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When there are no abortion laws: A case study of Canada

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A B S T R A C T

Canada decriminalized abortion, uniquely in the world, 30 years ago. We present the timeline of relevant Canadian legal, political, and policy events before and since decriminalization. We assess implications for clinical care, health service and systems decisions, health policy, and the epidemiology of abortion in the absence of criminal legislation. As the criminal abortion law was struck down, dozens of similar private member's bills, and one government bill, have been proposed, but none were passed. Key findings include that initially Canadian provinces attempted to provide restrictive regulations and legislation, all of which have been revoked and largely replaced with supportive policies that improve equitable, accessible, state-provided abortion service. Abortion rates have been stable over 30 years since decriminalization, and a falling proportion of abortions occur late in the second trimester. Canada demonstrates that abortion care can safely and effectively be regulated as a normal component of usual medical care.

Introduction

The recent #SheDecides movement has demonstrated the influence women can have in bringing about change in the laws controlling their reproductive rights [1–4]. Interestingly, there was foreshadowing of #SheDecides in Canada during legalization of abortion in 1969 manifest in the report of the Royal Commission on The Status of Women in 1970 [5] and a caravan of women who came to

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parliament that year and chained themselves inside the house [6]. From 1969 to 1988, abortion access was inequitable and legally only available in hospitals [7]. After a Supreme Court challenge in 1988 [8] and a subsequent failed attempt to reinstate criminal law controlling abortion in 1991 [9], Canada is currently among only four countries in the world that have no restriction in law. Liberalizing abortion laws does not necessarily equate to access as envisioned by #SheDecides. With decriminalization of abortion in Canada, abortion became a matter of health between a woman and her physician or, more recently, her health professional. The medical abortion pill mifepristone was introduced in 2017, and within a year, restrictive regulations were lifted [10,11]. Canada uniquely and rapidly began to realize abortion care within routine primary care services [12]. This opportunity may address geographic access disparities but may exacerbate the problem of maintenance of surgical abortion training, skills, and providers.

Background

In Canada, before the legalization of abortion in 1969, maternal deaths from unsafe abortion were common and under-reported. From 1930 to 1969, maternal mortality as a cause of deaths of women of reproductive age decreased to 2–3% from 10% to 15% [13,14] after the introduction of blood transfusion and antibiotics. However, the proportion due to reported unsafe abortion varied between 17% and 22.4% in Ontario and British Columbia (BC), respectively, with a report from BC between 1963 and 1970, suggesting that 27% of direct obstetric deaths were due to abortion [15,16].

Abortion laws were liberalized in most industrialized countries from 1950 to 1985 [17]. In 1994, 179 governments including Canada indicated their commitment to prevention of unsafe abortion by signing the International Conference on Population and Development Programme of Action [18].

The story of Canada

Timeline

1967–1970

Changes in the abortion law in Canada and key issues related to legal access to abortion are illustrated in a timeline (Fig. 1). Before the introduction of legal conditions for provision of abortion in a revision to the Canadian Criminal Code in 1969, a Royal Commission on the Status of Women was chaired by Florence Bird (1967–1970). Bird's report recommended

> "… birth control information be available free of charge to everyone and ensure that everyone has access to devices and drugs as needed." [5].

The report highlighted the UN 1968 proclamation of Tehran [19], which declared family planning to be a human right. Noting the lack of services in 1969, the report found that the year after federal decriminalization of contraception, there were only 38 centers across the country offering contraception. Bird's report stressed the need for services for all women and men including teens and the need for sex education in schools.

In considering abortion, the Royal Commission recommended

> "... that the Criminal Code be amended to permit abortion by a qualified medical practitioner on the sole request of any woman who has been pregnant for 12 weeks or less" [5].

and further that

> "… the Criminal Code be amended to permit abortion by a qualified practitioner at the request of a woman pregnant for more than 12 weeks if the doctor is convinced that the continuation of the pregnancy would endanger the physical or mental health of the woman, or if there is a substantial risk that if the child were born, it would be greatly handicapped, either mentally or physically." [5].

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1967-1970 **Royal Commission on Status of Women**

1967 **Canadian Medical Association Guidelines Submitted to Federal Government Committee**

1969 **Criminal Code Amended**

to allow conditions for legal provision of abortion and contraception; abortion must be performed by a physician in hospital after approval by a "Therapeutic Abortion Committee."

1970 **Abortion Caravan Arrives in Ottawa**

Rally on Mother's Day, women chained themselves inside the House of Commons to call for access to safe abortions and decriminalisation.

1973 **Henry Morgentaler Opens Abortion Clinic**

in Montreal, not lawful. After being arrested, charged, found innocent, then guilty on appeal three times, the Quebec government stops charging him and the clinic continues.

1981 **Province of Quebec sets up Abortion Clinics**

in local community service centres (CSLC), outside the law and backed by Quebec government.

1982 **Charter of Rights and Freedoms Enacted**

Morgentaler opens clinics in Winnipeg and Toronto and is charged with illegal abortion.

1988 **R. v. Morgentaler**

Supreme Court of Canada ruled that Canada's abortion law was unconstitutional, violating Section 7 of the Charter of Rights and Freedoms; infringed on a woman's right to "life, liberty and security of person". Abortion struck from criminal code, Canada had no law restricting abortion, treated like any other medical procedure. Provinces now responsible for regulations.

1989 **Tremblay v. Daigle**

Chantal Daigle's boyfriend obtained a court injunction preventing her from getting an abortion. Supreme Court later ruled that a father has no legal right to veto a woman's abortion decision.

1990 **Unsuccessful Attempt to Criminalize Abortion**

The federal government (Progressive Conservative) passed Bill C-43, sentencing doctors to two years in jail for providing abortions where a woman's health was not at risk. After passing the House of Commons, the Bill was defeated in a tied vote in the Senate in 1991.

1991 **The Supreme Court**

confirms that there are no legal rights of unborn babies unless they are born alive, as they are not yet recognised as "persons".

1994-1997 **Three Obstetrician Gynaecologists Shot**

at home, over four years, (Garson Romalis, Hugh Short, Jack Fainman). They provided abortions in Vancouver, Hamilton and Winnipeg respectively. All survived.

2006-2008, 2010, 2012

Continued attempts to pass legislation restricting abortion are unsuccessful.

2015 **Inter-Provincial Billing Agreement**

modified to include abortion, in line with the Canada Health Act.

