Task Group of Abortion Service Providers

Report on

Access to Abortion Services in Ontario

December , 1992

The Task Group
of
Abortion Service Providers

Ontario

December 9, 1992

The Hon. Frances Lankin
Minister of Health
10th Floor, Hepburn Block
80 Grosvenor Street
Queen's Park
Toronto, Ontario
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Dear Ms. Lankin:

The report of the Task Group of Abortion Service Providers is the culmination of the work of many dedicated, committed people. The original Consultation Group of more than 60 people contributed the inspiration, ideas and impetus for the work of the Task Group.

The recommendations contained in this report have been developed by the Task Group after many hours of work and extensive research into the real situation regarding abortion services in Ontario. Great care has been taken to consider the cost of provision of services without ever losing sight of our most important concern — the needs of the women of Ontario for quality health care. The Consultation Group has given full support to the final recommendations contained in the report.

The work and support of Catherine Brown and Kelly Kane of the Women's Health Bureau have made this extensive report possible, and the members of the Task Group wish to acknowledge their important contribution.

The Task Group looks forward to your support in seeing that the recommendations contained in the report are implemented.

Sincerely,

The Task Group of Abortion Service Providers

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Counselling & Referral //

Our major concern is now where do we go with it!

Task Group of Abortion Service Providers Report on Access to Abortion Services in Ontario

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Executive Summary

In November 1990, the government of Ontario announced its commitment to developing a co-ordinated policy on abortion service delivery. At the same time, it made clear its position that women have the right of timely access to safe abortions.

A Consultation Group of about 60 abortion service providers was established to advise the Ministry of Health on how to improve access to abortion services. At the second meeting of this group, concerns were raised about the slow progress of the government, and the Ministry of Health in particular, toward improving access. The Consultation Group recommended that the Ministry of Health immediately begin development of a workplan to address issues of access to abortion. A task group, composed of representatives from the larger group, was convened to assist with the development of the plan.

The immediate goal of the Task Group of Abortion Service Providers has been to identify the key barriers that perpetuate unequal access to abortion services in Ontario, and to develop strategies to overcome them. Our long-term goal is to ensure that every woman in Ontario — regardless of her first language, how much money she has, her race or origin, or where she lives — has access to safe and supportive abortion and related reproductive health services in her own community.

I. Government Commitment and Co-ordination

Abortion services remain inequitable and inaccessible in many areas of the province. So do reproductive and sexual health care. This is particularly true for young women, poor women, women with disabilities, aboriginal women, women of colour and immigrant and refugee women. Access is also limited for women in rural, remote and northern communities.

There are serious concerns about the lack of action to date from the government. No efforts have been made to establish additional community clinics. No new initiatives have been developed to improve the quality and availability of abortions in hospitals. Harassment by an anti-choice minority toward providers and women seeking abortions has been allowed to continue.

The government must take overall responsibility for ensuring equitable access to abortion and reproductive health care for women. We have recommended that the top priority of the Ministry of Health must be to facilitate the expansion of services in the northwestern, northeastern and eastern regions, as well as in underserviced areas in southern Ontario.

In addition to this priority, we recommend actions to overcome other key barriers to equitable access to abortion. The government must better co-ordinate its ministries and implement these recommendations within the stated timeframes in order to fulfil its commitment and its responsibility to the women of Ontario (see the attached List of Recommendations for a summary of all recommendations contained in this report).

II. Current Provision of Abortion Services

Availability of Providers

One of the most significant problems is that there are simply too few physicians and other health care providers trained and willing to provide abortion services. Opportunities for training in abortion must be expanded; the training that is currently available to physicians and other professionals must be improved. Financial and professional incentives for providers to work in the area of abortion must also be improved.

Hospital Services

Many women and communities continue to depend on hospitals for abortion and other reproductive health care. We have identified inadequacies in both the availability and the quality of care given to women seeking abortions in hospital settings. Therefore, the Ministry must take immmediate action to improve the quality and availability of hospital services. As well, resources must be effectively allocated to those hospitals making significant contributions to high-quality and accessible abortion care.

Clinic Services

In many areas, the establishment of community-based clinics to provide comprehensive reproductive health care has been identified as the most desirable method of abortion service delivery. Currently, there are only four clinic facilities providing abortion services, all located in Toronto. However, these clinics provide one-quarter of all abortions in the province.

Harassment

Harassment has a profound effect on access to abortion. Women's right to abortion services is often seriously limited or denied because of anti-choice harassment from individuals and groups. Harassment and intimidation are also one of the main factors responsible for the shortage of abortion service providers. Not only are most physicians reluctant or unwilling to perform abortions, most are reluctant to even be trained.

The government, and the Attorney General's office in particular, has done nothing concrete to end harassment of both providers and women seeking abortions. The government must take immediate action to ensure that all health facilities, service providers and women seeking abortion services are free of anti-choice harassment and intimidation.

III. Accessibility and Expansion of Abortion Services

Improving access to abortion will require the expansion of services. It may also include the need to improve or redistribute existing services or examine alternatives for service delivery. The most appropriate mix of facilities will depend on local needs and priorities, but the Task Group expects that this would include at least one hospital, commmunity clinic or other health facility in each major region to provide abortion services.

In many areas, a community-based clinic that could provide comprehensive reproductive health care is identified as the most desirable method of abortion service delivery. Consideration must also be given to expanding or modifying established community clinics, counselling services and referral networks to include abortion. Building on existing resources or facilities in this way may require little additional investment to improve access to a full-range of reproductive health care services for women.

Unfortunately, one of the most significant barriers to the expansion of community-based services lies within the mechanisms established by the Ministry of Health itself. The Task Group views the Independent Health Facilities Act (IHFA) as creating additional barriers rather than facilitating the development of abortion services. The Ministry of Health must evaluate the effectiveness of the IHFA and complete legislative, regulatory or policy changes that will allow for equitable participation by any provider, community group, community health centre or independent health facility interested in establishing comprehensive health care services for women.

IV. Towards Comprehensive Health Care

For women to exercise fully informed choices over their sexual and reproductive health, they need information about the options and services available to them. Therefore, sexual and reproductive health education and prevention programs must be extended to ensure that they are accessible, affordable and appropriate to all women. These services must also be expanded beyond traditional medical settings and made available in schools and a variety of community settings. As well, comprehensive counselling and referral networks that are accessible and available to women in their own communities must be developed.

The expansion of alternatives for women must also be examined. The use of antiprogestins, such as RU 486, is one method that could significantly increase access to abortion. However, progress in developing research and approval on the use of antiprogestins in Ontario has been slow. The provincial government, through the Ministry of Health, must urge the federal government to expedite testing and approval of antiprogestins in Canada, once application is made. Once approved, antiprogestins and the related counselling and services must be available free of charge.

Finally, the recommendations outlined in this report must be considered within the context of a clear long-term vision of how reproductive health care for women can best be provided. The Ministry of Health must therefore support innovative programs in hospital-based centres and community clinics that would provide full reproductive health care in accessible locations.

The government of Ontario has an opportunity to make a lasting contribution to women's equal access to abortion and their full freedom of reproductive choice. One important step it could take in this direction is to implement the recommendations in this report without delay.

List of Recommendations

The order of the following recommendations is based on the timeframe for implementation: immediate, long-term and short-term.

Within two weeks of the release of this report, the Ministry of Health must make a commitment that expanding services in identified regions will be its top priority.

