct maternal deaths (Khan, Wojdyla, Say, Gulmezoglu, & Van Look, 2006). Comparatively, in Canada, mortality rates related to legal abortion are close to zero (Sabourin & Burnett, 2012). Despite the safety of abortion (when done by a healthcare professional) in Canada, anti-abortion activists would have women believe that abortion is a risk to their health and future fertility. Often based in religious and patriarchal belief systems, people who are anti-abortion continue to propagate myths about the safety of abortion and its impact on women (Woliver, 2002). The success of their movement would mean a re-criminalization of abortion in Canada. Historical accounts remind us that women have had, and will continue to have abortions regardless of their morality, legality, of what the fetus may or may not be, and whether they are offered in safe medical settings or in clandestine conditions (The Childbirth by Choice Trust, 1998). The re-criminalization of abortion – the ultimate prevention of abortion access – would likely see an increase in the number of maternal deaths in Canada. Being a tool to prevent unnecessary death further reinforces abortion as a social justice issue.

“I love you Mommy”, and Other Things People say to Save Fetuses

As a legal medical procedure that is covered by the Canada Health Act and is protected by constitutional law, women must be able to access abortion. Furthermore, women must be able to access abortion without being harassed or discriminated against because of their decisions. Anti-abortion individuals work in almost every sector of society. They are social workers, hospital staff, and health clinic employees. While each person in Canada is guaranteed their right to “freedom of conscious and religion... thought, belief, opinion and expression” (Canada Act

1982, section 2, para. 1), there are many detrimental effects that anti-abortion people have on women, and on society. In Canada, anti-abortion activism can prevent women from being able to access abortion services, and fosters a culture of stigma and shame around a woman's right to end her pregnancy.

One of the most powerful and pervasive venues through which anti-abortion sentiment is expressed is the crisis pregnancy centre (Shaw, 2006). "Crisis pregnancy centres" (CPCs) are anti-choice organizations that exist to prevent women from having abortions (Canadians for Choice, 2008). They outnumber abortion clinics in Canada almost seven to one, with at least one CPC in each community where abortion is available, and others in communities where it is not (Arthur, 2009). CPCs often strategically locate themselves on the same block as abortion clinics, presumably to attract women who are looking for abortion care (Canadians for Choice, 2008). Though often religiously funded, not all CPCs are transparent about their religious orientation (Arthur, 2009; Canadians for Choice, 2008). It is through these CPCs that many of the judgement and misinformation about abortion is propagated (Arthur, 2009; Shaw, 2006).

While conducting research for the report *Reality Check: A Close Look at Accessing Abortion Services in Canadian Hospitals* (Shaw, 2006), I encountered many CPCs where I was told things such as, if you have an abortion:

- And ever get pregnant again in the future, your cervix will have to be sewn shut, and you will have to be in bed rest the entire nine months of your pregnancy, with your feet above your head, so that the baby doesn't fall out.
- You will be drawn to abusive men, because subconsciously, you will know that you deserve punishment.
- You will get breast cancer.
- Any future children you have are at a higher risk of developing cerebral palsy.
- You are likely to turn to drugs or alcohol and develop an addiction. You know you are already a mother.

Other studies confirm that these myths continue to be told, despite the clinical evidence that proves their inaccuracies (Bryant & Levi, 2012; Woodward, 2012, April 27). Perhaps the reason these myths continue to be told is because most CPCs operate using volunteers with no medical or professional mental health training (Canadians for Choice, 2008). The Canadian Association for Pregnancy Support Services (CAPSS) is an umbrella organization for many of the CPCs across Canada. Training manuals used by CAPSS CPCs include chapters called, the "Biblical Basis for the Sanctity of Human Life" and "The Role of the Gospel" for counselling (Arthur, 2009, p. 3). While faith-driven counselling is not necessarily problematic in itself, it is problematic when it combines anti-abortion judgements with inaccurate medical information. Some of the material used to train volunteers included statements about sex outside of marriage being "intrinsically wrong" and something that has "grievous consequences" (Arthur, 2009, p. 4). Upon review from a professional abortion provider, the CPC training manual was also found to have inaccurate information about what methods of abortion are used in Canada, and an exaggeration about the potential risks of abortion (Arthur, 2009).

Unfortunately, misinformation and judgement about abortion does not only come from crisis pregnancy centres; it can also come from medical staff and professional counsellors (Shaw, 2006). There are numerous examples of women receiving unprofessional and judgemental treatment from medical and mental health professionals (Arthur, 2009; Shaw, 2006). For instance, one woman shared that when she went to her family doctor to get a referral for an abortion, her physician placed a stethoscope on her abdomen and said, “I love you mommy... I love you mommy...” in rhythm with her heartbeat (Shaw, 2006, p. 48). When professional healthcare workers propagate myths and judgement about abortion, it makes it difficult for people from the non-medical population to decipher what is accurate. For women who have never studied abortion in depth, being able to obtain accurate information is especially important if they are faced with an unplanned pregnancy.