2016 **PEI Government Announces Centre**

to be established that will include medical and surgical abortions, after challenge from Legal Education and Action Fund (LEAF) for never providing full, unrestricted access to publicly funded abortion care in the Province of Prince Edward Island.

2017 **Mifepristone Available in Canada**

Within the first year regulations were updated to permit: use up to 63 days LMP; physician or nurse practitioner may write a prescription; pharmacist may dispense directly to a patient; patient may initiate at time and place of their choice. Most provincial governments offer free mifepristone for all residents.

Fig. 1. Abortion in Canada Timeline.

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While a federal committee was considering amendments to the Criminal Code in 1967, the General Council of the Canadian Medical Association (CMA) approved a change to extend the basis for legal termination of pregnancy from

> "Where the continuation of the pregnancy will endanger the life or physical or mental health of the mother"

to

> "If continuation of the pregnancy will endanger the life or health of the pregnant female or there is substantial risk that the child may be born with a grave mental or physical disability or where there are grounds to believe that a sexual offence has been committed from which pregnancy has resulted."

They recommended these abortions:

> ".. be performed in active public treatment hospitals accredited by the Canadian Council on Hospital Accreditation." [20].

When parliament passed amendments to the Canadian Criminal Code in 1969 [21], permitting abortions under certain conditions, the conditions specified were considerably stricter than recommended by the Royal Commission [5], or even the more conservative CMA. Under section 237 (4) of the Criminal Code the new law:

> "…. permitted a qualified medical practitioner in an accredited or approved hospital to procure a miscarriage if the hospital's therapeutic abortion committee, by a majority of its members, certified in writing that the continuation of the pregnancy would endanger the life or health of the woman." [21].

Another problem immediately arose; among 948 general hospitals in Canada, only 450 were accredited, which created confusion and fostered continued unsafe abortions [5].

Although public hospitals were required to setup therapeutic abortion committees to review physicians' requests for termination of pregnancy, many did not, and access became challenging and inequitable. Canada's abortion legislation was federal and thus held jurisdiction throughout the country. Canada has universal healthcare; however, health is under provincial jurisdiction. Each province or territory makes independent decisions on how to deliver health care [22]. Decisions facilitating or restricting access to abortion occurred at the provincial level. This is illustrated by two contrasting examples. The province of Quebec never implemented therapeutic abortion committees, yet operated services that were non-compliant with the 1969 law and set up abortion clinics in local community centers in 1981. Conversely, it was almost 40 years later, in 2016, before the province of Prince Edward Island finally agreed to comply with the law, to provide abortion services.

Women's groups across the country were outraged by the ongoing lack of access to safe abortion under the new legislation. In March 1970, there were local units of the Women's Liberation Movement in 16 cities from Vancouver on the Pacific coast to Halifax on the Atlantic coast. These units organized a caravan of women who came to parliament and chained themselves inside the House. Their aim was to draw attention to the ongoing deaths from unsafe abortion and lack of access [6,23].

1973 – Dr. Henry Morgentaler opens first abortion clinic

Operating outside legal parameters that specified abortion could only be performed in hospital, and after the approval of the therapeutic abortion committee, Dr. Morgentaler opened the first of his abortion clinics in Montreal [24]. He faced charges by the government of Quebec. After three arrests and convictions, ultimately, the Quebec government stopped charging him and the clinic continued.

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1977 — The Badgley report

With the 1969 change to the criminal code, physicians were rapidly overwhelmed by requests for abortion in a context where some hospitals had established therapeutic abortion committees and others had not. In 1971, 30,000 abortions were provided legally in Canada, but concerns about inequitable access were rampant, realizing some of the fears of the Women's Caravan [6]. In 1975, a federal committee was struck on the Operation of the Abortion Law, chaired by Professor Badgley, reporting in 1977 [7,20]. They determined the procedures provided in the law were not working equitably. In particular, therapeutic abortion committees varied widely in their approaches, from approving all applications, declining applications due to the interpretation of "health," to requiring an interview with the woman. Delays, caused by the processes variably implemented, averaged 8 weeks from the time of consultation to abortion procedure [7]. In addition, at least one of six abortions was obtained in the United States, owing to lack of Canadian access [7]. Cost barriers added to inequities, as women often faced extra billing [20]. (1) Only 20% of hospitals had set up Therapeutic Abortion committees by the mid-1970s [24]. It was clear that changes were required.

1982 — Charter of rights and freedom and 1988 — R v Morgentaler

In 1982, Canada enacted the *Charter of Rights and Freedoms* with guaranteed rights, including legal rights [25]. Once enacted, any law contravening the rights within the Charter could be struck down as invalid. Dr. Henry Morgentaler immediately opened clinics in Winnipeg and Toronto and was charged with illegal abortion. After lower court rulings, in 1988, the Supreme Court of Canada ruled that Canada's abortion law was unconstitutional, violating Section 7 of the *Charter of Rights and Freedoms,* as it infringed on a woman's right to "life, liberty and security of person." Abortion was struck from the criminal code, leaving Canada with no criminal law restricting abortion. Abortion would therefore be treated like any other medical procedure [8,26]. As a health matter, provinces became responsible for any regulations. In the absence of the law, there was significant confusion on the part of women and governments. Reports quickly emerged of women resorting to illegal abortion. Most provinces soon introduced regulations or legislation, all of which initially aimed to restrict access to abortion [9]. Premier van der Zalm, in British Columbia (BC), was opposed to the new status and indicated that there was no longer a need to publicly fund abortions. This provincial decision was ultimately nullified by the Supreme Court of BC [27]. Similarly, courts across Canada found most restrictions were unconstitutional [9]. Prince Edward Island required residents seeking abortion to travel out of province [28].

1989 — A fetus has no rights

In 1989, the Supreme Court of Canada decided a case that held that the fetus is not a human being, and thus, a fetus has no legal rights [29]. Ms. Daigle chose to have an abortion after the end of her relationship with Mr. Tremblay. However, Tremblay tried to prevent her abortion through an injunction by the Quebec Superior Court. Daigle appealed eventually to the Supreme Court of Canada where her right to have an abortion, independent of the wishes of the father of the fetus, was upheld.

1990–2016 — Recurrent unsuccessful attempts to re-criminalize abortion

Shortly after the 1988 decriminalization, the Canadian government introduced Bill C-43 to recriminalize abortion and sentence doctors to two years in jail for providing abortions if a woman's health was not at risk [9]. Although passed in the House of Commons, it was defeated by a tie vote in the Senate and did not become law. No recriminalization law has been introduced by any Canadian government since then. More than thirty private members' bills have attempted unsuccessfully to introduce legislation aiming to recriminalize abortion [30].

