



David Asper Centre for Constitutional Rights
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IMPROVING ACCESS TO ABORTION SERVICES IN CANADA

A What We Heard Report

PRESENTED BY

Reproductive Rights Working Group
David Asper Centre for Constitutional Rights

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Acknowledgements Page

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ABOUT THE ASPER CENTRE AND BACKGROUND TO THE PROJECT

The David Asper Centre for Constitutional Rights is devoted to realizing constitutional rights through advocacy, research, and education. The Asper Centre aims to play a vital role in articulating Canada's constitutional vision to the broader world. The Asper Centre regularly convenes student working groups that prepare policy briefs, draft public legal information materials, organize workshops and conduct research on current or emerging constitutional law issues. The Asper Centre's Reproductive Rights Working Group was convened in September 2022.

The Reproductive Rights Working Group originated as a reaction to the *Dobbs* decision in the United States.¹ In *Dobbs*, the United States Supreme Court overturned the holding of *Roe v Wade* which had previously maintained abortion access as a constitutional right.² The *Dobbs* decision thus allowed individual states to regulate abortion access. Several states had trigger bans that immediately came into effect post-*Dobbs* that implemented varying degrees of restriction. The Working Group sought to investigate and respond to the growing concern of how *Dobbs* may implicate reproductive rights in Canada and whether the Canadian regime is similarly vulnerable. Accordingly, the Working Group organized an expert panel of leading minds in the field on January 20th, 2023 ("Expert Panel"). The purpose of the Expert Panel was to investigate these pressing issues and to yield recommendations for policy makers. The Appendix lists the individuals who took part in the discussion.

¹ *Dobbs v Jackson Women's Health Organization*, 597 US (2022), 142 S Ct 2228 (WL) [*Dobbs*].

² *Roe v Wade*, 410 U.S. 113 (1973), [*Roe v Wade*].

I. INTRODUCTION

Access to abortion services is integral to the operation of a just and equitable society and healthcare system. In particular, abortion services are imperative to achieving gender and health equality.³ While decisions at the political and judicial levels have revealed the precarious nature of abortion rights in the United States, the Canadian abortion regime has not been so explicitly attacked. Instead, the findings of the Expert Panel revealed that the barriers to accessing abortion services in Canada are more insidious. The Expert Panel highlighted critical shortcomings in the current regime and proposed recommendations to address these issues.

This report summarizes the critical findings of the Expert Panel and is to be used as an advocacy tool to facilitate and improve access to abortion services in Canada. This report features an overview of the current landscape of reproductive rights in Canada, focusing on the following broad areas: access and use of abortion services; international and comparative constitutional norms regarding access and use; cross-border issues between Canada and the United States; and lastly, an overview of the strengths and weaknesses of enshrining the right to abortion in the Canadian Constitution. In each area of this report, contextual background and relevant issues are outlined, followed by the Expert Panel's relevant recommendations.

As it stands, the current operation of the healthcare system continues to hinder access to abortion and other reproductive services. The failure of the Canadian healthcare system to provide robust and accessible abortion services is particularly felt the most by Canada's most vulnerable and marginalized. Moreover, the fear that Canada will follow the Supreme Court of the United States decision in *Dobbs v. Jackson Women's Health Organization* (2022)⁴ with an all-out ban is largely unfounded and the product of alarmist media discourse. Nonetheless, improved access and protections are required.

The Expert Panel also noted that many of the cross-border concerns that have been raised, such as extradition, are negligible. While the Expert Panel does not recommend the implementation of a Constitutional amendment to preserve the right to abortion, it is integral that government actors adapt the current regime to ensure that Canadian healthcare needs are met throughout the country. For example, in order to comply with prevailing international standards as articulated in the 2022 World Health Organization's Abortion Care Guideline⁵ ("WHO Abortion Care Guideline"), a Federal

³ Canada, Government of Canada, "Sexual and Reproductive Rights: Canada's Approach" (last modified 15 August 2022) online: <www.international.gc.ca>.

⁴ *Dobbs*, *supra* note 1.

⁵ World Health Organization, "Abortion care guideline. World Health Organization" (2022), online: <<https://apps.who.int/iris/handle/10665/349316>> [World Health Organization].

policy on reproductive justice with tangible government commitments may be warranted.

SUMMARY OF EXPERT PANEL RECOMMENDATIONS

The following recommendations are non-exhaustive and should be seen as a starting point for ameliorating Canada's reproductive regime. Further consultation with minority groups and those most impacted by the weaknesses of the current state of reproductive rights in Canada is endorsed.

ACCESS TO & USE OF ABORTION SERVICES

1. Expand information about self-managed abortions through medications and investing in support for such medications, such as the mifepristone and misoprostol abortion pills.
2. Establish concentrated professional hubs for reproductive healthcare providers and specialists to facilitate continued learning and specialization in the reproductive health care area.
3. Develop a demedicalization policy framework to support a plurality of service-delivery approaches in abortion care, including self-management to further improve access to abortion services, particularly for those who require travel to access care.
4. Frame abortions as essential "care" rather than a service in order to comply with WHO's Abortion Guideline.⁶ There is a need to design inclusive healthcare systems and establish abortions as integral to healthcare.

INTERNATIONAL AND COMPARATIVE CONSTITUTIONAL NORMS REGARDING ACCESS AND USE

5. Utilize international treaties, such as Article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women, ratified by Canada in 1981⁷ and Articles 1 and 6 of the Inter-American Convention to Prevent and Punish Torture, which has not been signed or ratified by Canada but came into

⁶ *Ibid* at 2, 12-15, 47, 67-68.

⁷ *Convention on the Elimination of All Forms of Discrimination against Women*, 1 March 1980, 1249 UNTS 13, Can TS 1892 No 31 (Entered into force 3 September 1981, ratification by Canada 10 Dec 1981) [CEDAW].

force in 1987⁸ to provide a legal basis to challenge absolute prohibitions on abortion.

6. Employ international labour laws and fair treatment of providers of abortions services as an additional route to ensure access to abortion services.

CROSS BORDER ISSUES

7. Expand resources available to Canadian healthcare providers advising them of their legal risks, including:
 - (a) The risks that Canadian healthcare practitioners might face if they are served with an international civil lawsuit – particularly with respect to the potential harassment, intimidation and restriction of movement that could occur when travelling within the United States.
 - (b) Whether additional insurance coverage is available and/or necessary in order for healthcare practitioners to effectively protect themselves from these cross-border risks, and the rights of Canadian physicians to refuse care to American individuals seeking an abortion in Canada.
8. When interacting with the media, reproductive rights experts should shift the discourse away from the *legality* of abortion in Canada and towards more pressing issues of abortion access.

PURSUING LEGISLATION OR A CONSTITUTIONAL AMENDMENT

9. Acknowledge that additional legislation or a constitutional amendment to enshrine abortion into the *Charter of Rights and Freedoms* would hinder the protection and expansion of reproductive rights in Canada as this would unnecessarily politicize the issue.
10. As alternatives to legislation, focus on increasing access to abortion services; encouraging dialogue to reduce the taboos; improving education on reproductive health; and create stronger policies.
11. Increase dialogue between the federal health minister and Canadian medical bodies such as Ontario's College of Physicians and Surgeons on topics such as

⁸ Organization of American States (OAS), *Inter-American Convention to Prevent and Punish Torture*, 9 December 1985, OAS Treaty Series, No. 67, available at: <https://www.refworld.org/docid/3ae6b3620.html> [accessed 29 September 2023].

compliance with Canada's international commitments and international standards such as those included in the WHO Abortion Care Guideline.

12. Provide funding for education on reproductive health. Educational resources can include an online portal that provides accurate and judgement-free health information, a resource for debunking myths on abortion, and having more classes about gender equality in schools.
13. Create a federal policy on reproductive rights to comply with WHO's Abortion Guideline. This policy would set forth commitments and funding to enhance meaningful reproductive lives for people in Canada. The policy could help to increase equal access to abortion services, reduce taboos and the spread of misinformation, improve the quality and quantity of reproductive health education, as well as larger comprehensive reform to reproductive health outside of just abortion services.

II. ACCESS TO & USE OF ABORTION SERVICES

This section outlines the legislative and judicial context of abortion services in Canada. It then explores the access and use implications of the current Canadian regime to abortion service provision and regulation. The barriers faced by vulnerable and marginalized communities are also discussed. Lastly, this section comments on how Canada's abortion practices align with the policy recommendations provided in the WHO Abortion Care Guideline.⁹

1. CONTEXT

In 1988, the Supreme Court of Canada (the “SCC”) struck down s. 251 of the *Criminal Code* in the *R v Morgentaler* decision which limited a pregnant person's access to abortion by threatening criminal sanctions.¹⁰ The Court found that s. 251 was unconstitutional due to its violation of the right to security of person.¹¹ In her concurring decision, Justice Wilson noted that the right to liberty was also violated. A criminal law on abortion, she wrote, takes from a woman a fundamental personal decision of an intimate and private nature; it deprives a woman of her right to develop her full potential, to plan her own life and to make her own choices.¹² The *Morgentaler* decision had profound implications for the regulation of abortion as it transformed the issue from one of criminal law to a healthcare issue. As a result, *Morgentaler* effectively transferred abortion from federal jurisdiction to provincial jurisdiction.

Litigation following *Morgentaler* further shaped the state of reproductive rights in Canada. In the 1989 *Tremblay v Daigle* decision, the SCC held that a fetus has no legal status in Canada. Contrary to the holdings of the Quebec Court of Appeal, a fetus is not a “human being” under the Quebec Charter of Human Rights and Freedoms and cannot enjoy a “right to life” under section 1.¹³ In 1991, the SCC released *R v Sullivan*, in which it held that a partially born fetus is not a person within the meaning of s. 203 of the Criminal Code.¹⁴ Per Chief Justice Lamer, as he then was, “[i]t is clear from the wording of s. 206 that a fetus is not a ‘human being’ for the purposes of the Code.”¹⁵

Subsequent holdings of the SCC echoed this early case law. The Court held in its 1997 decision of *Winnipeg Child and Family Services (Northwest Area) v G. (D.F.)* that “the

⁹ World Health Organization, *supra* note 5; See Joanna N. Erdman, “The WHO Abortion Care Guideline: Law and Policy—Past, Present and Future,” in *International Journal of Gynecology and Obstetrics*, 162.3 (Sept 2023): 1119–1124.