“What is it like to have your Home Picketed?”

Anti-abortion individuals and organizations do not just attack women with their judgement they also attack abortion providers. Over the years, numerous abortion providers have reported being harassed, and even assaulted, at work and at home (Fainman & Penner, 2011; Todd, 2003). In 2010, a study found that 64% of Canadian abortion clinics experience some form of anti-abortion protest activity (Wu & Arthur, 2010). The harassment that abortion providers endure from anti-abortion individuals and groups could contribute to the shortage of providers that Canada currently faces.

Last April at a conference for pro-choice medical students, I overheard a student asking an abortion provider, “what is it like to have your home picketed?” This question highlights what can only be a speculation into why there are so few abortion providers in Canada. To date, while the fact that there is a shortage of abortion providers is known (Ogilvie, 2010, November 20; Shaw, 2006), the cause of the shortage is not fully understood. The question asked by the medical student suggests that potential abortion providers are cognizant of the risks that can be involved in offering abortion care. This is likely a deterrent, and may prevent physicians from incorporating abortion care into their practice.

The lack of abortion training in medical school could also contribute to why few new physicians are willing to offer the service. In Canada, more class time is reportedly spent discussing Viagra than abortion law, policy, procedures, and pregnancy options counselling combined (Koyama & Williams, 2005). Although 67% of Canadian medical schools include abortion as a topic in preclinical classes, few residents report feeling that they received enough training to adequately consider becoming a provider (Steinauer et al., 2009). Furthermore, residents stated that they would be more interested in offering abortion care if it was better integrated into their medical training.

In addition to a lack of training, the elusiveness of what abortion provision in Canada entails leaves people to speculate about what it must be like. An investigative report in the *Toronto Star* (Ogilvie, 2010) interviewed abortion providers about why they felt the next generation of physicians were hesitant to offer abortion care. Not having memories of what abortion was like when it was illegal was cited as one of the reasons seasoned providers thought new physicians are not driven to offer abortion care. Older Canadian physicians who can recall

the carnage that resulted from illegal abortion are more likely to recognize the importance of offering legal abortions from trained medical professionals (Romalis, 2008).

Some providers have suggested that discussing abortion more openly in Canada could be part of the provider shortage solution. As stated by one physician, "Providers recognize that we are few and far between... This is an essential service for women, and unless we are proactive in recruiting and educating young doctors in the area of abortion provision, we will not be able to offer women a safe and sensitive abortion service" (Ogilvie, 2010, *para. 64-65*). Continuing to recruit abortion providers is necessary to the furthering of women's rights.

Based on their ability to relieve women from the restrictions that pregnancy and childrearing can put on their lives, abortion providers are emancipatory actors in the fight for women's freedom. To be free from forced reproduction is to be able to control one's own social, political, and economic life (Woliver, 2002). Physicians who offer abortion care are, by the very nature of the work that they do, key figures in promoting social justice for women. By participating in the highly controversial service of abortion care, providers become advocates for women's rights and act as the tool through which social justice is enacted in the form of abortion care.

Whereas physicians in general may be understood to live relatively privileged lives within Canadian society, as far as salary, benefits, and status are concerned, abortion providers occupy a marginalized position. In the few autobiographical books that exist on abortion provision, physicians discuss having to travel to and from work wearing bulletproof vests, having their homes and offices picketed by protestors, having to deal with public verbal abuse, and having their children harassed at school (see for example Fainman & Penner, 2011; Poppema & Henderson, 1996; Wicklund, 2007). All of this harassment occurs because they provide abortions for women. Relative to other physicians, abortion providers are marginalized, simply because of the work that they do.

Conclusion

Social workers have a professional obligation to work towards the achievement of social justice, and there are many reasons why abortion is still a social justice issue in Canada. As a procedure that allows women to control their own bodies and lives, it is integral to the furthering of women's rights. Yet, abortion remains an issue that is stigmatized and attacked. Legal challenges leave the status of abortion in Canada in a precarious position, and abortion services are still not offered in accordance with the Canada Health Act. The access issues that surround abortion care continue to impact the way that women in Canada experience reproductive oppression. When women do not have access to abortion services, they are forced to resort to either expensive or dangerous methods. Furthermore, anti-abortion individuals and organizations perpetuate dangerous and judgemental myths that lead to abortion stigma and shame. Social workers must rise up against the injustices that exist in Canada in relation to abortion care. As a Canadian, a feminist, a woman, and a social worker, I will continue to fight to end reproductive oppression, and call on other social workers to do the same.

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