Between 1994 and 1997, three Obstetrician Gynaecologists who provided abortion were shot in their homes; all of them survived.

1991 — Supreme Court defines a person as one who is born alive

The Supreme Court of Canada defined personhood during a 1991 case brought against attending midwives for a fetal demise in the birth canal. The Supreme Court found that a person could not be charged with murder or homicide in the demise of a fetus, as a fetus does not become a person and does not attain the rights of a human being until it is fully born (separated from the mother) [31].

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Abortion in Canada, post-decriminalization

Rates of abortion in Canada

The overall number of abortions in Canada is tracked by federal government health statistics [32]. The Canadian Institute for Health Information (CIHI) reporting on hospital abortions is considered complete, as it forms part of standard submissions of hospital data to the federal information system. Due to the voluntary, and often manual, nature of reporting from community-based abortion clinics, and the increasing provision of abortion at clinics compared to hospitals (Fig. 2), it is challenging to capture complete data. Data from Quebec are included in some years and not included in others. CIHI estimates the proportion of missing data annually, which has varied from 5% to 30%. Although data capture 2006 to 2011 had even higher levels of missing data, partly resolved for 2012–2014, data for 2015 and 2016 demonstrated excellent capture.

The estimation of actual abortion rates in Canada (including reported abortions *and* estimates for nonreporting), since decriminalization in 1988, indicates a steady incidence of approximately 100,000 abortions per year. Although in 1987 before decriminalization, federal statistics tracked just under 70,000 abortions, it is known that illegal facilities were performing but not reporting, abortion. Reporting of clinic abortions improved after decriminalization until 1992, when data capture was considered to be highly complete. As the number of females in Canada aged 15–44 years has been stable over the years 1987–2016, Canada has had a stable abortion rate of approximately 14.5 per 1000 females aged 15–44 years [33,34].

Since decriminalization, more than 90% of abortions occur in the first trimester [32,35]. Half of them occur among women aged 18–29 years. About half are among those who have previously given birth, with more than half reporting using contraception at the time of conception [36], which is consistent with rates of use of contraception at the time of conception of a pregnancy later presenting for abortion as reported in other jurisdictions [37], and 30% reporting a prior abortion [32]. All induced abortions over 20 weeks of gestational age take place in hospitals and are predominantly related to fetal abnormalities. The Canadian collection of vital statistics defines pregnancy termination below 20 completed weeks of gestational age (or with a combined weight of pregnancy tissue under 500 g) as an abortion, but registers pregnancy terminations beyond 20 weeks or of a weight of more than 500 g as "stillbirth." Thus, centers across Canada that offer abortion at more than 20 weeks gestational age must register the event in the stillbirth data. Recognizing this anomaly, CIHI reports on all abortions which occur at a gestational age greater than 20 weeks in their report on national number of abortions annually. Among 100,000 abortions a year, approximately 600 are over 20 weeks of gestational age [32,33]. This rate of 0.6% has been stable since decriminalization [32,33].

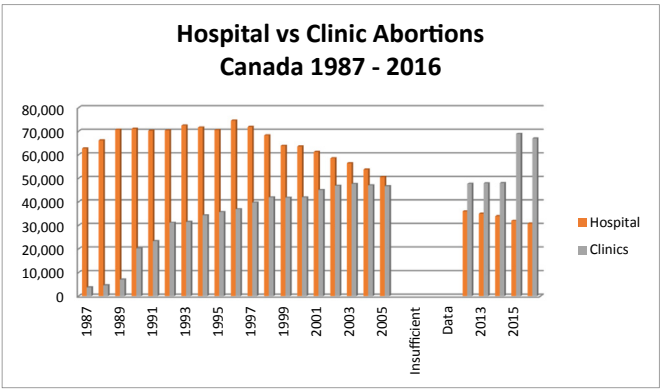

Fig. 2. Hospital compared to Clinic abortions in Canada 1987–2016. (Decriminalization 1988)
Legend Note: Data capture quality 2006 to 2011 is insufficient to give accurate representation, and 2012 to 2014 are considered to have a high proportion of missing clinic data.
Source: CIHI and Statistics Canada: Canada's Therapeutic Abortion Survey [36–41].

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Canada health act

The Canada Health Act,1985, is federal legislation regarding provision of health services by all provincial and territorial jurisdictions [38,39]. The federal and provincial cost sharing agreement is harmonized in the Canada Health Act, which defines standards for Universal Health Care to provide a uniform set of required services in all jurisdictions, aiming to address inequities through the public health system [38,39]. All provinces and territories determine health policy and services for their jurisdiction, within the principles of this Act [40]. Nonetheless, abortion access varies between jurisdictions [41].

Provincial regulation of hospital services

Several provincial laws and regulations aimed to improve equitable distribution of services [42–44]. In Quebec, development and planning to ensure accessible surgical abortion services span more than 4 decades [45].

BC similarly planned to support distributed services. A 1994 task force delivered specific recommendations for ensuring abortion access [46]. The 1996 legislation mandated service in designated hospitals [43], with laws added in 2001 guaranteeing access to services [47].

Concurrently, Ontario regulated the presence of at least 1 hospital providing abortion in each region [44].

Conversely, two provinces sought to limit access. New Brunswick, in 1989, limited provision to hospitals and required specialist provision and approval of two doctors. A January 2015 amendment removed the latter requirements but maintained the restriction to hospitals.

As mentioned above, Prince Edward Island legislated policy from 1988 to 2015, ensuring that no induced abortions would be performed in the province [28]. In 2016, under the threat of legal action, the government voluntarily reversed this policy and implemented abortion service [48].

Hospital and health region authority regulation of facility privileging

The regulation of abortion is additionally managed by accreditation standards for hospitals and surgical facilities. As both skill required and potential for complications increases with increasing gestational age, regulation of the gestational age limit at the time of abortion is a decision made by the regulator for each facility. A 2012 national survey of abortion facilities found 44% offered surgical abortion to 14 weeks or beyond, about a quarter mandated a limit of 12 weeks gestational age, and fewer than one in ten limited gestational age at or under 11 weeks [35].

Provincial regulation of health professional scope of practice

Health professionals in Canada are licensed by provincial health regulatory bodies [49]. Professions are self-regulating, and the health professional regulator expects each professional to practice only in areas where they have received adequate training and have demonstrated competence.

