My Body, My Choice: Or is It? The Importance of Renewed Feminist Activism to Altering Canadian Abortion Laws to Legalize Pharmaceutical Abortion

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Introduction

Since Canada's early beginnings as British North America, abortion has been an issue of concern for provincial governments and the federal government when the country was consolidated. Abortion was not always a criminal offence; it was once up to women to determine for themselves when having an abortion constituted a moral wrong. Unless there was definite evidence that a woman had become ill and/or died from a botched abortion, the authorities rarely charged and sentenced the woman and/or the parties involved in procuring the abortion. Alongside the rise of Western medicine, dominated by men, women's bodies began to be controlled, as they had never been before. Providing examples primarily from Western Europe, Mary Chamberlain's book *Old Wives' Tales: Their History, Remedies and Spells* traces the complex history of the rise of male medical practitioners starting in the sixteenth century when Britain's Royal College of Physicians was given "exclusive status" by Henry VIII, but "its authority and membership was that of an elite minority" (75). Women-centered knowledge about abortion, contraception, pregnancy and childbirth started dying out, as women came to be objects whose bodies needed to be studied and regulated by the medical profession. Laws surrounding abortion were one way to exert governmental control over women's bodies. Pro and anti choice debates remain controversial topics of discussion today. Despite attempts in the mid-to-late 1900s to remove restrictions on abortion and provide women with greater choice, abortion access remains uneven across the country.

This Independent Research Project will move past the pro-choice versus anti-choice debate to examine the continuing barriers to equitable abortion access and one potential way to combat these barriers, the legalization of a pharmaceutical abortion drug combination.[1] Pharmaceutical abortion is the use of prescription medications to induce an abortion akin to a miscarriage. I will argue that pharmaceutical abortion is an under-utilized medical technology that, if legalized, can improve access to abortion services for women across the country, but the potential of this contraceptive technology can only be realized if women's health activism is revitalized and allows a diversity of women to participate to ensure the creation of equitable abortion services that benefit all Canadian women. To forward my argument, pharmaceutical abortion will be examined in greater detail, first, as to the drug combinations available, the benefits over surgical abortion and the overall benefits of the mifepristone-misoprostol drug regimen for women. It is important to distinguish the efficacy of the various pharmaceutical abortion methods, as the mifepristone-misoprostol method is the most highly regarded amongst the three possible methods. Secondly, I will analyze the importance of second wave feminism's activism regarding changes in abortion laws that culminated in the 1988 Supreme Court

[1] **A Note on Terminology:** In this paper the phrases 'pharmaceutical abortion' and 'medical abortion' will be used interchangeably. However, I do recognize the confusion that the phrase 'medical' can cause and only use 'medical' in reference to source material. Other phrases sometimes cited in scholarship on this topic include: 'chemical abortion' and 'medicinal abortion.'

of Canada (SCC) ruling in *R v Morgentaler* and explain why this type of feminist activism seems to have disappeared and needs to be reinvigorated. Thirdly, I will explore the state of Canadian abortion law from the early days of British North America through to the 21st century. In Canada, the anti-choice stance carried over from British criminal law. These early laws have continued to influence anti-choice private member bills in the House of Commons in the last 30 years. Fourthly, the SCC majority decision in *R v Morgentaler* will be evaluated with respect to section 7 of the *Canadian Charter of Rights and Freedoms* (hereafter referred to as the *Charter*) to help explain how the government continues to infringe on each woman's right to 'life, liberty and security of the person' by delaying the legalization of a pharmaceutical abortion method. I will also explain why it is the way of the future for the government to provide Canadians with positive rights instead of simply protecting Canadians' rights. Finally, I will tie this discussion together by analyzing how women, generally and marginalized women, in particular, are limited in their abortion options by the current termination methods available and how feminist activism can be a catalyst for creating change.

The discussion, analysis and critique of these key issues will be carried out using secondary research from a feminist reproductive justice standpoint rooted in second wave feminism. It will include a wide variety of areas of scholarship, including: history, law, feminist activism, the waves of feminism and medicine. This type of research is crucial at this particular moment in history when the liberalization and privatization of health care in Canada has meant cutbacks for many groups in society, including women and their access to reproductive choice.

Reproductive choice is not only an issue for Canadian women in the general sense, it is also important for groups of women who have been severely victimized my medicine and had their reproductive rights stripped from them. Discussions of the historic *R v Morgentaler* case neglects "discussion of the forced abortions to which young women, racialized women, women with disabilities, and poor women are frequently subjected" (Majury, 318). In Canadian society, groups of women who have been traditionally marginalized are often those who have difficulties accessing abortion services when it is their choice to obtain one. Lack of financial resources often mean that women are unable to travel the required distances to a hospital or clinic to obtain an abortion. Intersecting categories of disadvantage and government inaction in providing equitable access to abortion combined with histories of eugenic sterilizations of marginalized women complicate their ability to make their own decisions and obtain the health care services of their choice.

I hope that this paper will spark a discussion and perhaps a wider movement towards renewed feminist activism regarding abortion access in Canada. Feminism needs to return to the activist roots present in second wave feminism in terms of women's health in order for change to occur. Second wave feminists were very active in protests, marches, plays, events and other creative means of delivering the message that women needed and deserved access to women-specific health care, including access to abortion services. As I will elaborate on in the discussion section, it is important for a renewed feminist activism to incorporate a diverse set of women to push for changes that will benefit all women, not just the privileged few.

Pharmaceutical Abortion

Methods[2]

i. Mifepristone (RU-486) and Misoprostol

The most common method used worldwide for pharmaceutical abortion is two medications: mifepristone and misoprostol (Berer, 20). In her article, "International Reproductive Rights: The RU-486 Question," Amy Porter reviews the development of RU-486, explaining that:

> RU 486, a medical alternative to surgical abortion, was invented by Etienne Emile Baulieu for Roussel Unclaf, a French subsidiary of the German parent company Hoescht, and was first licensed for use in France in 1988. RU 486 is a pill which, when taken with another drug, prostaglandin [e.g., misoprostol], acts to interrupt pregnancy (179-180).

For the first time there was an alternative available to surgical abortion that was successful at causing an abortion akin to a miscarriage.

According to Marge Berer, writing in the American context, in "Medical Abortion: A Fact Sheet," "[m]ifepristone is an anti-progesterone drug that blocks the action of progesterone in the body. It causes the gestational sac in early pregnancy, or the embryo or fetus at subsequent stages, to become detached from the uterine lining and it softens and opens the cervix" (2005, 20). Anti-progesterone drugs have a particular impact on the bodies of pregnant women by lowering the hormone progesterone, which is needed for a healthy pregnancy to develop. Porter writes that, "unlike progesterone, which causes pregnancy to develop, RU 486 acts as an antiprogestin inhibiting the production and effectiveness of the progesterone" (190-191). In other words, "RU 486 is an antiprogestin—literally anti 'progestation'—drug capable of preventing the implantation of a fertilized human ovum, or the continuing support of an early human embryo" (Mullen et al., 63). Additionally, "[m]isoprostol is a prostaglandin that causes contractions of the uterus, which result in the products of pregnancy being expelled" (Berer, 2005, 20). The mifepristone-misoprostol drug regimen is the most common pharmaceutical abortion method and is available in a few different dosage and administration methods.

A woman typically takes 600 mg of mifepristone orally and then between thirty-six and forty-eight hours later, she takes the prostaglandin (e.g., misoprostol) either orally or vaginally (Creinin, 55; Berer, 2005, 21; Shannon et al., 621; Wiebe et al., 813). While the typical dosage of mifepristone is 600 mg, "there is also substantial evidence that a 200 mg dose may be as effective" (Shannon et al., 621). Shannon et al.'s study, "Regimens of Misoprostol with Mifepristone For Early Medical Abortion: A Randomised

[2] The drugs used to induce a pharmaceutical abortion are not to be confused with the drug commonly known as Plan B or 'the morning after pill,' which prevents a pregnancy from occurring by interrupting the fertilization process following intercourse. However, anti-abortion advocates have made the argument that Plan B is in fact an abortion-inducing drug and/or that all contraceptives that interfere with pregnancy are abortifacients (see additional readings: Griffin; Hrokak; and Lewis et al.).

Trial" explains that the typical pharmaceutical abortion method in the United States and the United Kingdom is, "a regimen of 200 mg of mifepristone followed by 800 micrograms of vaginal misoprostol in 24-48 hours" (621). This particular dosage showed a 96-98 % success rate in Shannon et al.'s study (621).

The purpose of Shannon et al.'s study was to compare the efficacy of 400 or 600 micrograms of misoprostol orally or 800 micrograms vaginally as the drug used following mifepristone (622). The results showed that all three methods of misoprostol administration were "equally successful" (Shannon et al., 625). Shannon et al., ensured that this study was carried out under strict ethical guidelines and physician supervision, which is very important to the use of pharmaceutical abortion in general. As Berer notes, although women can use these drugs by themselves to induce an abortion, it is safer to use the medications with the assistance and supervision of a medical professional (2005, 21).

