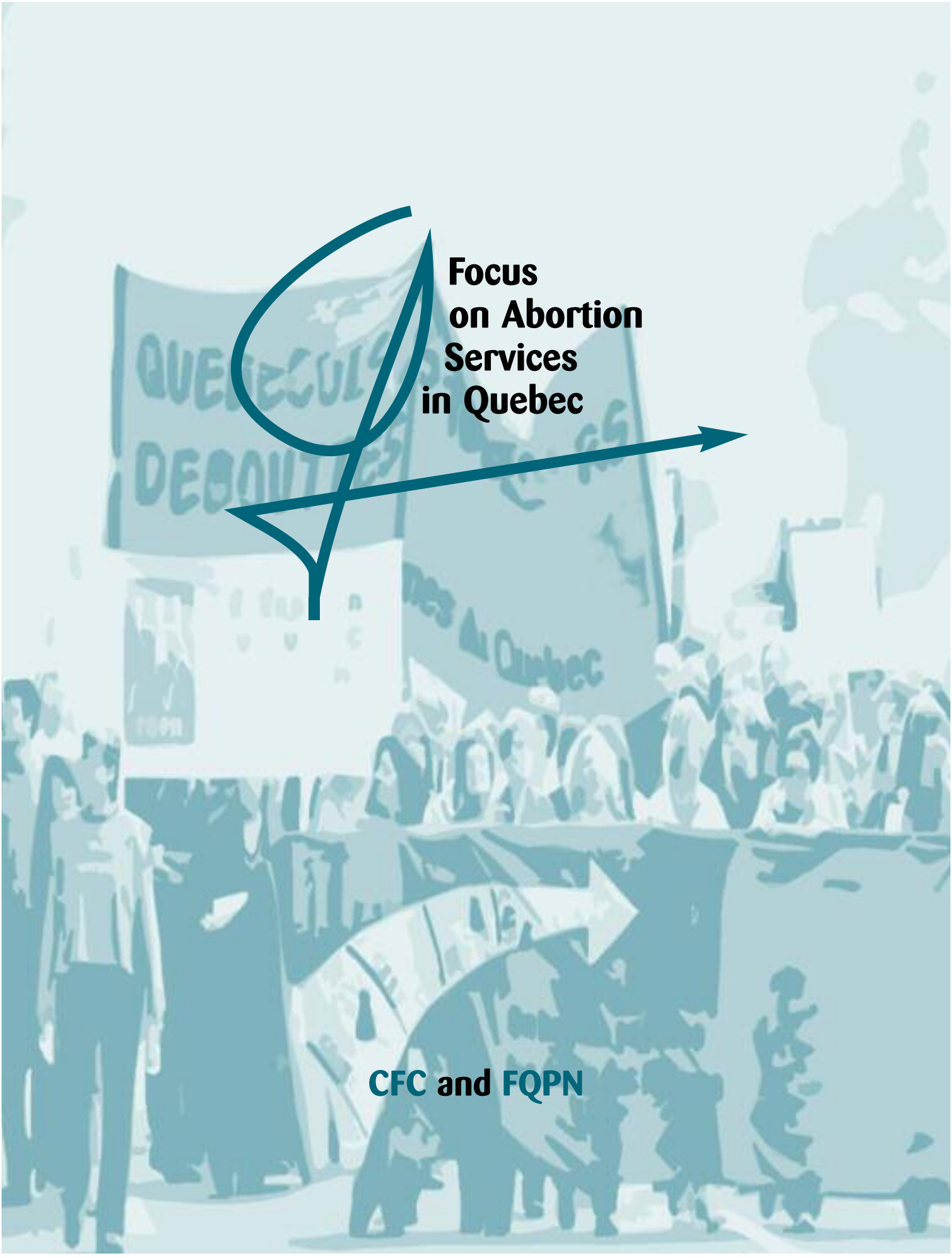

Focus on Abortion Services in Quebec

CFC and FQPN

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Legal Deposit
Bibliothèque et Archives nationales du Québec, 2010
The Library and Archives Canada, 2010
ISBN: 978-2-9810623-7-6 (print version)
ISBN: 978-2-9810623-8-3 (electronic version)

About CFC and the FQPN

Canadians for Choice (CFC) is a pro-choice, non-profit charitable organization dedicated to ensuring reproductive choice for all Canadians. At Canadians for Choice, we envisage a world where individuals – regardless of age, ability, race, gender, sexual orientation, place of residence, or socio-economic and other status – have access to the information, resources and services required to make and exercise informed choices on all aspects of their sexual and reproductive health and rights. For this reason, we work to ensure that the general public, policy-makers and health and education practitioners are well educated and informed about all aspects of sexual and reproductive health and rights. We also aim to enhance the quality and comprehensiveness of research and information on current and emerging sexual and reproductive health issues.

The **Fédération du Québec pour le planning des naissances (FQPN)** is an autonomous, feminist collective for popular education and advocacy of women's rights to reproductive health and sexuality. The FQPN comprises more than 60 organizations and individuals across Quebec.

Our mission is to promote a comprehensive approach to reproductive health, to defend the sexual and reproductive rights of women and to promote freedom of choice and informed decision-making in reproductive health. The FQPN demands, among other things, access to critical and independent information and free and universal access to comprehensive and quality family planning services.

The FQPN is the only group of organizations in Quebec that works on these issues from a feminist and reproductive justice perspective.

Acknowledgements

We wish to thank Julie Guérin and Mylène Sirois for their research assistance. We also thank Dr. Jean Guimond, Mariangela Di Domenico and Anne St-Cerny for their constructive insights and careful review on various parts of this document. We also thank Christine Dwyer and Julia Horel-O'Brien for their assistance with the translation of the report. We also thank the Clinique des femmes de l'Outaouais, the Comité de vigilance and the Intersyndicale des femmes for their financial support towards the creation of this document.

Summary

This publication aims to provide an update on the structure and quality of abortion services offered across Quebec in hospitals, *centres locaux des services communautaires*[1] (CLSCs), private clinics and women's health centres.

The current state of abortion services in Quebec begins with a history that reminds us of the important demands of the feminist movement and of the measures taken by the Ministry of Health and Social Services (MHSS), as well as those taken by the various public health, community and private institutions to establish free and accessible abortion services across the province. The second part presents the results of research conducted on abortion services. Firstly, anonymous calls to healthcare institutions that do and do not offer abortion services were placed to allow us to assess the accessibility of services for women in Quebec. Secondly, interviews with workers in abortion services were conducted to enable us to learn more about the organization of services and the successes and obstacles in each of the locations.

Key Findings

Both the anonymous calls placed to all hospitals and CLSCs across Quebec as well as the interviews with workers in abortion services lead us to certain conclusions about the state of abortion services in this province.

- In only 55% of the CLSCs, hospitals, private clinics, and women's health centres with abortion services, the receptionist was able to confirm that the institution offers these services and could describe the process to make an appointment or directed the call to a person who could provide the appropriate information.
- CLSCs and hospitals that do not offer these services should still be able to direct women to appropriate services. Yet only 58% of these institutions were able to direct a woman to appropriate services. The others referred callers to services that do not provide abortions, to nonexistent numbers, or to voicemail boxes. At six institutions, the receptionists allowed themselves to pass value judgments on abortion.

[1] Local Community Health Centres – referred to as CLSCs for the remaining parts of the document.

- The Info-Santé hotline contacted during the research was always able to provide adequate information in terms of referral to abortion services.
- Certain crisis pregnancy centres contacted did not clearly identify themselves as being opposed to abortion and provided false information on the consequences of abortion.
- Numerous service delivery points do not have ultrasound machines in their institutions or departments. Having to seek an ultrasound externally can increase the number of visits required for the procedure and may put women in contact with radiologists or technicians who are opposed to abortion.
- In several of the institutions offering abortion services, women must leave a message for someone to call them back due to lack of staff. The voicemail systems do not offer alternatives and pose a problem for women who do not have phones, cannot receive personal calls or fear for their privacy.
- Even today, women may sometimes have to wait up to three or four weeks before terminating a pregnancy.
- Lack of access to contraception and family physicians has been identified as a barrier for women. Moreover, sex education is almost absent in secondary schools and healthcare facilities.
- Numerous institutions have difficulty recruiting physicians who are trained in the practice of abortion or worry about having difficulty recruiting new ones when current doctors retire.
- More than half of the institutions are unable to financially assist women who do not have a health insurance card and who are not able to pay for an abortion.
- The vast majority of institutions offering abortion services suffer from a lack of resources: nurses, trained and available doctors, financial support, administrative support, etc. This lack of resources limits the supply of services, and also affects the quality of services, especially in terms of making appointments and post-abortion support.

Despite these obstacles, Quebec remains the province where abortion is most accessible. The policies and guidelines established by the MHSS provide a model for quality services in all administrative areas. In addition, abortion service providers throughout Quebec show great dedication, working overtime in order to provide quality services to women in need.

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List of Acronyms

APAA	Association pour l'accès à l'avortement (Association for Abortion Access)
CARAL	Canadian Association for the Repeal of the Abortion Law
CFC	Canadians for Choice
CFO	Clinique des femmes de l'Outaouais / Outaouais Women's Clinic
CLSC	Centre local des services communautaires (Local Community Service Centre)
CNALG	Coordination nationale pour l'avortement libre et gratuit (National Coordination for free abortion on demand)
CQDALG	Coalition québécoise pour le droit à l'avortement libre et gratuit (Quebec Coalition for the right to free abortion on demand)
CSF	Conseil du statut de la femme (Council on the Status of Women)
CSFM	Centre de santé des femmes de Montréal (Women's Health Centre of Montreal)
CSFQ	Centre de santé pour les femmes de Québec (Women's Health Centre of Quebec)
CSSS	Centre de santé et de services sociaux (Centre for Health and Social Services)
FCALA	Front commun pour l'abrogation des lois sur l'avortement (Common Front for the Repeal of Abortion Laws)
FLFQ	Front de libération des femmes du Québec (Women of Quebec's Liberation Front)
FQPN	Fédération du Québec pour le planning des naissances
LAM	Loi sur l'assurance maladie (Health Insurance law)
MHSS	Ministry of Health and Social Services
MSA	Ministry of Social Affairs (Ministère des affaires sociales)
NAF	National Abortion Federation
PPFC	Planned Parenthood Federation of Canada
PQ	Parti québécois
RAMQ	Régime d'assurance maladie du Québec (Quebec Health Insurance Plan)
RCSFQ	Regroupement des centres de santé des femmes du Québec (Women's Health Centres Collective of Quebec)
SMC	Specialized Medical Centres
TAC	Therapeutic Abortion Committee

Introduction

This publication presents a study of the structure and the quality of abortion services offered throughout Quebec, whether they are offered in hospitals, local community service centres (CLSC), private clinics, or by women's health centres.

More specifically, this document has two objectives: it aims to document and to make known Quebec's experience regarding the development and structuring of these services. Given that the province of Quebec is considered exemplary in the delivery of services, a review of its history is presented to help inspire the establishment of abortion services in the public health and community sectors elsewhere in Canada.

Further, the document presents the results of a research study conducted on the main obstacles to abortion services faced by women in Quebec today. The analysis of this study's findings aims to identify the improvements needed in terms of organization and quality of services.

This document addresses itself as much to decision-makers and health professionals as to abortion providers, researchers, activists, and organizations that work to promote women's health.

PART 1

History of the Establishment of Abortion Services in Quebec

The right to abortion can only be exercised if services are accessible. Quebec is the Canadian province with the highest number of abortion service providers. This section presents a succinct history of the establishment of abortion services in Quebec, which allows one to understand how they were constituted and how they evolved. It demonstrates how every decade brought its own share of demands, anti-choice pressures[2], obstacles, and gains – all embedded in Quebec's dynamic political and social context. The stage is set by the feminist movement that demanded the right to abortion as a fundamental means of securing gender equality in both law and in practice.

From 1960 to 1990, the main demand was the decriminalization of abortion. This victory was made possible in 1988 following a judicial battle, social changes, and women's increased awareness that led to the founding of the feminist movement. In Quebec, the abortion rights movement did not wait for decriminalization to put abortion services in place, which forced politicians to accept this state of affairs. In the early 1990s, demands focused on service accessibility, i.e. free, easily available, and quality services. The establishment of service delivery points in all the regions of Quebec, the creation of protocols for health professionals, and the coordination of second trimester services (for pregnancies of more than 14 weeks) were obtained after decriminalization. Nonetheless, today we face new challenges that must be taken into account to ensure access to, and even the right to, abortion.

Abortion before the 1970s

Before 1969, abortion was strictly prohibited in Canada, and the province of Quebec did not have any official abortion services. An 1869 federal law criminalized abortion with a penalty of up to life in prison for both the woman and the abortion provider, while an 1892 law prohibited the dissemination of information about contraception. During that time, the Catholic Church strongly influenced the politics and practices of Quebec society. The role of

2 The expression "anti-choice," rather than "pro-life," is used because it clearly describes the true goals of this movement, which are to oppose women's right to choose and to block abortion as an option.

women was often limited to that of reproducer and housewife. Any attempt to interfere in the "divine will" by controlling women's pregnancies and births was considered going against "nature."

Even illegally, abortions have always been performed in Quebec and in Canada. Women tried to delay their periods, to self-abort, or even to resort to abortionists or "angel workers" who acted clandestinely. But such practices were dangerous. Between 1960 and 1966, the Federal Office of Statistics reported 150 deaths linked to abortions. In 1966, more than 45,000 women were hospitalized after having tried to terminate a pregnancy, making it the primary cause of hospitalization for Canadian women that year.[3]

The 1960s ushered in a new social climate and, in Quebec, people's attitudes evolved. Among the upheavals were the secularization of Quebec society, the entry of women into the job market, the growing visibility of the feminist movement, and general aspirations to attain greater equality and freedom. These changes contributed to change the mindsets and politics vis-à-vis birth control. Several medical scandals related to clandestine abortions created such a stir that medical and legal organizations as well as religious groups from various denominations demanded changes to the Criminal Code. As a result, the federal government undertook a revision of the Criminal Code.

It was also during the 1960s that the first family planning associations were established: the Association de planning des naissances de Montréal[4] was founded in 1961, followed by the Centre de planning familial[5] in 1967. The first family planning clinic was created at the Notre-Dame Hospital. All three were funded by the Government of Quebec which, in 1967, became the first provincial government to do so despite legislative restrictions.

