A Review of Therapeutic Abortions and Related Areas of Concern in Canada

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Abstract

Objective: To review the legal status of abortion and its prevalence, safety, and accessibility in Canada and to highlight related areas of concern.

Methods: We conducted a review of research literature, published reports, websites, and articles in order to describe abortion services and associated issues such as access, availability, and safety in Canada.

Results: Therapeutic abortion is often the result of unintended pregnancy. Even so, emergency contraception may not be accessible for all Canadian women, and effective contraception is underutilized. In Canada, abortion has been decriminalized and is generally safe, but current reports of prevalence and complication rates are inconsistent. Abortion rates appear to be decreasing. Medical or surgical termination of pregnancy is available and often publicly funded. However, barriers related to time, cost, travel, and regional disparities hamper unrestricted access to therapeutic abortion in this country, and although the place of abortion in medical education remains controversial, current curriculum content appears to be inadequate.

Conclusions: The Society of Obstetricians and Gynaecologists of Canada states that comprehensive family planning services, including therapeutic abortion, should be freely available to all. The Canadian Medical Association affirms that induced abortion should be uniformly available to all women. In Canada, the issues related to therapeutic abortion access, availability, and safety must be addressed.

Résumé

Objectif : Analyser le statut juridique de l'avortement et sa prévalence, son innocuité et son accessibilité au Canada, ainsi que souligner les sujets de préoccupation connexes.

Méthodes : Nous avons mené une analyse de la littérature de recherche, des rapports publiés, des sites Web et des articles afin de décrire les services d'avortement et les facteurs connexes (tels que l'accès, la disponibilité et l'innocuité) au Canada.

Résultats : L'avortement thérapeutique est souvent le résultat d'une grossesse non prévue. Pourtant, ce ne sont pas toutes les Canadiennes qui peuvent obtenir accès à la contraception d'urgence et les moyens de contraception efficaces demeurent sous-utilisés. Au Canada, l'avortement a été décriminalisé et est généralement sûr, mais les rapports actuels traitant de sa prévalence et de ses taux de complication présentent des divergences. Les taux d'avortement semblent être en baisse. L'interruption médicale ou chirurgicale de la grossesse est disponible et bénéficie souvent d'un financement public. Toutefois, des obstacles liés au temps, aux coûts, aux déplacements et aux disparités régionales nuisent au libre accès à l'avortement thérapeutique au Canada, et bien que la place de l'avortement dans la formation médicale demeure controversée, le curriculum actuel en la matière semble être inadéquat.

Conclusions : La Société des obstétriciens et gynécologues du Canada déclare que des services exhaustifs de planification familiale (dont l'avortement thérapeutique) devraient être librement mis à la disposition de tous. L'Association médicale canadienne affirme que toutes les femmes devraient avoir uniformément accès à des services d'avortement provoqué. Au Canada, les questions liées à l'accessibilité, à la disponibilité et à l'innocuité de l'avortement thérapeutique doivent être débattues.

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INTRODUCTION

Unsafe abortion contributes significantly to global maternal mortality. Worldwide, unsafe abortions account for 12% to 30%, or more, of direct maternal deaths.[1] This human tragedy occurs primarily in low resource countries lacking access to legal and safe therapeutic options.[2] Restrictive abortion laws can lead to procedures being performed by unqualified providers in dangerous and unhygienic conditions. Unsafe abortion is a preventable cause of maternal morbidity and mortality. It

has been shown that when therapeutic abortion is legally available, it is generally safe.[3,4]

Various reports describe strategies to reduce the incidence of unsafe abortions. The first step is to enact policies and a legal framework to broaden the criteria under which abortion is legally permitted. Safe abortion services are then established, but they must be affordable and accessible to all. There is wide agreement that increasing contraceptive use to reduce unintended pregnancy and ensuring access to emergency contraception are necessary, as is post-abortion follow-up and care of women who experience complications.[2,3,5]

