

Far From Home? A Pilot Study Tracking Women's Journeys to a Canadian Abortion Clinic

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Abstract

Objective: Abortion has been recognized internationally as an essential health service. The geographical distance to an abortion provider is acknowledged as a major barrier to access. This pilot study tracks women's journeys to the Toronto Morgentaler Clinic for abortion services.

Methods: A questionnaire was developed specifically for this study and was administered over a four-month period to women using abortion services at the clinic. Questions asked for demographic information and details of the costs, distances, and women's experiences of their journeys to the clinic.

Results: A total of 1022 of 1256 surveys were completed for an overall response rate of 81%. The majority of women in the sample (54%) were 21 to 30 years old, had a partner (55.8%), were employed full time (50.5%), and had an income of less than \$30 000 per year (68.2%). Most women had travelled an hour or more to the clinic (73.5%), and the remainder had travelled for less than half an hour. Women reporting incomes of less than \$30 000 were more likely than wealthier women to have travelled from 200 km to more than 1000 km (OR 1.74; 95% CI 1.16–2.71). Women who were under the age of 30 were more likely to rate their journey as difficult or very difficult (OR 1.68; 95% CI 0.98–2.88).

Conclusion: More research is needed to determine how far women must travel for abortion services in Canada and to determine the wider health, political, and legal implications of these journeys.

Résumé

Objectif : L'avortement est reconnu de par le monde comme étant un service de santé essentiel. La distance géographique séparant le fournisseur de services abortifs et la patiente constitue un obstacle important en matière d'accès. La présente étude pilote fait le suivi des déplacements qu'ont dû effectuer les patientes de la clinique Morgentaler de Toronto pour obtenir des services abortifs.

Méthodes : Un questionnaire a été conçu spécialement pour cette étude et a été administré sur une période de quatre mois aux femmes ayant recours aux services abortifs offerts par la clinique. Les questions portaient sur les renseignements démographiques

et les détails quant aux coûts, aux distances parcourues et aux expériences des patientes pendant leur périple vers la clinique.

Résultats : Au total, 1 022 sondages sur 1 256 ont été remplis, ce qui représente un taux de réponse global de 81 %. L'âge de la plupart des femmes de l'échantillon (54 %) se situait entre 21 et 30 ans, elles avaient un partenaire (55,8 %), un emploi à temps plein (50,5 %) et un revenu inférieur à 30 000 \$ par année (68,2 %). La plupart des femmes avaient dû voyager pendant au moins une heure pour se rendre à la clinique (73,5 %), tandis que les autres avaient dû voyager pendant moins d'une demi-heure. Les femmes signalant un revenu inférieur à 30 000 \$ étaient plus susceptibles que les femmes mieux nanties d'avoir connu un déplacement se situant entre 200 km et plus de 1 000 km (RC, 1,74; IC à 95 %, 1,16–2,71). Les femmes de moins de 30 ans étaient plus susceptibles de considérer leur périple comme ayant été difficile ou très difficile (RC, 1,68; IC à 95 %, 0,98–2,88).

Conclusion : De plus amples recherches s'avèrent requises pour déterminer la distance devant être parcourue par les patientes souhaitant obtenir des services abortifs au Canada, ainsi que pour déterminer, dans une perspective plus large, les implications sanitaires, politiques et juridiques de ces déplacements.

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INTRODUCTION

Abortion has been recognized internationally as an essential health service for women that must be provided within a limited time. Yet abortion access remains a contentious issue both locally and globally.^{1–3} Even where abortion is legal, the distance to abortion providers, cost, anti-abortion harassment, limited gestational time during which abortion may be performed, and HIV-positive status are acknowledged to be major barriers to abortion access.⁴ Indeed, research shows that the farther a woman would have to travel for an abortion, the less likely she is to obtain one and the more likely she is to be young and underprivileged.^{5–7} Abortion in Canada is legal. It is also purportedly fully funded as a medically necessary service under the *Canada Health Act*. Still, many Canadian women report having to travel, often far from their home communities and at considerable personal expense, to abortion providers (see Table 1).^{8,9}