Before 2017, only physicians were regulated to provide abortion in Canada. Shortly after mifepristone became available in January 2017, the College of Nurses of Ontario authorized nurse practitioners in July 2017 to provide mifepristone medical abortion [50]. The federal drug regulator Health Canada followed in November 2017 removing the limitation to physicians, referring instead to authorized health professionals [11], thus confirming the jurisdiction of the provincial health professional regulators to establish scope of practice.

Access

Decriminalization of abortion has not ensured abortion equity. The 2016 UN Human Rights Commissioner's report [51] noted a lack of access to abortion in Canada and called on government to redress inequities. Three main access issues are cost, knowledge, and geography.

Cost

Typically, people who are resident for three months are enrolled in the universal health care system in each province or territory [38]. However, specific populations are not able to access coverage for their abortion. This affects vulnerable populations including undocumented immigrants, people with coverage under the plan of a parent or spouse who desire confidential care, and certain refugees and visitors to Canada.

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Cost could be a factor for those enrolled in a provincial health plan. After decriminalization, when suddenly abortion was not limited to hospitals, payment mechanisms were not immediately in place to provide for clinic-based abortions. Initially, and in some provinces for many years, insured residents covered under provincial health plans were required to self-fund a clinic abortion. A second issue involved insured residents currently living or working in a different province. From inception of the 1985 Canada Health Act, provinces and territories agreed on a system to allow "interprovincial billing" for services for their residents when in other Canadian jurisdictions. Abortion was not included universally within this agreement. Only in 2015 did all provinces and territories agree to allow reciprocal payments for abortion service.

Cost is also a factor among those seeking a mifepristone medical abortion. In Canada, Mifegymiso® (mifepristone 200 mg/misoprostol 800 μg) [52] costs approximately $300. Within the first year of availability, most health systems across Canada rapidly recognized this cost as a health system responsibility. However, up to April 2019, two provinces, Manitoba and Saskatchewan, still fail to provide coverage for mifepristone [53,54].

Cost is an access barrier for those who must travel to reach abortion services. Owing to Canada's vast rural areas, women from most communities have needed to travel to access services (see Geography, below). Sethna and Doull [55] found, among those able to access abortion, 15% reported no costs and 5% reported spending more than $100 on travel, including costs for airfare or transport by bus, rail, taxi, and ferry, fuel for a personal vehicle and the costs for a travel companion. Additional costs included time off work, accommodation, food, parking, and childcare.

Despite universal health care including provision of abortion services, cost is an important and inequitable barrier to access abortion in Canada.

Knowledge

Access is also related to knowledge. In Canada, health services are not advertised to the public; the main mechanism to find care is through the guidance of a primary care provider. Abortion services are situated in the normal health system but usually do not require a referral. Compounding the difficulty for patients to access abortions are patient concerns about the potential stigma or refusal should they request assistance from a healthcare provider who may not be supportive of their choice. This challenge is amplified by unprofessional tactics among some providers who hold a conscientious objection and may delay referral, order unnecessary tests, or refuse to refer or see a person requesting an abortion. Since 1988, the CMA has policies on expected professional behavior related to patients requesting abortion care [56]. This guidance was updated in 2018 to indicate that physicians must not discriminate against patients on the basis of disease or diagnosis and carry a duty to assist the patient to access the health care services [57]. Similarly, and with more power to enforce the standard, health professional licensing bodies require that health professionals ensure care for those seeking abortion services. For example, the Ontario regulator recently updated guidelines to stipulate that "physicians must not promote their own religious beliefs when interacting with patients…" and goes on to require "that physicians provide their patients with an 'effective referral' for those services the physician chooses not to provide for reasons of conscience or religion." [58].

As noted, some provinces have regulations enacted to improve distribution of services. The BC law additionally prohibits the public dissemination of information of where abortion services are provided, or who provides them, intended to protect those providing and accessing services. An unfortunate consequence is the limitation on facilities and advocates who might wish to share information of where services are provided. Thus, people seeking abortion may have difficulty finding the signposts.

With fewer than 300 abortion providers among 40,000 family physicians or specialists across the country, and with most communities not having any abortion providers, it is a challenge for many people, particularly those from rural or disadvantaged populations, to gain the knowledge to access abortion.

One solution is to include abortion information in provincial health information services. BC implemented a specific line dedicated to helping patients access abortion services [59]. This service, in the provincial women's hospital, was able to leverage co-located resources to provide information of the closest service, to offer options counseling, to facilitate access to preprocedure diagnostic tests, and to support travel and accommodation [59]. Now many provinces across Canada include information and referral for abortion in their "Nurse Health Line." [60] These toll-free provincial telephone advice services deal with a wide range of patient questions and provide an accessible and destigmatized resource for those trying to access abortion.

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Geographic

The most pressing abortion access issue in Canada remains geographic, with significant urban–rural inequities.

In 2006, only 14% of hospitals in Canada provided abortion services, and these are clustered in the largest urban areas [61].

The 2012 Canadian study of abortion providers [35] engaged participation from services providing more than 90% of all abortions. They reported 96% of abortions were surgical and located 94 facilities, half in the province of Quebec, where only one in five reproductive-aged females reside. The majority of facilities outside Quebec were purpose-specific abortion clinics and located only in the largest cities (census metropolitan areas, CMA) most of which were clustered along Canada's southern border. In BC, more than 90% of abortions were provided in CMAs, although only 56% of reproductive-aged females resided in these CMAs [62].

More than half of abortion providers in 2012 (56%) were family physicians and almost all of the rest were obstetrician gynecologists. These family physicians were not typically in primary care practice but rather in "focused" practice, predominantly in large urban family planning-specific clinics [35].

Thus, geographic access disparities before 2017 were exacerbated by a system of specialized surgical abortion services offered predominantly in large urban centers. However, people throughout Canada have primary care providers and smaller hospitals co-located in their rural and remote communities (Fig. 3). Ideally, these resources could be leveraged to provide closer-to-home abortion service.