Unintended pregnancies account for the majority of therapeutic abortions.[6] These pregnancies may be the result of contraception inaccessibility or failure. Other cited reasons for pregnancy termination include abusive relationships, lack of a supportive partner, financial difficulty, maternal health concerns, and known genetic conditions or malformations.[3,7] Termination of pregnancy is an important option in any of these cases. According to the Society of Obstetricians and Gynaecologists of Canada, comprehensive family planning, including abortion services, should be freely available to all.[8] The Canadian Medical Association affirms that induced abortion should be uniformly available to all women in Canada.[9]

This review of therapeutic abortion was undertaken to provide a national overview of the history of abortion, its legal status, accessibility, prevalence, and associated complications, and medical education regarding abortion. We draw attention to related areas of concern regarding access to and availability, reporting, and safety of termination of pregnancy in Canada.

METHODS

We reviewed original and review articles identified through a search of PubMed and Medline up to February, 2011. For the search we used the terms "Canada, induced abortion," "therapeutic abortion," "medical education," "contraception," "women's health," and "health services accessibility." The search was supplemented by hand searching references and by consulting the websites and publications of professional associations and organizations dealing with sexual and reproductive health and rights in Canada and internationally. Canadian statistics were obtained from published studies, from the Canadian Institute for Health Information, and from Statistics Canada.

ABBREVIATIONS

CIHI	Canadian Institute for Health Information
CMA	Canadian Medical Association
D&E	dilatation and evacuation
POWER	Project for an Ontario Women's Health Evidence-Based Report

LEGAL STATUS OF ABORTION IN CANADA

In 1869, the Criminal Code of Canada prohibited abortion, with providers facing life imprisonment. Women who attempted to induce their own abortion faced seven years of incarceration. The advertising of contraceptives was also an indictable offence, and their sale was punishable by a two-year jail term.[10] One hundred years later, in 1969, the Canadian laws were liberalized to allow abortion, but only under restricted conditions. They could be performed in hospital settings, with the prior approval of a therapeutic abortion committee composed of at least three physicians, in instances when the pregnancy posed a threat to the woman's life or health (including mental health).[11] However, by 1977 as few as 20% of hospitals had formed a therapeutic abortion committee, and most of these were located in large urban centres. There was no consensus for the definition of health used to evaluate a women's case. Commonly, these reasons resulted in lengthy delays and difficulty with accessibility.[12]

In 1988, Dr Henry Morgentaler successfully challenged the existing law. The Supreme Court of Canada declared the abortion law unconstitutional and a violation of the Charter of Rights and Freedoms.[13] Following the Morgentaler decision, some provinces attempted to limit funding for abortions.[11] The Federal Court of Canada upheld a ruling that taxpayers could not withhold tax money to protest government funding of abortions, and the Supreme Court also found that neither civil law nor common law recognizes the fetus as a "civil person."[11] In 1991, the senate narrowly defeated bill C-43, a bill to recriminalize abortion (unless it was performed by a physician who considered that the woman's life or health was otherwise threatened) that had passed in the House of Commons.[11,13] In 2008, a private member's bill known as the "Unborn Victims of Crime Act" was introduced but was not passed. Although not specifically dealing with abortion, this bill was vigorously opposed by the SOGC because it could lead to re-criminalization of therapeutic abortion by amending the Criminal Code to grant the fetus legal standing.[14] A policy analysis counts 26 private member bills, at least eight private member motions, and one government-sponsored

bill that have been introduced since 1989 with the purpose of limiting or restricting access to abortions.[15] However, since 1988 there has been no law specifically dealing with abortions in Canada.[11,13]

ACCESS ZONES LEGISLATION

Women seeking abortions, as well as abortion providers and clinics, may be concerned about their personal safety or the safety of their families. Physicians have been shot and clinics have been attacked.[16,17] The CMA states that there should be no discrimination against doctors who provide or do not perform abortion services.[9]