Bill C-150: A Major but Insufficient Legislative Change

In 1969, the federal government passed Bill C-150 (also known as the Omnibus Bill), regarded as a precursor to the Charter of Rights and Freedoms. Although abortion was still considered a crime, the law allowed therapeutic abortions to be performed under certain conditions: abortions had to be performed in an accredited hospital and women had to first receive approval from a therapeutic abortion committee (TAC). Comprising three physicians, these committees had to decide that the woman's life or health was in danger in order to grant her the right to have an abortion. Contested both by the people who supported the right to abortion as well as those who opposed it, Bill C-150 was a compromise. Abortion remained illegal, but doctors who practiced it for reasons considered therapeutic were protected against possible lawsuits. The implementation of Bill C-150 marked the beginning

3 Louise Desmarais, *Mémoires d'une bataille inachevée : la lutte pour l'avortement au Québec*, 1999, p. 22.

4 Family Planning Association of Montreal.

5 Family Planning Centre.

of a struggle which was at once political, legal, and social. On the same day, the sale and dissemination of information on contraception were legalized with the passage of Bill S-15.[6]

Since the 1970s, the movement for abortion rights had been carried out by women's groups, unions, and grassroots organizations in every corner of the province of Quebec. Provincial and regional coalitions were formed and many women activists, particularly those working in the field of community health, fought passionately for these rights.

The 1970s

The movement for the right to abortion was embedded in an ebullient political and social context that was favorable to the introduction of major changes. The Quiet Revolution of the 1960s had led the Quebec government to adopt the principles of the welfare state, to institute a true separation of Church and state, to loosen the Church's grip on the population, and to explore a new national identity. It was the emergence of a social movement. Inspired by "peace and love," it demanded free health and education systems, as well as the liberation of sexual mores long repressed by the influence of the Catholic Church. It was in this particular context that the first of many important changes regarding abortion services in Quebec began.

New Healthcare Institutions

In 1969, the implementation of the Régie d'assurance maladie du Québec[7] (RAMQ) marked a significant change in Quebec's healthcare services since it guaranteed access to free and universal healthcare. In 1972, the Centres locaux de services communautaires (CLSC) were established throughout Quebec. Prior to these institutional changes, popular clinics had been run by volunteers throughout Quebec, but their existence had been precarious due to recurring financial problems. These existing clinics were incorporated into the newly-created CLSC network. It is partly thanks to pressures from the general public and demands for accessible and democratic health services that CLSCs, unique institutions in Canada, now exist in Quebec.

The creation of CLSCs also aims to fill the void in primary healthcare. Their mission was threefold: to provide curative and preventive services, to provide individual social services, and to provide community action services. Originally, they were intended to be the gateway to the health system.[8] The educational and preventive mission of the first generation CLSCs

6 Louise Desmarais, *op. cit.*, p. 62.

7 Quebec Health Insurance Plan – referred to as RAMQ in the rest of this document.

8 Encyclopédie canadienne. « Santé publique au Québec » www.thecanadianencyclopedia.com/index.cfm?PgNm=TCE&Params=F1ARTF0009515. Accessed June 23, 2009.

was central to their mandate, which explains why these institutions played an important role in the establishment of abortion services throughout the province.

Also in 1972, the government of Quebec adopted the Politique québécoise de planification des naissances[9]. This policy provided various new measures, including information programs on prevention geared towards youth, information and consulting services in the CLSCs, as well as specialized services in hospitals and social service centres. The policy was accompanied by funding that allowed resource personnel to be hired to handle preventive information programs in CLSCs. Before 1976, however, the much-awaited services that had been planned for were scarce.

The early 1970s were also marked by the creation of groups that provided family planning information and services. In 1972, the Fédération du Québec pour le planning des naissances (FQPN) was established. At this time, the primary objective of the FQPN was to implement planning associations in all regions of Quebec to compensate for the lack of government services. The FQPN supplied information and training, in addition to carrying out political actions and lobbying the government to promote access to quality information about family planning and to emphasize freedom of choice. At first, the FQPN was mainly comprised of health professionals, doctors, nurses, sexologists, etc. Funding was initially provided by grants from the federal government through the Planned Parenthood Federation of Canada (PPFC).

The Difficult Implementation of the Therapeutic Abortion Committees (TAC)

In principle, since 1969, Therapeutic Abortion Committees (TAC) allowed women to have access to abortions in an accredited hospital upon obtaining the consent of three doctors. The criteria used by the TACs to determine whether or not a woman had the right to an abortion lacked standardization, which largely explained the disparities found in different hospitals and regions. Indeed, some TACs were composed of members who were opposed to abortion and requests were rarely granted. In other cases, a holistic approach to health was advocated and included psychological health, so that women more easily obtained the right to choose abortion. Other doctors, who were supportive of women's right to choose, approved de facto all requests for abortion, making the TACs a legal formality.

Despite the new legislation, access to abortion in Quebec remained very difficult. In 1970, 181 therapeutic abortions were performed, of which only one took place in a francophone hospital.[10] For several years, the large majority of abortions were performed in anglophone hospitals: 80% of abortions took place at the Montreal General Hospital.[11] In reality, not only

9 Quebec Family Planning Policy.

10 Louise Desmarais, *op. cit.*, p. 74.

11 FQPN, *Tabeau-synthèse : lutte pour l'avortement au Québec 1970-1985*, p. 2.

did illegal abortions continue to be performed, they were becoming increasingly organized with time. Some doctors performed abortions in their private clinics and numerous women from Quebec traveled to the United States, particularly to the state of New York, in order to have better access to abortion.

For-profit brokerage agencies also existed, requiring women to pay high prices to get an appointment for an abortion. These agencies, such as Interprovincial and Betty Farhood, to name the most famous, profited from the scarcity and the confusion that has often prevailed around the issue of access to abortion services. According to the Conseil du statut de la femme[12] (CSF), "some of these intermediaries were active until the early 1990s."[13]

1976: A Year of Political Change

In 1976, the Parti québécois[14] (PQ) was elected for the first time. New to the Quebec political scene, the party brought about some progress in terms of social rights. During his first year in office, the new Minister of Justice granted immunity to doctors who were qualified to practice abortion, basing his decision on the jurisprudence that recognized the defense of necessity. Thus, in Quebec, the legal proceedings were over: Morgentaler and other physicians who performed abortions without the consent of a TAC and outside of hospitals could no longer be sued. The PQ congress also voted a position in favour of free abortions upon request, but the party leader and premier, René Lévesque, vetoed it.

The new openness of the government allowed the practice of abortion to resume in physician's offices. For the Comité de lutte[15], it meant "the resumption of a flourishing network of clandestine abortions, allowing a few physicians to accumulate a small, untaxed fortune by pocketing the money of women under the table."[16] In addition, the RAMQ now allowed physicians to practice medical procedures related to abortion in private clinics (about $80 was refunded, although women paid doctors between $200 and $700).[17] Twenty-seven of the 95 hospitals in the province hosted TACs, but only 14 of these institutions had "functional" TACs, that is to say, TACs that met when there were requests. In 1976, 7,249 therapeutic abortions were performed in hospitals, including 5,000 at the Montreal General Hospital.[18]

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12 Council on the Status of Women, referred to as the CSF for the remaining parts of this document.

13 Conseil du statut de la femme, *L'avortement au Québec : état des lieux au printemps 2008*, Quebec, 2008, p. 36, (*translation ours*).

14 Refered to as PQ for the remaining parts of this document.

15 Action Committee.

16 Louise Desmarais, *op. cit.*, p. 149, (*translation ours*).

17 FQPN, *op. cit.*, p.2.

18 Claire Chabot, Manon Hotte et Sylvie Gravel, *Stratégie d'implantation des services d'avortement à l'intérieur des programmes de planification des naissances de certains CLSC*, 1983, p. 25.

Henry Morgentaler and Justice

Doctor Henry Morgentaler opened his first abortion clinic in Montreal in 1968, in complete illegality. He was arrested for the first time in 1970. Repeatedly delayed, his trial only began in 1973 after he publicly declared that he had performed more than 5,000 illegal abortions. Dr. Morgentaler was acquitted by pleading not guilty for "defense of necessity." An important notion in law, necessity implies being forced to violate the law in order to defend a larger social interest, without personal profit.[19] Dr. Morgentaler argued that his "criminal" acts were committed to protect others from imminent danger.

This decision was appealed. However, in a sharply divided ruling, Henry Morgentaler was finally found guilty by the Cour d'appel du Québec[20] in 1974, a decision that was upheld by the Supreme Court of Canada in 1975. He was sentenced to 18 months in prison. While incarcerated, Henry Morgentaler was on trial for a second time, which ultimately resulted in an acquittal. Once again, the judgment was appealed, but this time, the Court of Appeal did not overturn the decision.

In 1976, the legal saga continued with a third trial. Henry Morgentaler was again acquitted. The government of Quebec therefore made the decision to discontinue proceedings against him. Having always pleaded not guilty despite many pressures, trials, and a period of imprisonment, Dr. Morgentaler had become an important symbol of the fight for the decriminalization of abortion. In 2008, at age 85, Henry Morgentaler was nominated to receive the Order of Canada, the highest honor of the country. This recognition of his outstanding dedication to community still came with recriminations and pressures from anti-choice groups as well as one hundred MPs, which proved once again that the struggle for the right of women to control their bodies was not over.

19 Centre de traduction et de terminologie juridiques (CTTJ), Faculté de droit, Université de Moncton.

20 Quebec Court of Appeal.

Lazure Clinics: An Inadequate Improvement

In 1977, the MSA announced a new measure: clinics specialized in family planning would be located within hospitals and would offer abortion services, female and male sterilization, contraceptive services, and the prevention of sexually transmitted infections. They were called "Lazure clinics," named after the minister who introduced them. Twenty-one clinics within hospitals were planned, dispersed in all of the province's regions. Through these clinics, the MSA aimed to provide comprehensive family planning and abortion services to the women of Quebec. The government's objective was to have at least one hospital per region that would offer abortion.

In 1979, after more than two years of efforts to implement family planning clinics in each region of Quebec, five regions still did not offer abortion services. Nine hospitals performed abortions in the first eleven weeks of pregnancy only, in Montreal (three locations), Rimouski, Jonquière, Shawinigan, Val d'Or and Trois-Rivières. Six hospitals performed abortions after twelve weeks in Montreal (three anglophone and one francophone), Sherbrooke and Rouyn.[21] The establishment of other Lazure clinics was underway, but numerous pressures created obstacles. For example, in 1979, public protests were held in Val d'Or and anesthesiologists refused to participate in abortions; in Sept-Îles, the board of directors and physicians obstructed the establishment of an abortion clinic, while at the Centre Hospitalier de l'Université Laval in Quebec, public discontent made it difficult to set up the service.

Even with the establishment of Lazure clinics, the operation of TACs remained uncertain. Also in 1979, of the 75 cases studied by the TAC, only five abortions were allowed in Rimouski. In Jonquière, of the 35 requests for abortion, 12 cases were studied, but no procedure was performed. Consistently, the Montreal anglophone hospitals provided the most services with more than 4,000 at the Montreal General Hospital and a limit of 1,000 per year at the Jewish General Hospital.[22]

Despite the hope they had created, Lazure clinics were quickly criticized. A 1979 survey by the Coordination nationale pour l'avortement libre et gratuit[23] (CNALG) showed large gaps in services. It was hoped that these clinics would encourage the establishment of new TACs, but hospitals were free to choose whether or not to put these committees in place. Some hospitals' board of directors or board of physicians created systematic obstruction, either to prevent the introduction of a TAC or to block permission for an abortion from the women who requested it. In addition to the difficulties within the medical field and the quotas imposed, the implementation of Lazure clinics faced external criticism and heightened pressure by anti-abortion groups.

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21 FQPN, *Situation générale : les avortements*, 1981, p. 1-4.

22 FQPN, *Bilan des avortements pratiqués dans les Cliniques Lazure*, 1981, p. 1.

23 National Coordination for free abortion on demand. Referred to as CNALG in the remaining parts of this document.

Meanwhile, the CLSCs had been petitioning the Social Affairs Ministry (SAM) for authorization to provide abortion services. In 1978, the Fédération des CLSC[24] officially announced that CLSCs were ready to perform abortions before 12 weeks.[25] These efforts ended with a refusal by the government, which persisted in forbidding the practice of abortions outside hospitals although the province's RAMQ reimbursed doctors who performed abortions in private clinics.

In the late 1970s, very progressively, in an effort to compensate for the lack of government services, the FQPN managed to establish regional family planning associations in all of the administrative areas of the province. As family planning services were increasingly offered through the public healthcare system, regional associations were transformed. Some disappeared, while others became feminist collectives. This had the effect of changing the mission of the FQPN, which became a feminist umbrella organization in the early 1980s.

In 1981, after the CNALG investigation, the FQPN embarked on a general assessment of the Lazure clinics. The FQPN established that the clinics had improved the services offered in the regions of Quebec and the Northwest, but regretted that some areas still had no service delivery point, including the Outaouais, the Montreal North Shore and Chaudière-Appalaches. In other regions, such as Montreal and the Eastern Townships, the arrival of the Lazure clinics did not have a significant impact on the services offered.[26] The FQPN concluded that access to abortion services could only be ensured by the repeal of the law on abortion. The MSA could not ignore the increasingly vocal criticisms. It threatened to withdraw the funds earmarked for the development of TACs and abortion services in recalcitrant hospitals.

The 1980s

Abortions Without the Consent of the TACs

In the next decade, new actors entered the scene. First, women's health centres provided an alternative in the field of sexual and reproductive health for women. The Centre de santé des femmes du quartier Plateau Mont-Royal, better known as the Centre de santé des femmes de Montréal (CSFM), was the first to emerge in the francophone community in 1975. The founders of the centre clearly expressed their feminist and alternative objectives (at the time, strongly influenced by Marxist ideology):

24 The Federation of Local Community Service Centres.

25 CNALG, « Communiqué de presse », March 16th, 1982.

26 FQPN, « Les Cliniques Lazure : un constat d'échec », release, February 24, 1981.

"We want to develop an instrument that belongs to women and through which they can raise issues specific to their condition so as to take concrete action. [...] What determines the life of a woman is first and foremost the ability to have children. All her sexuality depends on it. Her health, too. The control of her own sexuality presents itself in terms of a struggle and power relations."[27]

Due to growing dissatisfaction with the traditional healthcare system, some women's health centres were established at the turn of the 1980s in the regions of Quebec, Lanaudière, Mauricie, Outaouais and Estrie. They offered information, referrals, training, public education activities, and research. In 1979, the Centre de santé pour les femmes de Québec[28] (CSFQ) opened its doors and was the first to offer abortion services. It was followed by the CSFM and the Clinique des femmes de l'Outaouais[29] (CFO) in 1981, then by the Centre de santé des femmes de la Mauricie in Trois-Rivieres in 1982. These abortions, not having been authorized by a TAC, were being performed illegally.

Despite the inaction of the government to establish abortion services in the CLSCs, some made the decision to offer the service illegally without the consent of the TACs. In 1982, five Montreal CLSCs and the CSFM publicly announced that they performed abortions in their facilities without women having to seek the approval of a TAC, in contradiction of the requirements of the Criminal Code. They had won their bet, which was to confront the MSA with reality and to force them to take a position on this controversial issue. The government decided not to prosecute, nor to stop this practice; the Minister of Social Affairs of the time, Pierre-Marc Johnson, justified his inaction by the existence of a "gray zone on the legal plan"[30] with respect to the issue of abortion.