¹⁰ *R v Morgentaler*, [1988] 1 SCR 30 [*Morgentaler*].

¹¹ *Ibid* at para 250.

¹² *Ibid* at para 247.

¹³ *Tremblay v Daigle*, [1989] 2 SCR 530 [*Tremblay v Daigle*].

¹⁴ *R v Sullivan*, [1991] 1 SCR 489.

¹⁵ *Ibid* at para 18.

law of Canada does not recognize the unborn child as a legal or juridical person.”¹⁶ Similarly, Courts “do not have *parens patriae* or wardship jurisdiction over unborn children.”¹⁷ Therefore, there was no legal person in whose interests the agency or court could act. Further, in 1999, the SCC released the *Dobson v Dobson* decision which investigated whether a mother should be liable in tort for damages to her child arising from a prenatal negligent act which injured her fetus.¹⁸ The Court found that a mother does not owe a duty of care towards her unborn child because public policy concerns “militate against the imposition of maternal tort liability for prenatal negligence.”¹⁹ The duty of a woman to her fetus should remain a moral obligation.

More recently, the Ontario Court of Appeal preserved policies mandating effective referrals where abortion services are denied for religious objections in the decision of *Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario*.²⁰ The Court held that when physicians have religious objections to providing services such as abortions and contraceptive care, policies that require that they make effective referrals, or “a referral made in good faith, to a non-objecting, available, and accessible physician, other health-care professional, or agency,” are justifiable infringements to freedom of religion under s. 1 of the *Charter*.²¹

2. ISSUES

(a) Inconsistency in Access Across Provinces

The decriminalization of abortion and subsequent transfer of jurisdiction has resulted in inconsistent provincial regulations and laws that govern abortions and reproductive healthcare. While the delivery of healthcare services falls largely under provincial and territorial jurisdiction, the federal government sets national standards through the *Canada Health Act* (“CHA”), which provinces and territories must comply with in order to receive federal funding.²²

Provinces inconsistently apply the CHA standards, which can be problematic for accessing abortion services. For example, New Brunswick enacted regulations which denied funding for abortions performed outside of hospitals (*Regulation 84-20* of

¹⁶ *Winnipeg Child and Family Services (Northwest Area) v DFG*, [1997] 3 SCR 925 at para 11.

¹⁷ *Ibid* at para 51.

¹⁸ *Dobson (Litigation Guardian of) v Dobson*, [1999] 2 SCR 753.

¹⁹ *Ibid* at para 21.

²⁰ *Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario*, 2019 ONCA 393.

²¹ *Ibid* at para 2.

²² *Canada Health Act*, RSC 1985, c C-6; *Constitution Act, 1982*, s 92. See Vanessa Gruben, *Regulating Reproduction in Canadian Health Law and Policy*, Joanna Erdman, Vanessa Gruben and Erin Nelson eds (5ed LexisNexis, 2017) 399-428, 409-410.

the *Medical Services Payment Act*).²³ This is in direct contradiction of the *CHA* and the WHO Abortion Care Guideline's second policy recommendation, which recommends against laws and other regulations that restrict abortion by prescribed grounds (i.e., specific circumstances such as fetal impairment).²⁴ This significantly limits access to abortion, especially given that only three hospitals in New Brunswick provide abortion services, and all three are located in two urban centers.²⁵ While there is currently a lawsuit challenging these regulations, these restrictions have been in place and restricting access for nearly 30 years.²⁶

In some Canadian provinces, regulations also deviate from the WHO's Abortion Care Guideline that abortions be available on the request of the pregnant person without the need for third-party authorization.²⁷ For example, for two decades, New Brunswick had the "two-doctor rule" whereby a pregnant person required permission from two doctors to receive an abortion in a hospital.²⁸ This posed a significant barrier to access, giving rise to difficulties in finding two doctors who will approve of the procedure, and increasing the wait time before an abortion can be performed. Furthermore, currently in Ontario, only four of the eight private abortion clinics receive funding under the provincial *Independent Health Facilities Act*. Clinics not under this Act have had to recover costs from patients directly. This has led to patients being charged fees for uninsured services related to insured surgical abortion services.²⁹

(b) Marginalized Groups

While the current abortion healthcare system can result in restrictions for all patients searching for care, young, rural-living, and marginalized (e.g., racialized, uneducated, impoverished) patients are the most significantly impacted by barriers to accessing safe and effective abortion services.

As noted in the WHO Abortion Care Guideline, common barriers to access to quality abortion care include lack of access to accurate information, "the provision of biased information or counselling," third-party authorization requirements, restrictions on the types of facilities where abortion services and by whom can be lawfully provided, lack of

²³ General Regulation, NB Reg 84-20, <<https://canlii.ca/t/55xn2>>

²⁴ World Health Organization, *supra* note 5 at 26.

²⁵ *CCLA v PNB*, 2021 NBQB 119 at para 7.

²⁶ *Ibid.*

²⁷ World Health Organization, *supra* note 5 at 43.

²⁸ Jeanelle Sabourin & Margaret Burnett, "A Review of Therapeutic Abortions and Related Areas of Concern in Canada" (2012) 34:6 J Obstet Gynaecol Can 532 at 535 [Jeanelle Sabourin & Margaret Burnett].; CBC News, "New Brunswick abortion restriction lifted by Premier Brian Gallant" (26 November 2014) online: *CBC News* <<https://www.cbc.ca/news/canada/new-brunswick/new-brunswick-abortion-restriction-lifted-by-premier-brian-gallant-1.2850474>>.

²⁹ Health Canada, Government of Canada, "Canada Health Act Annual Report 2018-2019" (February 2020), online: <<https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/canada-health-act-annual-report-2018-2019/pub1-eng.pdf>>.

affordable services, and conscientious objections.³⁰ Many of these barriers continue to exist in Canada. For example, in many provinces abortion providers are only established in urban centres.³¹ As a result, individuals who live in rural areas or on First Nations reserves are required to travel greater distances or to another province altogether to access care.³² Researchers have identified that broader systems of structural oppression shape access to facility-based services and quality of care, and have acknowledged the importance of building inclusive health care systems.³³

While a popular position may be to increase funding and expand our existing institutions, it is also important to acknowledge the historic and contemporary mistreatment of marginalized groups in the context of reproductive health care.³⁴ There exists mistrust of these medical institutions by racialized, Indigenous, disabled and sexual and gender minority populations, that has spanned generations. Therefore, further investment in these institutions that have demonstrated themselves to be untrustworthy only serves to reinforce their control over access to this important health intervention.

(c) Geographic Disparities

The Expert Panel reiterated that location is one of the largest barriers to overcome in order to make abortion more accessible. Notably, geographic disparities impact different groups in distinct ways. The concentration of abortion-providing clinics near the Canadian-U.S. border, regulatory and policy differences between provinces, movement of abortion care out of hospitals in rural areas, and distribution of primary care providers all impact access to abortion services within Canada. In their study examining spatial disparity and travel to abortion clinics, Sethna and Doull reported that 18.1% of women travelled more than 100 km to access abortion.³⁵ Results showed that younger women travelled the furthest, and Indigenous women faced unique challenges in accessing abortion services. Location barriers put those without the financial and logistical means to travel at a disadvantage and further exacerbates issues of inequitable access within the healthcare system.

³⁰ World Health Organization, *supra* note 5 at 22.

³¹ Action Canada for Sexual Health and Rights, “Access at a Glance: Abortion Services in Canada” (August 2019), online: *Action Canada SHR* <www.actioncanadashr.org/about-us/media/2019-09-23-abortion-access-across-canada-remains-unequal-new-report-shows>.

³² *Ibid.*

³³ *Ibid.*

³⁴ See Karine Coen-Sanchez et al, “Reproductive justice in patient care: tackling systemic racism and health inequities in sexual and reproductive health and rights in Canada” (2022) 19:44 *Reproductive Health*.

³⁵ Christabelle Sethna & Marion Doull, “Spatial Disparities and Travel to Freestanding Abortion Clinics in Canada” (2013) 38 *Women’s Studies Intl Forum* 52.

(d) Restrictions by Gestational Age Limits

Some provincial abortion provisions conflict with the WHO's third policy recommendation, which recommends against laws that restrict abortion by gestational age limits.³⁶ The Expert Panel identified that 1% of abortion seekers require abortion care at or after 20 weeks, further increasing the challenges in accessing appropriate medical care. The Expert Panel also noted those seeking abortion services after 24 weeks are often those who are facing other barriers such as untreated mental illness, homelessness, and domestic violence.

Therefore, the lack of abortion services in Canada after 24 weeks further marginalizes and endangers vulnerable populations. For instance, in PEI, abortion is only available up to 14 weeks gestation; in Yukon, the Opal Clinic at the Whitehorse General Hospital provides surgical abortions up to 15 weeks plus three days; and in Nova Scotia a procedural abortion is available up to 15 weeks and six days gestation.³⁷ Moreover, few providers in Canada offer abortion services beyond 24 weeks gestation.³⁸ A lack of later gestational age abortion care in Canada has required hundreds of Canadians to travel to the United States in order to access timely care, a barrier which is anticipated to become increasingly problematic following the *Dobbs* decision.

(e) Financial Costs

In addition to the costs and logistical challenges of travelling to access health care, abortion itself is often a costly procedure. Until 2015, abortion was one of only 16 medical interventions exempt from the "portability" requirement under the *CHA*, which compels provinces and territories to provide insured hospital and physician coverage to residents during their temporary absences (due to vacation or business) from their resident province or territory.³⁹ However, despite this change, financial challenges

³⁶ World Health Organization, *supra* note 5 at 28.