In 1995, the Access to Abortion Services Act was enacted in British Columbia. It created a zone around facilities providing abortion and around physicians' homes and offices in which protesting, "sidewalk interference," intimidation, or physical interference is prohibited.[18] There have also been injunctions against anti-abortion protests in the vicinity of select provider clinics, offices, and homes in Ontario and Alberta.[11,17] Some anti-abortion groups have advocated home picketing as a tactic to deter physicians from providing abortions. In this event, physicians can obtain injunctions, but these may be costly and time consuming to obtain, and of limited effectiveness because they deal only with specific details of the protest.[17]

CANADA HEALTH ACT

Abortions are medically necessary procedures, according to all provincial and territorial colleges of physicians and surgeons.[13] In 1995, the Federal Health Minister affirmed that abortion is a medically necessary procedure under the Canada Health Act and must be covered by provincial and territorial health insurance plans. Despite this, there have been open violations of this requirement, such as the failure to provide abortion services in provincial hospitals, listing abortions on the excluded list of reciprocal billing agreements between provinces, and refusing to reimburse women who obtain abortions at private clinics. Measures taken by the federal government, such as withholding transfer payments, have exerted minimal pressure on the provinces and territories to comply.[13,19]

RESPONSIBILITY OF CANADIAN PHYSICIANS

Physicians can choose not to offer therapeutic abortions, and there is no legal requirement that they refer to another health care provider who will perform the service. However, the SOGC Statement on Sexual and Reproductive Health Care directs physicians to make an appropriate referral in the case where a woman requests a termination and that physician is unwilling or unable to provide the service.[20] According to the CMA policy, a physician should not be compelled to participate in the termination of a pregnancy. When moral or religious beliefs prevent the physician from recommending or performing an abortion, the patient should be informed of this so that she may consult another physician. However, at the patient's request, the physician should indicate alternative sources for referral and there should be no delay in the provision of abortion services.[9,21]

AVAILABILITY OF ABORTIONS IN CANADA

Therapeutic abortions are offered in a minority of hospitals across the country and in private clinics and health care centres.[12] Some locations accept self-referral while others require a physician referral.

REGIONAL VARIATIONS

There is substantial variation in abortion services and policies across the country. For example, Prince Edward Island has no abortion providers.[10,12] In New Brunswick, two doctors must approve an in-hospital procedure; otherwise, women must pay $650 to $800 to undergo the procedure in the only available private clinic.[12,22] In Quebec, the many *Centres locaux de services communautaires* (local community service centres) and numerous hospital family planning units offer abortion, often performed within 24 hours. They also provide counselling and are considered a model for the rest of the country.[10]

Most providers are located in urban centres near the Canada–United States border.[10] A large study of over 1000 women from the Toronto Morgentaler Clinic indicated that 73.5% had travelled one hour or more to attend the clinic.[12]

The numbers of private clinics, abortion clinics, or women's health clinics associated with hospitals that are listed on the National Abortion Federation, Abortion Rights Coalition of Canada, and Canadians for Choice websites, as well as provincial and territorial funding policies, are shown in Table 1.[23–25] In 2007, Sethna and Doull reviewed the number of Canadian abortion clinics and hospitals.[12]

In Canada, termination of pregnancy after 20 weeks is not readily available. Abortions at this gestational age are normally done for maternal health reasons or serious fetal abnormalities. Women may be required to travel to clinics in the United States to access later abortions. The associated expenses may be funded in full or in part by some provincial governments.[26]

Table 1. Canadian abortion clinics (private or associated with hospitals) and funding policy*[12, 23–25,69]