Beginning with the following:

1. **The Minister of Health must make a commitment to support initiatives from the northwestern and northeastern regions of Ontario to expand access. The Ministry should work with District Health Councils (DHCs), local providers and women's health advocates to facilitate ways to expand services through existing facilities such as community health centres or hospitals.**

2. **The Minister of Health must make a commitment to work with the Waterloo District Health Council and community groups in Kitchener-Waterloo to explore alternative ways of providing abortion services. There are currently no physicians willing to provide abortion in the area because of harassment.**

3. **The Minister of Health must make a commitment to consolidate the support of local District Health Councils and facilitate the bureaucratic process within her own Ministry. Specifically, the Minister of Health, using her authority under the Independent Health Facilities Act, must immediately issue a request for proposals to expand service in the Ottawa region.**

4. **The Minister of Health must make a commitment to facilitate the delivery of abortion services in a community health centre setting. This centre will demonstrate how abortion can be an integrated component of a comprehensive program in women's health care, and establish the precedent of community health centres (CHCs) providing abortion care.**

Immediate Recommendations

These recommendations must be initiated within six months and completed within one year.

5. **The Ministry of Health must follow the timeframes given with these recommendations and report its progress to the Consultation Group of Abortion Service Providers within one year.**

6. **The Ministry of Health must designate a specific ministry representative to be responsible for co-ordinating the implementation of these recommendations and communicating with Consultation Group members, other ministries and the community.**

7. **The Ministry of Health must identify and work collaboratively with those ministries that need to be involved in the implementation of the recommendations in this report.**

8. **The Ministry of Health must utilize existing hospital and clinic data that illustrate the current inequities in the provision of abortion services in Ontario to:**

   a) **co-ordinate and implement local strategic plans for improved or expanded services;**

   b) **undertake a user survey to determine how women's needs for abortion services are best met. The survey should identify local barriers faced by women seeking abortions and determine women's preferences in the delivery of abortion services;**

   c) **take necessary steps to ensure that any needs assessment does not preclude or delay the ongoing development of abortion services in Ontario.**

9. **The Ministry of Health must undertake a survey of abortion facilities to determine the current level of access for women with disabilities and then develop and implement guidelines and standards to improve accessibility.**

10. **Consultation must be extended to women of colour, aboriginal, disabled, immigrant and refugee women and women in remote, northern or rural areas to identify additional recommendations required to meet their needs.**

11. **The Consultation Group of Abortion Service Providers continue to be involved in the government's action plan to improve access to abortion services in Ontario, and be used in a resource capacity during the implementation of the recommendations put forth in this report. However, the membership of the Consultation Group must be better balanced to represent the racial, cultural and geographical diversity of women in the province.**

12. **The Ministry of Health communicate the government's position on access to abortion to all District Health Councils (DHCs) and outline the DHCs' responsibility to facilitate service provision in each region. This communication could be achieved through the Association of District Health Councils of Ontario.**

21. **The government take immediate action to ensure that women have access to abortion services without being subjected to harassment by anti-abortion demonstrators:**

    a) **the Attorney General must seek an injunction to control harassment activity at abortion service facilities and providers' homes;**

    b) **The Solicitor General must issue a directive to all police forces indicating the measures necessary to ensure that all health facilities, service providers and women seeking abortion services are protected from the harassment of anti-abortion protesters.**

22. **The Attorney General explore specific legislative options, as are common in other North American jurisdictions, to prohibit harassment at reproductive health care centres.**

23. **The Minister of Health use her discretionary power as outlined in Section 5(2) of the Independent Health Facilities Act to issue requests for proposals for the establishment and operation of independent health facilities. Where indicated, the Minister must forgo a costly and time-consuming needs assessment.**

25. The Ministry of Health provide additional staff within the Ministry to monitor and facilitate the implementation of the IHFA in relation to the development of abortion services.

26. The Ministry of Health complete any legislative, regulatory or policy changes to allow for equitable participation in the request for proposal process by a broad range of abortion service providers in new or existing facilities, including independent health facilities, family planning clinics, community health centres and hospitals.

27. The Ministry of Health define accurate costing for hospital-based abortions and compare this to similar services provided in free-standing clinics.

30. The Ministry of Health ensure that all health units are:

    a) providing appropriate and accessible family planning services, as outlined in the Mandatory Health Programs and Services Guidelines, Sexual Health Program Standards (April 1989);

    b) working to expand these services beyond the traditional medical setting and into workplaces and community settings;

    c) receiving funding for the enhancement and expansion of family planning/sexual health counselling and clinical programs, where needed.

    d) accessible to women with disabilities; e.g., wheelchair accessible, with modifications for visually impaired and deaf and hard of hearing.

32. The Ontario Women's Directorate, in its role as chair of the Interministerial Committee on Sexual Assault, place greater emphasis on the prevention of sexual assault through education about sexual behaviour that is coercive, manipulative or assaultive.

33. The Ministry of Education must:

    a) develop and mandate a comprehensive sexual health curriculum that is compulsory in all schools from Grades K to 12 and OAC;

    b) develop a comprehensive program to qualify physical and health educators to deliver the sexual health curriculum;

    c) provide professional development to all teachers to increase sensitivity to sexual health issues;

    d) provide mandatory sexual health courses for all teachers as part of their core education;

    e) ensure that sexuality education is available for all students, including those with physical and mental disabilities (e.g., schools for the deaf and the blind).

34. The ministries of Education and Health must jointly sponsor an annual educational conference for all sexual health educators and counsellors.

35. The ministries of Education and Health must work to encourage co-operation between boards of education and public health units regarding preventive educational services.

36. The Ministry of Health must immediately establish a province-wide information line to provide facts about abortion, sexuality education, contraception and related issues. Information must be available in many languages and the TDD network for those who are hearing impaired.

38. The Ontario Medical Association and the Ontario Nurses' Association must provide information to their professions on abortion legislation, funded clinics, independent health facilities, and the ethical responsibility to make abortion referrals.

39. The College of Physicians and Surgeons must issue a statement to remind physicians that, regardless of their personal views, they have a professional responsibility to make abortion referrals.

40. The Ministry of Health must direct the chief medical officer of health to issue a statement to all health units and family planning clinics outlining how abortion referrals are to be made, and to make information regarding the provision of abortion services easily available. The medical officer of health must also reinforce the accessible provision of sexual health programs to any person requesting service, regardless of age.

43. The Ontario Medical Association, and other professional associations, encourage Roussel-Uclaf to submit an application to the Canadian government for the testing and approval of RU 486.

Short-Term Recommendations

These recommendations must be initiated within one year and completed within three.

13. The Ministry of Health and District Health Councils develop a service plan for each DHC that ensures equitable access to abortion in every area.

14. The Ministry of Health develop strategies to recruit and train abortion service providers.

    Training must:

    a) be comprehensive in that it will provide instruction in all procedures, including later stage abortions and the use of local anaesthetics, as well as counselling and education;

    b) be made available to all service providers, including family physicians, obstetricians/gynaecologists, anaesthetists, nurses and counsellors;

    c) initially be provided only where there is a direct link between training for service provision and need for service providers (i.e., in centres where a need has been identified);

    d) target family physicians as well as obstetricians/ gynaecologists;

    e) be available during residency and at the continuing medical education (CME) level.

15. The Ministry of Health must encourage the College of Physicians and Surgeons, the Society of Obstetricians and Gynaecologists, the Ontario Medical Association (OMA) and the faculties of medicine and health sciences to institute policies that will encourage physician participation in women's health care, including abortion.

16. The Ministry of Health must work with the OMA and other professional bodies to develop mechanisms to support and provide incentives for physicians to provide abortion services.

17. The Ministry of Health must mandate at least one hospital, community clinic or other health facility in each DHC region to provide abortion services.

18. The Ministry of Health must work with the Ontario Hospital Association to:

    a) encourage hospital allocation of operating room time and other resources to provide abortion services. This could include the use of day surgery or minor procedure rooms and operating rooms during off hours;

    b) develop mechanisms to support the staff providing abortion services, particularly if the procedure is performed in the evening or on weekends;

    c) remove barriers for physicians seeking privileges for the provision of abortion services.

19. The Ministry of Health must review the allocation of hospital funding for all women's health services, including abortion, to ensure that provision of service is linked to the provision of funding, and that accountability is enforced.