Finally, this drug combination can be utilized early on in pregnancy, up until the 9th week (Sibbald, 1999, 1753). The second possible pharmaceutical abortion method is not as effective and has a shorter usage time frame.

ii. Methotrexate and Misoprostol

If a Canadian woman wants a pharmaceutical abortion, one possible method is through the use of "methotrexate, followed 5-7 days later by misoprostol" (Dunn and Cook, 13). Typically, methotrexate is administered via an injection at a dosage of 50 mg and the misoprostol is administered orally or vaginally (Wiebe et al., 814). If this drug combination does not result in an abortion the misoprostol will have to be repeated or followed up with a surgical abortion (Wiebe et al., 814).

In Canada, this drug combination can only be used up until the 7th week of pregnancy (Dunn and Cook, 13). As a result, in order for the drugs to be effective, the utmost precision is needed in determining how far along the woman's pregnancy is because the amount of misoprostol and how often it must be taken will change the further along a pregnancy is (Berer, 2005, 21). The same is required when using misoprostol alone.

iii. Misoprostol

Misoprostol, the prostaglandin that helps expel the products of conception when used in combination with either mifepristone or methotrexate can also be used alone to induce an abortion. Misoprostol is responsible for the majority of the side effects when used alone or as part of one of the other two methods. In order to terminate a pregnancy, misoprostol must be taken in high dosages and repeated if the method fails and/or followed by a surgical abortion (Porter, 191; Society of Obstetricians and Gynecology, 2006, 1017). Some of the side effects of using misoprostol alone or in a combination method include: "nausea, abdominal cramping, gastrointestinal side effects, and extreme uterine pain…[which]…occasionally cause[s] a woman to request a pain killer" (Porter, 191, 193).

Research does not show an acceptable time frame for the use of the misoprostol only method, as misoprostol alone is not a highly regarded method of inducing a pharmaceutical abortion.

The Advantages and Disadvantages of Pharmaceutical Abortion Compared to Surgical Abortion

As with all prescription drugs and surgical procedures, there are always risks, side effects and complications that may arise. The Society of Obstetricians and Gynecologists (SOGC) recognizes that, "[m]edical induction and D&E [dilation and evacuation] are both safe and effective methods of second trimester termination…The particular technique should be selected according to the expertise of the physician and wishes of the patient" (2006, 1015). Choosing an abortion method is an important decision to be made between a woman and her doctor. Both methods have their advantages and disadvantages.

Despite questions surrounding the safety of the various pharmaceutical abortion methods, there are advantages to pharmaceutical abortion that have been documented in medical scholarship. Some of these advantages include: the avoidance of surgery and risk of damage to the uterus with surgical instruments, that it can be done early before the signs of pregnancy occur, that it may feel less invasive than surgery and that some women consider it to be more private because the expulsion takes place at home ("Sexual Health Center: Abortion: Medical Abortion"). The SOGC adds to this list noting that pharmaceutical abortion has additional advantages because it provides patient autonomy by allowing the patient to feel more in control and the process, making it less frightening, it is inexpensive, technically simple, an office procedure and an "alternative for failed surgical abortion, particularly if the problem involved difficulty accessing the uterus because of uterine leiomyoma or a congenital anomaly" (2006, 1018). While pharmaceutical abortion has certain advantages, it also has disadvantages compared with the surgical procedure.

Some of the problems with pharmaceutical abortion are that it: takes place over a week or more, involves several visits to the doctor, there is a ten percent risk that the procedure will be incomplete[3] and a surgical abortion will need to be done, sometimes heavy bleeding can occur and the drugs may have unpleasant side effects including nausea, diarrhea, abdominal cramping or pain, vomiting and/or hot flashes ("Sexual Health Center: Abortion: Medical Abortion"). Additionally, it is necessary for the patient to follow up with their doctor to ensure that the products of conception (POC) have been expelled and women must understand that they will likely experience the expulsion of the POC while they are home alone (Society of Obstetrics and Gynecology, 2006, 1018). Pharmaceutical abortion also is problematic because if the pregnancy continues there is the potential for "fetal abnormality" to occur and/or infection if the POC have not been fully expelled and confirmed by a medical practitioner (Berer, 1994, 130).

Despite some of the problems associated with pharmaceutical abortion, surgical abortion also has risks. The legalization of a pharmaceutical abortion method will have many positive implications for Canadian women that outweigh the potential risks. This

[3] This is debated. Many studies have documented an almost 100 % success rates for pharmaceutical abortion (for example, see: Shannon et al.)

will be especially true if women are provided with the necessary information to make their own choice with regards to abortion method. However, it is absolutely necessary for women to work with their medical practitioner to ensure the pharmaceutical abortion is complete.

The Importance of Pharmaceutical Abortion for Canadian Women

Due to the fact that mifepristone is not available in Canada, Canadian women are at a greater risk for complications because they have to utilize a drug that is not as effective (methotrexate) as mifepristone. While, methotrexate operates in the same way mifepristone does, it is not as effective because as Shelia Dunn and Rebecca Cook explain in their article "Medical Abortion in Canada: Behind the Times," that the methotrexate-misoprostol drug regimen:

> is the second-best method…its time course is longer and less predictable, with some abortions delayed several weeks after administration of methotrexate…the World Health Organization does not recommend it [methotrexate] because of its association with serious deformities in the infant if the abortion fails and the pregnancy continues (13).

The mifepristone-misoprostol pharmaceutical abortion method is the most highly regarded pharmaceutical option to abort a fetus and is advocated for by many health organizations. For example, "[m]ifepristone is included in the World Health Organization (WHO) *Model List of Essential Medicines*, and yet Canadian women do not have access to it" (Dunn and Cook, 13; see also: Erdman et al., 1767; Shulman; Rowlands, 117; Canadians for Choice). The WHO is not the only organization to stand behind mifepristone for use as an abortifacient.

The SOGC has supported the use of mifepristone for many years now. In 1992, the SOGC, "passed a resolution supporting the 'legal availability' of antiprogesterone steroids such as mifepristone in order to give 'Canadian women access to a treatment of proven efficacy'" (Sibbald, 1999, 1753; Sibbald, 2001, 82). In 2009 the SOGC released a policy statement reinforcing their commitment to mifepristone, stating:

> [t]he Society of Obstetricians and Gynecologists of Canada (SOGC) supports a woman's right to choose safe abortion services. In 1991, the SOGC supported the introduction of mifepristone into Canada for clinical trials, and now supports its clinical use…The SOGC supports the approval and availability of mifepristone and other antiprogestins, as well as their appropriate prostaglandin counterparts, for appropriate research and clinical use in Canada. The SOGC urges Health Canada to work with professional organizations and industry to make this product available to women living in Canada (1180; see also Berer, 1999, 134).

If Health Canada listened to organizations like the WHO and the SOGC and mifepristone was legalized by Health Canada, it would improve women's access to abortion across the country.

Jocelyn Downie and Carla Nassar's article, "Barriers to Access to Abortion Through Legal Lens" illustrates the potential improvements legalizing RU-486 can have for all Canadian women, explaining that:

> RU-486 makes abortion more widely available because it can be administered by

> nurses or midwives with physician supervision. It can increase the number of individuals able to be providers, and the places in which abortion services can be offered, as well as the number of abortions that can be performed in any given facility. As well, many abortion providers require that a woman wait until she is 5-6 weeks pregnant before performing vacuum aspiration, while medical abortion can be initiated as soon as the pregnancy is confirmed, diminishing access issues due to timing and travel (151).

These are only some of the many benefits of legalizing a pharmaceutical abortion method. Research has also shown that women themselves who have utilized the pharmaceutical abortion method are likely to choose it over the surgical abortion method. These positive qualities are very similar to the generally stated benefits of pharmaceutical abortion in medical literature.

Qualitative research studies have shown that women typically have a more positive experience with pharmaceutical abortion compared to surgical abortion. Studies from some western European countries, in particular, where pharmaceutical abortion has been available since the late 1980s or early 1990s have explored this trend. In France, studies suggest that the pharmaceutical method is preferable:

> [e]ight in every 10 women who participated in the choice of abortion technique chose the medical procedure, a higher proportion than that observed in any previous study. As the proportion of abortions performed medically has grown steadily in France, acceptability of the technique has improved over time for women…Women who felt they were given a choice were four times as likely to have a medical procedure as those who were not given a choice, which suggests that an increasing proportion of abortions will be medical procedures in France, if health care providers are willing to share the decision with their patients (Moreau et al., 228, 229).

Studies from Britain confirm this finding, "RU-86 was the self-determined choice of the majority of experienced women" (Porter, 216). The question that remains, however, is why do women prefer this method? How have their experiences informed what is known about pharmaceutical abortion?

There are many reasons women who have participated in qualitative studies cite for preferring the pharmaceutical method compared to the surgical method. Erdman et al. summarize these reasons, stating:

> [w]omen find medication abortion to be more private, because it happens at home over time, akin to a natural miscarriage. Many women prefer this experience and elect medication over surgical abortion…Medication abortion offers a different experience of abortion that may be more acceptable to and thus preferred by some women. Because no instruments are involved, many women describe a more natural experience, with their uterine pain resembling miscarriage or menstrual cramps. Medication may also be experienced as more private and respectful of the woman's dignity and as generating a more egalitarian clinical interaction (1764, 1766).