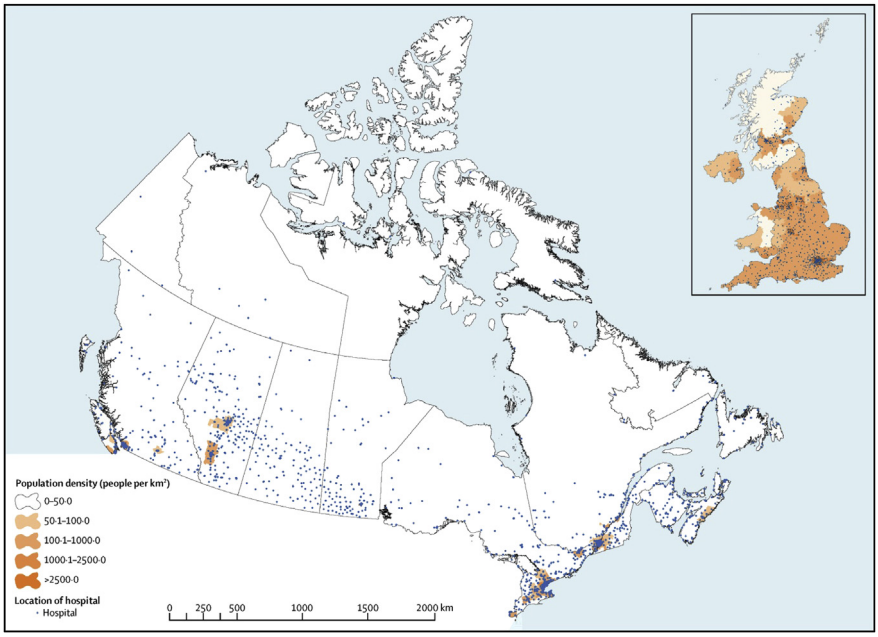

Fig. 3. Population Density and hospital location in Canada.
Legend: This map and inset relate general hospital locations to population density in Canada compared to UK. To illustrate the urban-rural abortion access disparity in Canada, note that general hospital services (blue dots) are distributed throughout Canada in proportion to the distribution of population. Prior to 2017 and the introduction of mifepristone medical abortion, abortion services were largely surgical (96%), and in purpose-specific clinics in the centres of highest population density, roughly corresponding to the dark orange areas. In contrast, in European centres as typified by the UK in the inset map, purpose specific abortion services in high density population centres are more geographically accessible. Provision of mifepristone medical abortion in primary care carries the potential to address Canada's urban-rural abortion access disparity.
Figure 3 is Reprinted from The Lancet, Martin et al. [39]. Copyright 2018, with permission from Elsevier [46].

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Training

Until the 2017 approval of mifepristone, the majority of first trimester abortions were provided surgically by family physicians. Gynaecologists also provide first trimester abortions and the majority of second trimester abortions. Canada offers two fellowship programs in Family Planning, one of which does not provide comprehensive abortion training. The Ryan Residency Training Program in Abortion and Family Planning operates at 84 North American sites, two of which are in Canada [63]. Residency programs in Canada are migrating to a national competency by design framework. Interestingly, as of July 2019, the wording for these competencies no longer explicitly includes skills for evacuating the pregnant uterus (first trimester) or termination of pregnancy as required competencies, although counseling and informed consent for contraception and abortion are included. Residency programs across the country vary in the inclusion of abortion skills as part of the resident experience. In general, most have included this training and plan to continue to do so within the new competency by design framework [64].

The College of Family Physicians of Canada does not specify any curriculum for abortion during family practice residency. A recent survey by Myran et al. [65] suggested a lack of exposure to abortion for family medicine residents and significant lack of awareness of legal and ethical requirements, with most not feeling competent to provide abortion. The respondents were strongly supportive of abortion being included in their training.

At the medical school level, ongoing interest and promotion to learn abortion skills has been successfully fostered since 2000 by Medical Students for Choice with current chapters at 15 of 17 Canadian medical schools [66].

Canada's approach to mifepristone transformed abortion access and leads de-regulation globally

Mifepristone medical abortion had been available in more than 50 countries around the world, in some for more than 25 years [67], when mifepristone was first approved in Canada. The introduction of mifepristone conferred the potential to address Canada's massive geographic abortion access disparities, potentially enabling Canadians to access abortion from their usual primary care provider.

The approval conditions of Health Canada effectively limited the provision of mifepristone to high volume-specialized urban services [10,68]. Limitations included the need for training, certification, and registration of a physician with the manufacturer before purchasing the medication, which could only be purchased directly from the manufacturer. Only a physician was permitted to dispense the medication directly to a patient and was required to have the patient sign a stipulated consent form and to directly observe the patient swallow the medication [10]. These conditions bypassed usual dispensing regulations in Canada, which recognize pharmacists as specialists and as the safest provider of dispensing services. In fact, Canadian health professional regulators had processes in place to discourage or forbid physician dispensing. Physicians not working in abortion-specific services were unlikely to purchase, stock, and dispense this medication, particularly at a per dose price exceeding $300 and a product expiry within one year [68,69].

Mifepristone was approved in July 2015, although not commercially available until January 2017. Before provision of the first mifepristone, national collaborations between researchers, health professional organizations, regulators, and policy makers [12,70] had resulted in the elimination of required observed dosing and had established in two of Canada's largest provinces (BC and Ontario) permission for any physician to write a prescription for mifepristone, which could be dispensed by any pharmacist [71,72]. Rapidly, other provinces followed. Within the first 11 months of mifepristone practice in Canada, Health Canada eliminated the need for signed consent form; physicians and pharmacists designated training and certification and registration with the distributor; physician-only dispensing; and physician-only prescribing [11,49,73,74]. Emerging data on the uptake of this novel practice indicate more than twice as many practitioners engaged in medical abortion practice within the first year of availability than had provided any abortion service before 2017, and in the two early adopter provinces within a year of the availability of subsidized mifepristone, nearly a third of all abortions were provided using mifepristone [12,75].

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Canadian regulators, health professional organizations, researchers, and policy makers worked together to translate global experience and research. They applied this evidence to the unique geographic challenges and context in Canada and implemented rapid uptake of practice, with minimal regulatory restrictions. In Canada, a patient wishing to have a medical abortion may see their closest nurse practitioner or physician, and receive a prescription, which they may fill at their chosen pharmacy, in most cases cost-free. The person may then choose to self-administer mifepristone at a convenient time and place [76]. Despite this near-complete deregulation of mifepristone practice, early data on outcomes aligns closely to best practice expectations [77].

Future considerations

As implementation continues for primary health care providers to be involved in access to medical abortion, the inequities faced by women due to geography, knowledge, and costs are expected to dissipate. Gestational age at the time of abortion may drop even further. Challenges will include the provision of contraception of choice at the time of medical abortion, specifically intrauterine methods (the contraceptive implant is not available in Canada), knowing that the context of women's lives, and telemedicine provision, can make it challenging to return for intrauterine method insertion.