³⁷ "Abortion Services" (June 22, 2023), online: *Prince Edward Island Canada* <<https://www.princeedwardisland.ca/en/information/health-pe/abortion-services>>; Yukon, Legislative Assembly, "Motion No. 448" by McPhee (Minister of Health and Social Services), Sessional Paper, 35-1, No 89, p. 2526 (November 2, 2022) <https://yukonassembly.ca/sites/default/files/2023-01/Hansard_Fall_%202022_Volume_7.pdf>; "Surgical Abortion (Procedural Abortion)" (June 6, 2022), online: *Nova Scotia*, <https://811.novascotia.ca/health_topics/surgical-abortion/#:~:text=A%20procedural%20abortion%20may%20be,type%20and%20pregnancy%20hormone%20level>.

³⁸ The Panel noted that Quebec has three clinics that practice abortion care after 24 weeks; "Access at a Glance: Abortion Services in Canada" (September 19, 2019), online: *Action Canada for Sexual Health & Rights* <<https://www.actioncanadashr.org/resources/factsheets-guidelines/2019-09-19-access-glance-abortion-services-canada>>; "How to Access Abortion After 24 Weeks", *Niagara Reproductive Justice* <<https://niagarareproductivejustice.com/2023/03/24/how-to-access-abortion-after-24-weeks/>>.

³⁹ Clare Joanna Shrybman, "Health Insurance, a False Dichotomy and a Negative Right to Abortion in Canada's Maritime Provinces" (2021). *LLM Theses*, 51, online: <<https://digitalcommons.osgoode.yorku.ca/cgi/viewcontent.cgi?article=1051&context=llm>>; Abortion Rights Coalition of Canada, "Position Paper #4" (February 2017), online: *Abortion Rights Coalition of Canada* <<https://www.arcc-cdac.ca/media/position-papers/04-Reciprocal-Billing.pdf>>.

associated with seeking an abortion persist. For example, the Government of Quebec only reimburses its residents for out-of-province services up to the rate of costs in Quebec. This contravenes the *CHA* and the “portability” requirement.⁴⁰

Furthermore, abortion services can also be costly for those who do not have provincial insurance, including people with precarious immigration status and temporary foreign workers. Thus, despite its decriminalization, accessing abortion remains logistically challenging and financially onerous on patients, particularly those who are already the most marginalized and face systemic barriers when attempting to access health care.

(f) Meaning of “Decriminalized”

The Expert Panel summarized that although abortion is formally decriminalized, there are regulations and regulatory offences that impede access to abortion care. Notably, there is no clear concept of what “abortion decriminalization” means. The WHO Abortion Care Guideline provides a good starting point for a definition of decriminalization in relation to abortion: “Removing abortion from all penal/criminal laws, not applying other criminal offences (e.g. murder, manslaughter) to abortion, and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors.”⁴¹ An example of the precarious state of decriminalization is the fact that mifegymiso is a Schedule I drug, and under the *Food and Drugs Act* cannot be lawfully sold to someone in Canada who does not have a prescription.⁴² Furthermore, it is “generally an offence under the *Food and Drugs Act* to import prescription drugs for personal use.”⁴³ These regulations further impede access to abortion pills and to self-managed abortions in Canada.

(g) Administrative Barriers Related to Self-Managed Abortions

The full potential of self-managed abortions has yet to be realized in Canada with medication abortions. The mifepristone abortion pill is often taken in combination with misoprostol for self-managed abortions, however, when access to mifepristone is restricted, the WHO recommends taking misoprostol alone.⁴⁴ The WHO first endorsed

⁴⁰ Health Canada, Government of Canada, “Canada Health Act Annual Report 2020-2021” (February 2022), online: <<https://www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2020-2021.html>>.

⁴¹ World Health Organization, *supra* note 5 at xiii.

⁴² Joanna Erdman, “Put abortion pills into people’s hands” (11 May 2022) online: *Policy Options* <<https://policyoptions.irpp.org/magazines/may-2022/abortion-pills-canada/>>.

⁴³ Julianne Stevenson & Jennifer Taylor, “A Choice of Options” (18 October 2021) online: *The Canadian Bar Association* <<https://www.cba.org/Sections/Women-Lawyers/Articles/2021/A-choice-of-options>>.

⁴⁴ *Ibid.*

abortion pills taken under physician supervision in 2002.⁴⁵ In 2022 the WHO now recommends abortion pills be taken through telemedicine or telehealth, if available.⁴⁶

Prior to the availability of medication abortions, most abortions in Canada were performed surgically, and were provided at around 100 facilities by less than 300 doctors.⁴⁷ Medication abortions present several advantages such as requiring less technical skill by providers, which allows the service to be delivered by a larger range of health care facilities. It is also more private, because it happens at home, which many women prefer.⁴⁸

In a 2020 study, researchers identified challenges that continue to impact access to mifepristone. For example, many initial changes to the federal restrictions related to the drug created confusion about how and when it could be prescribed, and there were challenges with diffusion and dissemination of important policy information.⁴⁹ Further, the 2020 study identified many local barriers in the primary care setting, including “provincial variation in patient subsidies and physician billing codes, provincial restrictions from the Quebec College of Physicians, and lack of motivation to provide mifepristone among some family physicians who assumed that abortion was already accessible in their communities.”⁵⁰

3. EXPERT RECOMMENDATIONS

(a) Self-Managed Abortions

The Expert Panel discussed possible remedies for geographic disparities. Specifically, the Expert Panel emphasized the importance of expanding information about self-managed abortions through medications and investing in support for such medications. Abortion through use of pills has significantly changed the landscape of abortion rights.

⁴⁵ Miriam Berger & Mikhail Klimentov, “Abortion pill at heart of Supreme Court ruling is approved in over 90 countries” (published April 19, 2023, updated May 17, 2023), online: *Washington Post* <<https://www.washingtonpost.com/world/2023/04/19/abortion-pill-mifepristone-global-approved/>>. See also Gynuity Health Projects, “Mifepristone Approved” (updated May 2023) online: <https://gynuity.org/assets/resources/map_mife_en.pdf> for an authoritative source of mifepristone approvals that is updated on an ongoing basis.

⁴⁶ *Ibid.*

⁴⁷ Sarah Munro et al. “Perspectives Among Canadian Physicians on Factors Influencing Implementation of Mifepristone Medical Abortion: A National Qualitative Study” (2020) 18:5 *Ann Fam Med* at 414 [Perspectives Among Canadian Physicians].

⁴⁸ Joanna N Erdman, Amy Grenon, and Leigh Harrison-Wilson. “Medication Abortion in Canada: A Right-to-Health Perspective.” (2008) 98:10, *American Journal of Public Health*, 1764 at 1766.

⁴⁹ Perspectives Among Canadian Physicians, *supra* note 47.

⁵⁰ *Ibid* at 417.

The medical abortion drug, mifepristone, has been legal in Canada since July 2015.⁵¹ A combination of mifepristone and misoprostol, under the name mifegymiso was approved in Canada in January 2017.⁵² According to Action Canada for Sexual Health & Rights, “mifegymiso is considered the ‘gold standard’ for medical abortion.”⁵³

A medication abortion can be used safely and effectively outside of formal health systems, self-managed with one or both drugs. In addition to being a safe and effective mechanism to terminate an early pregnancy, La Roche and Foster, in their study of Canadian abortion patients’ experiences with mifepristone and misoprostol, found that abortion with pills is preferred by many seeking abortion care.⁵⁴ Currently, patients can access abortion care in their community with a prescription, overcoming many of the above-noted barriers to accessing evidence-based, patient-centred care. This model still requires access to a physician who is willing and able to provide the prescription and to an equipped pharmacy. Given the mistrust of traditional medical institutions in some communities, such an application of resources to increasing access could be directed to organizations that have more of a trusted relationship with affected communities. Consultations with communities could inform such an approach.

(b) Establishing Hubs for Reproductive Healthcare Providers and Specialists

The Expert Panel recommended establishing concentrated professional hubs for reproductive healthcare providers and specialists to facilitate continued learning and specialization in the reproductive health care area. The Expert Panel noted that an unintended consequence of moving abortions out of hospitals was that medical students will not be sufficiently trained in the area of abortion services. As a result, physicians may lack confidence in providing abortion care, especially at a late gestational stage.

(c) Demedicalization

The Expert Panel supports the further demedicalization of abortions in order to facilitate self-managed care, which includes increasing the availability of abortion pills that do not require the use of tests or an ultrasound, as recommended by WHO.⁵⁵ In the context of abortion services, demedicalization “does not reject the framing of abortion as healthcare, but instead treats it as a form of healthcare that can be self-administered

⁵¹ “FAQ: The Abortion Pill Mifegymiso,” online: *Action Canada for Sexual Health & Rights* <<https://www.actioncanadashr.org/resources/factsheets-guidelines/2019-04-06-faq-abortion-pill-mifegymiso>>.

⁵² *Ibid.*

⁵³ *Ibid.*

⁵⁴ Kathryn LaRoche & Angel M. Foster, “It gives you autonomy over your own choices: A qualitative study of Canadian abortion patients’ experiences with mifepristone and misoprostol” (2020) *Contraception* 102:1 61.

⁵⁵ World Health Organization, *supra* note 5 at 67–68. Note that medical support for those who still need or want it is always recommended, see World Health Organization, *supra* note 5 at 98: “Women may self-manage parts or all of the abortion process for a variety of reasons related to individual circumstances and preferences.”

and that need not be always be mediated by a medical professional.”⁵⁶ It should be noted that for many vulnerable communities, such as Indigenous groups, members may be hesitant to seek out care within the healthcare system given the racism, culturally inappropriate care, and colonial legacies that permeate the system. Self-managed care would allow these groups to access the abortion services they need in a comfortable context (i.e., their own communities).