The key theme running through Erdman et al.'s analysis is that when women are presented with information about their options, they are more likely to choose pharmaceutical abortion because it allows them the autonomy to choose their abortion method and to participate in the abortion process itself. Whereas a surgical abortion can

be seen as an invasive procedure, placing the woman is in the passive role of the patient, the pharmaceutical method allows her to take the medications herself, monitor her symptoms and expel the contents of the pregnancy in the comfort of her own home. The inventor of mifepristone himself, Etienne Emile-Baulieu, wrote of this medication, in his book *The Abortion Pill*:

> [a]ny instrumental abortion is an intrusion. Physically, it is an operation and may leave a scar. Psychologically, it is an invasion of the most intimate reaches of a woman's body…Headline writers labeled RU-486 the 'abortion pill.' But there is no surgical invasion, no traumatic shock to the unwilling mother. In a sense, RU-486 is an unpregnancy pill (15, 18).

Emile-Baulieu hoped that this method of pharmaceutical abortion would revolutionize abortion care for women around the world. In particular, his hope was that the creation of RU-486 would provide women with an alternative to an abortion method that is performed upon a woman's body and that they have no role in, which is contrary to the medicalization of women's bodies which has attempted to exert external control over female bodily functions. Emile-Baulieu had another great hope for women, that eventually RU-486 would be able to change the abortion process entirely, "eventually, a single pill containing both RU-486 and a time-release prostaglandin may reduce the drama of abortion to a simple, dignified encounter between a woman and her doctor" (19). Thus far, a single pill has yet to be created that would allow for this to take place even though 27 years have passed since mifepristone was introduced into the French pharmaceutical market. This single pill, if created, would provide an easier method for women to access abortion services across the country, but the problem remains that Health Canada continues to delay the legalization of a pharmaceutical abortion method. A revitalization of women's health activism has the potential to push for governmental change with regards to pharmaceutical abortion.

Second Wave Feminism and The Women's Health Movement

The Women's Health Movement emerged out of second wave feminism, with the concern about the impact of the violence done to women and their bodies by male-dominated medicine and medical beliefs about women's ailments. Bascoe et al. define the Women's Health Movement in their article "The Women's Health Movement in Canada: Looking Back and Moving Forward," as a time when, "[w]omen came together to share experiences and knowledge…[and]…understood that women's health is a political, social, and economic matter" (7). Women formed collectives and consciousness-raising groups as a way to discuss important issues that they faced in their daily lives, because they recognized that 'the personal is political.' Two of the most important issues the Women's Health Movement advocated for were legal abortions and drug safety. For example, the Vancouver Women's Caucus (VWC), was one feminist group that was particularly concerned with the 1969 legal changes that placed restraints on abortion access.

The 1969 change in Canadian abortion law introduced Therapeutic Abortion Committees (TACs), which were responsible for deciding on a case-by-case basis, who would be granted abortions based on a determination of whether continuing the pregnancy presented a risk to the woman's life or health. The issues created by the TACs

will be explored in more detail later on in this paper, but second wave feminists took up this issue, in particular. The VWC, for example:

> settled on highlighting the issue of access to abortion by travelling in an Abortion Caravan from Vancouver to Ottawa in the spring of 1970. Hailed as 'the first national action' that kick-started second-wave feminist activism in Canada, the caravan attracted thousands of public spectators who expressed shock or delight at the women's well-staged discontent (Sethna and Hewitt, 464).

The purpose of the Abortion Caravan was to raise awareness about the deaths of many Canadian women from infection and/or hemorrhage due to unsafe, illegal abortions. The Abortion Caravan had a well-planned activist agenda to spread their message. To begin with:

> a caravan of cars would leave Vancouver to arrive in Ottawa on the symbolic Mother's day weekend of May 9-11. The lead vehicle would bear a coffin to represent the deaths of women from illegal abortion. The caravan would stop at cities along the route to Ottawa, performing guerrilla theatre, meeting with local women's liberation groups, gathering followers, and raising the profile of the abortion issue (Sethna and Hewitt, 473).

Once they arrived in Ottawa, the women involved in this caravan, staged two very important demonstrations to illustrate the importance of safe and timely abortions for Canadian women. The first event occurred on May 9, 1970. Women marched to 24 Sussex Drive, the residence of then Prime Mister Pierre Trudeau, who was away at Harrington Lake (Sethna and Hewitt, 488-491). This event occurred prior to the establishment of fences and security gates at 24 Sussex to keep the public out, so the protestors were able to occupy the lawn causing a security frenzy (Sethna and Hewitt, 488-491). In the end, the security team compromised, allowing members of the VWC to, "deposit the coffin [that had been part of their procession to Ottawa] at the main entrance to the residence if they left peacefully afterwards. The women complied" (Sethna and Hewitt, 491). The second major event occurred on May 11, 1970 when:

> [a]pproximately twenty-five women armed with passes containing the forged signatures of NDP politicians filed into the public galleried of the House. The women deliberately chose to wear respectable clothing and to carry purses. The strategy worked…Using bicycle chains they had smuggled inside their purses, the women locked themselves to their seats. At the appointed hour of 3 o'clock they stood up to denounce the new abortion law (Sethna and Hewitt, 492).

The activism of the VWC was very important because it brought to light the dangers Canadian women faced when trying to procure an abortion. Canadian women were at the mercy of the TACs who decided whether to grant or deny each woman's request based on whether or not carrying the fetus to term placed her health or life in danger. Many women did not meet these requirements and were denied abortions. Women wanted to be able to make their own choices with regards to whether or not abort a fetus, rather than allowing doctors to continually make the decision for them. These decisions had real world implications on women's lives and bodies. This is once again part of the legacy of male dominated medicine, enforcing their own regulatory beliefs about women's bodies onto women themselves.

A second important issue for the Women's Health Movement was saving women from the dangers of drugs that had not been properly tested and had severe side effects.

Feminist activists pushed for "the legalization of birth control, campaign[ed] for reproductive choice, and expose[d] the dangers of newly developed drugs for use during pregnancy and contraception" (Morrow, 43). These demands followed from the realization that, the pharmaceutical industry did not have the best interests of women in mind when promoting their products, "[f]or example, the commercial push to market a drug and increase profits could supersede the obligation to make safe and effective medicines available and to do follow-up on a drug's safety" (Bascoe et al., 8). Two of the reproductive technologies that epitomized the contradiction between commercial profit and women's safety with reproductive medications during second wave feminism in Canada were thalidomide and the Dalkon Shield.

Thalidomide was used, "as a treatment for morning sickness for Canadian women during the 1960s, a treatment that resulted in the birth of babies with severe damage to their limbs" (Morrow, 43). The consequences of thalidomide were, "the result…of inadequate research standards preceding distribution and marketing" of the drug (Levine quoted in Lyerly et al., 9). Whereas thalidomide was used during pregnancy, the Dalkon Shield was used to prevent pregnancy as an early Intrauterine Device (IUD). The problem with the Dalkon Shield was that the edges were jagged. These edges tended to implant themselves into the sides of the uterus causing infection. Second wave feminists recognized that, "[l]itigation concerning the Dalkon Shield intrauterine contraceptive device…[leads to]…sobering liabilities for manufacturers prepared to use women as living laboratories for their untested products" (Martin, 13). Fear of making another mistake by legalizing a drug that may be unsafe is part of Health Canada's reluctance to legalize a pharmaceutical abortion method. Second wave feminists were an important part of advocating for access to safe reproductive technologies that have undergone the rigorous scrutiny of drug trials. The consequence of the disasters brought about by thalidomide and the Dalkon Shield is that, while women can now legally access abortion and Canada has stringent drug laws to protect people's safety, government conservatism is inhibiting equitable access to abortion and safe reproductive technologies. The mifepristone-misoprostol method has undergone rigorous testing in many different countries and has been proven effective to terminate a pregnancy when used under medical supervision. Pharmaceutical abortion presents a positive alternative to surgical abortion, especially when so many barriers continue to exist to procuring a surgical abortion.

In their study, "Far From Home? A Pilot Study Tracking Women's Journeys to a Canadian Abortion Clinic," Christabelle Sethna and Marion Doull outline some of the barriers that continue to exist for Canadian women trying to access abortion services. Despite the gains that have been made for women in terms of reproductive rights, "many Canadian women report having to travel, often far from their home communities and at considerable personal expense, to abortion providers" (Sethna and Doull, 640). In addition:

> [a]lthough the Canadian health care system is public (with respect to finding for medically necessary services), private (with respect to provision of those services) operators do exist. In Ontario, abortions performed at clinics are fully funded because they are deemed a medically necessary service, but some Ontario clinics operate on a for-profit basis. These for-profit clinics usually disadvantage women who are less able to pay for them; nevertheless, with the diminution of abortion

> services in public sector hospitals, private abortion clinics, especially if they are provincially funded have given women an important health care alternative (Sethna and Doull, 642).