20. The Ministry of Health must develop mechanisms within the process of service rationalization to require all hospitals that offer obstetrics/gynaecology to include abortion as part of these services.

24. The Ministry of Health evaluate the effectiveness of the IHFA in enhancing access to abortion and reproductive health care. Abortion clinics should be handled separately within the needs assessment, approval and funding processes.

31. The Ministry of Health and the Ministry of Community and Social Services develop mechanisms to ensure the cost-effective and accessible delivery of a range of contraceptive products.

37. The Ministry of Health must use Health Number (HN) mailings to distribute information about sexual health, including abortion services.

41. The ministries of Health, Community and Social Services, Education and Citizenship must work to expand the role of agencies that currently provide counselling to also provide abortion referrals (e.g., Family Service Associations, Children's Aid Societies, Welcome Houses).

42. The Ministry of Health must make funding available to community organizations to deliver training for their staffs providing abortion counselling. This training must:

a) include counselling on decision making, the procedure, contraception and follow-up;

b) include counsellors from a variety of racial and cultural backgrounds;

c) include issues particular to disabled women.

44. The provincial government, through the Ministry of Health, urge the federal government to expedite testing and approval of antiprogestin drugs in Canada, once application is made.

45. The Ministry of Health guarantee that antiprogestins and the requisite counselling and services will be available free of charge when approved.

46. The Ministry of Health facilitate and support pilot projects and innovative programs that work toward providing broader ranges of reproductive health care in integrated ways.

Long-Term Recommendations

These recommendations must be initiated within two years and fully implemented within five.

28. The Ministry of Health establish an advisory committee to develop a protocol for abortion service delivery for all facilities providing services. This protocol must encompass the entire system of service provision, from counselling/referral through to general procedural guidelines in the facility and follow-up requirements.

The protocol must include, but not be limited to, guidelines for:

a) standards of referral, counselling, medical and nursing care;

b) standards of technical components of the procedures;

c) qualifications of counsellors;

d) confidentiality regarding information and retention of records;

e) informed choice;

f) delivering accessible services; for example, examination tables that lower to the floor, such as the Midmark chair;

g) appropriate, sensitive and ethical treatment of women who seek abortions.

29. The Ministry of Health and the Ontario Hospital Association must ensure that any protocol developed is used by all hospitals performing abortions.

Introduction

In November 1990, following the change of provincial government and two months before Bill C-43 was defeated in the Senate, the Ministry of Health announced its commitment to developing a co-ordinated policy on abortion service delivery. Its statement made clear the Ontario government's belief in two basic principles: that abortion is a health issue, and that women have the right of access to safe abortion services.

The 1990 announcement was the first time the government of Ontario had come forward with a pro-choice stand on abortion. The government's primary goal was to ensure timely and equitable access to safe and publicly funded abortions for the women of Ontario, while also providing education programs to reduce unplanned pregnancies and, therefore, the demand for abortions.

The Task Group of Abortion Service Providers

A consultation group of about 60 abortion service providers[1] was established in the fall of 1990 to advise the Ministry of Health on the development of a framework for improved access to abortion services. Abortion services are defined not only as the medical procedure, but as a broad range of medical, administration, nursing, counselling and education services.

All members of the consultation group share the belief that every woman has the right to a full range of reproductive health care in her own community and that no publicly funded facility should be allowed to refuse the provision of abortion services any more than it could refuse any other necessary health service. Furthermore, if a particular region is found to lack these services, all reasonable measures must be taken to provide them within that region.

At the second meeting of the Consultation Group of Abortion Service Providers, on May 30, 1991, concerns were raised about the slow progress of the government, and the Ministry of Health in particular, toward improving access. It was recommended that the Ministry immediately begin development of a strategic workplan to address issues of access to abortion services in Ontario.

A task group composed of representatives from the larger group was convened to help with the development of the plan. (See Appendix A for the task group membership and Appendix B for the group's mandate and terms of reference.) The following document was developed by the Task Group of Abortion Service Providers, with the assistance of the Women's Health Bureau of the Ministry of Health, to outline strategies for improving access to abortion services in Ontario.

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[1] The consultation group included physicians, pro-choice activists, counsellors, educators, administrators and representatives from professional associations and women's health organizations.

I. Government Commitment and Co-ordination

The NDP government has taken important steps to address the obstacles faced by women who seek safe and equitable access to abortion services in the province. The government played a key role in the pro-choice campaign against Bill C-43, and its defeat in the Senate on January 31, 1991 removed one of the most pressing obstacles to access. As well, the statements by the previous minister of Health represent the clearest commitment of any government in Canada to the principle that every woman has the right to control over her own body, including the right to choose an abortion.

Despite this commitment, abortion services remain inequitable and inaccessible throughout the province. Barriers that are specific to these services must still be removed. But these barriers must also be considered in the broader context of the fragmented nature of women's health care and the inadequacy of the provincial health care system in addressing women's total reproductive health needs.

The most comprehensive recent survey of access was the 1987 *Report on Therapeutic Abortion Services in Ontario* prepared for the provincial government by Dr. Marion Powell. It found that access was severely limited in many areas and highly inequitable across the province. For example, "the system does not provide timely and optimal support to women in need of abortion services. Difficulties were identified at each step from the time the woman suspects pregnancy to the completion of the abortion procedure. The entire process was found to be protracted, with women requiring three to seven contacts with health professionals before the actual procedure could be performed." In more than half of Ontario counties, Powell found, women had to leave the county to obtain abortion care (p. 7).

Since the release of the Powell Report, the government of Ontario has done little to improve the delivery of abortion services. Many of the problems identified by Dr. Powell have not been addressed, much less remedied. The following still exist:

- lack of physicians willing to make referrals for abortion;
- decreasing availability of gynaecologists and anaesthetists willing to perform the procedure;
- too many hospitals that do few or no abortions;
- lack of available counselling, both pre- and post-abortion;
- insufficient availability of operating room time for the procedure;
- inadequate use of procedures recognized as reducing complications;

- negative attitudes in the community; and
- punitive attitudes among some health professionals toward women seeking abortion services.

In addition, we have found that access to abortion and reproductive and sexual health care is particularly difficult for young women, poor women, women with disabilities, aboriginal women, women of colour, immigrant or refugee women, and women from rural, northern and remote areas. Too few hospitals and physicians provide abortion services and the existing free-standing clinics, all located in Toronto, are overextended. Far too many women have to leave their communities, often travelling long distances, to obtain this essential health service. Harassment of service providers and women seeking abortion by a small anti-choice minority remains a significant problem.

There are serious concerns that the government is not working quickly enough to improve access to abortion. Harassment has been allowed to continue at abortion clinics; no efforts have been made to establish additional community clinics, especially outside Toronto; and no new initiatives have been developed to improve the quality and availability of abortion in hospitals. As a result, the government has been criticized for not working collaboratively with its ministries and the community to develop and implement strategies that will remove barriers to access.

Government commitment is an important first step toward establishing an equitable and accessible abortion service system, but commitment alone is not enough. Solving service delivery problems will require a strategic plan, along with better co-ordination and immediate action by government ministries to implement that plan.

The role of the Task Group has been to identify the key barriers that perpetuate unequal access and to develop an action plan to overcome them. Our main goal has been to ensure that every woman in Ontario — regardless of her first language, how much money she has, her race or origin, or where she lives — has timely access to safe and supportive abortion and related reproductive health services in her own community.

The Task Group has identified a number of actions that the Ministry of Health must immediately take to remedy the lacks in the most underserviced areas of the province.