Since 2022, no province requires an ultrasound to obtain the abortion pill to induce a medical abortion.⁵⁷ This is consistent with the WHO Abortion Care Guideline.⁵⁸ However, steps can be taken to enhance self-managed care and further demedicalization. This includes providing prescriptions rather than referring to abortion clinics; altering provincial billing codes to incentivize this intervention; expanding prescribing rights to include nurse practitioners, midwives, and pharmacists; and preserving coverage by provincial health insurance programs. The possibility of online platforms for accessing medicated abortions should be further researched. For BIPOC communities, consultations could inform a strategy to include health professions that align with culturally-based healthcare preferences.

The Expert Panel’s recommendation aligns with the WHO Abortion Care Guideline that advocates for a policy framework to support a plurality of service-delivery approaches in abortion care, including self-management to further improve access to abortion services, particularly for those who would require travel to access care.⁵⁹ It should be noted that the WHO has found that generally, when people are informed, resourced, and supported, they can safely manage their own abortion in the first 12 weeks of gestation.⁶⁰ Making abortion pills affordable and readily available will significantly expand access to safe abortion care, especially for those who have been marginalized by the healthcare system. However, a potential drawback to this approach noted by the Expert Panel, is the decrease in funding for abortion clinics that will likely accompany it. This is problematic for individuals who need abortions without use of the pill and would therefore have to obtain the procedure at a clinic.

(d) Reframing Abortion

The Expert Panel noted the significance of framing abortions as essential “care” as consistent with WHO’s Abortion Care Guideline, rather than a service, and the impact this may have on law and policy. There is a need to design inclusive healthcare systems

⁵⁶ B. Jessie Hill, “De-Medicalizing Abortion” (2022) 22:8 American Journal of Bioethics 57 at 57.

⁵⁷ Selena Ross & Lillian Roy, “Ultrasounds no longer required in Quebec before getting abortion pill” (5 July 2022) online: CTV News

<<https://montreal.ctvnews.ca/ultrasounds-no-longer-required-in-quebec-before-getting-abortion-pill-1.5973986>>.

⁵⁸ *Ibid* at 47.

⁵⁹ *Ibid* at 12–15.

⁶⁰ *Ibid* at 2.

and establish abortions as integral to healthcare, rather than simply focusing on improving access.

III. INTERNATIONAL AND COMPARATIVE CONSTITUTIONAL NORMS REGARDING ACCESS AND USE

1. CONTEXT

There are a range of international norms that shape Canadian health policy and access to abortion services. These norms include international treaties to which Canada is a party such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) which came into force in 1981.⁶¹ In addition, Canada's *United Nations Declaration on the Rights of Indigenous Peoples Act* which came into force in 2021, affirmed the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) as an "international human rights instrument that can help interpret and apply Canadian law."⁶² Canada is also bound to consider policy documents such as the WHO Abortion Care Guideline by virtue of its membership in the WHO. This further informs the country's health policy and abortion services.

Abortion in Canada is legal at all stages of pregnancy and is publicly funded as a medical procedure, although it is subject to regulations and restrictions set out in every province and territory by the governing medical bodies.⁶³ Canada has no criminal restrictions on abortion; however, access to services and resources varies greatly by region.⁶⁴

CEDAW Convention

Article 12 of *The UN Convention on the Elimination of All Forms of Discrimination Against Women: A Commentary* states that:

Make affordable contraceptives accessible and available to all women and girls, in particular those living in poverty and/or in remote areas.⁶⁵ State parties shall take

⁶¹ CEDAW, *supra* note 7.

⁶² Canada, Government of Canada, "Backgrounder; United Nations Declaration on the Rights of Indigenous Peoples Act" (last modified 10 December 2021), online: <www.justice.gc.ca/eng/declaration/about-apropos.html#:~:text=On%20June%2021%2C%202021%2C%20the,Canada's%20relationship%20with%20Indigenous%20peoples>.

⁶³ J. Cherie Strachan et al., *Why don't women rule the world? Understanding Women's Civic and Political Choices* (USA: SAGE Publications) at 115.

⁶⁴ Action Canada for Sexual and Reproductive Rights, "Access at a Glance: Abortion Services in Canada" (19 September 2019), online:

<www.actioncanadashr.org/resources/factsheets-guidelines/2019-09-19-access-glance-abortion-services-canada>.

⁶⁵ UN Committee on the Elimination of Discrimination against Women, Concluding observations on the combined eighth and ninth periodic reports of Canada, 25 November 2016, <<https://digitallibrary.un.org/record/3802136?ln=en#record-files-collapse-header>> [CEDAW Canada].

all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to healthcare services, including those related to family planning.⁶⁶

CEDAW's two main concerns regarding punitive abortion laws are "the increased probability of higher maternal mortality and morbidity rates and denial of women's substantive equality, thereby contravening Article 12."⁶⁷ In addition Article 2(g) of CEDAW requires repeal of "all national penal provisions which constitute discrimination against women and continually asks states to remove penalties for women undergoing abortions."⁶⁸

Courts have used Article 12 to facilitate access to abortion. For instance, the CEDAW Committee found that to deny access to abortion services or post-abortion care was a violation of a person's right to health and was discrimination against women.⁶⁹ Additionally, the Constitutional Court of Colombia used Article 12 "to hold that the criminal prohibition of abortion in all circumstances is a disproportionate measure because it infringes the right to health of the pregnant woman."⁷⁰

Canada's abortion access has been reviewed at the international level by the Committee on the Elimination of Discrimination Against Women, established to monitor state compliance with CEDAW.⁷¹ The Committee's 2016 CEDAW Report recommended several improvements for Canada's abortion services, which is the last time the Committee addressed the issue of restricted abortion access in its reports on Canada.⁷²

While the Committee noted steps being taken to improve access to abortion services, it remained concerned about the economic and regional disparities impeding access. The Committee's 41st recommendation, was for Canada to:

- (a) Ensure access to legal abortion services in all provinces and territories;

⁶⁶ Undurruga, V. and R. Cook, "Article 12 [Health]" in P. Schulz et al eds., *The UN Convention on the Elimination of All Forms of Discrimination against Women: A Commentary* (Oxford University Press, 2 ed. 459-486, 2022) [CEDAW Commentary].

⁶⁷ *Ibid.*

⁶⁸ *Ibid.*; for the English translation of the decision, see

<https://www.law.utoronto.ca/sites/default/files/documents/reprohealth/colombia_2022_com_english_27pp.pdf>

⁶⁹ *L.C. v Peru*, CEDAW Committee, Commc'n No. 22/2009, U.N. Doc. CEDAW/C/50/D/22/2009 (2011) at para 8.15 and 8.17.

⁷⁰ CEDAW Commentary, *supra* note 65, see Cook, R.J. and B.M. Dickens, "Abortion," in Jan M. Smits, Jaakko Husa, Catherine Valcke, Madalena Barreto Torres de Mendonca Narciso eds., *Elgar Encyclopedia of Comparative Law*, 3 ed. 2023 <<https://www.elgaronline.com/display/book/9781839105609/b-9781839105609.abortion.xml>>; see I. C. Jaramillo Sierra, "The new Colombian law on abortion," *International journal of gynecology and obstetrics*, vol. 160, no. 1, pp. 345-350, 2023, doi: 10.1002/ijgo.14551.

⁷¹ CEDAW Canada, *supra* note 65.

⁷² Sarah Munro et al. "Perspectives Among Canadian Physicians on Factors Influencing Implementation of Mifepristone Medical Abortion: A National Qualitative Study" (2020) 18:5 *Ann Fam Med* at 413-414.

- (b) Ensure that invocation of conscientious objection by physicians does not impede women's access to legal abortion services;
- (c) Make affordable contraceptives accessible and available to all women and girls, in particular those living in poverty and/or in remote areas.⁷³

Canada's abortion regulations are similar to those in countries with strong protections, such as Sweden, Iceland, the Netherlands, and the United Kingdom.⁷⁴ Notably, Canada's abortion regime is arguably more permissive than these jurisdictions as these countries have varying gestational limitations which are not present in Canada. However, there are many examples of Canada failing to meet its international obligations because of equal access issues, as were discussed by the Expert Panel and covered in Part III of this report.

2. ISSUES

(a) Federalism

Canada's division of powers has a direct impact on Canada's ability to implement many international norms. It is generally the federal government that becomes a party to international conventions, yet it is up to the provinces to develop and implement the policies to reflect the conventions. The variability of abortion services in different provinces is one example.

Following the 1988 *Morgentaler* decision, criminal laws prohibiting abortion were deemed unconstitutional.⁷⁵ The decriminalization of abortion led to the procedure being reclassified as a healthcare issue, which shifted its jurisdiction from the federal government to the provinces.⁷⁶ After 1988, provinces and territories began to legislate

⁷³ CEDAW Canada, *supra* note 65..

⁷⁴ See Swedish Association for Sexuality Education, "About abortion" (2020) at 5, online: (pdf) <https://www.rfsu.se/contentassets/48adfec3a7254bd590c07c79766000a8/en_om_abort.pdf>; Swedish Association for Sexuality Education, "Sweden" (2011) at 1, online: (pdf) <http://www.abortion-clinics.eu/wp-content/uploads/2011/02/Pub_AbortionlegislationinEuropeIPPFEN_Feb2009-76-77.pdf>; *Termination of Pregnancy Act, 2019*, No. 43/2019, article 4 (Neth.), Government of the Netherlands, "Late term abortion", (2022) online: <<https://www.government.nl/topics/euthanasia/euthanasia-and-newborn-infants>>; IPPF European Network, "Abortion Legislation in Europe", (2009) at 60, online: (pdf) <https://www.spdc.pt/files/publicacoes/Pub_AbortionlegislationinEuropeIPPFEN_Feb2009.pdf>; Government of the Netherlands, "I am thinking about getting an abortion, what should I do?" (2022) online: <<https://www.government.nl/topics/abortion/question-and-answer/i-am-thinking-about-getting-an-abortion-what-should-i-do>>; MSI Reproductive Choices United Kingdom, "Abortion and your rights" (2020), online <<https://www.msichoice.org.uk/abortion-services/abortion-and-your-rights/>>; Denis Campbell, "MPs vote to continue abortion pills by post scheme in England" (30 March 2022) online: *The Guardian* <<https://www.theguardian.com/world/2022/mar/30/mps-vote-to-continue-abortion-pills-by-post-scheme-in-england>>.