Key Words: Abortion, abortion clinics, reproductive health, health services, Canada

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Table 1. Clinic abortion costs for home and out of province residents by province and territory

Province/Territory	Home province: approximate cost* to patient for clinic abortion services	Out of province: approximate cost* to patients for clinic abortion services
British Columbia	Fully funded by province	\$500–\$580
Alberta	Fully funded by province	\$375–\$900
		(Women from Saskatchewan and with written permission from Northwest Territories and Nunavut are covered under reciprocal billing agreements with Alberta.)
Saskatchewan	N/A no clinics in province, hospital access†	N/A no clinics in province
Manitoba	Fully funded by province	Unknown
Ontario	Fully funded by province	\$300–\$800
Quebec	\$300–\$500 (partially funded by province)	\$450–\$900
New Brunswick	\$500–\$750	\$500–\$750
Nova Scotia	\$400–\$750	\$400–\$750 plus additional \$100 physician fee
Prince Edward Island	No access to abortion services in PEI	No access to abortion services in PEI
Newfoundland and Labrador	Fully funded by province	\$400–\$775
Yukon Territory	N/A no clinics in territory, hospital access†	N/A no clinics in territory
Northwest Territories	N/A no clinics in territory, hospital access†	N/A no clinics in territory
Nunavut Territory	N/A no clinics in territory, hospital access†	N/A no clinics in territory

*Costs are for the abortion procedure ONLY and do not include travel expenses, accommodation, etc.

†See Table 2 for hospital information

Travel for health services is, of course, not limited to abortion. Recently, “medical tourism” has become a cause for concern. Accounts of Canadians who travel abroad, through necessity or choice, to pay for health services rather than face lengthy wait times for public health services at home have heightened the debate about private versus public health care.¹⁰ Their experiences may resonate with women who must, or who choose, to travel within Canada to have abortions.

There is little detailed information about the journeys women undertake for abortions within Canada, which is indicative of a significant gap in our understanding of an important women's health issue in health policy and health systems research in this country.¹¹

In preparation for a Canada-wide research project on the extent of women's travel to abortion clinics, the authors conducted a pilot study to test a questionnaire. The aim of

the questionnaire was to track the abortion journeys of individual women to one Canadian abortion clinic, the Toronto Morgentaler Clinic (hereafter referred to as the clinic), a private, non-profit abortion clinic, which is licensed and fully funded by the province of Ontario.

Abortion in Canada

Married or single, women have traditionally used abortion as a back-up method of birth control. The Criminal Code of Canada prohibited abortion from the late nineteenth century. Abortion providers faced life imprisonment, and any woman inducing her own abortion could be sentenced to seven years' incarceration. The law did, however, permit abortions in order to save the life of the mother. This loophole led some non-Catholic hospitals to compose therapeutic abortion committees of physicians who decided on a case-by-case basis whether or not to grant an abortion. Still, most doctors refused to perform abortions at all, because they feared legal repercussions.¹² Abortions that were self-induced or induced by medical or non-medical personnel remained secret. Many women died from resulting infections.¹³

In 1969, the Liberal government legalized abortion, but only under very restrictive conditions. Under the new law, only hospital TACs could approve an abortion, solely on

ABBREVIATIONS

CARAL	Canadian Abortion Rights Action League
CI	confidence interval
OR	odds ratio
TAC	therapeutic abortion committee

the basis of the threat to the life or health of the woman. However, few hospitals established TACs; those that did were located primarily in large urban centres, and the definition of health used to evaluate a woman's case varied tremendously. A 1977 federally sponsored report on the operation of the new law found that only 20.1% of public sector hospitals had formed TACs. The resultant lengthy delays forced many women to travel along "abortion referral pathways" to other jurisdictions inside and outside Canada for timely pregnancy termination.¹⁴ Amid the protests of feminists, pro-choice groups, and medical personnel opposed to the law, Dr Henry Morgentaler mounted a direct challenge to the legislation by performing abortions in his Montreal clinic and by opening one clinic in Toronto and another in Winnipeg in 1983. After years of legal battles, the Supreme Court of Canada struck down the abortion law in 1988.