Access and affordability to contraception will continue to pose barriers for some women until there is universal coverage for all methods. Training and maintaining skill and distribution of services for second trimester and surgical first trimester abortion will present an increasing challenge. Finally, political and legal attempts to limit abortion may continue; however, as has been the case since 1988, it seems unlikely they will succeed.

Technology continues to evolve. Social policy never remains the same. Thus, evolution ensures an ongoing need to monitor and address barriers to equitable access to appropriate, high-quality, provision of sexual and reproductive healthcare.

Summary

Canada decriminalized abortion in 1988 and remains the first and only country to do so. Over thirty years later, the rate of abortion did not substantially rise, and gestational age at the time of abortion appears to be falling. Following the Supreme Court case that struck down the abortion criminal law, dozens of private member's bills, and one government bill, proposed new criminal sanctions. None were passed into law. Initially provinces attempted to provide restrictive regulations; however, all have been revoked and largely replaced with supportive regulations and policies that improve equitable, accessible, state-provided abortion services. Mifepristone medical abortion has rapidly been taken up into usual services with a significant uptake in rural primary care since first introduced in January 2017. In some jurisdictions, up to a third of all abortions were provided by mifepristone within the first year. Conversely, maintaining skills for surgical abortion and particularly accessible skilled providers for second trimester abortion presents an increasing challenge. In 30 years since decriminalization, Canada has demonstrated clearly that safe and ethical abortion care can be regulated as usual for general reproductive health services, in the absence of a criminal law.

Practice points

- In Canada, there is no criminal law relating to abortion. Abortion care decisions are made between the woman and her health care provider, within the context of a universal health care system.
- In Canada, prescribing mifepristone is governed similarly to providing other prescription medications. Health practitioners may write a prescription. Any pharmacist may dispense mifepristone to the patient. The patient may choose when and where to take the medication.
- Medical abortion may be provided in Canada by telemedicine, enabling urban health care professionals to assess and manage abortion provision in areas with no prior abortion service.

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Research agenda

- Important next steps will be to quantify the extent to which mifepristone medical abortion is provided in primary care, how this practice is distributed geographically and by care provider type (including those offering abortion for the first time), and how this has impacted abortion service access.
- Global interest in the effects and outcomes of medical abortion deregulation indicates a priority for research on any impacts of distributed medical abortion services on abortion complication rates and costs to health insurance programs.
- An important research question for Canada is "How far is too far?" Many Canadians live four or more hours from access to surgery or blood transfusion. How far away from these life-saving services, can mifepristone safely be offered? Research could examine outcomes of current natural experiments in providing medical abortion through telemedicine and in communities remote from hospital and transfusion services.
- Delineating the mechanisms driving this innovative abortion model (providing abortion as normal primary care), and how this is diffusing into practice, will be important for other countries where access to specialized services may be restricted.

Conflict of interest

None.

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References

[1] Ploumen L. #SheDecides: International Planned Parenthood Federation. 2017 [cited 2019 Mar 25]. Available from: https://www.shedecides.com.
[2] Government of Ireland. Referendum on the thirty-sixth amendment of the constitution bill 2018 Dublin, Ireland. Government of Ireland; 2018 [cited 2019 Mar 15] Available from: http://www.referendum.ie/current-referendum/.
[3] Żuk P, Żuk P. Women's health as an ideological and political issue: restricting the right to abortion, access to in vitro fertilization procedures, and prenatal testing in Poland. Health Care Women Int 2017;38(7):689–704.
[4] Van Minh H, Ha BTT, Chuong NC, Anh ND. Women's health and health care in Vietnam. Health Care Women Int 2018;39(4):364–7.
*[5] Royal Commission on the Status of Women in Canada. Report of the royal commission on the status of women in Canada. Ottawa, Canada: Government of Canada; 1970.
[6] Greaves L. Personal and political: stories from the women's health movement 1960-2010. Second Story Press; 2018.
*[7] Badgley R, Caron D, Powell M. Report of the commission on the operation of the abortion law. Ottawa: Ministry of Supply and Services Canada; 1977.
*[8] Judgments of the Supreme Court of Canada R. v. Morgentaler. Supreme court judgments. 1988-01-28. Supreme Court Judgments; 1988. Case number: 19556. Available at: https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/288/index.do. [Accessed 22 March 2019].
[9] Erdman J, Gruben V, Nelson E. Canadian health law and policy. fifth ed. Lexis-Nexis Canada; 2017 Aug 17. p. 560.
[10] Health Canada. Regulatory decision summary: MIFEGYMISO. Ottawa: Health Canada; 2015. Available from: http://www.hc-sc.gc.ca/dhp-mps/prodpharma/rds-sdr/drug-med/rds_sdr_mifegymiso_160063-eng.php. [Accessed 3 October 2015].
*[11] Health Canada, MIFEGYMISO. Health Canada updates prescribing and dispensing information for Mifegymiso. Ottawa. 2017 Nov 7 [cited 2019 Mar 25]. Available from: http://healthycanadians.gc.ca/recall-alert-rappel-avis/hcsc/2017/65034a-eng.php.
*[12] Norman WV, Munro S, Devane C, Guilbert E, Brooks M, Costescu D, et al. Policy makers on the research team: real-time health policy improvements during mifepristone implementation research in Canada. Contraception 2018;98(4):331.
[13] Buckley S, editor. Ladies or midwives? Efforts to reduce infant and maternal mortality. A not unreasonable claim: women and reform in Canada, 1880s-1920s; 1979.
[14] Buckley KAH, Urquhart MC. Historical statistics of Canada. Toronto: Statistics Canada in joint sponsorship with the Social Science Federation of Canada; 1993.