⁷⁵ *Morgentaler*, *supra* note 10.

⁷⁶ Rachel Johnstone & Emmett McFarlane, "Public Policy, Rights, and Abortion Access in Canada." (2015) 51, *International Journal of Canadian Studies*, 97 at 103.

autonomously. Many provinces, except for Ontario and Quebec, implemented regulations that reduce abortion access, limiting the locations where the procedure can be conducted and narrowing the conditions in which public funding is available.⁷⁷ As a result, Canadians' access to abortion services greatly differs based on the province they live in.

Johnstone and McFarlane observed in 2015 the following regarding provincial differences:

“...[p]rovincial policies vary widely, with Quebec effectively affirming that abortion is a positive right, while others, notably PEI and New Brunswick, impose significant limits. PEI and New Brunswick have been commonly cited as the most stringent provinces in terms of access. PEI is the only province in Canada where abortions are not available [...]. While this policy does not prohibit the procedure, there are currently no providers, so women must leave the island to access services. Coverage for out of province abortions in hospitals is available with approval, but travel costs are not covered.”⁷⁸

Furthermore, inconsistent access has been observed in the Territories, Nova Scotia, and Saskatchewan, as abortions are only available in hospitals, most of which are in urban centers.⁷⁹ Thus, abortion issues have been fragmented since the provinces have utilized their jurisdiction.

(b) UN Declaration on the Rights of Indigenous Peoples

There is also a large disparity in the services offered to persons in urban and rural communities, and particularly to Indigenous women. This is in contravention to Canada's commitments under UNDRIP.

Section 21 of UNDRIP provides:

“Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, **health** and social security [emphasis added].”⁸⁰

⁷⁷ *Ibid.*

⁷⁸ *Ibid* at 103. PEI now offers surgical abortion to those up to 14 weeks pregnant, Government of Prince Edward Island, “Surgical Abortion” (25 January 2023) online:

<www.princeedwardisland.ca/en/information/health-pe/surgical-abortion>

⁷⁹ Christabelle Sethna & Marion Doull, “Spatial disparities and travel to freestanding abortion clinics in Canada” (2013) 38, *Women's studies international forum*, 52 at 53.

⁸⁰ *UN Declaration on the Rights of Indigenous People*, 13 September 2007, UN A/RES/61/295.

The word “improvement” suggests a positive duty on states to ensure healthcare access to indigenous persons.

Sethna and Doull in a 2013 study observed that the “further a woman has to travel to access abortion, the less likely she is to obtain one and the more likely she is to be young and underprivileged.”⁸¹ These disparities undermine a person’s ability to access the healthcare they are entitled to under UNDRIP. The same study revealed that “the women who self-identified as First Nations and Métis were almost three times as likely to report travelling more than 100 km to access abortion services, suggesting that they do not reside in urban centers. In addition to the complications of distance, Aboriginal women must endure a formal approval of funds system for off-reserve travel or else must pay for their own travel expenses.”⁸²

(c) Immigration Discrimination

Canada’s international migrant population is particularly vulnerable to challenges related to access to healthcare. In the UN’s Human Rights Committee (HRC) case of *Toussaint v. Canada*, Canada refused an application for public health coverage to an individual with several severe illnesses on the grounds that undocumented immigrants were ineligible.⁸³ The HRC held that “to protect the rights to life and non-discrimination, governments are responsible for ensuring migrants access to healthcare that is reasonably available and accessible to their non-migrant counterparts when absence of such care poses some foreseeable risk to life” and that Canada had failed on this account.⁸⁴ Canada has refused to provide such recommended coverage.

The decision highlights a responsibility that is particularly important in Canada, a country with a large population of immigrants, to remove systemic barriers to access to healthcare. Abortion is a medically necessary service that, if unavailable, can pose foreseeable risks to life. Canada has a positive duty, under its international obligations, to ensure that immigrants do not suffer undue hardships when seeking to obtain abortions.

⁸¹ *Ibid* at 53. This study also found: “[i]n Toronto, Montreal and Vancouver, where women can access abortion services at several freestanding clinics as well as hospitals, the proportion of women travelling more than 100 km to clinics ranged from 0% to 12%, reflecting their proximity to abortion services. In contrast, seventy-three percent of women travelling to the clinic in New Brunswick travelled more than 100 km to access services and approximately a third of women (29–36%) travelling to clinics in Alberta, Manitoba and Vancouver Island travelled more than 100 km to access services” at 55.

⁸² *Ibid* at 57.

⁸³ UNHRC, Communication No 2348/2014, *Toussaint v Canada*, UN Doc CCPR/C/123/D/2348/2014.

⁸⁴ Y. Y. Brandon Chen. “International Migrants’ Right to Sexual and Reproductive Health Care.” (2022) 157:1, *International Journal of Gynecology and Obstetrics*, 210 at 213
<<https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1002/ijgo.14149>>.

3. EXPERT RECOMMENDATIONS

(a) Articles 1 and 6 of the Inter-American Convention to Prevent and Punish Torture

International norms offer advocates many novel arguments for the protection of abortion rights. One expert discussed a rights-based argument that was raised in the *Beatriz* application before the Inter-American Commission on Human Rights (IACHR).⁸⁵ The case concerns a young Salvadorian woman living in poverty who was unable to terminate her pregnancy even if it was deemed dangerous for her health and her life and the fetus had no chance of survival outside the womb, given an absolute ban on abortion in El Salvador. Among other offences, the IACHR argues that El Salvador is in violation of Articles 1 and 6 of the Inter-American Convention to Prevent and Punish Torture. The Commission recognizes that forcing a woman to complete an unviable pregnancy amounted to torture and cruel punishment.⁸⁶ The Inter-American Court of Human Rights is set to decide the case in the near future. If successful, this argument presents a strong legislative angle which enforces the physical and psychological necessity of adequate abortion access.

(b) European Charter on Social Rights and Labour Laws

An expert discussed how the European Charter on Social Rights (“the Social Charter”) has been used to make rights-based arguments on reproductive health issues in the European Union.

In 2013, a group of Italian doctors made a complaint to the European Committee on Social Rights (“the Committee”) under the Social Charter. The group argued that their labour laws were being violated because as non-objecting doctors to abortion they faced acts of discrimination and moral harassment in the workplace.⁸⁷ The Committee examined the multiple claims brought forward and issued several decisions under the various articles of the Social Charter. Ultimately, the Committee found that doctors that did not raise the conscientious objection to abortion did face such discrimination and

⁸⁵ *Organization of American States*, “IACHR Takes Case Involving El Salvador’s Absolute Ban on Abortion to the Inter-American Court of Human Rights”, online: <https://www.oas.org/en/IACHR/jsForm/?File=/en/iachr/media_center/PReleases/2022/011.asp>; for an English translation of the decision, see <https://www.law.utoronto.ca/sites/default/files/documents/reprohealth/iacmhr_2020_el_salvador_beatriz_en.pdf>.

⁸⁶ IACHR, *Report on Merits*, Report No. 9/20, Case 13.378, El Salvador, March 3, 2020.

⁸⁷ International Campaign for Women’s Right to Safe Abortion, “Italy – Eight Years Later, the Right to Health and Non-Discrimination in Abortion Services Still Not Secured” (14 April 2021), online: <<https://www.safeabortionwomensright.org/news/italy-eight-years-later-the-right-to-health-and-non-discrimination-in-abortion-services-still-not-secured/>>; Elena Carruso, *The Hyper-Regulation of Abortion Care in Italy*, *International Journal of Gynecology and Obstetrics*, forthcoming 2023. See Elena Caruso, “The hyper-regulation of abortion care in Italy” (2023) 163:3 *International Journal of Gynecology* 1036.

harassment, presumably by doctors who were anti-abortion believers.⁸⁸ For instance, the Committee found that Article 1(2) of the Social Charter was violated which says that “...the Parties undertake to protect effectively the right of the worker to earn his living in an occupation freely entered upon.”⁸⁹ The violation stemmed from the fact that non-objecting doctors did not have the same career and workload opportunities as objecting doctors.⁹⁰

This approach allowed the Committee to look at systemic errors in the Italian abortion care system that has not only led to issues when providing abortion care, but also labour impacts on the doctors that provide them. This decision emphasizes that access to abortion must be tackled systemically, and there are multiple avenues of doing so.

⁸⁸ *Ibid.*

⁸⁹ Council of Europe, Committee on Social Rights, 1961 ETS No 035, *European Social Charter (Revised)* at 3.

⁹⁰ Council of Europe, Committee on Social Rights, 2015 No 91/2013, *Confederazione Generale Italiana del Lavoro (CGIL) v Italy* at 56; Karin Lukas and Colm O Cinneide, Gender Equality within the Framework of the European Social Charter in *Frontiers of Gender Equality*, R.J. Cook ed UPenn Press 2023, 219-236.