In other words, women face geographical and financial barriers to accessing surgical abortion services in Canada. Specifically, where women do not have access to a hospital that performs abortions, they may be required to pay for abortion care at a clinic. This may increase barriers to abortion access, especially for low-income women (Sethna and Doull, 644). Sethna and Doull emphasized that the women all came from a diversity of backgrounds with regards to marital status, employment, income and ethic background (644). Similarly, Sethna and Doull's data collection was varied with regards to women's choice of abortion facility, the barriers faced when attempting to access abortion services and travel time, distance and expenses (644-645). The differences in abortion experience were likely a result of women's demographic status indicators. With the continuation of the privatization of many healthcare services, abortion services are likely to be affected. While, the services referred to here are surgical abortions, if a pharmaceutical abortion method were legalized, Canadian women would have another option available to them (hopefully both in hospital and clinic settings), increasing their choices and access to abortion services. According to Joanna Erdman et al.'s article "Medication Abortion in Canada: A Right-to-Health Perspective," "[m]edication abortion (the use of drugs to terminate a pregnancy) could improve abortion care in Canada, but its potential remain unrealized" (1764). However, it is important to ask: where are feminist health activists today with respect to reproductive rights in Canada?

I would argue that there is a need to reinvigorate feminist activism with regards to women's reproductive rights because a pharmaceutical abortion method is still not available in Canada and the federal government continues to delay deciding on this important issue. Within third wave feminism:

> activism…is characterized by increased involvement of women in bureaucratic and institutional structures. With this has come increased influence over the development of women's health initiatives, policy, and research. However, it has also meant that some of the more radical and progressive aspects of women's health movement have become co-opted to fit various government and institutional agendas…Another related feature of the third wave is the degree to which feminist agendas are reactive to government and institutional agendas. That is, many of the organizations and initiatives established in the second wave of feminism have seen their funding cut as part of a general trend in Canada towards less social spending (Morrow, 49).

Women's health has been one area where government cutbacks have had tremendous effects. Feminists within bureaucratic structures have had little choice, but to celebrate the small victories made for women within the system. Returning to feminist activism and away from attempting to change policy from within government structures may be one way to bring women's health activism and pharmaceutical abortion back to the forefront of women's reproductive health politics in Canada and re-gain the attention of the government. Placing women's health activism within government structures is a form of male dominance over women because the feminist voice is not as loud when operating using the tools of the government, such as policy briefings and status of women commissions, as it is when feminists are out on the streets protesting. For example, the

report produced by the Badgley Committee, which was established in 1977 to examine the problems with the state of abortion in Canada did not result in concrete government action on the abortion issue, even though its main finding was that the 1969 "abortion law was not being applied equitably across Canada" (Dunsmuir). Recommendations are made, but not necessarily acted upon by the government. The government establishes such commissions to table these reports in the hopes that feminist groups will be appeased, but then ignores to do anything when changes most definitely need to be made.

Increased feminist activism has the potential to pressure the government and Health Canada to institute positive changes to Canadian abortion laws that will have lasting impacts for all women across the country and increase access to abortion, if this renewed activism genuinely welcomes all women to the forum. It is important that feminists in general do not appropriate the voices of marginalized women and assume that what women need generally is what all women need. I will return to this discussion of the need to ensure an intersectional perspective when advocating for reproductive change in the discussion section, where I will link the need for a diverse perspective to women's health activism to show why it is important. Marginalized groups of women in Canada have faced histories of violence that complicate and compound their experiences with reproductive rights. These histories have current day implications, which is why I will now acknowledge the history of abortion law in Canada to see why changes still need to be made.

History of Abortion Law in Canada

British North America and Confederation

The criminalization of abortion did not begin until the 19th century (Backhouse, 64). Prior to the 19th century, the concept of 'quickening' or when a woman first felt her fetus move determined whether or not it was socially acceptable to abort (Backhouse, 64). 'Quickening' takes place at approximately the 14th week after conception (Backhouse, 66). Once a woman felt the fetus quicken, it became a criminal offence to abort a fetus, but laws were not rigid and unless the woman died of a septic infection, it was not always easy to tell if she had had an abortion. Abortion laws in British North America were influenced by the 'quickening' distinction and by British criminal law.

Legal historian, Constance Backhouse explains the importance of a particular piece of British criminal law, *Lord Ellenborough's Act* in her article, "Involuntary Motherhood: Abortion, Birth Control and the Law in Nineteenth Century Canada," which was passed in 1803 and had implications for early abortion laws in British North America:

> [i]t specifically prohibited abortions upon women who had already quickened, something about which the common law had been unclear. However, the major significance of the act was its criminalization of abortions on women who had not yet quickened. The latter had never previously been viewed as criminal. The penalties reflected this situation; those who procured them before quickening faced a lesser sentence: 'a fine, imprisonment, whipping or transportation beyond the seas for up to fourteen years' (65)

Lord Ellenborough's Act set a new precedent because abortion prior to 'quickening' became a punishable offence under the law. *Lord Ellenborough's Act* also established absolute criminal guidelines for when abortion was considered a crime. Criminal law now stated that abortion was a crime before and after quickening. In British North America, the precedent set by *Lord Ellenborough's Act* became important and influenced laws in the provinces.

Until Confederation, each individual colony or territory passed their own laws, including laws governing women's bodies and reproductive freedoms, but these early laws followed from British law. In her book *The Nature of their Bodies: Women and their Doctors in Victorian Canada*, Canadian feminist historian, Wendy Mitchinson, who has written extensively on early laws in British North America establishing control over women's pregnancies, notes that:

> New Brunswick (1810) and Prince Edward Island (1836) were the first colonies to pass abortion legislation in British North America and each maintained the distinction between an abortion performed before and after quickening…In 1841, when Upper Canada passed its first abortion act it abolished the quickening distinction, as did New Brunswick in 1842. In none of the jurisdictions which had abortion laws was the woman liable to prosecution for attempting to abort herself; the focus was on the abortionist. Amendments to the New Brunswick Act (1849) and the introduction of Nova Scotia's first abortion law (1851), however, removed that protection. The full weight of the criminal law could now be brought to bear against the woman (1991, 134-135).

In British North America, British laws of the early 19th century were followed and eventually removed the distinction between a fetus having quickened or not. Backhouse provides a fuller explanation of the Upper Canadian law of 1841 known as *The Offences Against the Person Act*, which removed the quickening distinction (69). This law stated, "whosoever, with intent to procure the miscarriage of any woman, shall unlawfully administer to her, or cause to be taken by her, any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony" (Backhouse, 69). The implication of the wording in *The Offences Against the Person Act* was that any woman attempting to abort on her own was subject to criminal charges as was anyone who attempted to aid such a woman. Once British North America was consolidated into the country of Canada in 1867, the *Criminal Code of Canada* (hereafter referred to as the *Code*) took the abortion laws of the individual provinces and territories and enforced them at the federal level. Canadian laws coupled with medicine's increasing control over women's bodies gave the medical profession the ability to force their moral beliefs upon women because they had governmental support. The enactment of legislation such as the *Code* meant that doctors could reject women's requests for abortions, not only on moral grounds, but also for fear of being punished themselves should they be found to helping women abort.

The *Code* was enacted in 1892 and section 179 (C) dealt directly with issues of abortion and birth control (Mitchinson, 1991, 135; see also Backhouse, 110-111; McLaren, 323). Section 179 (C), "stipulated a two-year sentence for anyone who without lawful excuse or justification, offers to sell, advertises, publishes an advertisement of, or has for sale or disposal any medicine, drug, or article intended or represented as a means of preventing conception or causing abortion" (Mitchinson, 1991, 135; see also McLaren,

323; Mitchinson, 2013, 159). In addition, section 179 (C) reduced "the penalty for women who procured their own abortions…from a maximum of life to a maximum of seven years" and "created a new indictable offence, with a maximum of two years imprisonment, for selling or exposing obscene material to public view" (including providing information on the procurement of an abortion) (Backhouse, 1983, 110-111, 117). The specific criminal offences listed in Section 179 (C) of the *Code* further restricted a woman's ability to access even basic birth control information, let alone procure or attempt to procure an abortion, yet the punishments were a bit more lenient. Section 179 (C) of the *Code* remained in effect for 77 years, until the Liberal government of Prime Minister Pierre Trudeau altered it.

1969

While Prime Minister Trudeau thought that he was helping to liberalize abortion laws, the amendment to the *Code* in 1969 continued to infringe upon each woman's right to a safe abortion. Beverly Baines' article "Abortion, Judicial Activism and Constitutional Crossroads" explores the main change and problem with the 1969 alteration to the *Code* under section 251, which was the creation of TACs to determine which women would be eligible for abortions:

> [t]he exemption required that the abortion be performed (i) by a qualified medical practitioner, (ii) in an accredited hospital, (iii) after three other doctors constituted by the hospital as a therapeutic abortion committee, (iv) had stated the continuation of the pregnancy would or would be likely to endanger the woman's life or health, (v) in a written certificate that would be requisitioned by the Minister of Health either from the therapeutic abortion committee or from the doctor who had performed the abortion, along with other information pertaining to the circumstances of the abortion (3-4).

In other words, in order to obtain an abortion, women were at the mercy of a TAC, which had the right to judge each woman who came before them as to whether or not they would grant them an abortion. Only under certain circumstances would a woman be granted an abortion, if carrying the fetus to term placed the woman's 'life or health' in danger.[4] The problems created by the introduction of section 251 of the *Code* did not go unnoticed.