Since 1988, access to abortion across Canada has remained uneven for several reasons, both political and practical. Abortion may not be defined as a medically necessary service in the reciprocal billing agreements of some provinces, provincial governments may refuse to fund abortions performed outside hospitals, and provincial and federal powers may clash in their interpretation of the principles of the *Canada Health Act*.

The location of abortion services varies greatly by region, with Newfoundland women travelling up to 12 hours to the province's only clinic in St John's.¹⁵ By contrast, women in large cities like Toronto, Vancouver, and Montreal have access to several private and public sector options (Table 2).

Intimidation from anti-abortion groups can also be a serious hindrance.^{14,16-22} Notably, the clinic experienced an arson attack in the first year of its existence and was firebombed in 1992. As a safeguard against anti-abortion protesters, the clinic was moved from downtown Toronto to the north of the city with no outside signage, a video surveillance system and security guards, and an intake officer—located behind a locked door and bullet-proof glass—who verifies the photo identification and clinic appointment of every visitor before allowing entry.

Finally, the continued unevenness of abortion access may be related to the decrease in the number of providers and the diminution of abortion services in some public sector hospitals. Training in abortion techniques is neither extensive nor mandatory during obstetrics and gynaecology residencies; the lack of adequate training in abortion techniques and an aging population of abortion providers have resulted in fewer medical practitioners providing abortions. A survey conducted by the Canadian Abortion Rights Action League found that in 2003 only 17.8% of all public sector hospitals in Canada performed abortions, compared with 20.1% recorded in 1977. The CARAL survey established

that some provinces offer no hospital abortion services at all; that hospitals providing abortions sometimes place obstacles in the way of women trying to obtain one; that in many cases, hospital employees are not able to provide women with information about alternative resources; and that physicians and hospital employees can deny women access by refusing information and referrals or by referring women to anti-abortion agencies.⁸ More recently, in 2006, Shaw found that only 15.9% of Canadian hospitals offer abortion services, indicating a further decrease in access in just three years.²²

Although the Canadian health care system is public (with respect to funding for medically necessary services), private (with respect to provision of those services) operators do exist. In Ontario, abortions performed at clinics are fully funded because they are deemed a medically necessary service, but some Ontario clinics operate on a for-profit basis. These for-profit clinics usually disadvantage women who are less able to pay for them; nevertheless, with the diminution of abortion services in public sector hospitals, private abortion clinics, especially if they are provincially funded, have given women an important health care alternative.^{8,9}

METHODS

The clinic serves a diverse clientele and is fully funded by the province, so women with Ontario health insurance do not pay for procedures at the clinic. Women from other provinces may or may not pay and may or may not be reimbursed, depending on the regulations of their home province. For convenience, women are usually required to attend only one appointment at the clinic, which includes a counselling session, an ultrasound assessment, a medical examination, and the abortion. The clinic provides detailed post-abortion instructions and recommends that women have their own doctors perform a follow-up assessment two to three weeks after the abortion. If necessary, the clinic supplies the name of a physician near the woman's home who can perform this follow-up.²³

A questionnaire tracking women's journeys to the clinic was devised in consultation with clinic staff and an advisory committee. The advisory committee, consisting of medical personnel, pro-choice advocates, and women's health activists, provided feedback on the questionnaire. The questionnaire did not require the name of the respondent or her street address, thereby providing anonymity. The questions posed were demographic (age of respondent, marital status, nationality, ethnic group, first language, place of residence, employment status), logistical (distance travelled, mode of transportation used, expenses incurred) and experiential (reasons for choosing the clinic, assessment of the ease or difficulty of their journey). A final open-ended section

Table 2. Number of abortion clinics and hospitals by province with provincial abortion funding policy^{8,22,27}