IV. CROSS BORDER ISSUES

1. CONTEXT

In the United States, the cases of *Roe v. Wade*⁹¹ in 1973 and *Planned Parenthood v. Casey*⁹² in 1992 protected access to safe abortions as a constitutional right for all Americans. In the 2022 case of *Dobbs*,⁹³ the United States Supreme Court overturned abortion as a constitutional right, giving power back to individual states to criminalize abortion as they see fit. Many states had trigger bans that immediately came into effect with varying degrees of restriction.⁹⁴ An immediate concern following the decision centered on individuals who traveled to Canada from states with bans to have abortions performed. Canadian extradition is governed by the *Extradition Act*,⁹⁵ which stipulates double criminality as a requirement for extradition.⁹⁶ To satisfy the double criminality requirement, the alleged crime for which extradition is being sought must be punishable in both Canada and the requesting jurisdiction.⁹⁷

As there is no equivalent crime in Canada, there does not seem to be a risk of individuals facing extradition for accessing abortion in Canada. Canadian case law has affirmed this view.⁹⁸ In the 1909 case of *Re McCready*,⁹⁹ the Supreme Court of Saskatchewan (the “SCSK”) refused to extradite the accused to the United States for the offense of procuring an unlawful abortion, because there was not sufficient evidence to show that the operation was unlawful. The SCSK held that an operation necessary to preserve a woman’s life is not unlawful, despite abortion itself being unlawful.¹⁰⁰ Despite the apparent lack of extradition risk for women travelling to Canada for abortions or for doctors performing those abortions, other cross border issues relating to abortion rights remain critical.

⁹¹ *Roe v. Wade*, *supra* note 2.

⁹² 505 U.S. 833 (1992).

⁹³ *Dobbs*, *supra* note 1.

⁹⁴ See Centre for Reproductive Rights, “After Roe Fell: Abortion Laws by State” (accessed 19 August 2023), online: <www.reproductiverights.org/maps/abortion-laws-by-state/>.

⁹⁵ *Extradition Act*, SC 1999, c 18.

⁹⁶ *Ibid*, s. 3.

⁹⁷ *Ibid*.

⁹⁸ For example, see *M.M. v. United States of America*, 2015 SCC 62, and *Canada (Justice) v. Fischbacher*, 2009 SCC 46, where the Supreme Court has confirmed that no one can be extradited unless his or her conduct would constitute an offence that is punishable in Canada.

⁹⁹ *Re McCready*, [1909] SJ No 2, 14 CCC 481 (SK SKSC) at para 9.

¹⁰⁰ *Ibid* at para 8.

2. ISSUES

(a) The Chilling Effect of Threats of Civil or Criminal Actions

Though the Expert Panel agreed that it is very unlikely that an attempt to extradite an abortion care provider or individual seeking an abortion to the United States would be successful, they also agreed that this does not exclude the possibility of state governments filing criminal or civil charges against the provider or recipient of abortion. The chief issue, thus, is not the actual extradition of such persons, but the fear that such legal actions could instill in them, and the chilling effect that this could have.

The Canadian Medical Association Journal (“CMAJ”) stated that Canadian physicians might not have the assistance of the Canadian Medical Protective Association (“CMPA”) in foreign legal matters that could arise from the performance of abortions.¹⁰¹ The CMAJ emphasized that Canadian physicians performing elective abortions on American individuals might face criminal or civil charges in the United States.¹⁰² One of the Panel experts agreed that a main concern for their organization is to ensure that when travelling, their physicians do not cross states where they may face criminal or civil charges. In the Canadian context, if legal action were brought forward, it would most likely be an international civil suit.¹⁰³

The threat of possible legal repercussions might be enough to deter some physicians in Canada and the United States from performing elective abortions. Some of the Panel experts agreed that to encourage physicians to continue performing abortions in Canada and the United States, the respective medical associations should encourage extra liability protection for medical providers. One expert emphasized the importance of continued international medical support. An example of this is having Canadian physicians flown into a specific state for a couple of days to perform abortions. This would support the practitioners in the various states as there are many concerns about the health and safety of the physicians who would be performing abortions and live in state, regardless of the legality of the procedure.

¹⁰¹ Lauren Vogel and Diana Duong, Providing abortions to Americans could land Canadian doctors in legal trouble - without CMPA assistance. CMAJ, August 8, 2022 194 (30) E1072-E1073; DOI: <https://doi.org/10.1503/cmaj.1096010>.

¹⁰² *Ibid.*

¹⁰³ Olivia Bowden, “Canada studies legal risk to abortion providers who treat visiting Americans” (July 8, 2022), online: *The Toronto Star* <<https://www.thestar.com/news/canada/2022/07/08/canada-studies-legal-risk-to-abortion-providers-who-treat-visiting-americans.html>>.

(b) “Abortion Travel”

The Expert Panel also pointed out that considering the vulnerability of persons affected by the abortion bans, it is very unlikely that we will see individuals travelling from restricted states to Canada to obtain an abortion. Those who are most affected by abortion restrictions are individuals living on low incomes. As a result, it is unlikely that they would bypass states in which abortion remains legal and travel all the way to Canada. Therefore, any influx into Canada of individuals seeking abortions will likely come from states close to the border where abortion remains legal, and where such individuals cannot obtain an abortion due to the influx of individuals from restricted states into their states. In this way, the experts say it may be more helpful to reframe cross-border abortion issues as an issue of “abortion travel”. Some refer to this phenomenon as “medical tourism,” however this terminology has been criticized for a lack of sensitivity.

The Expert Panel agreed that looking at the new issues surrounding access to abortion in the United States through an “abortion travel” lens would be more helpful in understanding the issues that might accompany it. The low-income population will be most affected by the new restrictions in the United States. With this in mind, it is extremely unlikely that they will come to Canada as they cannot afford it.

(c) The Post-Dobbs Media Frenzy

The Expert Panel agreed that one of the most tangible effects of the *Dobbs* decision in Canada was the media frenzy surrounding abortion that ensued following its release, and the corresponding dissemination of misinformation. Many of the Expert Panel experts reported having been contacted by journalists seeking to write inflammatory articles, sensationalizing the issue of abortion and inciting fear amongst the Canadian population with respect to the strength of abortion rights in Canada.

The overturning of *Roe v Wade* bled into Canada in the form of a “media frenzy” intent on emphasizing the deficiencies of abortion law in Canada, preying on Canadians’ fear that their abortion access would also be taken away. Despite assurances from political leaders and reproductive rights experts, media outlets continued to print and discuss inflammatory material, stoking alarmist conversations about the legality of abortion all across the country.¹⁰⁴ The media sensationalized perceived weaknesses in Canadian abortion law, particularly the *Morgentaler* decisions, as clickbait.

¹⁰⁴ See for example: <<https://www.cbc.ca/news/canada-abortion-law-1.6503899>>, <<https://toronto.citynews.ca/2022/05/04/abortion-canada-rights/>>.

One of the Expert Panel experts expressed that in their early work with Canadian abortion seekers, it was evident they were experiencing a tremendous amount of anxiety regarding their continued access to abortion care, and some were surprised when they were told their access was not being affected by what was happening in the United States. The experts stated that it appeared that what was occurring in a number of states to the south of the Canadian border was drowning out the federal messaging that Canadian abortion services would continue uninterrupted.

The Expert Panel went on to address an element of this media attention that was possibly more alarming than the fear and anxiety it induced: by sensationalizing the legal element of abortion, it draws attention away from the very real barriers to abortion access that exist in Canada and broader conversations of sexual and reproductive healthcare in the country.

3. EXPERT PANEL RECOMMENDATIONS

After the release of the *Dobbs* decision, the response of many Canadian healthcare professionals was to ask what they could do to help. While this is a natural and compassionate response to have in the wake of what one expert calls “a gross violation of human rights,” one of the Panel experts noted that a lot of the groundwork supporting abortion services can, and should, be done in and by the United States. While there may be an opportunity for Canadian physicians to support an increased need for abortion care by flying into non-restricted states to perform abortions, such programs are already being established and staffed by American abortion providers. As well, American organizations are already working on ways to legally ship abortion medication from non-restricted states into restricted states.

Therefore, the recommendations in this report focus not on specific medical actions that healthcare providers can take in response to cross-border issues but pertain more generally to education and the dissemination of information within Canada.

(a) Expanding Resources

Firstly, with respect to the chilling effect that American legal actions against Canadian abortion providers and individuals seeking abortions could have, the Expert Panel recommended that the resources available to Canadian healthcare providers, advising them of their legal risks, be expanded. Organizations like CMPA have already begun creating such resources.¹⁰⁵

¹⁰⁵ “Abortion Services for Non-Residents” (September 28, 2022), online: *The Canadian Medical Protective Association* <<https://www.cmpa-acpm.ca/en/advice-publications/key-issues/abortion-services-for-non-residents?referral=keyissues>>.

The Expert Panel proposed that these resources be expanded and adapted to address new questions that have been identified by the experts. Examples of some topics that would benefit from the clarity that an informational resource could provide include:

- Risks that Canadian healthcare practitioners might face if they are served with an international civil lawsuit – particularly with respect to the potential harassment, intimidation and restriction of movement that could occur when travelling within the United States. This resource would be most valuable if it was accompanied by steps that a healthcare practitioner should take if served with an international civil lawsuit.
- Other topics that would benefit from an informational resource could include whether additional insurance coverage is available and/or necessary in order for healthcare practitioners to effectively protect themselves from these cross-border risks, and the rights of Canadian physicians to refuse care to American individuals seeking an abortion in Canada.

It would likely be helpful to view abortion care through the lens of “abortion travel” (as suggested by the Panel experts), and lean on the medico-legal field’s knowledge in that area to inform the answers to these questions. It would also likely be helpful to support these resources with a phone number that Canadian healthcare providers could call if they had other questions concerning the legality of providing abortion services, and the information resource could be updated to include and reflect any frequently asked questions. The Expert Panel believes that providing these resources would help to alleviate the uncertainty that Canadian abortion providers are currently experiencing and allow them to provide care quickly without fear that they are incurring legal risk.

(b) Focus on Access in Canada Rather than Legality

Second, with respect to the post-*Dobbs* media frenzy and dissemination of misinformation, the Expert Panel recommended that reproductive rights experts, when interacting with media, shift the discourse away from the well-established *legality* of abortion in Canada as much as possible. The Expert Panel considered recommending the creation of a resource describing the history of abortion access in Canada and its current security, but these resources already exist – Canada does not need more of them and providing them could just fan the flames of an already sensationalized topic.