"The establishment of abortion services on demand in women's health centres and in CLSCs will allow women to obtain quality services, accessible to all [...]. But above all, women no longer have to take steps that are demeaning and anxiety-provoking to get permission from therapeutic abortion committees to abort. The Centres des santé des femmes and the CLSCs recognize that it is up to women, and them alone, to decide to terminate an unwanted pregnancy."
CNALG Communiqué March 16, 1982

While the CLSCs began their approach within the political and legal context of the struggle for free abortion on demand, the public increasingly adopted a more favourable position on abortion. Given that the CLSCs had received special funding to develop information programs and family planning consulting services in 1976, some of them took the

27 Quoted in Louise Desmarais, *op. cit.*, p. 130, (*translation ours*).

28 Women's Health Centre of Quebec.

29 Outaouais Women's Clinic.

30 Quoted in Louise Desmarais, *op. cit*, p. 212, (*translation ours*).

Women's Struggle for the Right to Abortion

Without a doubt, the struggle for abortion rights is one of the most important battles of Quebec's feminist movement. Often associated with Dr. Morgentaler, this fight was first led by the thousands of women eager to regain control over their bodies. According to Louise Desmarais, author of the study Mémoires d'une bataille inachevée : la lutte pour l'avortement au Québec 1970-1992, Quebec's mobilization for the right to abortion occurred in four stages: the legal fight, the establishment of accessible services, the consolidation of claims, and a final period where the major gains materialized.

We Will Have the Children We Want

Free Abortion on Demand

Slogan of the Comité de Lutte, 1977

From 1970 to 1976, the legal aspect of the fight drew immediate attention. "The Morgentaler Case" became the trigger for the massive mobilization of women. At first demanding the decriminalization of abortion, many organizations sprang up and formed a support network for Henry Morgentaler, who was charged with performing abortions in his Montreal clinic, without the agreement of therapeutic committees. Various organizations mobilized together: the Front commun pour l'abrogation des lois sur l'avortement[32] (FCALA), the Comité de défense du Dr Morgentaler, and the Quebec section de Canadian Association for the Repeal of the Abortion Law (CARAL). Another network of feminist groups, whose ideological perspective was global and more radical, was also involved in the fight and included the Front de libération des femmes du Québec[33] (FLFQ), the Centre des femmes[34], et the Comité de lutte.

We, Quebecois Women, Want Control of our Lives

No More Abortion Butchery

Slogan of the FCALA, 1971[31]

From 1977 to 1982, in the second phase of the struggle, feminists mainly addressed their demands to the provincial government, tirelessly demanding a change in the Criminal Code to decriminalize abortion. The major challenge of the period was the need for free, accessible, and safe abortion services in Quebec. In 1978, a new group emerged and began to take a leading role in the struggle: the CNALG. Composed of representatives from feminist, civil, and political groups, unions, and groups of health workers, the CNALG participated in setting up the practice of illegal abortions in the CLSCs and women's health centres.

Between 1983 and 1989, attacks by abortion opponents forced the movement to adopt a more defensive attitude. During this period, conservatism gained some ground and the right was rising in Quebec. At the time, the most actively involved organizations were the FQPN, the Centre de santé des femmes de Montréal[35] (CSFM), and the Regroupement

Maternity: A Choice
Abortion: A Right

Slogan of the CQDALG, 1987

des centres de santé des femmes du Québec[36] (RCSFQ). A rallying group, the Coalition québécoise pour le droit à l'avortement libre et gratuit[37] (CQDALG), was formed in 1986.

The fourth stage of the struggle for abortion rights developed from 1988 to 1992. "Criminals, never again" was the slogan that set the tone for this period. Despite the decriminalization of abortion in 1988, feminists had to move quickly in the case of Chantal Daigle. With a demonstration involving approximately 10,000 people in Montreal, the message was clear: women in Quebec would no longer accept that their right to abortion be repealed. Several bills were filed in attempts to re-criminalize abortion, but without success. Feminists could thus devote themselves to the establishment of abortion services that were free, accessible and safe.

In this struggle, the central issue quickly became women's right to have control over their bodies. Throughout the years, the mobilization took various forms: demonstrations, memoirs, press conferences, manifestos, direct actions, petitions, letters, telegrams, teach-ins, articles, brochures, etc. The demands were for the right of women to decide if and when to have children, free abortion on demand, fertility control, control over one's body, and respect for women's choices.

It Is for Women to Decide
The State Can't Impose Anything

Slogan of CQDALG, 1989

The movement's demands touched upon two realms: the first, legal (the removal of abortion from the Criminal Code and the end of legal action against Dr. Morgentaler), and the second, political (free, safe, and efficient contraception for women; funding and increased support for family planning programs, including free, accessible, and safe abortion services throughout Quebec). From this moment on, feminists knew that abortion would never be a vested right. This is why they were, and still are, on the lookout for threats to this hard-earned right.

For more information, see: Louise Desmarais, *Mémoires d'une bataille inachevée : la lutte pour l'avortement au Québec 1970-1992*. Montréal, Trait d'union, 1999.

31 The research for slogans has been made by Louise Desmarais (translation ours).

32 Common Front for the Repeal of Abortion Laws.

33 Women of Quebec's Liberation Front.

34 The Centre des femmes, founded in Montreal in 1972 by four militant feminists and socialists, offers information and referral services for contraception and abortion. Doctors who collaborate with the centre see women by appointment.

35 Women's Health Centre of Montreal.

36 Women's Health Centres Collective of Quebec.

37 Quebec Coalition for the right to free abortion on demand. Referred to as CFDALG for the remainder of the document.

opportunity to expand their mission from referral services to the practice of abortions. The CLSCs justified their "illegal" activities by citing the exorbitant costs that were being charged by private clinics, and the inconsistent quality of services they offered. Since CLSC physicians and the Centre de santé des femmes who performed abortions were paid by public funds for medical procedures covered by Medicare, the government could not claim ignorance of this situation. Instead, it chose to tolerate it.

Maintaining Gains and Increasing Services

Following the dissolution of the CNALG in 1982, the Comité de vigilance[38] was established as an informal body that brought together feminist practitioners of CLSCs, the CSFM, and the FQPN. From this moment on, the movement was more often called the "pro-choice movement" both to focus on the idea that abortion must be a choice offered to women and to attract a greater number of adherents to this cause. The Comité de vigilance, a forum for information exchange and reflection, gradually became a networking space for all practitioners in abortion services from the public and community sectors as well as the private sector in order to foster the development of accessible and quality abortion services for women in Quebec.[39]

In addition to the CLSC precursors, which had not been forced to stop performing abortions, other CLSCs had established themselves outside of cities. The implementation of abortion services in CLSCs was also seen as a political gesture.

> "We want to situate the practice of abortions in CLSCs within its legal and political context. Providing free abortions on demand in CLSCs is not just one more service to the rest of our programs or interventions in family planning. Rather, it is taking a stand in a long and heated legal and political debate; it is also becoming a very real actor(tress) in the present struggle [...]. Across Canada, activist groups for free choice watch us and build on the gains made by the CLSCs and the Centres de santé des femmes to claim their turn, in their respective provinces access to free abortion on demand."
>
> **CLSC practitioners confront abortion**[40]

In 1985, one of the first research studies on the topic[41] showed that 18,413 abortions were funded (at least in part) by the government. These abortions were performed in hospitals with the approval of a TAC in 72% of cases, while 11% of abortions occurred in centres de santé

38 The Watchdog Committee.

39 Louise Desmarais, *op. cit.*, p. 225

40 Les intervenantes des CLSC face à l'avortement, [internal document written by caregivers], 1983, p. 13-14, (*translation ours*).

41 Luce Harnois, *Rapport de recherche sur l'avortement au Québec, Regroupement des centres de santé des femmes du Québec,* 1987.

des femmes, 9% in private clinics, and 8% in 23 CLSCs.[42] Clandestine abortions not reported to the government, estimated at between 2,100 and 8,300 per year, should also be added to these numbers. Even if new service locations were added in other regions, 65% of abortions still took place in Montreal in 1985.[43]

In the late 1980s, eight CLSCs joined the five Montreal CLSCs performing abortions, still without the approval of a TAC. In 1988, there was a total of seven CLSCs in the greater metropolitan area (CLSC Marigot, CLSC Montréal-Nord, Saint-Denis youth clinic, CLSC Rivière-des-Prairies, CLSC Hochelaga-Maisonneuve, CLSC Centre-South, CLSC Centre-Ville), two CLSCs in Montérégie (CLSC Saint-Hubert, CLSC La Pommeraie), two CLSCs in Saguenay-Lac-St-Jean (CLSC Le Norois, Saguenay-CLSC Nord), and two CLSCs from the regions of the Laurentians and Lanaudière: the CLSC Sainte-Thérèse (until 1986) and the CLSC Norman-Bethune (until 1988).[44]

Regression and Progression

Meanwhile, the second part of the 1980s was marked by an increasing resurgence of actions by anti-choice groups to block access to abortion services, which forced members of the Comité de vigilance to more frequently intervene in public spaces. The intensification of the action and lobbying of anti-choice groups was felt in Quebec as well as in other provinces. In addition to the major anti-abortion groups in Canada, which had founded new branches in Quebec, organizations such as R.E.A.L. Women and the Christian Heritage Party echoed their sentiments through the promotion of conservative ideas and the religious right.

One of their areas of action was lobbying for the recognition of foetal rights and anti-abortion propaganda in schools. For instance, the Coalition pour la vie de Groulx[45] managed to stop the practice of abortions at the CLSC Sainte-Thérèse by electing four board representatives who opposed abortion. Physicians who performed abortions were also grappling with these groups. The founder of Combat pour la vie[46] filed a complaint against Dr. Yvan Machabée of the Montreal private clinic with the same name in 1985, while the group Coalition pour la vie du Saguenay-Lac-St-Jean filed a complaint against Dr. Jean-Denis Bérube of the CLSC Saguenay-Nord the following year. These complaints were quickly rejected by the Liberal Justice Minister, Herbert Marx, who ordered the cessation of legal proceedings against doctors performing abortions based on the 1976 decision to not prosecute doctors for the practice of abortions.

42 Conclusions from Luce Harnois' study are quoted in Louise Desmarais, *op. cit.*, p. 292-293.

43 *Idem*.

44 CSF, *État de situation : la disponibilité des services d'avortement au Québec* [research and writing : Mariangela Di Domenico], 1989, p. 11-46.

45 Groulx Life Coalition.

46 Campaign for Life.

In response to the resurgence of the actions of the anti-choice movement, a new organization was born in 1986: the Coalition québécoise pour le droit à l'avortement libre et gratuit (CQDALG). More political stands were taken and actions multiplied to ensure that the fragile abortion services in Quebec were maintained. Among the activities organized in 1986 and 1987, there was a mobilization to defend the provision of abortion services in Saguenay-Lac-St-Jean, the holding of a "popular trial" in front of the CLSC Sainte-Thérèse, a Quebec Day of Action for the right to abortion, and a demonstration: "Motherhood a choice - Abortion a right!" In 1987, the CQDALG included 218 collective members (women's groups, grassroots groups, and unions).[47] Advances in anti-abortion organizations were being countered by a surge in mobilization.

Right versus Access

In January 1988, abortion was decriminalized in Canada. Dr. Morgentaler had been on trial since 1983, following the opening of an abortion clinic in Ontario. The Supreme Court of Canada ultimately acquitted him and amended the Criminal Code to remove article 251. It was now recognized that the physical and emotional integrity of women was contingent on their right to control their bodies, and therefore subject to the right to choose abortion.

> "We have proven that we were capable of fighting to have our rights respected and we will continue to do so." (*translation ours*)
> **FQPN, press release of January 29, 1988**

In Quebec, of course, this news was greeted with joy. The day immediately following this decision, on January 29, 1988, a celebration of the landmark case unfolded during which feminists emphasized the importance of continuing the struggle. In fact, the decriminalization of abortion did not lead to the end of anti-abortion pressure nor to the assurance of access to quality services across the province.

A year after the decriminalization of abortion, an event would shake up the women of Quebec. It was the story of Chantale Daigle, a pregnant woman who decided to leave her abusive partner, Jean-Guy Tremblay. The latter obtained, as a result of litigation, an injunction preventing his ex-girlfriend from obtaining an abortion in the name of the supposed "right to life of the foetus" and "father's rights" over his offspring. Thereafter called the "Chantale Daigle case," the story of this woman who did not have the right to choose abortion – the only one in Canada – evoked the dismay of feminists and of the women of Quebec. On July 27, 1989, more than 10,000 people gathered in the streets of Montreal, to show their support for Chantale Daigle through the appeal of the CQDALG. She would gain appeal from the Supreme Court of Canada, but did not wait for the verdict to act. Twenty-one weeks pregnant, she chose to defy the law and to appeal to the CSFM for help in organizing her abortion in the United States.

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47 Louise Desmarais, *op. cit.*, p. 230.

In 1989, the Morgentaler decision was also put into question by the filing of Bill C-43 under the Mulroney Conservative government. C-43 proposed legislation similar to that which had prevailed from 1969 to 1988, making abortion an illegal act, punishable by imprisonment of two years, except when practiced by a physician who deemed the life or health of the woman was in danger. Despite pressure from and mobilization of the women's movement, the House of Commons approved this controversial bill. The bill was narrowly defeated in the Senate following a tied vote.

The Morgentaler decision was quickly followed by upheavals in the legal arena, but it was the accessibility of abortion services that subsequently became the focus of the pro-choice movement.

The 1990s

The State of Services

Thanks to the decriminalization of abortion, the 1990s brought a period of engagement and public policy. The first observation was that the current state of available abortion services in Quebec had to be evaluated. A study conducted by the CSF met this need, and the results were made public in 1992. It showed that abortion services were offered in 46 institutions in Quebec, representing 27 hospitals (58.7%), 12 CLSCs (26.1%), 4 private clinics (8.7%), and 3 centres de santé des femmes (6.5%).[48]

Regional disparity had always been a major issue in the provision of abortion services. In the early 1990s, 40% of Montreal's resources for abortion were in hospitals, 50% of services were in CLSCs, and all of the private abortion clinics, as well as one of the rare centres de santé des femmes, offered the service. Three regions of the province still did not provide abortion services: Northern Quebec, Chaudière-Appalaches and Lanaudière. In the case of five regions, only a single service delivery point existed in the region, resulting in increased precariousness: a lack of personnel or equipment failure could mean the temporary suspension of abortion services. These less well-served areas were the Lower St. Lawrence, the Eastern Townships, Outaouais, Abitibi-Témiscamingue and Côte-Nord.[49]

In its study, the CSF deplored these disparities and affirmed wishing that more CLSCs would perform abortions in order to meet the needs of women. To explain the lack of CLSCs performing abortions, the Council mentioned, among other reasons, the "conservative values in some milieus, the resistance of doctors [...] and the lack of financial resources."[50] The

48 CSF, *L'accessibilité aux services de contraception et d'avortement*, May 1992, p. 30.

49 *Ibid.*, p. 31.