Province / Territory	Private clinics N (location)	Hospitals providing abortion services N (% of hospitals in province or territory)	Provincial abortion funding policy	Additional notes
British Columbia	3 (Vancouver)	26 (29)	Full funding for hospital and clinic abortions	
Alberta	2 (Edmonton, Calgary)	6 (6)	Full funding for hospital and clinic abortions Quota imposed on number of procedures funded at Calgary clinic Out-of-province women must pay a facility fee	
Saskatchewan	0	4 (6)	Full funding for hospitals only	The Saskatchewan government has been strongly opposed to clinics opening in their province
Manitoba	1 (Winnipeg)	2 (4)	Full funding for hospitals and Winnipeg clinic (since 2004 only)	Funding for abortion clinics resulting from a lawsuit that found that the government's hospital-only funding policy contravened women's right to access timely services under the Canada Health Act
Ontario	7 (Toronto) 1 (Ottawa)	33 (17), only one in Northern Ontario	Full funding for hospital and clinic abortions Northern Health travel grants available with referral for Northern women who must travel south	25% of all abortions are performed in Toronto-based clinics 66% of all abortions take place in Southern Ontario
Quebec	5 clinics 18 community health centres 3 women's health centres	31 (24)	Full funding for abortions in hospitals and community health centres (CLSC) Partial funding for clinic abortions, women pay remainder (approximately \$200)	Approximately 70% of abortion services in Quebec are concentrated in the Montreal area Private clinics perform approximately 50% of abortions in the city of Montreal
New Brunswick	1 (Fredericton)	1 (4)	Full funding for hospital abortions when procedure is approved by two doctors no funding for clinic abortions	Dr Henry Morgentaler is currently challenging the province's funding policy in court NB is the only province to require two physicians to approve a woman's abortion request
Nova Scotia	1 (Halifax)	4 (13)	Full funding for hospital abortions partial clinic funding, woman pays the remainder	Approximately 30% of Halifax clinic patients are from PEI
Prince Edward Island	0 (no access)	0 (0) no access	The province pays for abortions in one Halifax hospital only if the Department of Health and Social services approves the procedure as "medically necessary"	As of 2005, only one Halifax hospital will accept referrals for PEI women needing an abortion. Her PEI doctor must refer her there and apply to the province to have the procedure covered.
Newfoundland/ Labrador	1 (St. John's)	3 (21)	Full funding for hospital and clinic abortions	
Yukon Territory	0	1 (50)	Full funding for hospital abortions Partial funding for travel for women living outside Whitehorse	The Yukon government has a reciprocal billing agreement with BC, allowing women to access funded hospital abortion services in BC Partial funding is provided for clinic abortions in Alberta and BC
Northwest Territories	0	2 (67)	Full funding for hospital abortions Partial funding for travel	
Nunavut Territory	0	1(100)	Full funding for hospital abortions and travel	Women are flown from Nunavut to Ottawa if over 13 weeks

encouraged women to elaborate upon their journeys. The questionnaire and research methodology were approved by the University of Ottawa Ethics Board.

The clinic's intake officer offered the questionnaire to the patients upon their entry into the clinic. The intake officer suggested that patients complete the questionnaire while they waited to be seen for their appointment. If a patient agreed to complete the questionnaire, the intake officer repeated a standard set of instructions to ensure consistency in filling out the questionnaire. Once the questionnaire was completed, the patient was directed to seal it in an opaque envelope and hand it back to the intake officer.

The distribution of the questionnaires took place over two two-month phases during a four-month period. At the end of Phase One, the authors, clinic staff, and members of the advisory committee evaluated and revised the questionnaire. In the revised version, a medical expenses section was added, a question about travel expenses was reworded to indicate that respondents should include expenses for the entire journey to and from the clinic, and "student" was added to the employment status category. Women were also now asked if this was their first visit to the clinic. The revised questionnaire was distributed in Phase Two. The completed surveys were analyzed using SPSS Version 15.0 (SPSS Inc., Chicago, Ill). Simple counts and percentages were calculated for most variables. Where possible, odds ratios with 95% confidence intervals were calculated to quantify trends.

RESULTS

A total of 1256 original and revised questionnaires were distributed. Of these, 1022 were completed and returned for an overall response rate of 81%. In Phase One, 756 questionnaires were distributed and 602 were completed (response rate, 79% percent). In Phase Two, 500 questionnaires were distributed and 420 were completed and returned (response rate, 84%). Fifty-four percent of the respondents were 21 to 30 years old, 55.8% had a partner, and 50.5% were employed full-time. Most respondents (68.2%) reported an income of less than \$30 000 per year, and almost 30% of the 940 women who provided income details made less than \$10 000 annually.