Instead, it would be useful to ensure that individuals who are receiving comment requests from journalists about the legality of abortion are aware of the damaging impact that such articles are having on Canadian conversations surrounding abortion. Such individuals should be encouraged to steer the conversation away from the non-issue of legality and towards more pressing issues of abortion access.

V. PURSUING LEGISLATION OR A CONSTITUTIONAL AMENDMENT

1. CONTEXT

The United States Supreme Court's decision to overturn *Roe v Wade* has caused many Canadians to be concerned about the protection of reproductive rights in Canada.¹⁰⁶ While some pro-choice advocates contend that enshrining a right to abortion in the *Charter of Rights and Freedoms* is necessary to protect abortion rights, most pro-choice groups believe that legislation would make abortion more restrictive.¹⁰⁷ The following analysis confirms that amending the Constitution is not productive in protecting and expanding reproductive rights in Canada.

Abortion is currently decriminalized in Canada.¹⁰⁸ The legal status of abortion is primarily protected under the common law by key SCC decisions including *R v. Morgentaler 1988*, *Tremblay*, and *Morgentaler 1993*. These cases are discussed in section II.¹⁰⁹ Abortion is mainly treated as a health care issue in Canada. The federal government enacted the *CHA* to ensure uniform health care across the country.¹¹⁰ The *CHA* was reformed in the 1990s to establish national criteria that provincial health care must satisfy to qualify for federal funding.¹¹¹ For example, the *CHA* stipulates that provinces must provide hospital services, which includes “medically necessary services.”¹¹² The status of abortion under the *CHA* remains controversial because it is debated whether abortion is included under “medically necessary services.”¹¹³ This was somewhat cleared up when federal health minister Diane Marleau wrote to all provinces saying that if they failed to cover private clinic fees for medically necessary services, including abortion, they would face a financial penalty.¹¹⁴ Abortion care has ultimately been absorbed into Medicare by all provincial governments, to be treated and funded like any health care service.¹¹⁵

¹⁰⁶ *Roe v. Wade*, *supra* note 2.

¹⁰⁷ Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

¹⁰⁸ Although abortion is decriminalized, the *Assisted Human Reproduction Act*, SC 2004, c 2, does, however, effectively criminalize certain reproductive-related procedures such as prenatal sex-selection, which is subject to criminal sanctions.

¹⁰⁹ *Morgentaler*, *supra* note 10; *Tremblay v Daigle*, *supra* note 13; *R v Morgentaler*, [1993] 3 SCR 463.

¹¹⁰ *Canada Health Act*, RSC 1985, c C-6 [*CHA*].

¹¹¹ Joanna N Erdman, “Constitutionalizing Abortion Rights in Canada” (2017) 49:1 *Ottawa L Rev* 221 at 250 [Erdman].

¹¹² *CHA*, *supra* note 110, ss 2, 11(1)(ii).

¹¹³ Erdman, *supra* note 111 at 251.

¹¹⁴ *Ibid*.

¹¹⁵ *Ibid* at 252-252.

2. ISSUES

The main question addressed in this section is whether the development of legislation or a constitutional amendment can help to protect reproductive rights.

(a) Arguments in Favour of Legislating Abortion

Some activists who call for legislation on abortion rights believe the lack of a framework governing abortion in Canada will allow politicians to restrict reproduction rights. They argue *Morgentaler's* decision to decriminalize abortion left a “legal vacuum” concerning reproductive laws.¹¹⁶ The lack of current legislation means Canadians depend on future governments to respect reproductive rights.¹¹⁷ Without any laws protecting the right to abortion, Canadians must grapple with the fact that reproductive rights were never given to them.¹¹⁸ Since abortion is not a right, governments are disinclined to provide facilities for or access to abortion.¹¹⁹

(b) Arguments Against Legislating Abortion

However, many more experts and advocacy organizations do not support this approach. They warn that enshrining abortion rights into law would invite anti-choice activists to restrict abortion rights. This side maintains that abortion is a medical procedure; the fact that it is not governed by legislation is what has prevented anti-choice activists from making headway.¹²⁰ Therefore, abortion should continue to be treated as a medical procedure. If the current government were to introduce legislation on abortion, they would risk compromising with anti-choice politicians and achieving a “middle ground.”¹²¹ Anti-choice activists can claim that limits should be imposed on the right to abortion should Parliament move to enshrine this right.¹²² Introducing legislation on abortion would further politicize the issue, and since laws do not support other medical procedures, abortion should not be treated differently.

In addition, future governments could repeal any legislation introduced on abortion rights or use any new legislation to introduce restrictions such as gestational limits, mandatory counselling and waiting periods.¹²³ Further, abortion rights could be viewed as already protected under the *Charter* despite no explicit mention of the procedure.¹²⁴

¹¹⁶ Sarah Leamon, “Reproductive rights stand on a shaky foundation in Canada”, *The Georgia Straight* (16 May 2022).

¹¹⁷ *Ibid.*

¹¹⁸ Ethan Barkley, “Canadians long overdue for a policy protecting abortion”, *The Martlet* (26 May 2022).

¹¹⁹ Jenny Lamothe, “Roe v. Wade leak highlights need to enshrine abortion rights in Canadian law”, *Sudbury.com* (6 May 2022).

¹²⁰ “Why we do NOT need to enshrine abortions rights into law,” *Abortion Rights Coalition of Canada* (June 2022).

¹²¹ *Ibid.*

¹²² “Feminist Organizations Support No New Abortion Law in Canada”, *Action Canada for Sexual Health & Rights*.

¹²³ *Ibid.*

¹²⁴ *Ibid.*

S.15 of the *Charter* could be interpreted as protecting abortion rights since only people who can get pregnant may require abortion services.¹²⁵

Another argument against abortion legislation is that it may also exacerbate stigma associated with the procedure if the legislation is restrictive and requires service providers who do not support abortion to administer these services. Researchers have examined the effect of abortion legislation on the stigma associated with the procedure. In Uruguay, abortion is decriminalized up to 12 weeks gestation; however, a study found that stigma on abortion still appears in service delivery.¹²⁶ The Uruguayan model of care includes a 5-day reflection period and counselling for those who intend to terminate a pregnancy. The researchers interviewed 20 abortion clients and healthcare professionals and found that stigma appears in service delivery when abortion clients interact with medical personnel who do not support abortion. Notably, legislative restrictions on abortion also question a pregnant person's motives and further perpetuate abortion stigma. Similar issues may arise should Canada introduce legislation on abortion rights.

The American Journal of Public Health published a research paper examining how abortion-related legislation can exacerbate, reinforce, and perpetuate stigma at an institutional level.¹²⁷ Abortion laws may be built on misconceptions that the procedure is dangerous and that those who seek abortions are irresponsible or selfish. Public policy activates stigma on abortion by associating it with a group of people and a behaviour, or promoting news coverage that increases negative attitudes toward it. Importantly, laws that single out abortion facilities and regulate them differently than other clinics contribute to the exceptionality of abortion and convey the idea that abortion is different from other medical procedures. Laws that make abortion services difficult to access imply that pregnant people must be prevented from making the wrong decision. Finally, introducing abortion legislation in Canada can lead to a debate on abortion that fuels misinformation and further spreads anti-abortion sentiment.

Lastly, even if legislation or a constitutional amendment has unanimous support and was found to unequivocally enhance abortion rights, there are several issues related to the actual obstacles associated with amending the Constitution and enshrining the right to abortion services. This would include jurisdictional challenges between federal and provincial governments related to healthcare. It would also include challenges to the amending formula of the Constitution: to amend s. 7 of the *Charter* or to add new provisions to the *Constitution*, the general amending formula outlined in ss. 38 of the

¹²⁵ *Ibid.*

¹²⁶ Roosbelinda Cardenas, "It's something that marks you: Abortion stigma after decriminalization in Uruguay" *Reprod Health* 15, 150 (2018).

¹²⁷ J. M. Turan and H. Budhwani, "Restrictive abortion laws exacerbate stigma, resulting in harm to patients and providers," *American journal of public health* (1971), vol. 111, no. 1, pp. 37–39, 2021, doi: 10.2105/AJPH.2020.305998.

Constitution Act, 1982 would need to be used. This 7/50 formula requires the assent of the federal parliament and at least seven of the provinces representing at least 50% of the total population of Canada. Since the comprehensive amendment and addition of the *Charter* by the *Constitution Act, 1982*, there have been only seven successful constitutional amendments on social issues.¹²⁸ Only one of these, the *Constitution Amendment Proclamation 1983*, successfully used the 7/50 formula.¹²⁹ Given the current polarizing state of abortion access in this country, it would be challenging to amend the Constitution and enshrine a right to abortion access under the 7/50 formula.

Thus, rather than focusing on introducing legislation to enshrine a right to abortion, these advocates believe that Canadians should instead address the issue of *access* to abortion in Canada. The government should focus on fighting abortion misinformation, increasing funding for reproductive health programs and services countrywide, and enforcing the *CHA* to ensure provinces and territories address abortion access issues. This was the viewpoint supported by the Expert Panel.

3. EXPERT PANEL RECOMMENDATIONS

(a) Legislation or a Constitutional Amendment Should Not be Pursued

The unanimous consensus of the Expert Panel is that legislation or a constitutional amendment should not be pursued. Such an approach would be antithetical to enhancing reproductive rights in Canada. Passing legislation to protect reproductive rights risks compromising with anti-choice activists to achieve a “middle ground.” Furthermore, legislation on abortion can also increase stigma by introducing restrictions such as mandatory reflection periods or counselling. It is best to continue treating abortion services as healthcare and refrain from treating it differently compared to other medical procedures.