50 *Ibid.*, p. 33, (*translation ours*).

concluding recommendations of the study were made in light of the principles of autonomy and integrity of women. There were the issues of improving public information, of awareness, and of training in sex education and family planning. The CSF also demanded the introduction of abortion services in all regions of Quebec and added that all of the services should be provided for free.

During the same period, the Corporation professionnelle des médecins du Québec[51] published L'avortement : éléments d'un exercice de qualité. The first of its kind by a Canadian medical association, it dealt with the abortion issue from a purely medical perspective. It therefore recognized that abortion is a medical procedure that should be insured by provincial plans. The Corporation focused on ensuring the quality of abortion services offered and identified obstacles impeding the accessibility of services, such as the small number of physicians who performed abortions and regional disparities.[52]

Among the government positions taken during this time was a 1993 policy on the status of women, which addressed the challenges ahead for the next ten years including economic empowerment, the physical and psychological integrity of women, and the elimination of violence against women. The need to ensure access to integrated and comprehensive family planning and abortion services was highlighted.[53]

A year later, Cairo hosted the United Nations International Conference on Population and Development. Quebec and Canada were signatories to the action plan that was developed, which recognized, among other things, the right to reproductive health:

> "Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights document and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. [...] The principle of informed free choice is essential to the long-term success of family planning programs."[54]
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> **United Nations International Conference on Population and Development, Cairo, 1994.**

51 The Physicians' Professional Corporation of Quebec.

52 Corporation professionnelle des médecins du Québec, *L'avortement : éléments d'un exercice de qualité,* 1989, 18 p.

53 Secrétariat à la condition féminine, *Un avenir à partager : la politique en matière de condition féminine,* 1993.

54 UNFPA, Programme of Action Adopted at the International Conference on Population and Development, Cairo, 1994.

Women's Needs with Regard to Abortion

The need for integrated abortion services has been expressed for a long time, although very few institutions offer this possibility. Women want abortion services that are accessible, humane, and respectful of their experiences and of their choices. However, the paths leading to choice and to the accessibility of family planning services tailored to the needs of women are strewn with pitfalls. Whether it is the reduction of resources in the healthcare system, the anti-choice movement or the inequality between men and women which still prevails in society, the obstacles are many and varied.

The accessibility and quality of abortion services can be measured in different ways; the proximity of services, the promptness in obtaining the service, the provision of services at no cost, the involvement of women in the choice of intervention and of medication, and a respectful and non-judgmental approach are elements that must be provided to women choosing abortion. An action-research project of the FQPN, published in 2002, reported on the needs of women in family planning. Lack of family planning services in CLSCs that are accessible to all women, the erosion of services due to budgetary restrictions imposed on healthcare in the province's race to zero deficit, the general lack of resources (for individual interventions, the production of informative and objective documents as well as for the hiring of health professionals from multiple disciplines), and the abolition of sex education in secondary schools, are among the FQPN's worrying findings.

With regard to abortion, the waiting period (often three to four weeks) to obtain services was the main criticism voiced by the women of Quebec who participated in the action-research. We should also mention the concentration of service delivery points in urban areas, making access more difficult for many women who must travel more than a hundred kilometres to obtain an abortion. The transportation time and the duration of the intervention, which sometimes requires that a laminaria be inserted the night before, often force women to be absent from their home or work for one day. In addition, accommodation costs can increase the overall cost. In the case of abortions that take place after the first 14 weeks of pregnancy, these problems are more frequent.

For the FQPN, certain criteria are necessary to both meet the needs of women in abortion services and to ensure quality services.
They are:

Basic Criteria:

- Accessible, free and safe
- To respect the choices of women, without judgement or discrimination

Appropriate Services:

- Confidential and discreet
- Human contact (not an answering machine) for making appointments and for referral
- Support that promotes informed decision without pressure or coercion
- Support services post-abortion, if needed
- The option of being accompanied

Facilities for Women:

- After the decision is made, abortion should be available within a week
- Fewest trips and appointments possible

An Appropriate Environment:

- An environment offering support and empathy
- Comprehensive services (ultrasound, meeting before the intervention, etc.) offered in one location
- Service in a place reserved for that unique purpose with trained and pro-choice personnel
- Services offered by non-profit, accountable and transparent institutions.

Ministerial Guidelines for Quebec

In 1996, the family planning policy in 1972 was updated following the adoption of the Orientations ministérielles en matière de planification des naissances[55]. These commitments followed a consultation undertaken in 1992. The three guiding principles of these government policies were:

1. The freedom and responsibility of women and men to exercise choice in matters that affect their ability to procreate;
2. The fundamental right of women and men to physical integrity; and
3. Universal accessibility and free services.[56]

The objective of these guidelines was to promote the exercise of informed choices regarding family planning and to promote sexual health. Changes in sexual attitudes and behaviours among Quebec's population were acknowledged, as was the need to adapt health services to the new reality. Regarding abortion, the 1996 Orientations affirmed the need to support women with unwanted pregnancies in their decision-making, to meet the specific needs of women through appropriate interventions, to reduce the rate of abortions in the second trimester, to promote the use of less invasive techniques, and to meet the psychosocial needs of women who choose abortion.[57] Given the urgency of addressing certain specific shortcomings, detailed budgets were allocated for three priorities: $200,000 to reduce the rate of teenage pregnancy in disadvantaged areas, $70,000 to establish a supraregional point in the Quebec region for second trimester abortions, and $120,000 to establish a service delivery point for abortion in Chaudière-Appalaches.[58]

Apart from these three exceptions, no general budget accompanied these governmental objectives and the implementation of the guidelines was long overdue, a fact that has been critiqued by the women's movement. The situation was highlighted by others, including the CSF, who, in a document commenting on the Orientations ministérielles en matière de planification des naissances, reiterated that the government should financially support all abortions and guarantee to women that this medical service be provided for free.[59] In addition, the FSC stated that the guidelines "lack consistency and determination, due to a lack of firm ministerial commitment."[60] The fears expressed in 1996 by the CSF were realized only four years later, when a plan for the implementation of the guidelines was finally proposed, even though the situation had been considered a "priority." It was only in the 2000s that the action plan was implemented, resulting in an increase in funding and improvements in service organization.

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55 Ministerial Guidelines on Family Planning.

56 Gouvernement du Québec, *Orientations ministérielles en matière de planification des naissances*, 1996.

57 *Ibid.*, p. 24.

58 *Idem*.

59 Conseil du statut de la femme (CSF), Commentaires sur les orientations ministérielles en matière de planification des naissances, 1996, p. 11.

60 *Ibid.*, p. 21, (*translation ours*).

The 2000s

In the 1990s and 2000s, the Quebec public healthcare system underwent numerous transformations: ambulatory care, decentralization, budget cuts, reorganization and merging of institutions, etc. The obsession with a zero deficit and the "lack of funding" formed the main backdrop for the reorganization undertaken by the Government of Quebec. There was a gradual withdrawal of government and a transfer of collective responsibilities toward the individual and the private sector.

Family planning services did not emerge unscathed from these multiple transformations. Institutions had to cease some of their activities because of budget cuts. This was the case in the 1990s for the Régie régionale de Montreal-Centre, which closed two institutions that provided family planning and abortion services: the Royal Victoria Hospital in Montreal stopped offering second trimester abortion services, and the Charles-Lemoyne Hospital in Montérégie disbanded their family planning clinic, henceforth providing abortions only at the department of day surgery.

Many institutions, both CLSCs and hospitals, facing drastic cuts, were also obliged to reduce the number of abortions provided per week. In some cases, the recommended solution was to fold the services of family planning into current services or to offer these services only to "target clients," particularly youth and women dealing with multiple issues. Add to this the frequent interruption of services in some institutions, in connection with, among others, a lack of human resources. Those responsible for planning services painted a dim picture of their reality at work in the portrayal of family planning services published in 2001 by the FQPN.[61] Indeed, a large majority reported an increased need and demand for services, the increasing complexity of issues, and an increase in their tasks. All this was occurring in a context of budgetary constraints and declining human resources.

The Consolidation of Abortion Services

Despite this difficult situation, the government's commitment remained. The steps taken by the MHSS in 1992, which gave the Orientations ministérielles en matière de planification des naissances in 1996, had led to the development of an action plan in 1999. In October 2001, the Quebec government finally provided the funding necessary to meet these commitments.

61 FQPN. *Le planning des naissances au Québec : portrait des services et paroles de femmes*, 2001, 106 p.

"Quebec women can now count on accessible abortion services, throughout the province of Quebec. There was a strong government commitment towards women, and this commitment is reflected now in the form of $ 3.2 million of funding."
Agnès Maltais, ministre déléguée à la Santé, aux Services sociaux et à la Protection de la jeunesse, Press Release, October 4, 2001

Abortion services had been functioning with the budgets allocated in 1972, even before the decriminalization of abortion. The new investment was therefore eagerly anticipated. Of the $3.2 million invested to strengthen abortion services, the government provided $2.7 million in recurrent budget. A regional breakdown of this injection of funds was assured; all areas received an amount calculated to minimally ensure a service delivery point for abortions in the first trimester (the amounts varied from $13,000 in the Laurentians up to $800,000 for the Montreal area) and a non-recurring amount of $485,000 for the purchase of specialized equipment or the development of service locations in four regions: Outaouais, Abitibi-Témiscamingue, Chaudière-Appalaches and Montérégie. With the development of services for the Chaudière-Appalaches region, all regions of Quebec were now minimally serviced by a service delivery point for first trimester abortions.

Guidelines and Protocol

The bid for funds in 2001 was followed by the completion of two important protocols: guidelines from the Collège des médecins du Québec[62] and a protocol used for second trimester abortions from the MHSS.

Indeed, after a first publication in 1989, the Collège des médecins revisited the issue in 2004 with the document *L'interruption volontaire de grossesse : lignes directrices du Collège des médecins*.[63] Its main objective was to present guidelines to general practitioners and obstetricians-gynaecologists for the practice of minimally invasive clinical interventions, and the psychosocial aspects they should consider to ensure quality service to women choosing abortion. The Collège des médecins would therefore ensure quality practice in hospitals and CLSCs, as well as in private or community clinics.

The document addressed abortion from a purely medical point of view. Moral judgments, and also the defence of the legitimacy of the act were excluded from the guidelines of the Collège des médecins. In effect, doctors had a "conscience clause" allowing them to refuse the practice of medical procedures they deem contrary to their moral sense.

62 Quebec College of Physicians.

63 Voluntary Pregnancy Terminations: Guidelines from the College of Physicians.

"Opinions differ on abortion, and these guidelines do not have the goal of advocating in its favour, doctors and women always have the freedom to choose"
Collège des médecins[64]

Among the considerations cited in the guidelines, the knowledge required – both by doctors and other health personnel – was considered essential. The Collège also emphasized that the presence of female staff could foster an environment that is favourable for women undergoing the procedure. The pre-abortion assessment, including the gynaecological and contraceptive history of women and a full physical examination to determine gestational age, were also regarded as prerequisite practices. Ensuring informed consent and improving access to counselling were other recommendations made by the Collège des médecins. The 2004 guidelines also stated that several methods could be used to relieve pain and that the choice must be tailored to the situation (the paracervical block should be promoted first because it is less invasive, while epidural anaesthesia and general anaesthesia are reserved for special cases).

The Collège des médecins also explained the different types of abortions. For interventions in the first trimester (the first 14 weeks), they recommend the surgical method (a safe method, in some cases requiring the preparation of the cervix using drugs or laminaria stalks) or the method by drugs (pharmacological method to be used for pregnancies of less than 63 days in an environment designed for this purpose). Regarding interventions during the second trimester (over 14 weeks), which is less frequent, the Collège des médecins outlines three types of operative techniques, depending on gestational stage and situation: dilation and suction curettage (pregnancy of less than 15 weeks, similar to the surgical method used in the first trimester), dilation and evacuation (technique requiring the use of forceps and adapted speculums and may require two applications of laminaria stems), or induction of labour (an alternative to the surgical approach for pregnancies terminated after 20 weeks, this technique requires hospitalization).

The Protocole d'accueil et de référence pour les interruptions volontaires de grossesse (IVG) du deuxième trimestre[65] was also published in 2004. This protocol, intended for personnel involved in the health and social services sector, described the referral indications to follow for abortion services over 13 weeks. In fact, to ensure increased accessibility of second trimester abortion services to the women of Quebec, the MHSS had established service corridors and three regions were mandated to offer this service: Quebec, the Eastern Townships and Montreal. These three regions were able to provide abortion services for 14 to 20 weeks and the Eastern Townships provided service to all of Quebec in respect to abortions up to 22 weeks of pregnancy. In addition, the Montreal area, through the CSSS Jeanne-Mance, was assigned the mandate of provincial coordination of abortion services of 23 weeks and over as these rare cases were referred to the United States.

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64 Collège des médecins, *L'interruption volontaire de grossesse, Ligne directrices du Collège des médecins*, septembre 2004, p. 4, (*translation ours*).

65 Intake and referral protocol for voluntary termination of second trimester pregnancies.

In terms of the cost of second trimester abortions, the intervention as such was provided by the public system, but costs such as travel could add up for women. The Politique de déplacement des usagers[66] of the MHSS was applied in these cases; in order to be paid by the state, moving to one of three service delivery points for abortion had to exceed 250 km. In such situations, the cost of gas and a lump sum of $75 per day were granted. For smaller relocations, financial losses (travel, holidays, childcare, etc.) had to be borne by the woman. In the case of abortions performed in the United States, the procedure was covered by the government of Quebec, but other costs were assumed by the woman. In 2004, additional costs for women travelling for abortion in the state of New York (up to 23 weeks) were evaluated at $500, and almost $2,000 in the State of Kansas (more than 24 weeks). The assassination of Dr. George Tiller on May 31, 2009, one of the few physicians who performed late abortions, and the subsequent closure of his clinic in Kansas, seriously compromised access to such services which remain crucial for women.

The Orientations ministérielles en matière de planification des naissances in 1996 stressed that improving abortion services was a government priority. Yet it was not until five years later that this priority was realized by an investment of $3.2 million, and that the organization and coordination of services in the public system were also improved. Despite this, a serious problem remained. By the middle of the 2000s, nearly one third of abortions were being performed in private clinics and CSFMs, where women had to pay or contribute financially to obtain the service. The provision of abortion services free of charge, a key principle of the Orientations ministérielles, was still not being applied.

The Class Action Suit of the Association pour l'accès à l'avortement

In 2006, an important decision shook things up in terms of the accessibility of abortion services in Quebec. The Association pour l'accès à l'avortement[67] (APAA), established to defend the free aspect of these services, filed a class action lawsuit against the government of Quebec to reimburse women who had paid for an abortion from 1999 to 2005.

In the early 2000s, in addition to the 40 public institutions (CLSCs and CHs) offering abortions, four private clinics (all located in Montreal) and three women's health centres practised abortion in Quebec. In 2006, 44% of abortions in Montreal were performed by private clinics and at the CSFM, the five points of services that charged fees ranging from $40 to $350 (non-refundable by the RAMQ) for abortion services. Therefore, in 2006, one in four women had to pay to receive abortion services throughout the province of Quebec, according to the estimates of the CSF.