Province/Territory	Location, n	Gestational age limit	Provincial/Territorial funding policy
British Columbia	1 Kelowna 4 Vancouver 1 Victoria	Up to 24 weeks	Hospital and clinic costs covered Patient pays for medications (medical abortion) and laminaria
Alberta	2 Calgary 1 Edmonton 1 Grande Prairie	Up to 20 weeks	Hospital and clinic costs covered
Saskatchewan	1 Regina 1 Saskatoon	Up to 14 weeks	Hospital costs covered. Travel to and costs at Alberta clinic also covered
Manitoba	2 Winnipeg	Up to 16 weeks	Hospital and clinic costs covered
Ontario	1 London 2 Ottawa 1 Sudbury 1 Thunder Bay 7 Toronto	Up to 24 weeks	Hospital and clinic costs covered (fees apply at two clinics)
Quebec	48 throughout province	Up to 23 weeks	Hospital, CLSC, and clinic costs covered (In private clinics, only the doctor's fee is covered)
New Brunswick	1 Fredericton	Up to 16 weeks	Hospital abortions covered but require permission from two doctors (Patient pays in the only private clinic)
Nova Scotia	1 Halifax	Up to 16 weeks	No clinics in the province
Prince Edward Island	0	Up to 15+ weeks based on ultrasound results	Abortions in approved hospital are covered if referred by a doctor
Newfoundland and Labrador	1 St. John's	Up to 15 weeks	Clinic cost covered
Yukon	1 Whitehorse	Up to 12 weeks	Territorial plan covers costs at hospital (and travel to outside location after 12 weeks)
Northwest Territories	1 Yellowknife	Up to 14 weeks	Territorial plan covers costs at hospital
Nunavut	1 Iqaluit	Up to 12 weeks	Territorial plan covers costs at hospital

*Hospital providers are not included in this list unless they have a dedicated abortion or women's health clinic

CLSC: centre local de services communautaires

TYPES OF ABORTIONS

Medical and surgical options exist throughout the country. The SOGC clinical practice guidelines on induced abortion can assist physicians in describing the available procedures to patients and providing the service safely.[27]

Medical Abortions

Medical abortion may be chosen by up to 50% of eligible women and can be offered up to 56 days' gestation. It has the advantages of being non-invasive, being private, and not requiring special equipment. Descriptive studies have affirmed its safety, although it is generally less efficacious than surgical termination, with completion rates of approximately 90% in gestations up to 49 days and declining with advancing gestational age. Because of the relatively high failure rates, unconditional follow-up is required, and multiple contacts between health care provider and patient are necessary.[27] Certain providers will follow women clinically and with serial assays of serum beta hCG, and others will routinely schedule an ultrasound examination. There may be one or two visits before the administration of methotrexate. Vaginal misoprostol is usually inserted at home, but a follow-up appointment one week later for a pelvic examination or ultrasound to confirm a completed abortion may be necessary. If retained products of conception are present, another dose of misoprostol may be given, followed by another appointment and ultrasound. If this regimen is unsuccessful, a surgical termination of pregnancy is recommended.[27–30]

There are no medications approved in Canada for pregnancy termination, but Canadian laws do not prohibit the "off-label" use of pharmaceuticals approved for other indications. Medical abortion is carried out using methotrexate and misoprostol or misoprostol alone.[27] The anti-progestin mifepristone (RU-486) is not approved in Canada, and is available only in the context of approved clinical trials, despite its approval elsewhere and wide use and safety record.[31] Mifepristone has been used by over three million women in China and Europe, and has been approved for use in the United States since 1996.[32]

A multicentre trial demonstrated that abortions induced with mifepristone complete faster and are more acceptable to patients than those induced with methotrexate. Both regimens have similar overall success rates, side effects, and complications.[33]

The actual number of medical abortions conducted in Canada is unknown because these terminations are not always reported and independently tracked by the Canadian Abortion Survey.[34] This method is much less commonly used than surgical procedures and accounted for less than 4% of procedures done in Canadian hospitals in 2009.[35–37] A hypothetical model based in Ontario that compared the costs of the medical and surgical options concluded that medical abortions cost less for the health care system, but are more costly for the patient, because she incurs the fee for the medication.[38]