The precedent set forth by *Morgentaler* was also discussed by the Panel. One expert thought that while *Morgentaler* was far from perfect (the Supreme Court has never held that there is a “right to abortion” per se), *Morgentaler* did lead to subsequent case law that suggests that the Court would maintain that a right to abortion exists if asked.¹³⁰ Further, *Morgentaler* is not likely to be overturned like *Roe v. Wade* because the SCC is

¹²⁸ See *Constitution Amendment Proclamation 1983* (Indigenous rights); *Constitution Amendment 1987* (Newfoundland education); *Constitution Amendment 1993* (New Brunswick language rights); *Constitution Amendment 1997* (Newfoundland education), *Constitution Amendment 1997* (Quebec education), *Constitution Amendment 1998* (Newfoundland education), and *Constitution Act 1999* (Nunavut senate representation).

¹²⁹ *Constitution Amendment Proclamation 1983* (Indigenous rights).

¹³⁰ See e.g., *Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario*, 2019 ONCA 393; *Dobson (Litigation Guardian of) v Dobson*, [1999] 2 SCR 753; *R v Sullivan*, [1991] 1 SCR 489; *Tremblay v Daigle*, [1989] 2 SCR 530; *Winnipeg Child and Family Services (Northwest Area) v DFG*, [1997] 3 SCR 925.

not as politicized in Canada, and that current rights protection under the *Charter* is enough.

(b) Alternatives to Improving Reproductive Justice

The Expert Panel expressed understanding over the “instinct” of pursuing legislation or a constitutional amendment to enhance reproductive rights. In response, one expert thought it was important to provide “a counter-offer” to the issue, rather than just outlining the myriad of issues that would result from a constitutional amendment or legislation. Further, one expert emphasized the importance of recognizing that access to abortion services varies greatly due to structural discrimination since women and people who can become pregnant have their rights affected in a differentiated manner. This expert argued that the government should put effort into reforming the healthcare system to ensure that women and people who can become pregnant can have access to reproductive services without discrimination.

The Expert Panel then reiterated several alternatives to improving reproductive justice. These alternatives included increasing access to abortion services; encouraging dialogue to reduce the taboos; improving education on reproductive health; training medical and judicial personnel on how their actions and omissions can lead to acts of discrimination and gender-based violence and creating stronger policies. One expert noted that there should be increased dialogue between the federal health minister and Canadian medical bodies such as Ontario’s College of Physicians and Surgeons on topics such as compliance with Canada’s international commitments and international standards such as those included in the WHO Abortion Care Guideline. Furthermore, focusing on education funding could assist in providing accurate judgment-free health information through an online portal, debunking myths on abortion, and having more classes about gender equality.

For racial minority and indigenous communities, effective reproductive health education would require collaboration with community leaders, organizations, and educators. Furthermore, it would be useful to integrate reproductive health education into comprehensive health programs to tackle issues such as substance misuse, suicide and mental illness, chronic illness, and HIV prevention within frameworks of community well-being, decolonization, cultural connection, and sovereignty. A singular focus on abortion care may reinforce existing barriers by compelling people to seek education and care in circumstances that expose them to stigma. Integrating reproductive health education into comprehensive health programs is likely to yield more empowering and culturally-appropriate outcomes.

(c) Create a Federal Policy on Reproductive Justice

One notable recommendation raised, which was endorsed by many of the Panel experts, is the need for a “federal policy on reproductive justice.” This policy would set forth a series of commitments towards improving reproductive justice in Canada such that people could have “reproductive lives and futures that are meaningful to them.” As witnessed with other policies in climate justice, food, or housing policy, this would mean there would be an allocation of funding seen in the federal budget to various services, measures and supports.

Such a policy would be comprehensive and updatable to emphasize many different reproductive health issues, not just that of abortion access. Simply put, abortion would be one of many services and supports to giving people meaningful reproductive lives. For example, the reproductive health issue of compulsory sterilization could also be addressed under the policy. One of the experts suggested that such a policy could go further and also address the many laws in Canada that are still functionally anti-abortion. This policy could review and weed out these laws that undermine access to abortion. Other suggestions for the federal policy include providing training to health professionals from within racialized and Indigenous populations who could implement trustworthy, culturally appropriate, and anti-racist abortion care in their communities.

APPENDIX. List of Roundtable Experts

Rebecca Cook

Professor Emerita | UofT Faculty of Law & Faculty of Medicine



Professor Cook is a Co-Director of the International Reproductive and Sexual Health Law Program at the University of Toronto. She is also a Legal and Ethical Issues co-editor of the International Journal of Gynecology and Obstetrics and serves on the editorial advisory board of Human Rights Quarterly. She is a Member of the Order of Canada, a Fellow of the Royal Society of Canada, and the recipient of the Certificate of Recognition for Outstanding Contribution to Women's Health by the International Federation of Gynecology and Obstetrics (FIGO).

Relevant publications: Abortion Law in Transnational Perspective: Cases and Controversies (2014); Human Rights of Women: National and International Perspectives (1994); Gender Stereotyping: Transnational Legal Perspectives (2010) and Frontiers of Gender Equality (2023).

Joanna Erdman

Professor | Schulich School of Law & MacBain Chair in Health Law and Policy

Professor Erdman chairs the Global Health Advisory Committee of Dalhousie's Public Health Program and serves on the advisory board of the Women's Rights Program, Open Society Foundations. She is a past chair of World Health Organization's Department of Reproductive Health and Research Gender and Rights Advisory Panel. Her research focuses on sexual and reproductive health and human rights in a transnational context. She also teaches fundamentals of public law, health law, and an international sexual and reproductive health and rights practicum.



Relevant publications: "Abortion Law in Transnational Perspective: Cases and Controversies" (2014); "Understandings of self-managed abortion as health inequity, harm reduction and social change" (2018); "Constitutionalizing Abortion Rights in Canada" (2018)

Daphne Gilbert

Professor | Faculty of Law | University of Ottawa



Professor Gilbert specializes in teaching criminal and constitutional law, including courses in Criminal Law and Procedure, American Constitutional Law, and Advanced Sexual Assault law. Her research interests lie primarily in the Charter of Rights and Freedoms, with a particular emphasis on equality rights, reproductive rights, medical assistance in dying (MAID), sexual violence, and safe sport/abuse in sport. Prof. Gilbert is President of the Board of “Women Help Women”, an international abortion service provider.

Relevant publications: “Attesting to Fundamental Human Rights: The Backlash to the Active Promotion of Equality in Canada” (2020)

Angel M. Foster

Professor | Faculty of Health Sciences | University of Ottawa

Dr. Foster holds a doctorate from the University of Oxford in Middle Eastern Studies, an MD from Harvard Medical School, and both master’s and bachelor’s degrees from Stanford University. Dr. Foster is a global abortion researcher and leads projects in 22 countries. She has authored more than 100 articles and co-edited three books; she also led the most recent revision of the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. Dr. Foster serves as the Chair of the Board of Directors of the National Abortion Federation, Canada, the Co-Chair of the Safe Abortion Care Sub-Working Group of the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) and the Editor-in-Chief of *Perspectives on Sexual and Reproductive Health*. The recipient of numerous awards in honours, she received the Guttmacher Institute’s 2017 Darroch Award for Excellence in Sexual and Reproductive Health Research and was inducted into the Canadian Academy of Health Sciences in 2023.



Relevant publications: “Abortion, politics, and the pill that promised to change everything: The global journey of mifepristone” (Forthcoming); “Emergency contraception: The story of a global reproductive health technology” (2012); “‘If I ever did have a daughter, I wouldn’t raise her in New Brunswick:’ exploring women’s experiences obtaining abortion care before and after policy reform” (2017)

Kat Owens
Project Director | LEAF



Kat Owens leads LEAF's Reproductive Justice Project. Her work focuses on using law reform to advance reproductive justice in Canada, particularly through LEAF's branches. The project focuses on advancing reproductive justice in Canada through provincial and territorial law reform advocacy. LEAF works to identify areas in need of law reform, put together reform proposals targeted at these areas, and advocate for changes to achieve reproductive justice.

Relevant publication: "Beyond Complacency: Challenges (and Opportunities) for Reproductive Justice in Canada" (2022); Relevant publication By LEAF: "A Long Way to Go: Collective Struggles & Dreams of Reproductive Justice in Canada" (2022)

Julia Tétrault-Provencher
Lawyer

As a feminist lawyer, Julia seeks to continue her journey advocating for the respect of sexual and reproductive rights with a focus on menstrual health and hygiene, the prevention of maternal morbidity, and abortion rights. Julia works as a Legal Counsel in Sexual and Reproductive Rights for Lawyers without Borders Canada (ASFC) in Quebec City. She is also a NAWL Steering Committee member and Chair of the Reproductive Justice Working Group. Before joining ASFC, Julia worked as an independent human rights consultant for various non-governmental organizations, including the International Federation for Human Rights and the Global Survivors Fund.

Relevant publications: "Replicating the Definition of 'Forced Pregnancy' from the Rome Statute in a Future Convention on Crimes Against Humanity: A Tough Pill to Swallow" (2022).



Charmaine C. Williams (Reviewer)

Dean & Professor | Factor-Inwentash Faculty of
Social Work | University of Toronto



Dean Williams' research focuses on health equity issues affecting various populations, including racial minority women, LGBTQ communities, and families affected by mental illness. As a social worker in the mental health care system, Dr. Williams worked with individuals, families and groups, and was also active in organizational change initiatives directed at increasing access for racial and ethnic minority populations. She has extensive experience developing and delivering professional education in the areas of anti-racism, cultural competence, mental health and addictions. Recent activities include serving on the expert panel for the Mental Health of Black Canadians Initiative at the Public Health Agency of Canada and serving on the Anti-Racism Advisory Panel that developed the Toronto Police Service's race-based data collection policy. She is PI for the SSHRC funded project "United we stand, divided we falter: Advancing a family-centred agenda for research on caregiving."



David Asper Centre for Constitutional Rights
UNIVERSITY OF TORONTO

78 Queens Park, Toronto, ON M5S 2C5
(415) 978-0092 | www.aspercentre.ca