66 Users' Travel Policy.

67 Association for Abortion Access.

At this time, waiting times were virtually nonexistent in private clinics, while in the public sector, women could wait up to three or four weeks for an appointment. The CSF, in its assessment of abortion services in Quebec[68], reported that the waiting time could be an important factor in a woman's decision to choose the institution where she will have her abortion[69], despite the costs incurred by a procedure in private clinics. Women in the Greater Montreal Area and surrounding areas who could afford to pay for an abortion benefitted from a two-tier system, which contradicted the principles of universal access and free services.

In the judgement of the collective lawsuit, issued August 17, 2006, Justice Nicole Bénard emphasized that women should not have to pay for an abortion, but that the situation persisted because the public sector was not able to respond to the demands in regards to abortion. It was pointed out that the fact that a significant proportion of abortions were performed in the private sector and, therefore, financially borne by women, demonstrated that the situation was known and even encouraged by the government of Quebec.

> "Allowing private clinics to charge additional fees for services provided, and while knowing that it is for their survival, sets up a system that the law prohibits. [...] The government knows very well that women pay a premium for services but closes its eyes and tolerates it. [...] [T]he Court concludes that it is not the LAM[70] that is causing the problem but rather its non-compliance, not only tolerated but encouraged by the government and this, for economic reasons."
>
> **Madame Justice Nicole Bénard**[71]

In her ruling, Judge Bénard sentenced the government of Quebec to reimburse women who incurred costs for abortions in private clinics or at the CSFM between May 2, 1999 and February 22, 2006. She noted that in addition to having to reimburse women for a total of $13 million, the government should not circumvent its own law (MIL) and should provide free services. The RAMQ was responsible for administering the claims process, which ended in September 2007. In total, 5,639 women were reimbursed, but that number represents only 12.6% of the women who paid for an abortion in the period covered by the lawsuit. At the time of this writing, the use of unclaimed millions of dollars had still not been clarified by the judicial authorities.

New Measures for the Montreal Area

The government of Quebec would not appeal the ruling of the Superior Court. While the decision settled the question of free services for women affected by this collective action, the situation did not change much for the practice in Montreal and the government had to find

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68 *Idem*, p. 32.

69 Conseil du statut de la femme, *L'avortement au Québec : état des lieux au printemps 2008*, Québec, 2008, p.32.

70 Health Insurance Law.

71 Cour supérieure, *loc. cit.*, (*translation ours*).

a solution for the short and long terms to avoid other proceedings. To do this, the MHSS first sought to increase the public system's capacity to meet the demand for abortion. It began working with agencies in Montreal and surrounding areas in order to determine their ability to increase the services offered. These steps included an increase of services in certain establishments, particularly in Montérégie, where a recurring budget of $75,000 had been granted to double the supply of services by the CSSS Vaudreuil-Soulanges.

The original intention of the MHSS was to reimburse abortion services provided in private clinics and at the CSFM in cases where the public sector was not able to provide services within a reasonable time. In September 2007, the MHSS approved a budget for the Agence de la santé et des services sociaux de Montréal[72] to establish a coordination centre for the first trimester abortions in the Montreal area. The coordination centre, administered by the CSSS Jeanne-Mance, was mandated to ensure that women in Montreal and surrounding areas have access to abortion services in a timely manner.

Parallel to these efforts, the Agence de Montréal had been mandated to negotiate an agreement with medical clinics and with the CSFM so that they could offer their abortion services for free. This agreement came into force in January 2008. Since that time, women have had access to free abortion services at any time, regardless of the type of institution offering the service. The coordination centre remains in existence to facilitate access to abortion services and to reduce waiting times for women seeking services in the Montreal area.

Privatization Issues

In December 2007, in the wake of the aftermath of the class action lawsuit, abortion has also been included in the regulations of Bill 33. This bill, the result of the Chaoulli Judgement, has caused much controversy in Quebec as many saw it as an opening to the increased privatization of the health system.

> "Instead of reinvesting in the public system, the government, through Bill 33, proposes to develop the private sector which ultimately can only drain public resources and therefore weaken the public healthcare system."
> **Fédération interprofessionnelle de la santé du Québec**[73]

Bill 33 amended the Loi sur les services de santé et les services médicaux[74] by permitting the provision of medical services paid by the state, in new private entities: specialized medical centres (SMC). In its study of the current state of abortion in Quebec published in 2008, the

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72 Health and Social Services Agency of Montreal.

73 Fédération des infirmières et infirmiers du Québec (FIIQ), *Mémoire : des cliniques publiques financées publiquement*, Québec, 12 septembre 2006. The fédération des infirmières et des infirmiers du Québec is now the Fédération interprofessionnelle de la santé du Québec, (*translation ours*).

74 Health and medical services law.

CSF had already raised specific concerns about the inclusion of abortion in the regulations, both for the integrity of the public health system in general and for the provision of abortion services in particular: to practice "specialized medical services, including abortion, institutions that are not integrated into the public system, meaning private clinics and the three women's health centres, must transform themselves into SMC." (*translation ours*)

In 2009, Bill 34, which sought to clarify certain provisions relating to specialized medical centres, had catalyzed the concerns raised by the CSF. Indeed, the application of this law required the three women's health centres to become specialized medical centres and to have a permit held by a physician or by a group composed mostly of physicians. This requirement broke up the centres' method of participatory management and threatened their autonomy and the preservation of their alternative approach to abortion. The three centres orchestrated a vigorous campaign of political action aimed at their exemption from the bill. The campaign, supported by women's movements and trade unions, paid off. During consultations on the aforementioned bill, the women's health centres were exempted from this law and from the obligation to become SMC in May 2009.

Despite this victory, abortion was still one of the procedures subjected to the regulations of laws 33 and 34, which remained incomprehensible to many providers. Certainly, abortion is not comparable to breast surgery, cosmetic surgery or skin surgery, other procedures covered under the regulation. In the summer of 2009, the issue hit the headlines, following the announcement of the closure of abortion services at the clinic l'Alternative, which had been unable to comply with the new standards of practice arising from the application of Bill 34. The new standards required that the abortion be performed in conditions similar to those of a hospital surgical unit. The application of these standards necessitated significant investments in material and financial resources, which threatened the supply of abortion services in private clinics and women's health centres.

At first opposed to the idea of reviewing these new standards, the Minister of Health and Social Services, Mr. Yves Bolduc, was forced to rethink the issue as a result of the media controversy generated by this issue and called for the Collège des médecins to give their recommendations on the matter. After a few days, the Collège des médecins asked the government to remove abortion from the application of the restrictive norms under Bill 34 and to withdraw the procedure from the medical services subjected to this bill: "The context surrounding abortion is very different from other surgeries provided for in the regulations under Bill 34, and, therefore, standards of safety and quality must be tailored to the type of procedure performed. Therefore, given the way the regulation is being applied, the Collège believes it is justified that abortion be removed from the regulations arising from the adoption of Bill 34." (*translation ours*) This recommendation was immediately adopted by the Minister.

Permanent Injunction

The late 2000s was also marked by another important legal gain. On June 16, 2008, the Superior Court of the district of Hull granted a permanent injunction (a first in Quebec) to the Clinique des femmes de l'Outaouais (CFO), forbidding all persons to demonstrate within a quadrilateral surrounding the location of the clinic, the parameters of which were determined by the Court. The request for an injunction was in response to an anti-choice protester who put into question a first interim injunction granted to the clinic in 2001.

In this case, both parties spoke of fundamental rights: the CFO called on the right to privacy of women, and the defendant, Mr. Rénald Veilleux, one of the well-known demonstrators in front of the clinic and also a member of Respect de la vie Outaouais[75], evoked the right to freedom of expression.

In his ruling, Judge Roy recognized that the rights present were fundamental rights that must be balanced and he gave precedence to the right to privacy of women and of the clinic staff. He judged it fundamental to avoid harassment, and also to ensure free access to the clinic. He acknowledged that "the presence of demonstrators violates the right to privacy of patients who wish to legitimately use the services offered by the Clinic." In conclusion, the judge banned all demonstrations within a quadrilateral surrounding the clinic, which served to reconcile the respect for women's privacy and the freedom of expression of demonstrators.

In sum, the events of the 2000s have demonstrated that various barriers to abortion access continue to exist, and that ongoing legal and political battles are necessary to ensure access to abortion services in Quebec.

75 Respect for Life Outaouais.

PART 2

Access to Abortion in Practice

History demonstrates that women in Quebec and their allies have had to fight in order to win the right to exercise free choice. The history of establishing abortion services in Quebec presented in the first part of this report allows us to better understand how they have developed over time.

Quebec remains one of the Canadian provinces where abortion is the most accessible to women who need it. It has more service delivery points than the other provinces and they are better distributed across the territory[76]. Quebec is also one of the only provinces that have standards and guidelines to ensure the provision of abortion services to its population.

Now that we know how abortion services are structured on paper, it is important to study what happens on the ground. The second part of this report looks at exactly how accessible the service delivery points for abortion truly are for women throughout the province facing an unplanned pregnancy.

First, we focus on how information on abortion is transmitted by the various health facilities. To find out if it is easy for a woman facing an unwanted pregnancy to obtain comprehensive information on abortion, we studied the quality of the information provided by institutions that do and do not offer this service. The analysis of the results highlights the obstacles that are faced by women wishing to terminate their pregnancy.

Secondly, we studied the functioning and structure of abortion service points throughout the province. This allowed us to have a clearer picture of the organizational processes of each institution, to highlight the innovations of certain institutions, and to report on the obstacles faced by the personnel who provide abortion services throughout Quebec. These observations have led us to propose some suggestions to the institutions and the authorities who govern the provision of abortion services in the hope of improving the access to services and the experiences of women who make the decision to terminate their pregnancy.

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76 Jessica Shaw, *Reality Check: A close look at accessing abortion services in Canadian hospitals,* 2007, p. 36.

The Quality of Information Transmitted by Health Institutions

Methodology

The basic, or frontline, information that is given to people seeking a health service is their gateway into the healthcare system. For this reason, we wanted to know more about how information on abortion is transmitted by various healthcare institutions from the point of view of a woman wanting to terminate a pregnancy. To do this, we used an anonymous telephone questionnaire. A researcher phoned each institution of the public network of health and social services of Quebec, whether they do or do not provide abortion services, pretending to be a young woman who had just learned she was pregnant and wanted to obtain information on abortion.

In order to ensure that variations in responses could not be attributed to the way in which the question was asked, the same methodology was used at all times. When someone answered the call, the researcher said, "Hello, I am pregnant and am considering an abortion. Do you provide abortion services?" (See Appendix 1 for the anonymous questionnaire used).

After asking whether the institution offered abortion services, the researcher took note of the following elements in the responses:

- Are abortions performed in this establishment?
- Was the person who answered the call aware of the available abortion services at their institution?
- If abortions are performed at this institution, did the person who answered the call provide information on the steps to continue this process? Did the caller have to insist in order to obtain this information?
- If the institution does not provide abortions, did the person who answered the call direct the caller to another location that could help? Did the caller have to insist in order to obtain this information? Was the information given to the caller helpful? Did it help her to find the necessary information?
- If abortion services are available within this institution, what is the procedure to make an appointment?

The researcher noted how she was treated by the person who answered her call. She also noted the number of calls she had to make before being able to talk to someone capable of responding adequately, as well as the number of people with whom she had to speak before obtaining the information sought. The researcher also noted any other information considered relevant.

All of the CLSCs and hospitals listed in the 2007 version of the Canadian Almanac & Directory were contacted using the phone number provided in the main directory. The hospitals included under the categories of auxiliary hospitals, nursing stations, specialized treatment centres, nursing homes and long-term care facilities were not selected for the purposes of this study. In addition, the researcher also called the women's health centres and private clinics known to offer abortion services, making a total number of 339 calls to various institutions.

Hospitals	CLSCs	Private Clinics	Women's Health Centres	TOTAL
108	224	4	3	339

The anonymous calls made by the researcher revealed that it is not always easy to obtain adequate information about abortion services in various health institutions in the province. Some receptionists are unfamiliar with the services offered by their institution, some do not know how to respond to a request for information, and others pass value judgments about abortion and deliberately create obstacles to accessibility.

Results

Information Obtained from Facilities Providing Abortion Services (see Figure 1)

The researcher began by calling the 51 CLSCs, hospitals, private clinics and women's health centres that offer abortion services in Quebec.

Number of Facilities Providing Abortion Services

Hospitals	CLSCs	Private Clinics	Women's Health Centres	TOTAL
21	23	4	3	51

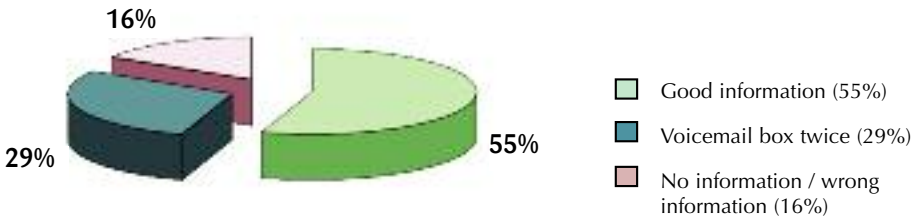
We were surprised that the researcher received detailed information on available services in only 55% of cases; the receptionist was able to confirm whether the institution offered abortion services and could either describe the process to follow to make an appointment or direct the caller to a person with the appropriate information.

In 38% of cases, the receptionist transferred the researcher to a voicemail. If she was transferred to a voicemail the first time, she called back the next day at a different time. In 29% of institutions, both of the researcher's calls ended up in a voicemail box where she had to leave contact information for someone to return her call, which in many cases is neither a desirable option nor one that is possible. Some women do not have a phone and others do not want household members to know they are pregnant or considering an abortion. Some live in abusive situations and cannot receive personal calls. Others may doubt the confidentiality of these systems and do not feel comfortable leaving a message about such a personal topic.

In four institutions, the recorded message of the voicemail box informed the caller that she could mention if her call was confidential, suggested that she call Info-Santé to obtain information on abortion, provided a telephone number to another service delivery point for abortion, or mentioned the schedule during which someone would answer the phone in person. Offering alternatives to voicemail is a step in the right direction.

Of the calls transferred to voicemail, seven resulted in a voicemail box that instructed the researcher to leave a message without indicating whether it was indeed the correct place to leave a message to book an appointment for an abortion. In three cases, the receptionist mentioned the name of the person to whom she transferred the call and stated that it was the person in charge of abortions. Then, when the call was routed, the owner of the mailbox was actually the person named by the receptionist. The recorded messages of five voicemail boxes clearly explained that it was the family planning department or the appointment department.

Figure 1 – Information Obtained from Facilities Providing Abortion Services



In 16% of calls to institutions providing abortion services, our researcher was not able to obtain information regarding services or the information that she did receive was wrong. In two institutions, the receptionist said that abortion services were not offered. In two other cases, the researcher was unable to obtain information since all referrals or telephone transfers led to nothing. For example, the researcher was transferred to more than four different extensions and then ended up reaching a pre-recorded voice menu that did not mention abortion. In an institution providing abortion services for women under the age of 18, the receptionist refused to direct the researcher, who was 20 years old, to another institution. Finally, in two other institutions, the receptionist transferred the researcher to appointment-making services without offering information about the process and without confirming whether abortion services were offered.