> **Therefore, within two weeks of the release of this report, the Ministry of Health must make a commitment that expanding services in identified regions will be its top priority.**

Beginning with the following:

1. **The Minister of Health must make a commitment to support initiatives from the northwestern and northeastern regions of Ontario to expand access. The Ministry should work with District Health Councils (DHCs), local providers and women's health advocates to facilitate ways to expand services through existing facilities such as community health centres or hospitals.**

2. **The Minister of Health must make a commitment to work with the Waterloo District Health Council and community groups in Kitchener-Waterloo to explore alternative ways of providing abortion services. There are currently no physicians willing to provide abortion in the area because of harassment.**

3. **The Minister of Health must make a commitment to consolidate the support of local District Health Councils and facilitate the bureaucratic process within her own Ministry. Specifically, the Minister of Health, using her authority under the Independent Health Facilities Act, must immediately issue a request for proposals to expand service in the Ottawa region.**

4. **The Minister of Health must make a commitment to facilitate the delivery of abortion services in a community health centre setting. This centre will demonstrate how abortion can be an integrated component of a comprehensive program in women's health care, and establish the precedent of community health centres (CHCs) providing abortion care.**

Immediate implementation of these recommendations will significantly improve access in the north and east as well as in underserviced areas and communities in southern Ontario. In addition, such actions will demonstrate how services can effectively be expanded by building on existing resources or projects already committed by the government.

We strongly urge that a range of initiatives begin at once. As well as directly contributing to improved access, these initial projects and commitments will establish vital precedents for change, and concretely demonstrate the range of possible innovations for the future. By graphically illustrating the government's commitment to women's reproductive health and autonomy, they will encourage communities across the province to explore how the diverse and particular needs of women in their areas can best be met.

In addition to these priorities, we have identified and recommended actions to overcome other key barriers to equitable access to abortion. Specific timeframes for action are included with these recommendations, which the government must follow in order to fulfil its commitment and its responsibility to the women of Ontario. The timeframes within which these recommendations must be implemented are:

IMMEDIATE (IMM) recommendations must be initiated within six months and completed within one year.

SHORT-TERM (ST) recommendations must be initiated within one year and completed within three.

LONG-TERM (LT) recommendations must be initiated within two years and fully implemented within five.

The timeframes given for recommendations in the report are designed so that the present government can establish a solid foundation for pro-choice health care within its term of office (see List of Recommendations).

Planning and Priorities

We recommend three components to strategic planning for improved abortion services:

First, the government must take overall responsibility for ensuring equitable access to abortion and reproductive health care for all women. We have developed Recommendations 5 to 10 to help the Ministry of Health with this responsibility:

5. **The Ministry of Health must follow the timeframes given with these recommendations and report its progress to the Consultation Group of Abortion Service Providers within one year. (IMM)**

6. **The Ministry of Health must designate a specific ministry representative to be responsible for co-ordinating the implementation of these recommendations and communicating with Consultation Group members, other ministries and the community. (IMM)**

7. **The Ministry of Health must identify and work collaboratively with those ministries that need to be involved in the implementation of the recommendations in this report. (IMM)**

Government planning must be based on accurate information about the current state of abortion provision and women's service needs. However, because inequality of access has been well documented and the barriers to equitable provision so well identified, there is no need for a comprehensive provincial needs assessment before this action plan is implemented. Similarly, the priorities we have already identified are so apparent that local needs assessments would create unnecessary delay and waste scarce resources. However, this is not to suggest that the strategic development of the overall system of abortion and reproductive health care will not require sound information and planning.

Local needs and priorities must determine (i) the most appropriate mix of facilities needed in an area; (ii) the ways in which abortion services are integrated with other women's health care, community support services and referral networks; and (iii) the most effective policy directions and programs needed. For example, some areas may be best served by expanding the obstetrics/gynaecology services currently provided in local hospitals; others may develop innovations such as mobile clinics or travelling providers or rely more heavily on trained non-physicians.

Clearly, abortion is a decision women consider carefully. Having made the decision, it is essential that services are responsive and appropriate to their varying needs. Many practical factors contribute to how women obtain abortions: the type of service offered, its location, accessibility in rural and remote communities, anonymity, referral from a physician, attitudes and sensitivity of service providers, personal costs for travel or services not covered by OHIP, and the availability of accessible services for disabled, aboriginal, immigrant and refugee women and women of colour.

Therefore, improving access to existing services or expanding the range of available services must be based on the needs and priorities of the women using abortion services. An essential first step is to learn how and why women use them in the way they do.

Hospital and clinic data clearly illustrate the inequities in the current abortion delivery system. These data indicate how many abortions are performed in each region, by whom and for whom. However, no adequate mechanism exists to determine the optimum model for service delivery in each region of the province. As well, it is difficult to determine the migration patterns of women who travel to free-standing clinics in Toronto, to other regions, to another province or to the United States. Mechanisms are not in place to identify the number of women who travel to have abortions, nor to accurately determine where they go.

There is also a need to better identify the reasons women leave their own communities to have abortions. We do know women travel elsewhere because of the unavailability of services in their home region, waiting lists, discomfort with a hospital setting, preference for clinic service, unavailability of a local anaesthetic, the need for later stage abortions, and the need for greater anonymity than is available locally. However, it is still difficult to establish which factors are most important to women in particular communities or regions.

Accurate identification of need must be obtained from diverse groups of women. This is best achieved through the development of a standardized user survey that allows women to identify barriers to access and their preferences in service options. In some communities, women identify barriers related to their culture, race, language, income or disability; in others, geographic barriers may be a problem. It is important to collect this information from women at the outset because many women do not attend clinics, hospitals or referral agencies for follow-up once the procedure is complete. However, we stress the need for sensitivity when requesting this information, particularly at the time a woman may be making the decision to have an abortion.

Therefore, we recommend that:

8. **The Ministry of Health must utilize existing hospital and clinic data that illustrate the current inequities in the provision of abortion services in Ontario to: (IMM)**

    a) **co-ordinate and implement local strategic plans for improved or expanded services;**

    b) **undertake a user survey to determine how women's needs for abortion services are best met. The survey should identify local barriers faced by women seeking abortions and determine women's preferences in the delivery of abortion services;**

    c) **take necessary steps to ensure that any needs assessment does not preclude or delay the ongoing development of abortion services in Ontario.**

9. **The Ministry of Health must undertake a survey of abortion facilities to determine the current level of access for women with disabilities and then develop and implement guidelines and standards to improve accessibility. (IMM)**

10. **Consultation must be extended to women of colour, aboriginal, disabled, immigrant and refugee women and women in remote, northern or rural areas to identify additional recommendations required to meet their needs. (IMM)**

Second, as this strategic planning can be carried out only with the participation of community providers, advocates and the pro-choice community, we recommend that:

11. **The Consultation Group of Abortion Service Providers continue to be involved in the government's action plan to improve access to abortion services in Ontario, and be used in a resource capacity during the implementation of the recommendations put forth in this report. However, the membership of the Consultation Group must be better balanced to represent the racial, cultural and geographical diversity of women in the province. (IMM)**

Finally, effective local co-ordination and planning of reproductive health care services is also required. To that end, we recommend that:

12. **The Ministry of Health communicate the government's position on access to abortion to all District Health Councils (DHCs) and outline the DHCs' responsibility to facilitate service provision in each region. This communication could be achieved through the Association of District Health Councils of Ontario. (IMM)**

13. **The Ministry of Health and District Health Councils develop a service plan for each DHC that ensures equitable access to abortion in every area. (ST)**

II. Current Provision of Abortion Services

Availability of Providers

One of the most significant problems in the provision of abortion services is that there are simply too few physicians and other health care providers trained and willing to provide abortion services. According to the Ontario Medical Association (OMA), 629 obstetricians/gynaecologists were practising in the province in 1990/91. Of these, only 54% (341) were performing abortions.

The OMA also reports that there were 10,068 practising family physicians in 1990/91. Of these, fewer than 1% (39) performed abortions.

These figures point to the small number of obstetricians/gynaecologists available to perform abortions and the large population of family physicians who could potentially provide the service. Overall, this indicates the need to recruit and train family physicians and other professionals to provide abortion services.