Angus and Arlene McLaren have written extensively on the history of women's reproductive rights in the Canadian context in their book *The Bedroom and the State: The Changing Practices and Politics of Contraception and Abortion in Canada, 1880-1997*. McLaren and McLaren explain that, "[i]n the early 1960s lawyers and doctors were complaining of the rigidity of the existing law on abortion. Some doctors were especially perturbed by the fact that women continued to die as a result of back-street abortions" (136). The concern surrounding the problems with the new abortion law did not simply end there. Feminist activists began to take up this issue forming "a campaign for the repeal of the abortion law" in 1970 to fight for women's reproductive rights with the underlying belief that abortion is, "a private matter between a woman and her physician"

[4] The implications of TACs on Canadian women will be explored in greater detail later on in the paper.

and not an issue for the state to regulate (McLaren and McLaren, 137). Almost two decades would pass before any positive change for women would occur.

The 1970s and 1980s

Women's activism and pressure on the government did not subside in the years leading up to the SCC's 1988 ruling in *R v Morgentaler.* One of the results of feminist activism and pressure on the government was the establishment of a committee to examine the state of abortion in Canada. However, their report did nothing to change the circumstances of abortion in Canada. McLaren and McLaren explain that:

> [t]he federal government, in an effort to contain discontent, established in September, 1975, a Committee on the Operation of the Abortion Law under the chairmanship of Robin F. Badgley. Its final report pleased no one…Ottawa attempted to ignore the issue and although in 1977 the federally funded Badgley Committee Report that critically examined the operation of the abortion law was published, no changes were made (138, 143).

The Badgley Report was more of a way for the government to appease pro-choice protestors, than it was to actually create real change to abortion laws in Canada. In her review of developments in abortion law in Canada entitled *Abortion: Constitutional and Legal Developments*, Mollie Dunsmuir outlines some of the issues the Badgley Committee identified with regards to abortion access in Canada.

The Badgley Committee, "found, quite simply that 'the procedures set out for the operation of Abortion Law are not working equitably across Canada.' In large part, this was because the intent of the law was neither clear nor agreed upon, although the procedures set out in the law were specific" (Dunsmuir). TACs had to determine if a woman's request for an abortion was to be carried out based on whether carrying the pregnancy to term would endanger the woman's 'life or health.' The definition of what constituted a threat to a woman's 'health' was one of the major problems outlined by the committee because the endangerment of a woman's 'health' had not been specifically defined by section 251 of the *Code* (Dunsmuir). Within a TAC, each doctor on the committee could define what constituted a threat to 'health' differently (Dunsmuir). Therefore, there was no uniformity, resulting in section 251 of the *Code* being applied unequally across the country. The lack of official regulations governing the operation of the TACs allowed individual doctors to force their moral values upon women. This abuse could and did take place because abortion was socially unacceptable. The report of the Badgley Committee did not result in any concrete action taken by the government to alter abortion laws. It would take the legal fight of Dr. Henry Morgentaler to change the 1969 abortion law.

The 1988 SCC decision in *R v Morgentaler* is the most well known of the legal cases that Dr. Morgentaler faced, but his work began long before this case came before the SCC. Dr. Morgentaler's first legal case for publicly admitting in 1973 that he had been performing abortions illegally in Montreal found him not guilty of "violating Article 251 of the Criminal Code" (McLaren and McLaren, 137). However, the Quebec Court of Appeal, "in February 1974, in an unprecedented action, quashed the jury findings and ordered Morgentaler imprisoned" (McLaren and McLaren, 137). He was later acquitted "after two more jury trials" (McLaren and McLaren, 137). Yet, this was

not the end of Dr. Morgentaler's legal battles. In 1983 Morgentaler was again arrested in Toronto for performing illegal abortions and acquitted in 1984 (McLaren and McLaren, 143). Morgentaler then "appealed his case to the Supreme Court of Canada in October 1986, arguing that the abortion law violated Section 7 of the *Charter of Rights and Freedoms*, which guaranteed Canadians 'the right to life, liberty and security of the person'" (McLaren and McLaren, 143). This appeal is important because Morgentaler took the law into his own hands in order to make a case as to why the *Code* violated women's *Charter* rights. Morgentaler had to appeal to the SCC because, "[n]o government was willing to go out on the political limb of respecting and supporting a woman's right to choose abortion, despite the fact that the majority of Canadians support such a position" (Majury, 316-317). There was a need for the SCC to rule directly on the issue of abortion as the lower courts and appeal courts continually contradicted each other.

There were many questions the SCC had to consider in this case, but I will focus on the issues surrounding section 7 of the *Charter* because this will be crucial for my discussion of how women's rights to a pharmaceutical abortion method are still being violated by Health Canada based on what section 7 of the *Charter* promises them. Section 7 of the *Charter* guarantees all Canadians the right to, 'life, liberty and security of the person.' Focusing on section 7, the question the court had to consider was, "does section 251 of the *Criminal Code* of Canada infringe or deny the rights and freedoms guaranteed by s… 7…of the *Canadian Charter of Rights and Freedoms*?" [*R v Morgentaler* [1988], 1 SCR 30.]. The result of this case was:

> a majority decision (5 of 7 judges) of the Supreme Court of Canada rejected s. 251 of the *Code* as unconstitutional under the *Canadian Charter of Rights and Freedoms*. The decision called on the federal government to devise a new law to reflect a balance of the state's 'legitimate' interest in the fetus and the protection of women's constitutional rights (Mullen et al., 64).

The SCC set a precedent for overturning as unconstitutional section 251 of the *Code* and pressed the federal government to create a new, more equitable law. The majority judges in this decision wrote three different affirmative positions on this ruling, which will be used to justify the need for Canadian women to be able to safely access pharmaceutical abortion. Since the 1988 decision, abortion has remained a controversial issue that divides people including members of the federal government.

The 1990s and 2000s

In 1989, the Conservative government under Prime Minister Brian Mulroney introduced Bill C-43, which "sought to remedy the state of 'lawlessness' which has existed respecting abortion ever since the decision reached by the Supreme Court of Canada in *R v Morgentaler*" (McConnell and Clark, 81; Abortion Rights Coalition of Canada; see also Sabourin and Burnett, 533-534). The purpose of Bill C-43 was to recriminalize "the exercise of the right of reproductive choice, thus limiting women's right to reproductive control, and did nothing to cure the real problem" (McConnell and Clark, 82; see also Sabourin and Burnett, 533-534). As a result, Bill C-43 "was defeated in the Senate on January 31st, 1991" (McConnell and Clark, 81; see also Sabourin and

Burnett, 533-534). While the 1988 SSC decision set an important precedent, it has not resulted in equal access to safe, timely abortions.

In terms of private member bills, "45 anti-choice private member bills or motions have been introduced in Canada's Parliament since 1987" (Abortion Rights Coalition of Canada). During the 39th Parliament alone from 2006 to 2008 under Prime Minister Stephen Harper, four private member bills to recriminalize abortion have been put forward in the House of Commons, but all have either been defeated or stalled in the political approval process (Richer, 4-5, 20-23). The bills introduced into the House of Commons by Members of Parliament have attempted to recriminalize abortion or provide the 'unborn' with rights, which by extension would criminalize a woman's right to choose. What 'legitimate' interest could a fetus have that is more legitmate than a woman's control over her own body? This is the reason these bills have failed because they refuse to acknowledge the rights of women to make their own reproductive decisions, as was determined by the SCC. The SCC "decision called on the federal government to devise a new law to reflect a balance of the state's 'legitimate' interest in the fetus and the protection of women's constitutional rights" (Mullen et al., 64). Instead, what these 45 private member bills show Canadians is the opposite; major inequality to abortion still exists across the country because anti-choice ideologies continue to be articulated in society. In her article, "The Charter, Equality Rights, and Women: Equivocation and Celebration," Diana Majury calls the decision in *R v Morgentaler*, "'a narrow…victory' in that it did nothing to resolve any of the myriad problems that deny many women access to safe abortion in Canada" (318). The legalization of pharmaceutical abortion would provide a possible alternative for Canadian women, but it will take the help of feminists and direct government intervention to ensure equal access to abortion.

Pharmaceutical Abortion, *R v Morgentaler* and Section 7 of the *Canadian Charter of Rights and Freedoms*

The 1988 Supreme Court of Canada decision in *R v Morgentaler* struck down section 251 of the *Criminal Code of Canada* as unconstitutional. Section 251 had been Prime Minister Pierre Trudeau's 1969 attempt at liberalizing abortion in Canada. However, what this section of the *Criminal Code* actually did was establish Therapeutic Abortion Committees (TACs) that were responsible for determining which women would be provided with abortions [*R v Morgentaler* [1988], 1 SCR 30]. TACs determined whether a woman would receive an abortion based on the question, would "the continuation of the pregnancy of…[a]…female person…be likely to endanger her life or health" [*R v Morgentaler* [1988], 1 SCR 30]? TACs created many barriers to accessing abortion care.