Although the majority of receptionists who work in institutions that provide abortion services gave appropriate information, two cases were noted in which the receptionists made value judgments. When the researcher asked if abortion services were available, the receptionist asked her: "What? You didn't want to keep it?", "What did you do to get pregnant?" or "Ten weeks, that's late to be consulting a doctor. Why did you wait so long?"

Information Obtained by Institutions That Do Not Offer Abortion Services (See Figure 2)

Methodology

In addition to institutions providing abortion services, the researcher called 288 hospitals and CLSCs that do not offer abortion services, using the same questions and the same procedure as explained in the previous section. Information on abortion services and the process to make an appointment were noted.

Results

Of the institutions reached, 58% were able to provide useful and accurate information about abortion services available in their region and province; the receptionist directed the caller to an institution offering services or transferred the call to a colleague who directed the caller to appropriate services. Forty-four institutions that do not offer abortion services referred the caller to Info-Santé. Each time the researcher called Info-Santé, the nurses who answered the calls gave accurate and detailed information about the services available in their region. Since this information was adequate, the institutions that referred the researcher to Info-Santé are considered to have offered relevant information.

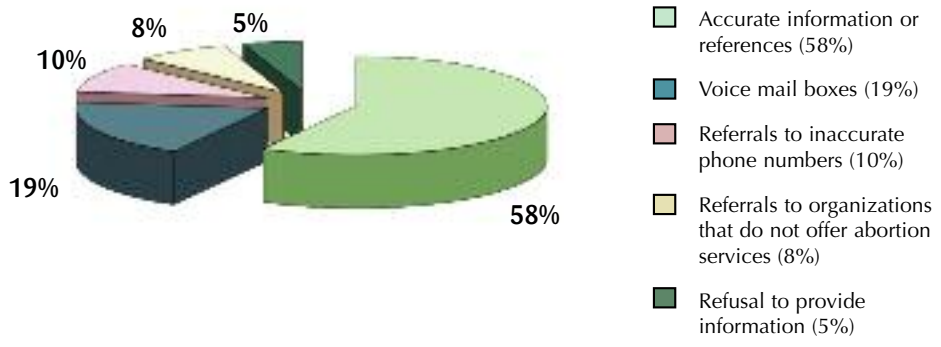
When the researcher was transferred to a voicemail box, she called back the next day at a different time. In 19% of cases, the researcher's call ended up in a voicemail box more than once. A woman wishing to obtain information on abortion services in these institutions must leave her name and phone number and wait for her call to be returned. In 10% of cases, the referrals provided were unsuccessful because the telephone number did not work or the receptionist put the researcher on hold for over twenty minutes on more than two occasions.

In 8% of cases, the receptionist who answered the researcher's call directed her to institutions that do not offer abortion services or advised her to go to any CLSC or to a hospital emergency department. These last two referrals are unsuitable, because abortion services are far from being available in all CLSCs. In addition, going to the emergency department of a hospital, even if abortions are provided there, is not the procedure to follow. In 5% of institutions, the operator simply refused to disclose any information concerning abortion, hanging up or saying that she was unaware of the procedure to follow, without providing additional information.

Although the majority of receptionists and practitioners treated the caller with respect, it is important to note that in many cases, the receptionists were trying very hard to avoid saying the word "abortion" or "choosing to terminate a pregnancy," and instead used "it" to talk about abortion. In addition, six people allowed themselves to express value judgments. For example, to the question: "Do you offer abortion services?" the researcher noted the following responses:

> "We don't do that here!" and the receptionist hung up (in three different institutions);
>
> "Oh my God no!" and the receptionist hung up;
>
> "What? You don't want to keep it?"
>
> The receptionist simply hung up.

Figure 2 – Information Obtained from Institutions That Do Not Offer Abortion Services



In four cases, the researcher was told that abortion services were provided in the institution when they were not. In a CLSC, she was told: "That's done everywhere, ma'am. You just need to come to the CLSC." In another case, the receptionist said that abortions were provided and that she would transfer her to the appropriate department. The researcher was immediately transferred to the Department of Fertility, where she was told that they did not offer abortion services. In two cases, the caller was transferred to the Department of Pregnancy Care, which does not offer abortion services.

The Structure of Abortion Services

Methodology

To better understand the structure of abortion services and to help identify the barriers faced by staff and by women who are trying to access services, we conducted interviews with caregivers working in each of the institutions offering these services. Prior to our study, a letter was sent to each institution informing them of the purpose of our research and requesting their cooperation. The researcher then contacted each institution to make an appointment for a telephone interview lasting approximately 20 minutes. In general, the questions were related to the procedure to follow when booking an appointment, the number of appointments needed for the procedure, waiting times, support in decision-making, confidentiality measures, safety measures, etc. At the end of the interview, caregivers were invited to express their concerns about the obstacles they encounter in their work and any other relevant comments (See Appendix 2 for the questionnaire used in telephone interviews).

Fifty of the fifty-one institutions offering abortion services agreed to answer the researcher's questions. One institution refused to participate in the study due to lack of time. The data collected was analyzed and compared to provide a comprehensive picture of abortion services across the province.

Results

Number of Appointments Needed for an Abortion for a First Trimester Pregnancy (see Figure 3)

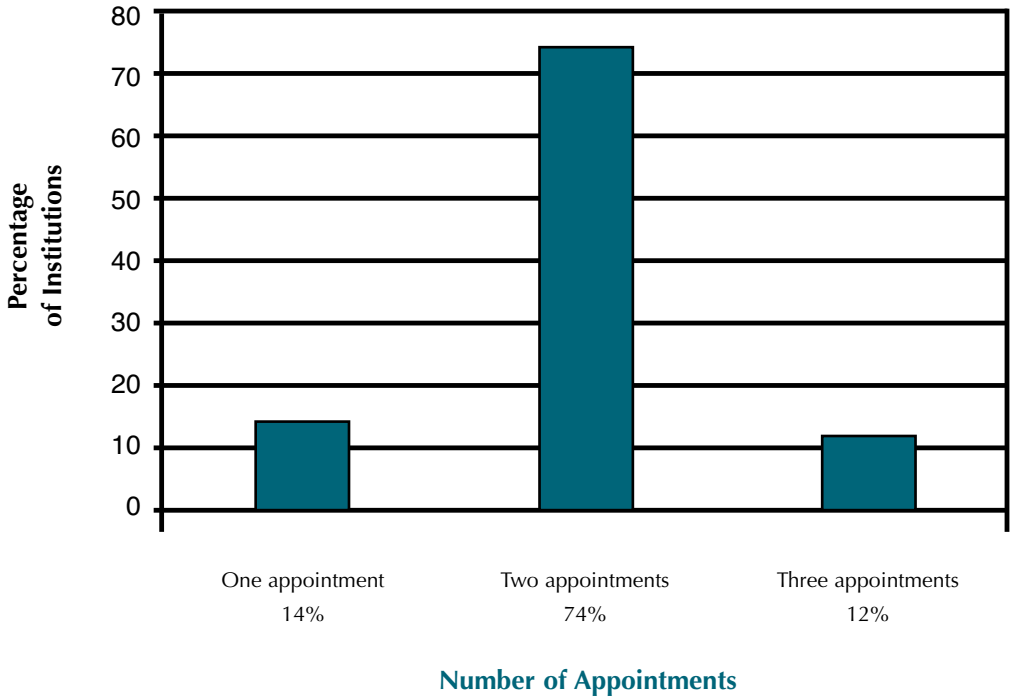
In 74% of institutions, two appointments are required for an abortion. The first appointment, or preparatory meeting, includes a nursing component, a psychosocial component and a medical component. The meeting with a nurse includes opening a medical file, obtaining a pregnancy test and a blood sample, discussing contraception, an explanation of the procedure and related risks, as well as post-abortion advices. The psychosocial aspect includes discussing the decision and informed consent. The last component consists of meeting with the doctor for a gynecological examination, an ultrasound, and screening for sexually transmitted infections. In addition, 20% of these institutions provide an additional meeting, if the woman is ambivalent and wants to discuss her decision in more depth. For women who live in remote areas, 4% of establishments allow the preparatory meeting and the procedure to take place on the same day. Also, one women's health centre explained that it conducts the preparatory meetings in groups, because it allows for interesting discussions among women.

Only 14% of establishments, the vast majority of which are private clinics, perform abortions and the preparatory meeting in a single appointment.

In 12% of establishments, three meetings are required for the procedure. In three of these establishments, the ultrasound must be performed outside the facility. In the other three institutions, the three appointments are divided thusly: the first is an interview with a nurse to discuss informed consent and to describe the medical procedure; the second appointment, which usually takes place the day before the abortion, involves meeting with the doctor for a medical examination; and the third appointment is for the abortion procedure. For women who live far from the institution, it is possible to conduct the meeting with the nurse and the meeting with the doctor on the same day, but there must be a second appointment for the abortion.

In over half the cases, women receive a list of recommendations to follow after the procedure at the initial meeting. These recommendations include an advice guide on health, telephone numbers in case of medical emergency, and information on the support that a woman can obtain if needed.

Figure 3 – Number of Appointments Needed for an Abortion for a First Trimester Pregnancy

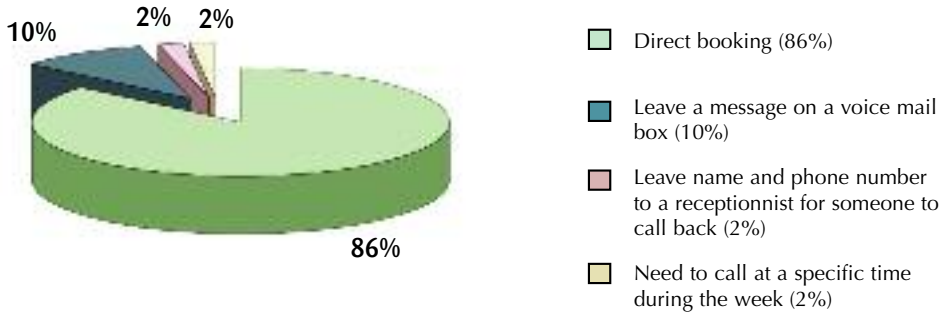


Booking Appointments

In Quebec, a woman does not need a referral from her family doctor to have access to abortion services. She may call the various institutions herself to get an appointment.

In 86% of Quebec institutions providing abortion services, a woman can directly book an appointment for the procedure. In 10% of cases, she must leave a message on a voicemail system so that she will be called back. These institutions say that their schedule does not allow them to take calls at all times of the day. In 2% of institutions, women must leave their contact information with the receptionist; a nurse or psychosocial worker returns the call to schedule an appointment. In 2% of establishments, a woman must call at a certain time in the week to make an appointment **(see Figure 4)**.

Figure 4 – Booking Appointments



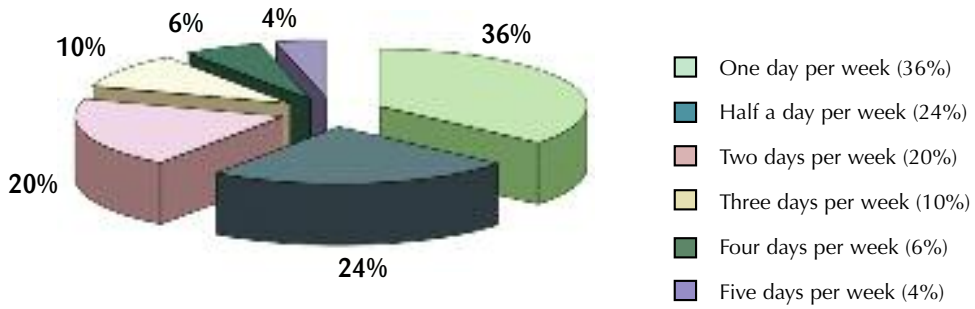
In the vast majority of cases (78%), there is no confirmation of appointment for the intake appointment. In 12% of institutions, women must call to confirm their appointment. In 10% of cases, it is the employees of the establishment that try to contact the patient to confirm the appointment. Many receptionists ask the woman if the call should be confidential and may agree on a password to protect her privacy.

In most cases (70%), the appointment for the abortion itself is not confirmed. However, several workers mentioned that they follow up with women if they felt they were ambivalent during the initial call or preliminary appointment. Twenty-two percent of institutions ask the woman to call the clinic two or three days before her appointment to confirm. If she has not called back, they will attempt to reach her once by phone and, if they are unable to contact her, her appointment will be given to another woman on a waiting list. In 8% of institutions, patients are reminded three days before the appointment to confirm.

The time slots allocated to abortion vary widely from one institution to another. This depends partly on whether the institution is situated in a rural area or in a large urban centre. Twenty-four percent of institutions, the vast majority of which are located in rural areas, set aside a half-day per week for abortions, 36% set aside one day per week and 20%, two days per week. A total of 20% offer abortion services at least three days per week, 10% offer three days per week, 6% four days and 4% five days per week. Two private clinics also offer the service on Saturdays **(see Figure 5)**.

The number of abortions performed on a weekly basis by each institution varies between 3 and 68. Institutions located in rural areas generally perform five abortions and do not generally exceed more than 15 abortions per week.

Figure 5 – Timetable

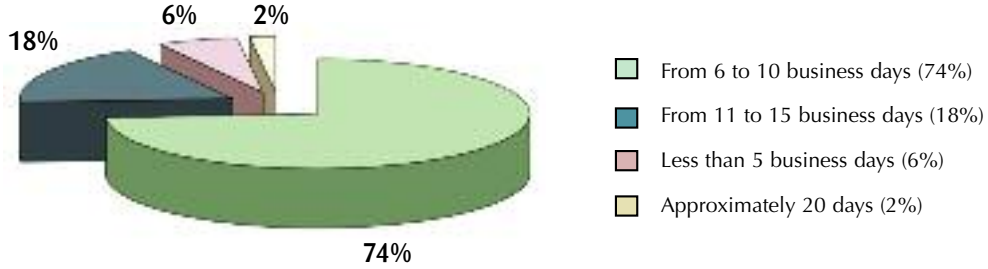


Wait Times (see Figure 6)

The average waiting time between the first call and the procedure is 10 working days. The majority of institutions, or 74%, offer abortions 6 to 10 working days after the first call, 18% after 15 days, and for 2% of establishments, the waiting time is approximately 20 working days. Six percent of institutions are able to perform the abortion within five working days after the first call.

Once their waiting time exceeds 10 or 15 working days, 60% of institutions still consider themselves able to meet demand without having to refer women to other institutions. However, 40 institutions refer women fairly regularly to other abortion service delivery points. Also, 67% of establishments located in Montreal (region 6) use a coordination centre when their waiting time exceeds two weeks. In 40% of institutions, providers indicate that it

Figure 6 – Wait Times Between the First Call and the Abortion



is possible to add an extra half-day or to extend services during the day when the waiting time exceeds two weeks, or if an urgent need arises. Most of them are located in rural areas or cities where they are the only provider offering abortion services.