Obstetricians/gynaecologists are generally not encouraged to seek abortion training or to provide the service once practising, and there is no continuing medical education (CME) program for abortion providers once they have completed their clinical training. While training in abortion procedures is available during residency, this training is not mandatory and there are no special incentives for obstetricians/gynaecologists to choose electives in abortion provision.

As well, we learned from health professionals participating in the consultation that many obstetricians/gynaecologists do not provide abortions because (i) the service is not seen as worthwhile in light of the other medical services they can provide; (ii) there is a lack of financial and social supports to offer the service; and (iii) there is a threat and reality of harassment.

Generally, family physicians are not trained to provide abortion services. Most of those who currently perform abortions received their training from another provider in a clinic setting. Other family physicians who expressed interest in performing abortions have been refused training by gynaecologists.

Most communities have only a small number of physicians providing abortions and, as with many physician services, rural and northern communities are often hardest hit by shortages. The fragility of the abortion service system in Ontario is apparent when a physician's retirement, illness or relocation can lead to more restricted or even discontinued services in certain communities. For example, the Niagara region was well-serviced a year ago but physician relocation and retirement in that area have significantly reduced service. The northeast and

eastern regions face similar difficulties since 64% and 44%, respectively, of providers in these areas are nearing retirement.

Harassment, of course, also continues to limit the number of physicians willing to provide abortion services. Often physicians and related staff experience social stigma, professional isolation, peer pressure, inadequate incentives and a lack of community support. Some communities have active anti-abortion physician organizations, and doctors who perform abortions risk a significant decrease in other ob/gyn referrals. Service in Kitchener-Waterloo has already been terminated due, in part, to pressure from anti-abortion physicians in the community.

With the current shortage of providers, the onus is on a relatively small number of health care professionals to provide all abortion services. They must "in a sense compensate for the reluctance of their colleagues or the unwillingness of other hospitals to allow abortions to be performed" (Powell, 1987, p. 26).

We recommend that:

14. The Ministry of Health develop strategies to recruit and train abortion service providers. (ST)

Training must:

a) be comprehensive in that it will provide instruction in all procedures, including later stage abortions and the use of local anaesthetics, as well as counselling and education;

b) be made available to all service providers, including family physicians, obstetricians/ gynaecologists, anaesthetists, nurses and counsellors;

c) initially be provided only where there is a direct link between training for service provision and need for service providers (i.e., in centres where a need has been identified);

d) target family physicians as well as obstetricians/ gynaecologists;

e) be available during residency and at the continuing medical education (CME) level.

15. The Ministry of Health must encourage the College of Physicians and Surgeons, the Society of Obstetricians and Gynaecologists, the Ontario Medical Association (OMA) and the faculties of medicine and health sciences to institute policies that will encourage physician participation in women's health care, including abortion. (ST)

16. The Ministry of Health must work with the OMA and other professional bodies to develop mechanisms to support and provide incentives for physicians to provide abortion services. (ST)

Hospital Services

Currently, three-quarters of all abortions in Ontario are provided in hospitals. While hospitals are essential in the provision of abortion services, hospital structure can create a number of additional barriers to adequate service. For example, abortion procedures are often not given priority, and are only booked by availability of space. Therefore, the need for operating room time for more pressing or emergency surgeries then places abortion patients on a waiting list (Powell, 1987). The onus is then on women seeking abortions to either wait and have a later stage abortion or travel outside the region or province. This travel results in significant personal expense, delays that increase the risk of complications, and unnecessary anxiety and stress.

Furthermore, the Powell Report (1987) and anecdotal information from birth control clinics and counsellors have identified inadequacies in the quality of care given to women in certain hospitals. These reports point to unsympathetic treatment, hostility from physicians or auxiliary hospital staff, unnecessary use of general anaesthesia and breaches of confidentiality.

Physicians often experience difficulty in obtaining privileges to perform hospital abortions. According to Section 33 of the Public Hospitals Act, boards of directors are responsible for hospital staff and have the authority to determine who will be granted operating room privileges. As a result, the granting of privileges to perform abortions is dependent on the composition and philosophy of each hospital's board. It may be unwilling to grant privileges if individual directors do not support abortion, or if they fear harassment or loss of financial donations as a result of providing the service.

Refusal to grant doctors' privileges has been used in many cases to ensure that abortions are not performed. Members of anti-abortion groups often get appointed to hospital boards and work towards the elimination of abortion services. This strategy is clearly evident in British Columbia, where abortion opponents have

attempted to ban hospital abortions throughout the province by dominating elected boards and voting to discontinue abortion services. British Columbia's NDP government has effectively responded by introducing regulations within the Hospital Act and Hospital Insurance Act to order public hospitals within each region to provide services. The introduction of similar regulations must be considered by the Ontario government to prevent services from being more restricted or even discontinued throughout the province by this type of anti-abortion harassment.

As well, the Powell Report (1987) concludes that abortion procedures have generally not kept pace with the trend to provide services of similar technical difficulty on an outpatient basis. The majority of abortions in Ontario are performed using general anaesthesia. This requires an anaesthetist and an operating room. In addition to the difficulties in obtaining operating room time, there is the barrier of having to find an anaesthetist willing to assist at the procedure. These standard methods of providing abortions are also costly in terms of resources, generally more time-consuming, and use an operating room when a minor procedures room could be used (p. 34).

These barriers and complications in the hospital system of abortion referral and provision cause delays that result in later stage abortions. Not only is the risk of the abortion then greater, but the procedure is more time-consuming and costly. Most hospitals do not perform abortions beyond 12 weeks, which means women requiring later stage abortions must often travel outside their community or the province. While later stage abortions make up only a small percentage of abortions, they are the least available. The lack of availability routinely causes additional delays for late stage abortions.

As the majority of women and communities rely on hospitals to provide abortions and other reproductive health care, the quality and availability of hospital services must be improved. Therefore, we recommend that:

17. The Ministry of Health must mandate at least one hospital, community clinic or other health facility in each DHC region to provide abortion services. (ST)

18. The Ministry of Health must work with the Ontario Hospital Association to: (ST)

a) encourage hospital allocation of operating room time and other resources to provide abortion services. This could include the use of day surgery or minor procedure rooms and operating rooms during off hours;

b) develop mechanisms to support the staff providing abortion services, particularly if the procedure is performed in the evening or on weekends;

c) remove barriers for physicians seeking privileges for the provision of abortion services.

19. The Ministry of Health must review the allocation of hospital funding for all women's health services, including abortion, to ensure that provision of service is linked to the provision of funding, and that accountability is enforced. (ST)

20. The Ministry of Health must develop mechanisms within the process of service rationalization to require all hospitals that offer obstetrics/gynaecology to include abortion as part of these services. (ST)

Harassment

Removal of abortion from the Criminal Code represented an initial step in ensuring women's right of access to safe abortions. However, women often cannot exercise this right because anti-choice harassment from individuals and groups continues to deny or seriously limit access. As discussed, harassment is one of the main factors underlying the shortage of abortion service providers. Not only are most physicians reluctant or unwilling to perform abortions, most are reluctant to even be trained in abortion procedures.

Those who do perform abortions continue to experience anti-choice harassment at their offices and homes. Such harassment is frequently extended to the families and neighbours of service providers, and ongoing harassment has resulted in a number of physicians discontinuing their services. As the number providing the service decreases, those physicians who continue to perform abortions become more easily targeted for harassment.

Despite its stated commitment, the NDP government has done nothing concrete to end harassment of both providers and women seeking abortions. Anti-abortion harassment continues to occur throughout the province and has resulted in an overall decline in service provision over the past two years. Harassment has successfully eliminated services in several southwestern Ontario communities and severely restricted them in other regions.

In the United States, women's right of access to abortion has been dangerously undermined by anti-abortion harassment and violence. Such groups as Operation

Rescue engage in extreme tactics, including bombings, arson, death threats, kidnapping, burglaries and vandalism. The government must ensure that these tactics are not permitted in Canada.