With proper follow-up and the availability of timely surgical abortion when necessary, primary care providers can offer medical abortions. One Canadian study suggested that many primary care providers would like to receive more information on the topic, as they rate their knowledge in this area as poor.[39]

Surgical Abortions

Manual vacuum aspiration with a paracervical block can be offered as an office procedure in gestations of less than 10 weeks. Vacuum aspirations are an option for pregnancies up to 13 weeks, while second trimester terminations are generally done by dilatation and evacuation. Labour induction and other techniques are also available.[27] Surgical procedures account for the majority of abortions in Canada.[35–37,40] Over 90% of the reported abortions performed in Canadian hospitals in the years 2007 to 2009 were by suction curettage or dilatation and curettage; D&E procedures ranged from 3.6% to 4.6% over this three-year period.[37]

REPEAT ABORTIONS

At least one third of women undergoing induced abortions in Canada have had a prior abortion. A survey of 1127 Canadian women presenting consecutively for termination of pregnancy in an Ontario hospital found that 23.1% were seeking a second abortion and 8.7% were seeking a third or subsequent abortion. As previous studies have demonstrated, these women were more likely than those presenting for a first abortion to be using contraception at the time of conception (adjusted OR 2.17 for a second and 2.6 for a third or subsequent abortion). In this study, a history of physical or sexual abuse was significantly associated with repeat induced abortions.[41]

CONTRACEPTION AND EMERGENCY CONTRACEPTION IN CANADA

Preventing unintended pregnancy is fundamental to reducing the number of abortions performed, but effective and reliable contraception is necessary to prevent unintended pregnancy.[42,43] There are a wide variety of contraceptive options approved in Canada.[8] Physician visits and surgical procedures such as sterilization are publicly funded. However, pharmaceuticals and devices are not universally covered by insurance. Provincial social assistance programs may fund some non-surgical contraceptive methods. Aboriginal Affairs and Northern Development Canada provides coverage for some pharmaceuticals and IUDs for Aboriginal women who have Status. Some women or their partners have private health insurance, and many of these plans provide partial reimbursement for contraception. Furthermore, community health clinics are provincially financed and may provide contraceptives at no cost or at a reduced price.

Despite the availability of contraception, the most recent Canadian contraception survey found that only 65% of women who had had vaginal sexual intercourse in the preceding six months and who did not wish to conceive "always" used a method of contraception. Women could identify more than one method of contraception in this survey, and oral contraceptives were used by 44% of patients, condoms were used by 54%, and withdrawal by 12%. These methods have "typical use" failure rates of 8%, 14%, and 19%, respectively. Methods with lower typical failure rates, such as male and female sterilization and intrauterine devices (13% and 4%, respectively) were used less frequently.[42]

Since even the best contraception is not perfect, emergency contraception can be used to reduce the number of unintended pregnancies safely and effectively. Rates of unintended pregnancy in Canada are unknown, but in the United States more than 95% of aborted pregnancies are unintended.[6,35] The use of emergency contraception is dependent on increased public and professional awareness and improved access to this intervention.[43]

Levonorgestrel, marketed as Plan B (Paladin Labs Inc., St-Laurent QC), is the only drug approved in Canada for emergency contraception. Since 2005, it has been available behind the counter as a Schedule II medication with no prescription required.[44] Some pharmacies in Canada have elected not to provide it, and some charge a counselling fee or a dispensing fee in addition to the cost of the medication.[45] Access is unequal because it may not be universally stocked, and pharmacies have refused

to dispense it if a woman refuses to supply personal information such as her name.[46,47] A proportion of women may not be able to afford this medication, while others may not know where to obtain it.[42] Some provincial welfare agencies fund emergency contraception for women supported by social assistance. Other options available for emergency contraception include the use of combined oral contraceptives given as "off-label" emergency contraception and the insertion of a copper IUD within seven days of intercourse.[43] Mifepristone is not used in Canada for emergency contraception because it remains unapproved.[43]