There are times when demand increases significantly. For example, institutions are unanimous in saying that return to work after the holiday season is the busiest time. Several explain this by the fact that there was closure or a reduction of services during this period. Some private clinics say that demand increases during the summer because the services offered in some hospitals decrease during this vacation period.

Since January 2008, Quebec women have had access to abortion without having to pay for the service, regardless of where it is practiced. This new reality, which affects only the Montreal area, has led to some rather drastic changes in the city, where the private clinics and Le Centre de santé des femmes de Montréal are located. Private clinics have also seen an increase in demand leading to a tripling of their wait times. In contrast, two CLSCs and three hospitals have noticed a decrease in wait times. One of them stressed that the number of cancelled appointments was up while another said that women are "shopping around" more to get an appointment on a particular day or at a particular time. The other 15 institutions in the Montreal area did not notice any significant changes.

Finally, 80% of institutions are satisfied with the number of abortions they provide while 20% would like to do more, as they are not currently able to meet the demand. Among these, there are private clinics that feel that the main obstacle to providing more abortions are the quotas imposed on them.[77] There are also three CLSCs and two hospitals in an urban centre, and four CLSCs in rural areas, for which the main limitation is related to the budget allocated to abortion: lack of resources to increase services and lack of nurses. In addition, 12% of institutions believe that the lack of doctors or their lack of availability remain a major obstacle limiting the supply of abortion services. The current state of infrastructure was also mentioned as a limiting factor in 4% of cases.

Supporting Informed Decision-Making and Post-Abortion Follow-Up

All of the providers interviewed acknowledged the importance of properly supporting a woman so that she is able to make an informed decision regarding facing the end of a pregnancy. All of the institutions have the resources to do this with the utmost respect for the choice of women. In 62% of cases, the nurse talks with the woman at the initial appointment to see if she is ambivalent about her decision. Then she will offer her the opportunity to meet with a psychologist, a social worker or a sexologist on site. In 16% of establishments, all women wanting an abortion must meet with a psychologist or a social worker. In 14% of cases, if the nurse who did the initial meeting detects ambivalence, she will refer a woman

77 At the time of publishing, the Quebec Ministry of Health and Social Services had announced a significant increase in quotas.

to a psychologist or social worker outside the establishment. Finally, in 8% of institutions, the nurse is available for additional meetings if a woman chooses, but she will not be referred to another resource.

During these psychosocial meetings, institutions adopt different approaches to supporting women in their decision making. For example, documentation is provided before the meeting and the provider refers to this material to ask questions. In other institutions, women must respond to a written questionnaire, which leads her to consider several decision-making factors that are then discussed during the appointment. In other cases, the worker conducts an informal meeting during which a woman can ask questions. In an establishment in Northern Quebec, they ensure that the worker shares the same cultural background as the woman.

A support meeting after the abortion is available on demand for women in 90% of institutions, while 6% routinely plan for one. At 4% of establishments, a post-abortion meeting will not be available even if the woman requests it. Instead, the woman is referred to a CLSC or to alternative resources. Six percent of establishments follow up with women two to three weeks after the procedure to see how they feel physically and psychologically, and to ask whether they need additional support. One institution also offers a support service for family members or spouses. At least 6% of institutions submit a questionnaire to women at the time of departure and ask them to return it. This questionnaire asks women who receive the service about the level of satisfaction, their suggestions for improvements and their general feelings.

Contraception

All of the institutions talk about contraception at the initial meeting; however, they do not all deal with it in the same way. In two institutions, each woman receives a prescription for contraception. At another institution, they do not want to push the issue; contraception is addressed not to impose a contraceptive choice, but to have a dialogue about existing methods. Also, the intrauterine device (IUD) is available in most institutions. Yet 40% of institutions refuse to install an IUD immediately after an abortion; they will only do so at a subsequent appointment, depending on the physician's preference.

The Physicians Providing Abortion Services

In the majority of CLSCs, clinics and women's health centres, abortions are performed by general practitioners. Moreover, in two institutions, it is important that the physicians who work there are women. In hospitals, the practice varies: in 56% of cases, abortions are

performed only by gynaecologists, whereas in 10% of hospitals, they are done only by general physicians. In 34% of hospitals, we found a combination of gynaecologists and general practitioners. There is a hospital where all gynaecologists are willing to perform abortions. In other institutions, only some are willing to do so. In one region, for example, only two out of ten gynaecologists perform abortions.

Forty-two percent of institutions report a high stability of doctors practicing abortion. However, two institutions found that it is increasingly difficult to find doctors who practice abortions, since the doctors who have provided abortions for several years have reduced their workload. A hospital in a rural area needs a new doctor to take over abortion services but has been unable to recruit one. Nine institutions have to hire doctors in rotation, which makes management more difficult and causes a reduction in services. Also, two institutions located in rural areas mentioned that in the absence of doctors, it is impossible to replace them and they must cancel appointments for abortion services.

Waiting Room (see Figure 7)

According to the staff interviewed at the institutions, women who come for their initial appointment or for their abortion must wait in the common waiting room of the facility, in a room dedicated to planning services, or in a waiting room reserved for abortions. At institutions where women wait in the common room, this choice was made to avoid women being identified as coming for an abortion. Institutions that have opted for a separate room have done so to provide a place where women and accompanying persons can wait without fear of being judged and to avoid being in the same room as pregnant women or couples coming for pregnancy follow-up appointments.

For the initial meeting, 60% of institutions require women to wait in a common waiting room. Two institutions mentioned their desire to have separate rooms but indicated they lack the infrastructure to do so, 18% of institutions require women to wait in a waiting room at the family planning department, and 22% of institutions require women wait in a room reserved for abortions, including the few clinics and health centres that provide abortion services exclusively.

For the procedure, 48% of institutions ask women and their companions to wait in a waiting room reserved for abortions. In one of the institutions, women also have the option of waiting in a common waiting room if they prefer. Twenty percent of institutions require women to wait in a common waiting room and 18% in a waiting room at the family planning department. Eight percent of facilities, all of which are hospitals, give women the option to wait in a private or semi-private hospital room. Finally, in 6% of cases, they may enter directly into the preparation room for the procedure.

Figure 7a – Waiting Room for the Initial Meeting

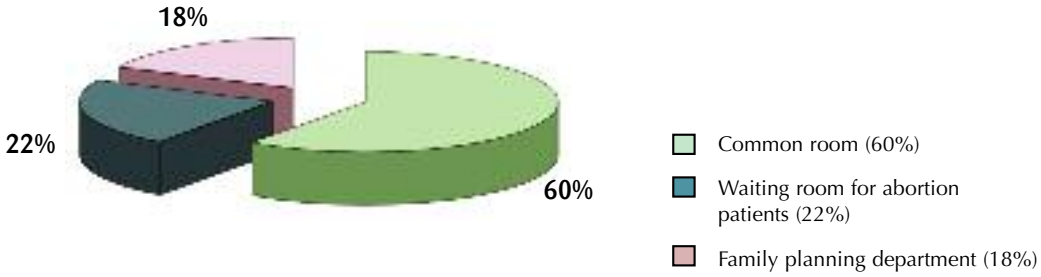
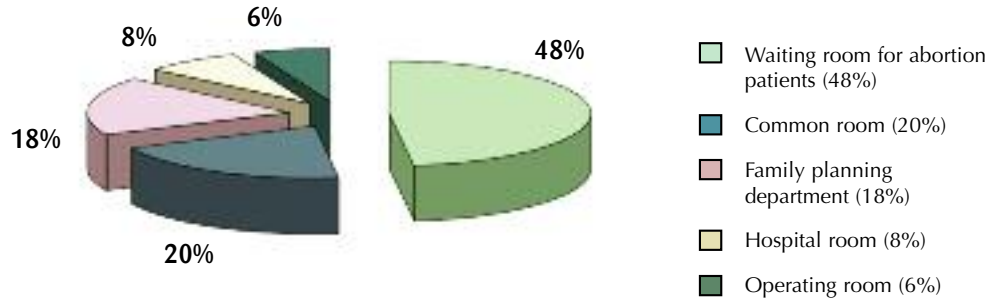


Figure 7b – Waiting Room on the Day of the Abortion



Refusal to Perform Abortions

In 42% of establishments, a woman whose decision lacks ambivalence will never be refused. However, if the staff notices that the woman is unable to give informed consent due to consumption of illicit substances or alcohol, the appointment will be postponed. If it is suspected that the woman is being pressured by a spouse or another person, they will ask her certain questions at the psychosocial meeting. Thirty-four percent of establishments, including all clinics, women's health centres and CLSCs, must sometimes refuse patients for medical reasons. However, they will direct women to a hospital capable of providing the service.

Because they lack the space and must prioritize women in their territory, 8% of institutions, all located in rural areas, consistently refuse women from other regions. Four per cent of institutions sometimes refuse women due to lack of space, but they refer them to other institutions, which can be located a few hours away.

Furthermore, it should be noted that all of the institutions follow the Protocole d'accueil et de référence pour les interruptions volontaires de grossesse de deuxième trimestre when the stage of pregnancy is too advanced.

Financial Support

Since abortion is recognized as a medically necessary service, it is covered by the RAMQ, and thus in all healthcare facilities since 2008. Therefore, the procedures will be the same as for any healthcare service if a woman has lost her health insurance card or if it has not been renewed.

Women who do not have a health insurance card from Quebec often pay out of their own pockets for the procedure. According to providers, it seldom happens that women are unable to pay. In 52% of institutions, it is impossible to financially assist women who are seeking an abortion and who cannot afford to pay. Forty-six percent of institutions say they do not refuse to perform abortions because of financial reasons and instead offer financial agreements, either by offering a discount or by asking doctors to not be paid for the procedure. Two of these institutions have a fund to help women who are unable to pay. Also, 2% of the establishments are members of the National Abortion Federation (NAF) and can request support from the organization if a woman is unable to pay.

Confidentiality

Eighteen per cent of establishments follow the usual measures of confidentiality that exist in all institutions belonging to the health and social services network. However, because of the nature of the service, 82% of institutions take additional measures to ensure confidentiality. These various measures include:

- using only the first name of the woman without the family name;
- when confirming an appointment or giving information, asking the woman if the call should be confidential and, when appropriate, opting not to leave a message or to use a password;
- using colour codes on the records to indicate whether a case is confidential or not;
- not sending files to the archives of the institution and keeping them under lock and key;
- signing confidentiality agreements with practitioners working in abortion services;
- using a code to identify urine samples and pathology;

- soundproofing the consultation offices;
- using curtains between the beds in the lounge;
- having spaces reserved for abortions, with a waiting room for this purpose and a separate entrance.

In addition, 4% of centres believe that confidentiality is an important issue to improve in order to improve all their services. These institutions would like to provide more confidentiality, but their infrastructure does not allow them to.

Security

Several institutions have had to review their security measures to protect women, caregivers, and doctors against anti-choice demonstrators or abusive partners. Security measures, like confidentiality measures, vary between institutions, and 28% of institutions have no additional security measures. However, the vast majority of institutions, 72%, have adopted special security measures following threats or assault or as preventive measures. The following is a list of security measures used:

- a single door giving access to abortion services. Women and employees must come forward and identify themselves by intercom or at the reception desk to be allowed to enter.
- when a woman arrives at the institution on the day of the procedure, she is asked if she will be accompanied. If so, the name of her companion is noted and no one else will be allowed to enter in the clinic or department.
- the doors of the procedure room and recuperation room are locked permanently and can be opened only by authorized personnel.
- several clinics and hospitals have emergency buttons in the procedure rooms, in the recuperations rooms, and at the reception. In one institution, employees carry an emergency button with them at all times.
- companions are not allowed to enter the abortion room or the recuperation room.
- two institutions have obtained injunctions preventing demonstrators from approaching the building.
- the presence of security cameras or security guards on site.

In addition, 10% of institutions indicate that safety is a problem and would like to better protect women and employees from abusive partners or anti-choice demonstrators.

The Major Obstacles in the Provision of Abortion Services

During the interviews, practitioners were asked to comment on the obstacles they encounter in their work. The following is a list of the barriers identified, in order of frequency reported:

Shortage of nursing staff: 20% of institutions indicate that a shortage of nursing staff is the main obstacle to providing good service. On one hand, nurses complain about the extra work required and do not consider it normal to expect so much overtime. On the other hand, they note that it is because of their dedication to women and to the cause of abortion that the service works. In at least 6% of institutions, practitioners say that if they took a vacation, there would be an interruption in services. Booking appointments is also affected by a lack of human resources. Many women must leave a message in a voicemail box. Moreover, cumbersome administrative tasks prevent practitioners from focusing their energy on providing services. In today's network of health and social services, many fear that this problem will become increasingly serious. The retention of staff in the departments of family planning or abortion constitutes a major problem that creates significant needs in terms of training.

Availability of physicians: Eighteen percent of institutions need more doctors or greater availability from those they already have. Practitioners were unsure of whether or not the department would be able to maintain services if a doctor got sick or had to go on maternity leave. Also, 12% of institutions worry that doctors who work in abortion services will retire in the next year or two and are concerned about the impact this will have on the availability of services; 6% of these institutions wonder if the service would continue at all since they have so much difficulty recruiting new doctors who practice abortion.

Long wait times: 16% of institutions, the majority of which are outside of Montreal, find that long waiting times are a significant barrier to providing quality services. They would like to be able to offer the procedure within two weeks after the first call, but there is not enough space available to do so, either because of a lack of staff (nursing or medical), lack of budget, or due to the imposition of quotas.

Budget: 14% of institutions find that their budget is insufficient and that it is difficult to provide quality services with so little. Moreover, they fear that their budget will be further reduced in the coming years.

Inadequate infrastructure: 14% of institutions report that their infrastructure is inadequate for offering the best possible service. The premises are cramped and can pose a problem of confidentiality when numerous women have to be in the convalescence room at the same time, or when a social worker does not have a closed office and must conduct an

assessment in a poorly isolated room. In addition, there are security issues: the doors do not lock, access to the resting room or procedure room is not controlled, and there are people constantly going back and forth in the department.

Inability to perform the ultrasound on site: 14% of institutions reported having to send women out of the department or office for an ultrasound. This complicates booking an appointment because ultrasounds are not done every day. It can also mean that the woman must have an extra appointment before the abortion. One provider also mentioned a case in which the ultrasound technologist does not support the right to abortion and mistreats women who undergo an ultrasound before their abortion.

Lack of services related to contraception: In 10% of institutions, providers complained that women in both urban and rural areas have difficulty accessing contraception. Many have no family doctor and have trouble getting an appointment after the abortion to have a contraceptive method prescribed. These practitioners would like to offer a service that includes prevention and education at the heart of their work.