As 127 different ethnic backgrounds were recorded, similar responses and regions were grouped into broader categories. Fifty-six percent of respondents were classified as White/Caucasian, 13.2% as Black, African, or Caribbean, 7.7% as of European descent (for example, Irish, Italian, Russian), 7.3% as South Asian, 4.5% as Asian, 4.1% as South American, 2.8% as bi-racial, 2.5% as First Nations or Métis, and 2% as of Middle Eastern origin. Just over 70% of respondents were born in Canada. The highest level of

education in respondents was high school for 41.3%, and university or college for 37.8%. More than 94% of respondents spoke English at home, and 6.9% also communicated in another language at home.

The clinic was the first facility the majority of women (81.5%) had contacted. Their main reasons included the clinic's good reputation (39.7%), a doctor's referral to the clinic (28.8%), knowledge of someone who had already been to the clinic (24.1%), and proximity of the clinic to their place of residence (18.8%). Reasons cited less often included previous visit(s) to the clinic, no extra fees charged by the clinic, and the inability or refusal to use abortion services closer to their residence because of inadequate facilities, the weeks of gestation at which the facility would perform an abortion, or concerns about confidentiality. Some women also cited satisfaction with the clinic's safeguards against anti-abortion protesters as another reason for contacting this clinic first.

Respondents who first contacted other clinics or hospitals for abortion services (18.5%) encountered a number of critical inconveniences: no appointments were available (33.5%), the fees were too expensive (18.2%), they were concerned about their safety because of anti-abortion protesters (15.3%), the staff were rude (12.5%), or the other clinic or hospital was too far from their residence (10.2%). Approximately 37% of women added hand-written comments explaining why they were unable or unwilling to have an abortion at the clinic or hospital they first contacted. The most frequently cited hand-written explanation was an inability to get an appointment within the necessary time.

The majority of women (73.5%) who provided information about travel time travelled an hour or more to the clinic. The remaining 26.5% travelled for less than half an hour to get to the clinic. The majority (55.6%) of the respondents lived within 100 km of downtown Toronto, in the Greater Toronto Area (including suburbs such as Mississauga, Scarborough, and Whitby) or the nearby cities of Barrie and Hamilton (for travel distances see Table 3). Slightly more than 15% of the women travelled between 101 km and more than 1000 km to get to the clinic. Women reporting incomes of less than \$30 000 (for whom the cost of travel was a greater burden) were more likely than wealthier women to have travelled between 200 km and more than 1000 km (OR 1.74; 95% CI 1.16–2.71). Most women (62.5%) travelled to the clinic by a car driven by a travel companion. Although clinic instructions insist that women do not drive themselves to or from their abortion appointments,²⁴ 11.7% of the 973 respondents providing information about mode of transportation said they drove themselves. Of the rest, 2.5% walked, 16.1% travelled by bus

Table 3. Distance from selected Canadian cities to Toronto

Canadian city	Approximate distance to Toronto (kilometres)	Estimated travel time by car* (hours)
St Catharines, Welland, Hamilton	100	1.0
Niagara Falls	130	1.5
Peterborough	135	1.5
Belleville	190	2.0
North Bay	390	4.25
Ottawa	400	4.5
Timmins	680	8.5
Sault Ste Marie	690	9.0
Thunder Bay	1375	18.5
Winnipeg	2060	22.0

*Based on distance only, does not account for traffic, weather, etc.

(city and/or regional), 5.9% by train, 7.4% by taxi, 0.8% by streetcar, and 0.7% by plane ($n = 973$).

Only slightly more than half the sample responded to the question about travel expenses, and costs may have been underestimated; some respondents totalled the costs of the return journey, but others indicated only the cost of getting to the clinic. Most of the women (approximately 90%) spent less than \$50 on transportation to and from the clinic, and approximately 20% reported that they spent nothing getting to the clinic. Women spending from more than \$50 to more than \$100 made up approximately 10% of the sample. The majority of women (93.6%) reported paying nothing for accommodation; however, the majority of those who did have accommodation expenses paid more than \$100.