Some physicians may believe that emergency contraception is a form of abortifacient and, therefore, decline to prescribe it. The precise mechanism of action of emergency contraception is uncertain and may vary depending on the day of administration in the menstrual cycle. Most laboratory evidence suggests that the mechanism of action of emergency contraception does not include post-fertilization events.[48,49] A single oral dose of 1.5 mg of levonorgestrel inhibits or delays ovulation but does not prevent fertilization or implantation. It is ineffective in preventing implantation after fertilization has occurred and does not affect a successfully established pregnancy.[48,49]

The SOGC has issued a clinical practice guideline to increase awareness and appropriate use of emergency contraception.[43]

MEDICAL EDUCATION ABOUT ABORTION IN CANADA

Evidence to date suggests that clinical exposure to abortions increases the likelihood of a physician becoming a future abortion provider, and those exposed are also more likely to discuss this option as part of their counselling of patients.[50,51]

A survey of medical schools, including nine in Canada, conducted in 2002–2005 reported that six of these Canadian schools covered medical and first trimester surgical abortions in their pre-clinical curriculum. Late termination procedures, as well as ethics, law, policy, and availability of abortions, were taught in only 56% of schools. Some schools may discuss abortion only as an ethical issue and not as a medical procedure.[52] A recent Canadian publication concluded that medical students have a limited understanding of abortion. The authors suggested that curriculum reform is needed to provide opportunities to explore unplanned pregnancy as a medical issue, and not only as a social, political, or ethical issue.[53]

A 2006 survey found that all obstetrics and gynaecology residency training programs in Canada at that time offered training in abortion procedures.[54] One half of these routinely integrated abortion training into the curriculum, while the other half did not mandate training but provided an elective opportunity to learn. Most abortion methods were taught, although only one quarter of programs provided training in manual vacuum aspiration. At least 70% of residents surveyed felt competent offering surgical first trimester abortion or second trimester induction, compared with only 39% for medical induction and 26% for second trimester D&E. Almost one half of the residents surveyed planned to offer first trimester surgical abortion, while 38% would provide medical abortion and only 21% would provide elective second trimester abortions. There has been no follow-up of how many residents actually provided abortions once in practice. It is possible they did not plan to offer regular abortion services, but would provide the service when necessary on call in a hospital. Concern has been expressed about a declining population of qualified abortion providers.[12]

CANADIAN ABORTION STATISTICS

Comprehensive information has not been available from the Therapeutic Abortion Survey since 1988, when the Supreme Court of Canada struck down the 1969 abortion law, which contained a clause requiring the collection of data on all induced abortions in the country. With the absence of any legal requirement, reporting is voluntary, and some providers do not respond or submit only summary counts rather than detailed records of each abortion.[34] The Canadian Institute for Health Information has been responsible for collecting and processing therapeutic abortion data since 1995 and now posts the data publicly. Currently, data for rates and complications are incomplete and have not been compared with data from previous years.[37]

Almost 100 000 abortions per year are reported in Canada. In 2009, the CIHI reported 93 755 abortions in Canada, fewer than in the two previous years (95 876 in 2008 and 98 754 in 2007). Clinic abortions totalled 52 115 in 2009. Hospital reporting is mandatory and considered complete, but clinic abortions may be underestimated.[37] The most recent comparative statistics are from 2005 and indicate that the rate of induced abortions per 1000 women aged 15 to 44 was 14.1 and has been decreasing over the last decade, from 16.6 in 1996. This decrease was seen mostly in women under age 20 (from 18.9 per 1000 to 13.0). The ratio of abortions for every 100 live births was 28.3, also lower than the previous decade, when it peaked at 32.2

in 2000. This decrease in abortion rate coincides with a declining birth rate in younger women: in 1996 there were 18.6 births per 1000 women under 20, and in 2005 this rate had fallen to 11.1.[55]