Missed appointments: 8% of facilities mentioned that many women who have an appointment for an intake meeting or an abortion do not show up and do not call to cancel. Even if all the slots available for appointments or abortions are filled, women sometimes do not show up. This can be frustrating for physicians and for the team who are trying to decrease the wait time for abortion services.

Anti-choice staff: 4% of establishments, hospitals and CLSCs reported instances in which employees of the institution opposed to abortion have locked the doors to block entry to the procedure rooms, or have made comments to women awaiting abortion. This creates an unhealthy environment for women.

Limit in terms of stage of pregnancy: 4% of institutions report that the limit related to the stage of pregnancy is a major obstacle in their practice. Many women present themselves with slightly more advanced pregnancies and must be sent outside of their area of residence for service, often having to travel long distances.

General Findings

The survey results allow us to learn more about the structure and accessibility of abortion services. We can see that although the services offered by institutions vary greatly, there are many good practices that can be shared with all the service delivery points. The survey and data analysis we have conducted have led us to make a number of recommendations that could help improve services. These findings are described in this section.

Anonymous calls to health facilities that do and do not offer abortion services indicate that it is still difficult for a woman facing an unplanned pregnancy to obtain adequate information on abortion. Whether or not an institution provides abortions, it is important that frontline workers be aware of services offered by the institution and be able to refer women to appropriate services in their area or elsewhere.

The Info-Santé service contacted during the study was always able to give adequate information about abortion services. The healthcare facilities that do not have information about abortion services available in their area should refer women to Info-Santé for information and referrals for abortion services.

Considering the importance of direct human contact and respect for confidentiality when dealing with abortion, it is ideal if a woman can talk about abortion with a health professional during her first call, rather than having to leave a voicemail message. Reaching a voice mailbox and having to book an appointment by leaving a message pose many potential problems for women and should be avoided when possible. When it is not possible to speak to someone directly during the first call, it is strongly recommended that the pre-recorded message on the voice mailbox specify that it indeed is the right place to obtain information about abortion or to book an appointment for an abortion. The receptionist should also clearly explain the process to the woman to whom her call is being transferred so that she can feel confident about leaving a message. It is also recommended that the recorded message offer an alternative to voicemail; for example, a message could indicate if someone is available to answer calls at a particular time or offer an alternative number for someone who really cannot leave a message to obtain information about abortion or post-abortion follow-up. Finally, it is also recommended that the recorded message give women the opportunity to indicate that their message is confidential so that additional measures can be taken to protect the privacy of the woman when returning her call.

During intake meetings or abortions, it is important that institutions show flexibility and adaptability in order to avoid multiple trips for women, particularly those who live far from abortion services. Combining the two or three appointments needed into one day could save hours of traveling time for women from remote areas. The ultrasound should not necessitate an additional visit or travel for women. If an ultrasound is considered necessary, it should be available in the same institution as the abortion. The ultrasound should be offered for free,

anywhere, anytime. When a woman must be sent outside of the institution for an ultrasound, for example, due to medical reasons, institutions should ensure that the staff assigned to the ultrasound are neutral and respectful of women, whatever their choice.

Long wait times are a barrier to accessing abortion services. It is essential to respond quickly to the needs of women regarding abortion. Ideally, the waiting time between booking the appointment and having the procedure should not exceed one week, and should be within two weeks at most. The wait times of several institutions regularly exceed two weeks. For others, the wait time fluctuates during the year and increases during periods of high demand, such as after the holidays or during summer vacation. According to service providers, the main reasons for long delays are lack of human resources (medical or nursing staff), lack of financial resources, and the imposition of quotas. It is important to increase the funding necessary to ensure that all points of abortion services meet the maximum waiting period of two weeks and have the flexibility to increase their services during peak periods.

Respecting a woman's decision is fundamental in abortion. All facilities performing abortions should be able to provide decision-making support prior to the abortion. Women who feel the need to talk more in-depth about their ambivalence should have the option of meeting with a psychosocial worker promptly and free of charge. Women who are certain of their decision should not be forced to do this. All facilities performing abortions should be able to provide medical or psychosocial support services after the abortion for women who feel the need. Since the rate of absenteeism is high when the post-abortion appointment is compulsory, it is recommended that the meeting be optional.

Lack of access to contraception has been highlighted by providers as a problem for women. All women in Quebec should have access to a range of contraceptive services. However, access to a family doctor is a problem throughout the province. Ideally, all points of service should offer information and contraceptive counseling services that are comprehensive and respectful of women's choices. A lack of sex education in schools and healthcare facilities has been cited as a major problem by abortion providers. It is therefore important to establish a genuine sexuality education program in primary and secondary schools in collaboration with community organizations, within the public network of health and social services, the nonprofit sector, colleges and universities.

In Quebec, it is primarily general practitioners who perform abortions. Only about fifty doctors perform abortions, and many have been practicing for the past 10 and even 25 years. Many institutions have difficulty recruiting physicians trained in the practice of abortion and worry about not having doctors to replace them in a few years. Family planning and abortion should be part of university training programs in family medicine. Students in medicine should be exposed to the historical, political, social, and ethical contexts of abortion in Quebec and need to be aware of this reality. Students enrolled in family medicine must have access to practical training at the abortion service delivery points in order to familiarize

themselves with the various abortion techniques. These placements should also be eligible for academic credit. This would enable a new generation ready to continue providing this necessary medical service to women in Quebec.

Since waiting rooms are not always reserved solely for abortion services and some are shared with maternity services, women may cross paths with anti-choice staff or may have their privacy neglected. When the infrastructure permits it, abortion services and family planning should be offered in separate spaces that are reserved for their purpose. When waiting rooms are common, institutions should ensure that women are not in touch with anti-choice staff, that the rooms are devoid of decorations and references to motherhood, and that staff members adopt special measures to ensure and respect the confidentiality and security of women.

Confidentiality is extremely important when it comes to healthcare and more specifically to abortion. It is recommended that institutions that have not yet done so adopt special measures to ensure that women's confidentiality is guaranteed and respected, and to ensure that all staff comply with the codes of conduct and professional ethics in terms of confidentiality and respecting the choices of people who use their services.

In the past, several institutions have reviewed their security practices to protect women and people working in abortion services against anti-choice protesters or abusive partners. Many feel that security is a problem and would like to be able to better protect the women who use their services. It is recommended that funds be available to implement the necessary measures to ensure the safety of staff and women using abortion services. In addition, institutions that are targeted by anti-choice demonstrations should be able to obtain injunctions to protect women and staff of abortion services from intimidation by protesters opposed to free choice.

More than half of the institutions providing abortion services are financially unable to help women who can not pay for an abortion, whether it is women who are not registered with the RAMQ or who are temporarily in Quebec. Abortion is an essential and urgent service for women who decide to use it. It is therefore important to establish an emergency fund managed jointly by stakeholders and women's rights advocacy groups to pay for abortion services for women who are unable to do so.

Conclusion

Quebec is the Canadian province with the most points of service for abortion. This can be attributed to the strength of the demands of the women's movement and its alliances, to a more open political environment as well as to public opinion that generally supports the right of women to choose abortion.

The implementation of abortion services has suffered many upheavals over the years. From the significant influence of the Catholic Church to the arrest of physicians who performed abortions, anti-choice pressures have always been present. Either by acting on behalf of Catholic values in the 1960s, by opposing the sexual revolution in the 1970s, by attempting to criminalize women by giving rights to the fetus in the 1980s, or by forming part of a resurgence of the ideals of the conservative right and evangelists in the 2000s, the anti-choice movement has always been present in various forms, with the underlying objective of socially controlling women's bodies. In 2006, this movement moved dangerously close to power with the election of a federal government composed of a majority of anti-choice MPs. The influence of this movement threatens both the right and access to abortion.

Despite the many advances and changes in recent years, it is clear that access to abortion services still needs to be consolidated. It remains difficult to obtain comprehensive information on the abortion services available across the province. Women who call their local CLSC or hospital will sometimes come up against voice mailboxes and the judgment of receptionists. Fortunately, the Info-Santé services as well as numerous receptionists at hospitals, CLSCs, clinics or women's health centres, thoughtfully provide adequate information to women wishing to terminate a pregnancy.

Less than 25% of the public network facilities (hospitals and CLSCs) offer abortion services, including the procedure itself or support and counseling services. The four private clinics that provide abortions are all located in Montreal and only three regions have a community women's health centre. The vast majority of establishments suffer from a lack of resources: nursing staff, trained and available doctors, financial and administrative support, etc. This lack of resources limits the supply of services, including the availability of staff for booking appointments and for providing post-abortion support. In some areas, women may

sometimes have to wait up to four weeks for the procedure. However, there is a very strong commitment on the part of caregivers to help women gain access to a medical service they have chosen.

Lack of access to contraception and sex education for the general population makes the situation even more difficult, as many unplanned pregnancies could be prevented.

Future battles include the need to obtain the financial resources required to provide women with equal quality services offered under optimal conditions, anywhere in Quebec, without ignoring the need to counter the mounting threats and strategies of the anti-choice movement in Quebec and in Canada. To this end, we must also add the fight to maintain and improve the public and community health system, in order to provide quality abortion services for all women in Quebec.

APPENDIX 1

Anonymous Questionnaire on the Accessibility of Information about Abortion and Services in Hospitals and CLSCs

Hospital: _____

Phone Number: _____

Address: _____

Website: http://www. _____

You are calling to inquire about abortion services. You are about 10 weeks pregnant. If they ask you about the date of your last menstrual period (LMP) take the date you are calling on and count backwards 10 weeks. (For example, if today is June 15th, your LMP would be April 7th.) Information that you may divulge over the phone includes:

- 10 weeks pregnant
- just independently moved to the area for temporary residence (from outside province)
- no family or friends nearby
- no family doctor
- 20 years old
- have healthcare (but it's from a different province)
- name (when asked) is **Caroline Lemieux**

Today's Date: _____

LMP: _____

Script

Call the main hospital number. Talk to the first person that answers the phone. Say, "Hello, I am pregnant and am considering an abortion. Do you provide abortions at your hospital?"

YES NO

Comments: (reaction when asked about services)

- Reception didn't know

_____

_____

_____

If YES, record the process that you must follow in order to get referred to a physician for scheduling. (Circle if: you needed to ask for the info OR if info is offered to you.)

_____
_____
_____
_____

Ask what the average wait time is for an abortion.

_____

If NO, did they offer referrals without being asked? (If they do not, ask for referrals.)

YES NO

List of referrals offered: (Name, nuàmber and details?)

_____
_____
_____
_____
_____

When contacted, was this referral useful?

YES NO

Comments:

_____
_____

END OF PHONE CALL

Overall, the person on the phone from the hospital was:

- Helpful, understanding
- Rushed, impatient, abrupt
- Rude, unpleasant
- Indifferent
- Knowledgeable
- Needed to be pushed for information
- Unsure, willing to check
- Unsure, unwilling to check

Number of calls needed to get info: _____

Number of people spoken to: _____

Additional comments:

_____
_____
_____
_____
_____

APPENDIX 2

Telephone Questionnaire to Practitioners: The Current State of Abortion Services in Quebec

What is the procedure to book an appointment for an abortion at your institution? (Do women have to reconfirm their appointments? Do you call women to reconfirm? What is the schedule for booking appointments?)

How many appointments are necessary for the procedure? What happens during appointments?

During the pre-abortion meeting, do you talk about contraception with women? Do you offer IUD insertion?

Who performs abortions in your institution? General practitioners or obstetrician-gynaecologists? How many are they? Are they always the same doctors or do they work in rotation?

What is the waiting time for an abortion? (For locations where there are two meetings: what is the delay between the first call and the pre-abortion meeting; and between the pre-abortion meeting and the abortion? Are there times of the year when the wait time is higher or lower. Why?

For institutions in the Montreal area: was there a change following the agreement with the health agency to ensure that abortions in private clinics are reimbursed? Has your wait time changed?

If you do not have availabilities, do you refer to other institutions?

What limits your ability to provide services? Would you like to provide more abortions?

For institutions that provide abortions under 14 weeks: Where do you refer women who are over 14 weeks pregnant?

What support is available for informed decision-making? What procedure do you follow when a woman is ambivalent?

Where do women wait for their pre-abortion meetings and for the abortion? (Are there waiting rooms reserved for women who have abortions?)

Is your clinic/institution safe? What security measures are in place (to avoid violent spouses, anti-choice demonstrators, etc.)?

What advice do you give to women after the procedure? Do you offer post-abortion counseling services? Is this service offered systematically or on demand? What does this service consist of?

What measures are used to ensure the confidentiality of patients?

Do you ever refuse to perform an abortion? If yes, why?

For women who have no health insurance card, can you help them financially? How does this work? Is it based on case-by-case or a funding limit?

Do the procedures take place in a secure location? What security measures are in place?

What are the biggest obstacles you face in your work?

Are there factors that make you think that there will be a change in the services offered at your institutions in the coming months or years? (Increase or decrease in service ... doctors retiring, a climate of insecurity).

Is there other information that would be relevant to add?

Thank you very much for your cooperation.

APPENDIX 3

Anonymous Calls to Crisis Pregnancy Centres Identified As Anti-Choice

Many women facing an unwanted pregnancy search for answers to their questions on the Internet. In searching for "Abortion Quebec" on google.ca, the sites that appear are those of private clinics, research centres, and crisis pregnancy centres. With names like "Care Centre" or "Pregnancy Options", these centres generally present themselves as being neutral and as providing support to women in their decision-making. In reality, some of these centres try to discourage women from choosing abortion.

We thought it would be relevant to call the centres that describe themselves as crisis pregnancy centres to check what type of information and support they provide to women facing an unplanned pregnancy. The results of this survey should be subject to further research with all centres.

A researcher contacted these centres to assess the quality of information offered on abortion and to see if they spoke openly of their bias against abortion. She pretended to be a young pregnant woman who was considering abortion and wanted more information about the procedure and where she could access it. In total, the researcher made thirteen calls and was able to talk to someone in nine centres. She noted the information received from each of them, paying particular attention to whether or not that the person revealed his or her bias against abortion as well as the type of information given.

When the researcher said she was pregnant and thinking about having an abortion, seven of these centres declared their opposition to abortion. Among these, three centres still continued the call by giving false information on the consequences of abortion. Four other centres reported not being able to give any information on this subject, including one who suggested that the caller speak with a doctor or community health centre if she wanted more information. Two centres presented themselves as neutral and able to provide information and support for all possible options when facing an unwanted pregnancy. But in fact, the information given on abortion was incorrect.

Five of the centres we contacted gave incorrect information about abortion, whether or not they displayed their position from the outset. Some examples of the responses included: "Doctors do not explain the whole process of abortion and its consequences," "the procedure is atrocious," "the suction instruments used by these doctors are 30 times more powerful than a household vacuum," "the baby is fully developed at 12 weeks, therefore abortion is murder." The caller was again told that abortion results in severe physical and psychological stress, or that the woman could suffer post-abortion stress, become sterile, have problems with her sexuality, or develop breast cancer. In addition, several receptionists told the researcher that the majority of women regret their abortions, and that this procedure destroys the lives of the women who choose to terminate a pregnancy.

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