First of all, every TAC could interpret the meaning of 'life' and 'health' in their own way [*R v Morgentaler* [1988], 1 SCR 30]. Secondly, hospitals within each province were not required to establish TACs, so women may not have had the option of having an abortion in their local area [*R v Morgentaler* [1988], 1 SCR 30]. As a result, access to abortion services was uneven across the country. Unfortunately, even after the *R v Morgentaler* decision, abortion access continues to be a problem for women across Canada. Pharmaceutical abortion presents a solution, as it can break down the many

barriers that currently exist to abortion provision. The problem remains, however, that the inaction of Health Canada infringes on women's rights under section 7 of the *Charter* to legalize the necessary drugs for pharmaceutical abortion.

Section 7 of the *Charter* protects each citizen's right to, "life, liberty and security of the person" [*R v Morgentaler* [1988], 1 SCR 30]. One of the main questions facing the Supreme Court of Canada in *R v Morgentaler* was "does section 251 of the *Criminal Code* of Canada infringe or deny the rights and freedoms guaranteed by s…7…of the *Canadian Charter of Rights and Freedoms*" [*R v Morgentaler* [1988], 1 SCR 30]? The majority of the judges involved in this case answered affirmatively, yes, section 251 of the *Criminal Code* does infringe upon or deny the rights and freedoms guaranteed by section 7 of the *Charter*. This question can be extended to ask, does delaying the legalization of an effective, timely and accessible pharmaceutical abortion method violate a woman's rights and freedoms guaranteed by section 7 of the *Charter*? The problem with this question is that when answered affirmatively, it would require the government to take direct action and provide women in Canada with a positive right.

While the *Charter* protects Canadians' rights, it does not provide citizens with positive rights under the law. However, the language of section 7 is questionable in that citizens are also "not to be deprived thereof except in accordance with the principles of fundamental justice" (Martin, 1989, 40). Abortion itself is no longer a crime against the justice system, yet many Canadian women *are* being deprived of abortion services. Therefore, the government would have to enact a provision in the *Canada Health Act* ensuring the provinces provide women with access to abortion services, such an action would constitute a positive right. Whether the government should provide Canadians with positive rights has been a subject of legal debate since the inception of the *Charter* in the *Constitution Act* of 1982.

Since the invention of the *Charter*, legal scholars have also critiqued it because it does not provide some of the most basic needs of life, for example: housing, poverty alleviation/welfare and reproductive choice (see additional readings: Jackman; Dorothy Shaw; Mary Shaw). *Charter* scholars such as Martha Jackman, Dorothy Shaw and Mary Shaw argue that the government should enact legislation to ensure positive rights to the basic necessities of life are met for Canadians. Yet, what these scholars also recognize is the complicated nature of the *Charter* and the conflict between the responsibility of the government to the individual and the responsibility of the individual citizen for themselves. In other words, the difference between formal equality and substantive equality is crucial to understanding this argument.

In her article "The Charter, Equality Rights, and Women: Equivocation and Celebration," Diana Majury differentiates between formal and substantive equality. Majury writes that, "[f]ormal equality is premised on the understanding that equality means treating likes alike and posits same treatment as its defining feature. It focuses on procedures with the goals of ensuring equality of opportunity" (305). Formal equality explains that all citizens are treated in the same manner to allow them the same prospects to lead successful lives. However, not all Canadians are the same nor do all Canadians begin their lives under the same conditions that allow everyone an equal chance at success. Canada is made up of a diversity of peoples, including groups that have been historically marginalized. The law has to recognize the implications of these differences because they result in differential treatment for certain groups of people:

> [s]ubstantive equality recognizes that in order to further equality, policies and practices need to respond to historically and socially based differences. Substantive equality looks to the effects of a practice or policy to determine its equality impact, recognizing that in order to be treated equally, dominant and subordinated groups may need to be treated differently (Majury, 305).

Women are different from men and from each other. For instance, Aboriginal women living on reserves will likely have a more difficult time travelling to an abortion clinic than a woman with secure employment living in Toronto. Additionally, immigrant women may face language and cultural barriers to accessing abortion services in any given Canadian community. Majury confirms that:

> [t]he ideology of formal equality masks and neutralizes inequality. In this context, disparate impact is constructed as natural and inevitable or as a product of choice or consent, and not as a function of discrimination. Marginalized claimants then have an uphill battle to prove inequality or discrimination, especially when that inequality is long-standing and deeply entrenched (301).

Instituting legislation requiring the provincial and territorial governments to provide equitable access to abortion services would be a positive right for Canadian women across the country and would be a step towards repairing inequalities in abortion access amongst diverse groups of Canadian women. This requires that the government take a substantive approach to the law.

As Chris Kaposy argues in "Improving Abortion Access in Canada," "the Federal Government in particular has a responsibility under the *Canada Health* Act to ensure that medical services necessary for the health of Canadians are covered under provincial/territorial medical insurance plans" (30). Questioning and critiquing the language of section 7, in light of scholarship on pharmaceutical abortion and the majority opinions of the judges in *R v Morgentaler*, shows an implicit bias in current government drug policy dealing with controversial medications. While the *Charter* is an important document, it has been in place for over 30 years now, and it is time the government amended certain policies to provide citizens with more secure rights. This will help ensure that section 7 of the *Charter's* requirement to 'life, liberty and security of the person' is met for Canadian women across the country.

Moira McConnell and Lorenne Clark's article, "Abortion Law in Canada: A Matter of National Concern," confirms much of what has already been mentioned, that "with the striking down of s. 251, Canadian women now have a liberty, or *negative right* to control their reproductive capacities. What they lack is a claim, or *positive right* of access to safe, subsidized and efficient abortion facilities" (81; emphasis mine). The 1988 decision in *R v Morgentaler* had three different affirmative positions that can help explain the problem with the lack of a pharmaceutical abortion method as it applies to section 7 of the *Charter*.

The 'Right to Life'

In relation to the 'right to life,' Justice CJ Dickson and Justice J Lamer expressed that:

> [s]tate interference with bodily integrity and serious state-imposed psychological

> stress, at least in the criminal law context, constitutes a breach of security of the person...as a result of the delay in obtaining therapeutic abortions caused by the mandatory procedures of s. 251...results in a higher probability of complications and greater risk. The harm to the psychological integrity of women seeking abortions was also clearly established [R v Morgentaler [1988], 1 SCR 30].

This quotation regarding the violation of the 'right to life,' expresses an important theme present in the current discussion about pharmaceutical abortion: the negative impact of decisions made by the state in the lives of Canadian women.

Delaying the legalization of mifepristone as part of a pharmaceutical abortion method can be viewed as 'state interference' because there is no 'real' reason for the Canadian government drug approval process to take so long. Mifepristone was marketed for use in France by Roussel Uclaf and their German parent company Hoechst in 1988 and has undergone numerous drug trials, studies and approval processes in countries around the world since the late 1980s (Chalker and Downer, 213). One of the reasons cited for the continued illegality of mifepristone in the Canadian context is the failure of Canadian drug trials. In Canada, "[i]ndependent trials were being conducted in…2001, but were stopped when one participant died due to a rare infection that was *not* related to the drug" (Downie and Nassar, 167; emphasis mine). Fourteen years have gone by and Canada has not started a new set of drug trials nor made significant steps towards legalizing the drug even though the participant in the drug trial that died, died from an unrelated cause. Two other reasons are also commonly discussed for inhibiting the legalization of a pharmaceutical abortion method. According to Erdman et al., these barriers are: "financial incentive and political bias" (1767).

The financial 'concern' at issue is that, "the application for approval costs between $ 52 000 and $ 117 000 and the annual number of Canadian abortions which would be eligible for mifepristone use may not be seen to be sufficiently lucrative" (Downie and Nassar, 151-152). Research has shown that:

> [i]n many countries, medication abortion has proven less profitable than expected. In Canada, it is predicted that revenues will be moderate because of cost controls and will not offset high regulatory approval costs. Revenues from abortifacients medicines are expected to be lower than from other drug products because of their relatively infrequent use and the likelihood of negotiated pricing with public agencies and professional groups (Erdman et al., 1767).

Profitability should not triumph over the right to safe and effective reproductive technologies. Furthermore, pharmaceutical abortion is available in 57 countries worldwide, if mifepristone were not profitable or drug companies were not able to make up the lost revenue in some way, this medication would not be available in so many countries (Dunn and Cook, 13). Additionally, legalization of mifepristone and misoprostol has been shown to alter the distribution of abortion methods.

French studies have proven that, "[w]omen who felt they were given a choice were four times as likely to have a medical procedure as those who were not given a choice, which suggests that an increasing proportion of abortions will be medical procedures in France, if health care providers are willing to share the decision with their patients" (Moreau et al., 229). As a result, the change in distribution means that more women may choose the pharmaceutical method over the surgical procedure after considering their options, making the government's financial concern null and void.