Most women seeking abortion are in their early twenties (28 of every 1000 women aged 20 to 24 years in 2005; ratio not calculated for more recent years).[37,55]

The CIHI recently updated their abortion data from 2007 to 2009. The reports now include gestational age at the time of the procedure, previous obstetrical history, method used, and complications for the majority of procedures done in Canadian hospitals. This specific information is not comprehensive since it is not available for all hospital abortions or any clinic abortions.[37] In 2009, 19.6% of patients had a history of one and 11% had a history of two or more previous induced abortions. Available statistics show that the majority of hospital terminations take place at less than nine weeks' gestational age or between nine and 12 weeks (approximately 30% and 40%, respectively). Only 5% of abortions are performed after 17 weeks. Almost all abortions (90.1%) were completed by aspiration and curettage or dilatation and curettage, while 3.4% were medical procedures only.[37]

The POWER Study is a project producing a comprehensive provincial report on women's health in Ontario, based on billing data that capture more abortion information than is available to Statistics Canada or the CIHI.[56] The study demonstrates higher abortion numbers from Ontario in all categories than are reported by Statistics Canada. The latest summary (published in 2011) indicates an abortion rate of 15 per 1000 women aged 15 to 49 years. Ninety-three percent were performed at less than 16 weeks' gestation. The study confirmed that the highest rates are in women aged 20 to 24 years (34 per 1000), but women aged 15 to 19 years have the highest ratio of abortions per 100 live births at 152. Abortion rates and ratios to live births were higher in women residing in lower-income neighborhoods.[56]

COMPLICATIONS OF ABORTIONS IN CANADA

Complications of abortions are not well-studied, and reporting in Canada is voluntary.[34] The available data confirm that serious complications have been rare in Canada since abortion was decriminalized. Mortality rates approach zero, according to the Special Report on Maternal Mortality and Severe Morbidity in Canada.[57] In this review from 1997 to 2001, 44 total maternal deaths are described. Of these deaths, only one, a result of sepsis, was related to "abortion," and it is unclear whether this was a case of induced or spontaneous abortion. In 2001, there was one reported fatal case of *Clostridium sordelli* septic shock, associated with medical abortion using mifepristone and misoprostol in Canada. There was no trauma, no retained tissue, and no other predisposing factor found in the patient. The author of the report noted that mifepristone and misoprostol have no known effects that could have contributed to this event, and that the rate of infection in medical abortion is generally low (0.09% to 0.5%).[58] *C. sordelli* has an atypical presentation without fever and is a very rare infection; the few cases reported also include infections associated with vaginal delivery and Caesarean section.[58] Two deaths related to induced abortion were reported in a review of all causes of maternal mortality in British Columbia from 1971 to 1986. One death was the result of an abortion performed in another country and the other was caused by an overwhelming *Clostridium perfringens* infection after an attempt at self-induced abortion. The authors contrasted the current rarity of abortion-related deaths with those reported before the liberalization of abortion law (32 cases in 1955 to 1962 and 16 in 1963 to 1970).[59]

Potential complications related to abortion include uterine perforation, retained products of conception, hemorrhage, cervical laceration, and infection. In 1993, a study in Quebec demonstrated complication rates of 5.1% for 2908 suction curettages performed at < 15 weeks' gestation and 2.9% for 447 D&E procedures performed at 15 to 20 weeks' gestation. The most common complications were infection (2% and 3.4% for suction curettage and D&E, respectively, and of these 11% required the patient to be hospitalized), and incomplete abortions (0.4% and 0.9%, respectively).[60] In a retrospective analysis of 83 469 procedures performed in Ontario in 1992 and 1993, the immediate complication rate was 0.7%. There were no deaths reported, and 54% of complications were related to retained products of conception. Complications were most frequent when abortions were performed in the second trimester and in procedures that involved saline or prostaglandin instillation into the uterus.[61]