Please cite this article as: Shaw D, Norman WV, When there are no abortion laws: A case study of Canada, Best Practice & Research Clinical Obstetrics and Gynaecology, https://doi.org/10.1016/j.bpobgyn.2019.05.010

[15] McLaren A, McLaren AT. Discoveries and dissimulations: the impact of abortion deaths on maternal mortality in British Columbia. B C Stud Br Columbian Q 1984;(64):3–26.
[16] Benedet J, Thomas W, Yuen BH. An analysis of maternal deaths in British Columbia: 1963 to 1970. Can Med Assoc J 1974; 110(7):783–4. 7.
[17] Rahman A, Katzive L, Henshaw SK. A global review of laws on induced abortion, 1985-1997. Int Fam Plan Perspect 1998; 24(2):56–64.
[18] United Nations Department for Economic Social Information Policy Analysis. Population and development: Programme of action adopted at the international conference on population and development, cairo 5-13 september 1994. New York: United Nations, Department for Economic and Social Information and Policy Analysis; 1995.
[19] United Nations. International conference on human rights Tehran, Republic of Iran, 22 April to 13 may 1968. New York, NY: United Nations; 1968. Available from: http://www.un.org/en/development/desa/population/theme/rights/. [Accessed 22 March 2019].
[20] Thomas W. The Badgley report on the abortion law. Can Med Assoc J 1977;116(9):966.
*[21] Canada. Criminal law amendment Act, 1968-69. Statutes of Canada; 1969. Available at: https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/5076/index.do. [Accessed 22 March 2019].
[22] Palley HA. Canadian abortion policy: national policy and the impact of federalism and political implementation on access to services. Publius J Federal 2006;36(4):565–86.
[23] Benston M. The political economy of women's liberation. Mon Rev 1989;41(7):31–44.
[24] Sethna C, Palmer B, Ackerman K, Janovicek N. Choice, interrupted: travel and inequality of access to abortion services since the 1960s. Labour Le Travail 2013;71:29–48.
*[25] Canada. Constitution Act, Canadian charter of rights and Freedoms. Government of Canada; 1982 [cited 2019 Mar 25]. Available from: https://laws-lois.justice.gc.ca/eng/Const/page-15.html.
[26] Norman WV, Downie J. Abortion care in Canada is decided between a woman and her doctor, without recourse to criminal law. BMJ 2017;356:j1506.
[27] Dooley D. Vander Zalm and media prejudice. Interim 1988;1988(July 23). Available at: http://www.theinterim.com/issues/society-culture/vander-zalm-and-media-prejudice/. [Accessed 22 March 2019].
[28] Health services payment Act, RSPEI 1988, c.H-2. 1988.
[29] Tremblay v. Daigle, 62. Sect. 0012-5350 Supreme court of Canada. 1989.
[30] Abortion Rights Coalition of Canada (ARCC). Anti-choice private member bills and motions introduced in Canada since 1987. 2018 [cited 2019 Mar 25]. Available from: http://www.arcc-cdac.ca/presentations/anti-bills.html.
[31] R v. Sullivan 1 S.C.R. 489 sect. Supreme court of Canada. 1991.
[32] Canadian Institute of Health Information. Induced abortions reported in Canada in 2016. Government of Canada; 2019. Available at: https://www.cihi.ca/sites/default/files/document/induced-abortion-can-2016-en-web.xlsx. [Accessed 22 March 2019].
[33] Canadian Institute of Health Information. Induced abortions reported in Canada in 2015. Government of Canada; 2017. Available at: https://www.cihi.ca/sites/default/files/document/induced-abortion-can-2015-en-web.xlsx. [Accessed 22 March 2019].
[34] Statistics Canada. Population estimates on July 1st, by age and sex. In: 17-10-0005-01 (formerly CANSIM 051-0001). Canada; 2019. 1987–2016. Available at: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1710000501. [Accessed 25 March 2019].
[35] Norman WV, Guilbert ER, Okpaleke C, Hayden AS, Steven Lichtenberg E, Paul M, et al. Abortion health services in Canada: results of a 2012 national survey. Can Family Phys Medecin de famille canadien 2016;62(4):e209–17.
[36] Norman WV, Brooks M, Brant R, Soon JA, Majdzadeh A, Kaczorowski J. What proportion of Canadian women will accept an intrauterine contraceptive at the time of second trimester abortion? Baseline data from a randomized controlled trial. J Obstet Gynaecol Can JOGC – Journal d'obstetrique et gynecologie du Canada SWSJOGC 2014;36(1):51–9.
[37] Jones RK. Reported contraceptive use in the month of becoming pregnant among U.S. abortion patients in 2000 and 2014. Contraception 2018;97(4):309–12.
[38] Canada Health Act R.S.C., 1985. c. C-6. 1985. Available from: http://laws-lois.justice.gc.ca/eng/acts/c-6/fulltext.html. [Accessed 22 March 2019].
[39] Martin D, Miller AP, Quesnel-Vallée A, Caron NR, Vissandjée B, Marchildon GP. Canada's universal health-care system: achieving its potential. Lancet 2018;391(10131):1718–35.
[40] Leeson H. Constitutional jurisdiction over health and health care services in Canada. The governance of health care in Canada, vol. 3. The Romanow papers; 2004. p. 50–82.
[41] Eggertson L. Abortion services in Canada: a patchwork quilt with many holes. 2001.
[42] Direction générale des programmes Service à la condition féminine. Direction générale de la planification et de l'évaluation. Orientations ministérielles en matière de planification des naissances. Ministère de la santé et des services sociaux. 1995. Quebec city, QC.
[43] British Columbia. Access to abortion services Act. R.S.B.C.. Government of BC; 1996. Available at: www.bclaws.ca/Recon/document/ID/freeside/00_96001_01. [Accessed 24 March 2019].
[44] Sinclair DG, Rochon M, Leatt P. In: Riding the third rail: the story of ontario's health services restructuring commission, 1996-2000. Institute for research on public policy. Montreal, QC, Canada: McGill-Queen's University Press; 2005.
[45] Desmarais L. Mémoires dune bataille inachevée: la lutte pour lavortement au Québec, 1970-1992. Montréal: Éditions trait d'union; 1999.
[46] British Columbia. Realizing choices. Report of the British Columbia task force on access to contraception and abortion services. Victoria, BC: Government of British Columbia; 1994.
[47] British Columbia Bill 21–2001. Abortion services statutes amendment Act. Government of BC; 2001. Available at: https://www.leg.bc.ca/36th5th/1st_read/gov21-1.htm. [Accessed 28 February 2015].
[48] Stettner S. The unfinished revolution. 1 ed. Athabasca University Press; 2016. p. 366.
[49] College of Physicians and Surgeons of Ontario. About the College. 2019 [cited 2019 Mar 25]. Available from: https://www.cpso.on.ca/About-Us.