The second issue, bias, applies specifically to the government and the branch responsible for drug legalization, Health Canada, "[b]ias against reproductive health medicines, and especially abortifacients drugs, may also act as a strong disincentive for application. Health Canada has been perceived as biased against reproductive health medicines, largely because of stringent requirements for the approval of oral contraceptives" (Erdman et al., 1767). Jill Fisher and Lorna Ronald's article, "Sex, Gender, and Pharmaceutical Politics: From Drug Development to Marketing," confirms the conservatism of the Canadian government on drug policy (360). Fisher and Ronald compare Canadian drug policy to drug policy in the United Kingdom and the United States to show the stringency of Canada's drug approval processes compared with these other western nations (360). Shelia Dunn and Rebecca Cook's article "Medical Abortion in Canada: Behind the Times," takes this one step further by commenting specifically on Canadian drug policy and reproduction, stating, "[d]rug approval generally takes longer in Canada than in the US, but the lag time difference is longer for contraceptives" (14). In other words, Health Canada is conservative in general with regards to drug legalization, but where controversial birth control medications are concerned, they are even more stringent. As the issue currently stands:

> [m]ifepristone, also known as RU-486, has been under consideration by Health Canada since December 2012. It usually takes about nine months for pharmaceuticals to work their way through the approvals process, making mifepristone overdue for a decision…If approved, the drug would be available by prescription to terminate pregnancies of up to nine weeks (Payton, 2014)…Health Canada has requested additional information from the drug's manufacturer, a request that will delay until next fall a decision on whether to approve mifepristone…if the drug were to be approved in the fall, it wouldn't hit the market until 2016 (Payton, 2015).

The problem is, however, the country is in a federal election year, so it is not likely that mifepristone will be legalized this year. During a federal election year competing parties are interested in telling potential supporters what they will do for them, but these campaign promises do not necessarily become reality when the party that is voted in takes charge of the government. The winning party in the election must form a government and gain enough support from their opponents to ensure the piece of legislation will survive a vote in the House of Commons. Therefore, pharmaceutical abortion method will likely have to wait until well after the election and then depending on the government sworn in and their priorities, the wait may continue and the issue never settled.

The 3-year delay in legalizing the mifepristone-misoprostol drug combination for pharmaceutical abortion can be considered political interference because the government is compromising each woman's 'right to life.'

<u>The 'Right to Liberty'</u>

> With specific reference to the 'right to liberty,' Justice Wilson wrote that: [t]he right to 'liberty' contained in s. 7 guarantees to every individual a degree of personal autonomy over important decisions intimately affecting his or her private life. Liberty in a free and democratic society does not require the state to approve

> such decisions but it does require the state to respect them [R v Morgentaler [1988], 1 SCR 30].

In other words, Justice Wilson makes it clear that the state must respect women's reproductive decisions even if they do not approve of them. However, government intervention and requirements that inhibit the use of pharmaceutical abortion imply that the government does not support an abortion method that would make abortion more accessible generally.

While the mifepristone-misoprostol method is the favoured drug combination because it works faster than other methods, it is not available in Canada (Wiebe et al., 817-818). Instead, the methotrexate-misoprostol combination or misoprostol alone is utilized in Canada, but has to be used as an "off-label" medication (Sabourin and Burnett, 535). In her book, *Law and Reproductive Autonomy*, Erin Nelson explores the only way pharmaceutical abortion can be used in Canada, stating that:

> Canadian regulatory policy provides for a process whereby Canadian physicians can apply for access to unapproved drugs on behalf of their patients; but because the process requires a separate application for each patient seeking access to the drug, this is not an appropriate route for improving access to medical abortion for Canadian women (143).

Erdman et al.'s confirm this finding, stating, "Health Canada programs to ensure access to unapproved drugs do little to increase access to medicines intended for public health benefit. Physicians must file an application for each patient to be considered individually. This process is not only cumbersome but also likely to produce inequalities in access" (1768). Pharmaceutical abortion can also only be used within a very specific time-frame, up to the 9th week of pregnancy ("Sexual Health Center: Abortion: Medical Abortion") and delays resulting from the application process for doctors to use this method may mean that a woman becomes ineligible to use this method and has to resort to a surgical abortion instead, even though this may not be her method of choice.

Pharmaceutical abortion has many benefits for Canadian women and is supported by the SOGC. However, just because abortion is legal does not mean that access is always available. Part of the problem is that political biases have stalled the introduction of this beneficial abortion method and made it cumbersome for women to obtain a pharmaceutical abortion method even when their doctor is willing to apply for the drugs to be used. With specific reference to 'liberty' Sheilah Martin explains in "Canada's Abortion Law and the Canadian Charter of Rights and Freedoms," that "[*l*]*iberty* may mean more than the absence of physical restraint, and it may even include the positive concepts of self-determination and the freedom to choose between alternatives on the basis of enlightened self-interest" (1986, 397; emphasis original). Martin's statement can apply to pharmaceutical abortion in that being able to choose between two legal abortion methods would improve access to abortion for women and eliminate many of the restrictions that women continue to face in trying to procure abortion services.

The 'Right to Security of the Person'

Finally, the 'right to security of the person' was explained by Justice Beetz and Justice J.J. Estey, as:

> includ[ing] a right of access to medical treatment for a condition representing a danger to life or health without fear of criminal sanction. If an act of Parliament forces a pregnant woman whose life or health is in danger to choose between, on the one hand, the commission of a crime to obtain effective and timely medical treatment and, on the other hand, inadequate treatment or no treatment at all, her right to security of the person had been violated [R v Morgentaler [1988], 1 SCR 30].

Canadian women still have to submit to 'inadequate treatment' with regards to abortion health care services because of the long wait times for surgical abortion and the potential dangers of attempting a pharmaceutical abortion on one's own.

In 2007 the Canadian Broadcasting Corporation reported that despite the legality of abortion in Canada, access to abortion services remains difficult to obtain and serious delays often occur (Dube). In her investigative news report, "Abortion Wait Times in Ottawa Hit Six Weeks," Rebecca Dube discovered that:

> a woman who wants an abortion in the city must wait about 3 ½ weeks…The consequences of long wait times for abortion are problematic, advocates and doctors say, because the window of opportunity is so narrow: The cutoff for an elective abortion in many parts of Canada…is 20 weeks…The longer a woman is pregnant, the more risky and complicated her abortion will be.

While waiting 3 ½ weeks is better than the statistic presented in the 1977 Badgley Report on abortion access in Canada, which found that women faced a delay of 8 weeks in obtaining a therapeutic abortion, it is still problematic that women are waiting even 3 ½ weeks because the wait can cause unnecessary stress that can exhibit itself physically and emotionally [R v Morgentaler [1988], 1 SCR 30].

While it is no longer a crime to have an abortion, the government is effectively only providing 'inadequate treatment' for those wishing to procure an abortion. As Dorothy Shaw notes in her article, "Abortion and Human Rights:"

> [a]dvances in health and technology including antibiotics, blood transfusion, contraceptive methods and safe medical and surgical abortion techniques should have meant that women no longer need to put their lives at risk, although they may not have access to such services, nor the autonomy to make decisions on their own sexual and reproductive health (633-634).

There is the implication that the lack of government policy with regards to pharmaceutical abortion is continuing to place women in a dangerous position where they face inadequate medical care in obtaining an abortion. Attempting to access pharmaceutical abortion in different ways that are not technically legal may negatively impact women's safety, but women have attempted to find ways to abort since the solidification of medication and laws supporting society's negative views on abortion took their control over this issue away from them.

It has been suggested that, "Canadian women may try to buy the drug [mifepristone] in the US…[according to]…Dr. Ken Milne of the SOGC…However, he warns that if Canadian women manage to get RU 486 across the border it is 'essential that they confide in their physicians. To withhold may well jeopardize their well-being'" (Sibbald, 2001, 82). This may prove especially true in the province of Prince Edward Island where there is no access to abortion services at all. Writing for the Canadian Broadcasting Corporation, Amber Hildebrandt confirms that, "no doctor on the island

[Prince Edward Island] is currently performing surgical abortions, though medical abortions are secretly being conducted, according to reports." There is no solid data in terms of quantitative or qualitative information that this is occurring, but there is knowledge it is occurring. The problem is, that both abortion methods need to be performed under the care and supervision of a trained medical professional. Therefore, if a woman travels to the United States, obtains mifepristone and misoprostol and goes home to administer the medications to herself, if the entire POC are not expelled, she will end up with an infection. While she can seek medical treatment, there are risks involved with utilizing mifepristone and misoprostol on one's own, primarily infection and excessive bleeding. Thus far there do not seem to be any cases where women have either been charged for obtaining these drugs across the border[5] or have died from sepsis or severe blood loss, but it is a serious possibility that can be avoided by direct government action, legalizing the mifepristone-misoprostol method, which has been thoroughly tested in other countries.

A woman's 'right to security of the person' is infringed upon when women only have inadequate abortion options. Particularly where there are no abortion options, attempting to procure an abortion on one's own places their health, life and by extension 'security of the person' at risk.

The decision in *R v Morgentaler* provides that women be granted access to legal abortions and that the government has a role to play in ensuring that this requirement is met. As can be seen, especially with the 45 private member bills that have been introduced since 1987, the government is failing to respect the judgement of the SCC. The *Charter* protects rights, but it does not give people the right to certain things like reproductive freedom.