However, serious instances of these forms of violence have already been reported here. The freestanding clinics in Toronto are particularly vulnerable because service providers and women attending the clinics are easily identified. These clinics have reported vandalism, arson, and bomb threats. The seriousness of these activities is evident in the May 1992 destruction of the Morgentaler Clinic in Toronto as a result of a fire bombing. In addition to these extreme measures, more common and ongoing tactics such as blockading clinics and assaulting patients and staff have had a profound impact on access.

Those involved in anti-abortion harassment move from community to community. Smaller communities are vulnerable to harassment because the providers and the women using the services are more likely to be identified. It is difficult for anti-abortion groups to protest at hospitals because of problems in identifying those women who are seeking abortions, so harassment occurs at the homes of providers instead.

Anti-choice harassment delays or denies women's access to government-funded health facilities that provide abortion services because women seeking abortions are often subjected to psychological as well as physical harassment. These experiences are frightening and may result in women delaying or abandoning their decisions to have abortions.

It is also a common strategy of anti-abortion protesters to target those women who are most vulnerable. This includes subjecting women of colour and women alone to more extreme treatment than white women or those accompanied by a man. Immigrant women from countries where the police are feared are often targeted by protesters because they are not likely to report harassment to the police. As well, many other women are unwilling to involve the police because of their need to remain anonymous.

The elimination of anti-abortion harassment requires full government and community support, which has not yet been achieved.

On May 19, 1992, in response to the May 17 fire-bombing of the Morgentaler Clinic, the government announced a strategy intended to begin to counter anti-abortion harassment.

On May 20, clinic providers and community representatives met with the government to discuss the strategy. The community had many unanswered questions as to how the government arrived at its position and what other options were considered.

The community response was not positive. It was suggested that the government reconsider its approach to harassment and return to the community with better options. There has been no further update on progress being made, particularly by the Attorney General's office.

The government must immediately reaffirm its support for women's right to abortions, as well as the right of physicians and auxiliary staff to provide this medical service free from harassment and intimidation. This affirmation by government must be supported with strategies that are flexible and effective, and that will impose the least possible burden on service providers and women seeking abortion services. Harassment must be discouraged by ensuring that applicable laws prohibiting illegal harassment are strictly enforced. Police services across Ontario must be informed and must protect women's right to access and the rights of services providers to be free of harassment and threats. At the same time, abortion facilities must be protected. Toward this end, we recommend that:

21. The government take immediate action to ensure that women have access to abortion services without being subjected to harassment by anti-abortion demonstrators: (IMM)

a) the Attorney General must seek an injunction to control harassment activity at abortion service facilities and providers' homes;

b) The Solicitor General must issue a directive to all police forces indicating the measures necessary to ensure that all health facilities, service providers and women seeking abortion services are protected from the harassment of anti-abortion protesters.

However, because injunctions are a blunt and poorly focused instrument, and because police forces are not consistently responsive to provincial directives, we also recommend that:

22. The Attorney General explore specific legislative options, as are common in other North American jurisdictions, to prohibit harassment at reproductive health care centres. (IMM)

III. Accessibility and Expansion of Abortion Services

"Access" to abortion services refers not just to the number of abortions being performed, but to the availability of appropriate services for all women in Ontario. Improving access may require the expansion of service, but it may also include the need to improve or redistribute existing services or examine alternatives for service delivery.

Abortions are currently provided through hospitals, hospital-based women's health centres and free-standing clinics. In 1991, 57% of the hospital abortions were performed in five centres — Toronto, Ottawa, Kingston, Hamilton and London. The provinces's four free-standing clinics, all located in Toronto, provided about 25% of abortions that year. Considering hospital and clinic abortions together, two-thirds (68%) of the 41,500 procedures in 1991 were performed in only five areas in the province.

The optimum model for service delivery will vary across the province. It depends on the size of the community, its overall attitude toward abortion, and the number, ages and racial or cultural make-up of women in that community. The most appropriate mix of facilities will depend upon particular community needs, but the Task Group would expect that this would include at least one community clinic and one hospital-based women's centre in each major region.

In many areas, the establishment of community-based clinics that could provide comprehensive reproductive health care is identified as the most desirable method of abortion service delivery. Consideration must also be given to expanding or modifying established community clinics, counselling services and referral networks to include abortion. This expansion or modification may require little additional investment or operating costs to improve access to a full range of reproductive health care services for women.

Delivering services in independent health facilities may also be more cost-effective than performing abortions in hospitals. At present no mechanism exists to accurately compare the costs of hospital and clinic abortions. There are wide variances in their services, and the actual cost will depend on the abortion procedure used and on such related services as counselling or translation.

Free-standing clinics maintain detailed statistics to determine the cost of an abortion; hospitals do not. There is a need to develop a template that would accurately identify the type and cost of similar abortion services in each (e.g., procedure, counselling, translation services).

Barriers also exist that make it difficult to expand present facilities or create new independent ones that could provide integrated women's health services, including abortion. The Task Group views the Independent Health Facilities Act (IHFA) as creating additional barriers rather than facilitating the development of accessible abortion services for women.[2]

Concerns have been raised about the inadequacy of IHFA mechanisms to identify community needs for service. District Health Councils (DHCs) are to identify needs, prioritize proposals and make recommendations to the Ministry of Health. The Ministry then calls for proposals and decides whether to approve and fund facilities. This process has been criticized for being too slow and unfair.

In addition, the IHFA's dependence on unsolicited proposals from potential providers does not ensure that a community's needs will be addressed. Significant areas of the province may remain without adequate abortion service. There is also the threat that District Health Councils, like hospital boards, may be subject to take-over by anti-abortion groups.

The process of obtaining licensing under the IHFA also creates obstacles for community groups interested in establishing comprehensive reproductive health care services for women. This process, which includes development of a proposal, needs assessment, and evaluation by the DHC and the Ministry, can be daunting for established professionals and institutions. It can seem insurmountable for community groups without lawyers, funding, consultants or other resources. The complex process creates barriers that may prevent local community-based groups from ever achieving comprehensive health care services for women. Because of these barriers, community groups have questioned whether the IHFA is the most appropriate mechanism for the establishment and regulation of abortion facilities.

Within the Act, the Minister also has considerable discretionary power. While this could allow the government to ensure progressive developments in service delivery, it could also result in the future of abortion services being left to the will of subsequent governments. That is why this government should move quickly to ensure a framework for the equitable provision of abortion is firmly established. Accordingly, we recommend that:

> **23. The Minister of Health use her discretionary power as outlined in Section 5(2) of the Independent Health Facilities Act to issue requests for proposals for the establishment and operation of independent health facilities. Where indicated, the Minister must forgo a costly and time-consuming needs assessment. (IMM)**

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[2] The IHFA provides the legislation to regulate and fund non-hospital community-based independent health facilities.

24. The Ministry of Health evaluate the effectiveness of the IHFA in enhancing access to abortion and reproductive health care. Abortion clinics should be handled separately within the needs assessment, approval and funding processes. (ST)

25. The Ministry of Health provide additional staff within the Ministry to monitor and facilitate the implementation of the IHFA in relation to the development of abortion services. (IMM)

26. The Ministry of Health complete any legislative, regulatory or policy changes to allow for equitable participation in the request for proposal process by a broad range of abortion service providers in new or existing facilities, including independent health facilities, family planning clinics, community health centres and hospitals. (IMM)

27. The Ministry of Health define accurate costing for hospital-based abortions and compare this to similar services provided in free-standing clinics. (IMM)

Quality Assurance

As already discussed, abortion service delivery is inconsistent and, in many cases, inadequate. Many women cannot find information about services or experience such gaps in service as inadequate testing or a lack of counselling. Other women encounter service duplications; they may be assessed or counselled at several points or by more than one provider during the process. Either situation can result in delays, increased stress and ineffective use of limited funds.