Details of respondents' expenses varied widely, from \$2.50 for a bus ticket and \$2.50 for a train ticket to \$4445.05 for travel and hotel accommodation. Expenses increased for women who travelled with a companion, and supplemental expenses included child care, phone calls, meals, and loss of wages (often for travel companions as well the women themselves).

Women's characterization of their journeys from place of residence to the clinic also differed widely: 12% asserted that their journey was difficult or very difficult. Women who were younger (under the age of 30) were more likely to be in these categories (OR 1.68; 95% CI, 0.98–2.88). Sometimes the difficulties were related to the length of the journey, the expenses incurred, the mode of transportation, or the physiological discomfort involved. At other times, the difficulties were related to the emotional conflicts

associated with the women's travel to the clinic for pregnancy termination.

Conversely, 88% of the respondents claimed that their journey was easy or very easy because, for example, they followed the directions provided by the clinic, because someone drove them, because the clinic was close to home, or because a friend had been there before.

DISCUSSION

The women in this pilot study relied on the clinic to provide abortions within a limited time frame and at no extra cost. The respondents did not question the lack of abortion services located closer to home and did not challenge the necessity of travel, even when they had to travel far from their home communities and when the journeys generated logistical, physiological, or emotional difficulties and additional expense for the respondents or their travelling companions. The authors acknowledge that some women from small towns may want to travel to a large urban centre to keep their abortion a secret from their home community. However, some respondents appear to have felt fortunate to have access to abortion services at all, regardless of the difficulties inherent in that access. The vulnerability of certain populations of women, such as the younger respondents and the respondents from lower income brackets, may help explain why women's abortion journeys receive so little attention even within the debate about private versus public health care in Canada. The 81% overall response rate for the questionnaire may indicate that women seeking abortions do wish to participate in that debate but in venues that provide them with a measure of security and privacy.

This pilot study has four major limitations. First, the survey method and instrument were previously untested. Even though the questionnaire was revised midway through the study, it is entirely possible that both the method and the instrument negatively affected the reliability of the information gathered. Second, even though there are seven abortion clinics, as well as other abortion services, available in hospitals in the city of Toronto, this study focused on one clinic only. Because this clinic is in a large urban centre, it may have attracted an urban population that is not necessarily representative of the population at large. Third, although revisions were made to the questionnaire, some questions had low response rates, especially those about costs of travel, income, and place of residence. Likely because respondents were concerned about maintaining anonymity, place of residence was the demographic variable most often missing. When respondents did disclose place of residence, they indicated province of residence rather than city or town. The lack of more detailed information about place of residence made it difficult to calculate just how far women had travelled to the clinic. Future studies will need to use alternative means to capture place of residence and more accurate ways of measuring distance travelled to abortion services. They could also acquire information on the availability of post abortion care. Fourth, a control group or condition was not used for this study. Implementing a study of abortion services and incorporating a comparative case of another health service requiring patients to travel would strengthen the design significantly.

Despite its limitations, this pilot study has pressing implications for the debate on private versus public health care. The Court of the Queen's Bench in the province of Manitoba ruled in 2004 that women who undergo abortions at the province's private clinics because of lengthy wait times in the public health services sector should be reimbursed for their expenses.²⁵ A similar ruling was rendered by the Quebec Superior Court in 2006.²⁶ It ordered the Quebec government to reimburse a total of \$13 million to 45 000 women who were charged extra fees between 1999 and 2005 for provincially funded abortion services. Both courts ruled that women's rights under the *Canadian Charter of Rights and Freedoms* were violated because they were forced to pay for a service designated as medically necessary in the *Canada Health Act*.^{25,26} If, as this pilot study indicates, some women were forced to travel to the clinic for abortions because wait times or extra fees denied them access to abortion services in their home communities, the decisions of the Manitoba and Quebec courts may entitle them to legal recourse. More research is needed to determine the extent of women's travel for abortion services in Canada and the wider health, political, and legal implications of these journeys.

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