Please cite this article as: Shaw D, Norman WV, When there are no abortion laws: A case study of Canada, Best Practice & Research Clinical Obstetrics and Gynaecology, https://doi.org/10.1016/j.bpobgyn.2019.05.010

[50] College of Nurses of Ontario. What NPs should know about Mifegymiso. 2017 Jul 18. Available at: http://www.cno.org/en/news/2017/july-2017/what-nps-should-know-about-mifegymiso/. [Accessed 24 March 2019].
[51] United Nations. Committee on the Elimination of Discrimination against Women: concluding observations on the combined eighth and ninth periodic reports of Canada. United Nations High Commissioner on Human Rights; 2016. Available at: http://www.etoconsortium.org/nc/en/404/?tx_drblob_pi1%5BdownloadUid%5D=194. [Accessed 24 March 2019].
[52] Health Canada Drug Product Database. Mifegymiso. 2015. Available at: http://www.hc-sc.gc.ca/dhpmps/prodpharma/databasdon/index-eng.php. [Accessed 21 October 2015].
[53] von Stackelberg M. Abortion pill access in Manitoba falls short, medical student group says 2019 Mar 08 CBC. 2019 [cited 2019 Mar 25]. Available from: https://www.cbc.ca/news/canada/manitoba/manitoba-abortion-pill-access-1.5048150.
[54] Pasiuk E. U of S med students call on provincial health ministry for universal access to abortion pill: CBC. 2019 [cited 2019 Mar 25]. Available from: https://www.cbc.ca/news/canada/saskatchewan/mifegymiso-abortion-pill-universal-access-saskatchewan-1.5064647.
[55] Sethna C, Doull M. Spatial disparities and travel to freestanding abortion clinics in Canada. Wom Stud Int Forum 2013;38:52–62.
[56] Canadian Medical Association. CMA induced abortion guidelines 1988. CMAJ 1988;145(11):1176A.
[57] Canadian Medical Association. CMA code of ethics and professionalism: CMA. 2018 [cited 2019 Mar 25]. Available from: https://policybase.cma.ca/en/viewer?file=%2fdocuments%2fPolicypdf%2fPD19-03.pdf#phrase=false.
[58] College of Physicians and Surgeons of Ontario. Professional obligations and human rights: College of physicians and surgeons of Ontario. 2015 [cited 2019 Mar 25]. Available from: https://www.cpso.on.ca/Policies-Publications/Policy/Professional-Obligations-and-Human-Rights.
[59] Norman WV, Hestrin B, Dueck R. Access to complex abortion care service and planning improved through a toll-free telephone resource line. Obstet Gynecol Int 2014;2014:913241.
[60] Ministry of Health. About 8-1-1 health link BC. Government of British Columbia; 2019 [cited 2019 Mar 25]. Available from: https://www.healthlinkbc.ca/services-and-resources/about-8-1-1.
[61] Shaw J. Reality check: a close look at accessing abortion services in Canadian hospitals. Ottawa: Canadians for Choice; 2006.
[62] Norman WV, Soon JA, Maughn N, Dressler J. Barriers to rural induced abortion services in Canada: findings of the British Columbia Abortion Providers Survey (BCAPS). PLoS One 2013;8(6):e67023.
[63] Steinauer JE, Turk JK, Pomerantz T, Simonson K, Learman LA, Landy U. Abortion training in US obstetrics and gynecology residency programs. Am J Obstet Gynecol 2018;219(1). 86.e1-.e6.
[64] Kent N, Ubhi J. Residency training in obstetrics & gynecology in Canada. In: Shaw D, editor. Personal communication; 2019.
[65] Myran DT, Bardsley J, Hindi TE, Whitehead K. Abortion education in Canadian family medicine residency programs. BMC Med Educ 2018;18(1):121.
[66] Abortion Rights Coalition of Canada. Training of abortion providers/medical students for choice Canada: abortion rights coalition of Canada. 2018 [cited 2019 April 2]. 2018 Feb: Available from: http://www.arcc-cdac.ca/postionpapers/06-Training-Abortion-Providers-MSFC.PDF.
[67] Gynuity. Map of mifepristone approvals. New York: Gynuity Health Projects; 2019. Available from: http://gynuity.org/resources/info/map-of-mifepristone-approvals/.
[68] Norman WV, Soon JA. Requiring physicians to dispense mifepristone: an unnecessary limit on safety and access to medical abortion. CMAJ 2016;188(17–18):E429–30.
[69] Vogel L. Doctors, pharmacists push back on medical abortion rules. CMAJ 2017;189(12):E480–1.
*[70] Norman WV, Munro S, Brooks M, Devane C, Guilbert E, Renner RM, et al. Could implementation of mifepristone address Canada's urban–rural abortion access disparity: a mixed-methods implementation study protocol. BMJ Open 2019:e028443. https://doi.org/10.1136/bmjopen-2018-028443.
[71] Ontario College of Pharmacists. Dispensing Mifegymiso: guidance for pharmacy professionals who are dispensing Mifegymiso®. 2017 Aug 23. Available at: http://www.ocpinfo.com/library/practice-related/download/Dispensing_Mifegymiso.pdf. [Accessed 24 March 2019].
[72] College of Pharmacists of British Columbia. Options for dispensing Mifegymiso in BC. 2017 Jan 12. Available at: http://www.bcpharmacists.org/news/options-dispensing-mifegymiso-bc. [Accessed 24 March 2019].
[73] Blaze Baum K. Health Canada eases restrictions on abortion pill Mifegymiso. 2017. Available at: https://www.theglobeandmail.com/news/national/health-canada-eases-restrictions-on-abortion-pill-mifegymiso/article36860275/. [Accessed 22 March 2019].
[74] Health Canada. MIFEGYMISO (mifepristone and misoprostol tablets) - Canadian Distribution and Administration Program. Available at: http://healthycanadians.gc.ca/recall-alertrappel-avis/hc-sc/2017/63330a-eng.php?_ga=2.209520661.688245650.1504820818-1040716025.1490733726. [Accessed 19 May 2017].
[75] Norman WV. CART-GRAC. Rate of uptake of medical abortion in BC and Ontario within the first year. University of British Columbia; 2019. Unpublished Data.
*[76] Kenney A. My abortion was the most positive experience I had with Canadian healthcare. Vice. 2019. Available at: https://wwwvicecom/en_us/article/zmaqwy/my-abortion-was-the-most-positive-experience-i-had-with-canadian-healthcare. [Accessed 25 March 2019].
[77] Warden S, Genkin I, Hum S, Dunn S. Outcomes during early implementation of mifepristone-buccal misoprostol abortions up to 63 Days of gestation in a Canadian clinical setting. J Obstet Gynaecol Can 2018 (in press). Available at: http://www.jogc.com/article/S1701216318304687/fulltext. [Accessed 29 March 2019].

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