Consultation Group members report frequent breaches of confidentiality by health facilities around abortion, pregnancy testing, STDs and contraception. This includes informing patients' parents or relatives, posting abortion schedules in public areas near operating rooms, or inadequate security for patients' records or files. Other reports indicate mistreatment or insensitivity by physicians or auxiliary staff toward women seeking abortions, particularly young, disabled, aboriginal, immigrant and refugee women and women of colour.

There is a need to develop a protocol for abortion service delivery that includes guidelines on standards for care, training, counselling and confidentiality. Free-standing abortion clinics have such protocols, which could be used as a basis for similar models. We recommend that:

28. The Ministry of Health establish an advisory committee to develop a protocol for abortion service delivery for all facilities providing services. This protocol must encompass the entire system of service provision, from counselling/ referral through to general procedural guidelines in the facility and follow-up requirements. (LT)

The protocol must include, but not be limited to, guidelines for:

a) standards of referral, counselling, medical and nursing care;

b) standards of technical components of the procedures;

c) qualifications of counsellors;

d) confidentiality regarding information and retention of records;

e) informed choice;

f) delivering accessible services; for example, examination tables that lower to the floor, such as the Midmark chair;

g) appropriate, sensitive and ethical treatment of women who seek abortions.

29. The Ministry of Health and the Ontario Hospital Association must ensure that any protocol developed is used by all hospitals performing abortions. (LT)

IV. Towards Comprehensive Health Care

As well as improving access to abortion services in Ontario, it is essential that the Ministry of Health, with other government ministries, address the need for improved services in the related areas of prevention, education, counselling and referral.

Prevention

Reducing unplanned pregnancies will directly result in a decline in the need for abortion services. This statement is supported in Orton and Rosenblatt's 1991 report, which concludes that available sexual health programs led to a decline in pregnancy rates, and therefore the demand for abortions.

The study examined the pregnancy rate from 1976, the first year the Ministry of Health provided full funding to health units to develop family planning services. The Ontario rate declined from 54.2 pregnancies per 1,000 adolescent females in 1976 to 41.6 per 1,000 in 1986. This decline represents 31,000 fewer pregnancies, which reduced both short- and long-term pressure on the province's health and social service systems.

One of Orton and Rosenblatt's previous reports (1986) estimated that for every $1 spent on family planning services, more than $10 is saved in welfare and family benefits alone. The relationship between effective preventive programs and the potential decrease in such problems as single income mothers living in poverty must also be considered.

Information about prevention is less accessible to women of colour and aboriginal, immigrant, refugee, disabled and young women (Orton & Rosenblatt, 1991). Access to information is also limited for those in rural, remote and northern communities. These services must be extended to ensure that they are accessible, affordable and appropriate to all women regardless of age. As well, Orton and Rosenblatt point out the need to target males for prevention programs that address and eliminate manipulative, coercive or assaultive sexual behaviours (p. 11).

Alternative methods are also needed to reach women who do not use the traditional health care system. Sexuality education and prevention programs must be expanded beyond traditional medical settings and made available in schools and such community settings as drop-in centres, women's centres and welcome houses. We recommend that:

30. The Ministry of Health ensure that all health units are: (IMM)

a) providing appropriate and accessible family planning services, as outlined in the Mandatory Health Programs and Services Guidelines, Sexual Health Program Standards (April 1989);

b) working to expand these services beyond the traditional medical setting and into workplaces and community settings;

c) receiving funding for the enhancement and expansion of family planning/sexual health counselling and clinical programs, where needed;

d) accessible to women with disabilities (e.g., wheelchair accessible, modifications for visually impaired and deaf and hard of hearing).

31. The Ministry of Health and the Ministry of Community and Social Services develop mechanisms to ensure the cost-effective and accessible delivery of a range of contraceptive products. (ST)

32. The Ontario Women's Directorate, in its role as chair of the Interministerial Committee on Sexual Assault, place greater emphasis on the prevention of sexual assault through education about sexual behaviour that is coercive, manipulative or assaultive. (IMM)

Education

There is a need to educate the population as a whole about the availability of abortion services, as women and physicians alike are generally not well informed in this area. Departments of public health and professional associations have a responsibility to provide their staffs and members with updated information on abortion legislation, costs, funded clinics and other details about the availability and location of services.

Similarly, women often do not know about the current status of abortion in Ontario, or how and where to find information, services or referrals. Disabled, aboriginal, immigrant and refugee women and women of colour face even greater barriers to information, referrals and community networks. Many immigrant and refugee women newly resident in Ontario may be unaware of Canadian laws on abortion. Often women are intimidated by the health care system, hesitant to inquire about abortion services and unable to find accurate information. Some

refugee women are not covered by provincial health insurance and do not have the financial resources to get health care services.

Public education on abortion services must be widely distributed, in many languages, through both the health care system and such community settings as workplaces, drop-in centres and welcome houses. As well, information must be available in forms other than print, such as tape and braille. Euphemisms like "unwanted pregnancy" or "pregnancy termination" are misleading, especially to young women or women whose first language is not English. All public education and advertisements must avoid such euphemisms and use the word "abortion" in their place.

There is no single co-ordinated provincial service to provide information on abortion, including location of facilities, costs, procedures and related services. Such a service is necessary and would be particularly useful for women in remote or isolated areas and for those who want information anonymously. The information available to callers through this service should be comprehensive, providing information about contraceptives and other sexual health issues as well as abortion.

Young women and children also have a right to sexual health information for their own education and protection. The current policy for primary and junior grades indicates that school boards must provide only two sexual health units; one in Grade 7 or 8, and the other in Grade 9 or 10. Topics discussed in these units include puberty development, birth, STDs and AIDS. Issues regarding teenage sex, pregnancy and contraceptives can be included but are not mandatory.

At the secondary school level, one credit is compulsory in physical and health education, which includes a component on sexual health. Although the sexual health guidelines are not mandated, they strongly suggest instruction in such issues as changes at puberty, pregnancy, conception, birth and abstinence. However, education about abortion is not mandatory or even strongly suggested; it is only mentioned in the guidelines as an issue that *might* be discussed. We recommend that:

33. The Ministry of Education must: (IMM)

a) develop and mandate a comprehensive sexual health curriculum that is compulsory in all schools from Grades K to 12 and OAC;

b) develop a comprehensive program to qualify physical and health educators to deliver the sexual health curriculum;

c) provide professional development to all teachers to increase sensitivity to sexual health issues;

d) provide mandatory sexual health courses for all teachers as part of their core education;

e) ensure that sexuality education is available for all students, including those with physical and mental disabilities (e.g., schools for the deaf and the blind).

34. The ministries of Education and Health must jointly sponsor an annual educational conference for all sexual health educators and counsellors. (IMM)

35. The ministries of Education and Health must work to encourage co-operation between boards of education and public health units regarding preventive educational services. (IMM)

36. The Ministry of Health must immediately establish a province-wide information line to provide facts about abortion, sexuality education, contraception and related issues. The line must be available in many languages and the TDD network for those who are hearing impaired. (IMM).

37. The Ministry of Health must use Health Number (HN) mailings to distribute information about sexual health, including abortion services. (ST)

Counselling and Referral

The delivery of all abortion services in Ontario must be based on the recognition that it is a woman's right to choose whether or not to have an abortion. What each woman chooses will depend on her life circumstances, values and goals. One function of the health care system is to make available to women a range of referral options and services that provide counselling on abortion procedures, the risks, and the decision itself.

Women need non-judgmental counselling provided by a trained counsellor to assist them with their decision or to provide support for that decision. Some women have no difficulty with their decision: their choice to have an abortion is not ambivalent; their response after the abortion is relief. For others, issues such as poverty, inadequate housing, unemployment and lack of day-care and other supports make the decision more complicated.