Discussion

One way to ensure the government keeps pharmaceutical abortion on their agenda is the return of feminist health activism. It is very important for women to return to health activism as opposed to remaining in the bureaucratic world of policy change. While change can be created from within governmental structures, the advocacy of second wave feminists created some very important changes for women in Canada. In her article, "Creating Incentives to Market Mifepristone: No-Fault Insurance for Drug-Caused Birth Defects," Glynnis Burt explains that, "In Canada, the feminist demand for the increased ability of women to gain control of their reproductive functions contributed to the 1988 demise of the criminal prohibition against abortion and a Supreme Court of Canada judgment which recognized women's interest in bodily autonomy and human dignity" (2-3). Feminists were an integral part of educating the general public about the

[5] While there are no Canadian cases where women have obtained mifepristone and misoprostol in the United States there are American cases where women have obtained these drugs either online or on the Canadian black market. While each U.S. state has jurisdiction over abortion laws, the 20-year prison sentence of Purvi Patel in Indiana and the arrest of Kenlissia Jones in Georgia for utilizing these drugs to induce miscarriages alludes to the potential, where abortion is illegal, for women to be charged for obtaining and using these medications. Simply because abortion is allowed in Canada does not necessarily mean a woman could not be charged for the procurement of illegal medications (see additional readings: Woolf; The Associated Press).

fact that women deserved to make their own reproductive choices. Of course not all people are pro-choice advocates, but feminist groups like the VWC aided in staging many different types of events to gain public attention for the plight of women who had died from unsafe abortions. A renewed women's health movement could help prompt the government to take direct action on pharmaceutical abortion.

If there is to be renewed commitment by feminists to women's health activism, it must take into account and place the needs of marginalized women front and center. Women who occupy marginalized statuses within the country, for example, Aboriginal women, women living below the low-income cut off line and immigrant women are likely less able to be able to obtain the financial resources and personal support necessary to help hem make an informed decision about what to do if they are facing an unwanted pregnancy.

Exploring some of these examples in more detail points to further possible complications in accessing abortion services. For instance, women who are new immigrants to the country may not be able to access abortion services because of language barriers or complications caused by conflict between their own beliefs and western beliefs about women's bodies. Women with mental or physical disability face the legacy of forced sterilizations, which permanently took away women's rights to bear children. For disabled women (and also Aboriginal women) who have faced histories of sterilization in institutions, their own desire to abort may conflict with these violent acts done to those that came before them at the hands of the medical system. At the same time, for disabled and Aboriginal women, any choice to abort may also be influenced by the continuation of stereotypes that place them below the average Canadian woman and deem them unworthy or incapable of successful mothering. These are only a few of the possible difficulties of deciding to abort for women who have face conflicting belief systems and/or who have faced government sanctioned reproductive violence.

The complexity of identity categories that any given Canadian woman may face needs to be central to a renewed women's health activism because the government is likely to only create an abortion strategy that is for the greater good of the greatest number of women. Without an intersectional analysis and critique of the failings of current abortion services, a new system will never be created that takes account of the many complexities of women's identities and their specific needs. The Canadian government and Health Canada are unlikely to critique the current disjointed service provision based on how it makes it even more difficult for marginalized groups of women to obtain abortion services and the historical violence done to these groups that further complicates discussions of reproductive choice. One way forward to provide equal abortion access is to provide pharmaceutical abortion as an option in all abortion service centers (hospitals and clinics). The reason pharmaceutical abortion is a more equitable option is because it can be offered in more locations and under the supervision of medical professionals other than doctors. For example, counselors and nurses trained in this abortion method, located at a health clinic on a reserve would be able to offer this option to Aboriginal women, so women would not have to travel far from home to access abortion services. Similarly if a woman's shelter has medical practitioners, they too may be able to offer this as a possible option. Some women may still choose to have a surgical abortion in a larger city, but if pharmaceutical abortion is an option, women have

a method available closer to their homes. Certain health clinics may even offer services in languages other than English or French, which would also benefit new immigrants.

Downie Nassar reflect on the potential changes that could be made to allow the legalization of the mifepristone-misoprostol drug regimen:

> support for making RU-486 available in Canada indicates that independent groups would likely be willing to support further trials if, relieved of the burden of conducting the testing and application for approval, manufacturers would be willing to make mifepristone available to Canadian physicians and Health Canada would accept an application for approval from individuals or groups other than the manufacturers…An argument could therefore be made that the process by which drugs are approved in Canada should be changed. Specifically, applications to begin trials of mifepristone should be accepted not only from manufacturers, but also from public interest groups or medical groups. This way, independent trials could be conducted and the drug approved despite the industry fears of anti-abortion backlash against them or insufficient potential profits from the drug. Pro-choice advocates could lobby the federal government for changes to the *Food and Drugs Act* and *Food and Drug Regulations* (167).

There is support from the WHO and the SOGC regarding the safety, efficacy and legalization of the mifepristone-misoprostol abortion method. Health Canada could allow a new set of trials on mifepristone to ensure Canadian drug trials correspond to the wealth of data from drug trials that have been carried out on mifepristone in other countries around the world. Two possible solutions to allow the legalization of the mifepristone-misoprostol drug combination would be for Health Canada to liberalize their drug policy regulations to allow for a new set of trials or allow a different medical entity to take on the pharmaceutical abortion issue.

The federal government could take direct action to change laws surrounding abortion to ensure equitable abortion access. McConnell and Clark explain that:

> [l]egislation should be enacted requiring all provinces and territories to provide abortion services in order to make possible the effective exercise of the right to reproductive choice regardless of province of residence. Such legislation should provide that enough facilities be available to ensure safe, easily accessible abortion services to all women within the jurisdiction and that all such services be paid for under existing government health insurance plans. This would then give all Canadian women the positive right they need to ensure their continuing liberty and security of the person in accordance with s. 7 of the *Charter*" (85).

Legalizing a pharmaceutical abortion method could be part and parcel of ensuring that all Canadian women have the ability to access abortion across the country and would provide a positive right for Canadian women, which may be how the federal government should move forward in terms of providing people with the necessities of life. Feminists have a role to play in advocating for this positive right, exploring the language of the *Charter* and how it can be a potential tool to influence change and critiquing the way the *R v Morgentaler* decision neglected an intersectional analysis. While the *R v Morgentaler* decision legalized abortion, it did nothing to ensure a law was created that provided women access to abortion countrywide. Canadian women still want reproductive choice, but it is the government that is preventing them from having a choice in their abortion method. The existing *Charter* only provides so many protections

and does very little to oblige the government to ensure these rights are protected in areas like reproduction. The government has decided that women only have access to pharmaceutical abortion under off-label applications from a physician, but response to the application may come too late for the method to be used successfully to terminate a pregnancy.

Conclusion

The lack of access to abortion affects all Canadian women, but likely some more than others. As a result, equitable access to abortion is a feminist issue and it is an issue that Canadian women, however we may choose to identify ourselves, need to reignite. The protests of the VWC across Canada and specifically in Ottawa proved to the government that feminists would not stay silent on the abortion issue any longer.

Third wave feminism has tried to work for and create change from within the bureaucratic structures of the Canadian government, but this has not proven successful. It is time for a return to feminist protest outside the walls of academia, policy briefings and commissions set up to review the status of women. Marge Berer concurs in her article, "Inducing A Miscarriage: RU486 and PG For Early Abortion," "I believe the women's health movement should support and campaign for the introduction of RU486 + PG for early abortion in good conditions as part of the continuing campaign for safe abortion internationally" (1994, 140). Used under proper medical supervision, the mifepristone-misoprostol abortion method is a safe alternative to surgical abortion. As has been outlined above, pharmaceutical abortion has particular advantages that surgical abortion does not. If legalized, pharmaceutical abortion can improve access to abortion services across the country.

No member of the provincial, territorial or federal governments are likely to read this Independent Research Project or any potential publication that might result from this larger document. However, I hope that feminists will take up and read this important document, as it is a testament to where feminism has helped influence important decisions and where feminism and the government have both stalled in continuing to ensure women's rights are fully respected.

The way of the future for the government to ensure the rights of citizens are protected is to provide positive rights for the most basic of issues that are considered important human rights. This analysis of the 1988 *R v Morgentaler* case and how the judges might apply section 7 of the *Charter* to argue for the legalization of a pharmaceutical abortion method has shown that the government is not amoral or objective, they carry out their own agenda that is not necessarily in the best interests of all citizens. *R v Morgentaler* provides women with the right to abortion services, so it follows that the government ensure this right is met. Since the *R v Morgentaler* decision, no attempts have been made to change abortion laws for the benefit of women trying to obtain abortion services. While the individual provinces and territories oversee health care, a federal law is needed to ensure equitable service delivery and compliance in the provision of abortion services. Women's reproductive rights are not currently on the government's agenda, but feminist activism, especially surrounding pharmaceutical abortion can change this.

There are many benefits to pharmaceutical abortion, but the main benefit is that it can improve access to abortion services for women across the country. Many of the reproductive issues facing women today are similar if not the same as the issues women were facing in the 1960s, 1970s and 1980s, it is time for change and for the government to do something to ensure women's reproductive rights to are met. As Porter remarks, "the highest level of attainable psychological and physical health is likely to be achieved when the methods of abortion are safe and the choice of abortion is self-determined" (Porter, 216). Legalizing abortion was a major step forward, but providing all women with accessible abortion services is the next step to be taken in ensuring women's reproductive choices and freedoms are respected. Continuing to ensure women's reproductive rights are respected is part of the unfinished business of feminism.

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