Current abortion referral and counselling systems are inadequate to support women considering or seeking abortions. Often women do not know where to find services or referral networks; they must search for them on their own. These difficulties are compounded if no local services are available and women must search outside of their own communities. As well, anti-abortion physicians sometimes purposely delay women seeking abortions or refuse to refer them to other physicians or agencies. These barriers result in delays in the delivery system and increase the likelihood of later stage abortions and the accompanying risks, including the need for travel. All of these add to women's stress and anxiety.

In addition, there are too few qualified abortion counsellors; many of those currently offering the service have no specialized training in the field. The shortage of counsellors presents an even greater problem for staff in immigrant and refugee women's centres where counsellors must address all health and social issues because no other appropriate services exist.

Counselling must be available to women both before and after the procedure. As well as helping in the decision making, it must provide procedural explanations so women can ask and receive information in non-medical language. This help must be offered at the first visit. At the same time, it must be acknowledged that the decision to have an abortion may be made by the woman alone or with the help of her own support network. That means counselling must not be imposed, coercive or judgmental, resulting in one more obstacle to be handled by a woman considering abortion.

Pre-abortion counselling is more readily available than post-abortion. Counselling following abortion is inadequate due to limited staff time and funds, and many women do not return for follow-up visits.

Follow-up is important to make sure that no complications resulted from the procedure, and it is often the best time to talk about birth control. Discussing contraceptives when women are trying to decide whether or not to have an abortion can be inappropriate. However, Task Group members report that providers do not see many women following the procedure, and it is difficult to know if they have received adequate follow-up. Whether women return for post-abortion counselling may depend on the networks available. It would be helpful to have follow-up counselling available at other facilities in addition to where the abortion was performed. We recommend that:

38. **The Ontario Medical Association and the Ontario Nurses' Association must provide information to their professions on abortion legislation, funded clinics, independent health facilities, and the ethical responsibility to make abortion**

referrals. (IMM)

39. **The College of Physicians and Surgeons must issue a statement to remind physicians that, regardless of their personal views, they have a professional responsibility to make abortion referrals. (IMM)**

40. **The Ministry of Health must direct the chief medical officer of health to issue a statement to all health units and family planning clinics outlining how abortion referrals are to be made, and to make information regarding the provision of abortion services easily available. The medical officer of health must also reinforce the accessible provision of sexual health programs to any person requesting service, regardless of age. (IMM)**

41. **The ministries of Health, Community and Social Services, Education and Citizenship must work to expand the role of agencies that currently provide counselling to also provide abortion referrals (e.g., Family Service Associations, Children's Aid Societies, Welcome Houses). (ST)**

42. **The Ministry of Health must make funding available to community organizations to deliver training for their staff providing abortion counselling. This training must: (ST)**

    a) **include counselling on decision making, the procedure, contraception and follow-up;**

    b) **include counsellors from a variety of racial and cultural backgrounds;**

    c) **include issues particular to disabled women.**

RU 486 and Other Antiprogestin Drugs

Improving access to abortion will also require expansion of service options available for women. The use of antiprogestin drugs is identified as one method that could significantly increase access to abortion.

RU 486 (or Mifepristone), one type of antiprogestin, in combination with a prostaglandin has been widely used in France for termination of pregnancies up to seven weeks. This method currently accounts for one-third of that country's abortions. In 1991, RU 486 was approved for use in Britain for pregnancies up to nine weeks. Sweden, the Netherlands and other Scandinavian countries are also

currently licensed to market this drug or are involved in negotiations with Roussel-Uclaf, the French pharmaceutical company responsible for its development.

Antiprogestins are not available in Canada. Statistics indicate that, if made available, they could benefit more than 35,000 Canadian women each year who have abortions within the first eight weeks of pregnancy. This figure represents about half of all abortions performed yearly in Canada.

The discovery of RU 486 represents a significant advancement in women's health. It provides an alternative to current procedures, avoids the need for anaesthesia, and reduces many other risks as well as the physical invasiveness inherent in any surgical abortion procedure.

To date, the progress in developing research on the use of antiprogestins in Ontario and obtaining supplies of these drugs for use in the provision of abortion services has been slow. A strategy to encourage the testing and approval of RU 486 in Canada has been to gather support in the form of resolutions from professional organizations, such as the Society of Obstetricians and Gynaecologists of Canada, the Canadian Medical Association, the Ontario Medical Association and the College of Family Physicians. Several meetings have taken place between community groups, governments and Roussel-Uclaf.

Success in establishing research programs for RU 486 in order to expand abortion options for women will require active interest from Roussel-Uclaf and support from the government of Canada. To that end we recommend that:

> **43. The Ontario Medical Association, and other professional associations, encourage Roussel-Uclaf to submit an application to the Canadian government for the testing and approval of RU 486. (IMM)**
>
> **44. The provincial government, through the Ministry of Health, urge the federal government to expedite testing and approval of antiprogestin drugs in Canada, once application is made. (ST)**
>
> **45. The Ministry of Health guarantee that antiprogestins and the requisite counselling and services will be available free of charge when approved. (ST)**

There is another way in which this Ministry and the government must look to the future. The recommendations outlined in this report must be set within the context of a clear long-term vision of how reproductive health care can best be provided. Two key developments provide opportunities for innovation: the expansion of

access to abortion that follows our report and the integration of community midwifery into the health care system. The Ontario Ministry of Health has the opportunity to lead the way in Canada in bringing these and the full range of reproductive health care services together in innovative models.

The women's health movement has long emphasized the ultimate goal of providing care for the full spectrum of women's reproductive lives in a comprehensive, integrated and empowering manner. Activists have promoted the value of women's reproductive health centres that provide full care in accessible locations. This would include safe and effective contraception, abortion, community midwifery, prenatal care and education, birthing, well-woman and well-baby care, sexuality counselling and all other facets of reproductive health care developed according to women's needs and priorities.

We hope to see, in the very near future, hospital-based centres and community clinics that provide this full range of services in accessible locations. We therefore recommend that:

> **46. The Ministry of Health facilitate and support pilot projects and innovative programs that work toward providing broader ranges of reproductive health care in integrated ways. (ST)**

Conclusion

This government has the opportunity to make a lasting contribution to women's equal access to abortion and their full freedom of reproductive choice. The opportunity must not be wasted.

This report has identified key directions that must be taken to improve access to abortion services for women in Ontario.

The Task Group of Abortion Service Providers trusts that its recommendations will be implemented without delay.

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Appendix A

Members of the Task Group on Abortion Services

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Appendix B

Task Group Mandate and Terms of Reference

The work of the Task Group has been guided by the overall mandate and terms of reference, as follows.

Mandate

The Task Group will plan a co-ordinated strategy that will provide a comprehensive, fiscally responsible framework to ensure the provision of timely access to abortion services for all women of Ontario.

The Task Group will open and maintain avenues of communication between the government, service providers and the community for the development of specific recommendations to improve access. It will also gather suggestions for innovative methods by which abortion service needs can be addressed throughout the province.

This work will be achieved through:

(i) The Task Group working closely with the Women's Health Bureau and other affected Ministry branches in developing a co-ordinated, comprehensive approach to provincial abortion service delivery.

(ii) The Task Group working with the Consultation Group and Ministry representatives in the development of the long- term strategy.

Terms of Reference

1. To review data[3] on the current status of abortion services in Ontario and related jurisdictions.

   Areas of focus will include direct service, prevention/education, availability of providers and harassment.
2. To review the data collected and determine:

   a) the need to expand or redistribute service;

   b) the need to improve existing services and examine available options.

3. To examine existing mechanisms for expansion and improvement of service.

4. To develop options for addressing provincial demand that allow for individual needs and active participation of communities.

5. To develop models by which service needs can be met in a specific region or provincially.

6. To identify fiscally responsible and realistic methods of meeting provincial service needs, utilizing needs and service-based planning.

[3] This review was limited to available Ministry of Health data. In-depth data collection was not undertaken due to limited resources.