More recently, the POWER study found that the rate of emergency department/same day surgery visits within 14 days of abortion was 4.5%, and 0.4% of abortions resulted in hospitalization. The study classified any of these events as a complication, and it may overestimate rates by counting unrelated events.[56] According to the CIHI 2009 report, there were no complications in 97.7% of 28 814 abortions reported and performed in Canadian hospitals. The complications in the remaining 2.3% were hemorrhage (0.8%), infection (0.4%), retained products of conception (0.4%), a combination of complications (0.3%), or other

complications (0.5%). Of note, complications may be underrepresented because those occurring at subsequent visits or transfers were not included.[37]

The National Abortion Federation is the professional association of abortion providers in North America, and it offers training and services to abortion providers. In Canada, 80% of therapeutic abortions are performed by National Abortion Federation members. The National Abortion Federation collects quality indicators from its members, but these are not released publicly.[62]

AREAS OF CONCERN

Termination of pregnancy remains an important option in any case of unintended pregnancy. Unintended pregnancy can result from lack of contraception, contraceptive failure or sexual assault and may be unwanted because of no supportive partner, financial difficulties, a genetic condition, a serious fetal malformation, or maternal health concerns. Reducing the number of unintended pregnancies could lower abortion rates. However, many women do not use contraception effectively and may not be aware of emergency contraception. Logistical, cost, and accessibility issues for both of these have been documented.[42,43,47,63]

It is worrying that despite liberal laws and public funding, there are still barriers to universal access to abortion in Canada. These have been recognized in several studies, articles, and reports, and are summarized below.[10,12,13,15–17,50–54,63–67] Access barriers to abortion and their consequences, as compiled by the International Reproductive and Sexual Health Law Programme at the University of Toronto, are summarized in Table 2.[68]

Those seeking a termination of pregnancy may encounter uninformed or judgemental health care personnel who do not provide accurate information, disclose the availability of this service, or facilitate a referral to an appropriate provider. Not all providers accept self-referral, and some require parental consent before terminating a pregnancy for a minor.[10,16,40,62,66, 68]

Medical abortions are non-invasive and may be less costly to our health care system. Currently, medical abortions account for very few terminations of pregnancy in Canada, and mifepristone remains unapproved despite its safety and efficacy. Some patients cannot access medical termination because of advancing gestational age and lack of local availability. Health care professionals must be aware of the medical option so that more physicians can provide it.

Finding an abortion provider, especially in a timely fashion, can be challenging.[10,12] The number of providers is decreasing, and they may encounter harassment or violence and may fear for their safety or that of their family.[16,17] Currently, only 16% of Canadian hospitals provide abortion services, compared with more than 20% in 1977.[10] Some provinces and territories do not have abortion clinics, and most providers are in urban areas. Many women are required to travel to access this service or to ensure anonymity, and women may face protesters at abortion clinics. In some centres, two or three visits are necessary, and there can be wait times of up to six weeks. Additionally, restrictions are placed on the service depending on gestational age (Table 1). Cost is still an issue for some, as women may need to pay fees in certain clinics or when out of their home province because of reciprocal billing issues.

The medical training in Canada does not appear to teach students comprehensively about abortions. Since training is neither extensive nor mandatory, many obstetrics and gynaecology residents do not feel competent in the procedures, and the number of abortion providers is decreasing.[12,] Furthermore, providers and health care facilities have been subject to harassment, threats, and attacks, which may lead to further decreased availability.[16,17]

Finally, there is inconsistent and inadequate reporting of prevalence and complication rates of abortions in Canada, and improved reporting is necessary for quality assurance and to ensure safety.

CONCLUSION

The SOGC affirms that abortions are a necessary component of comprehensive family planning services. The CMA states that induced abortion should be uniformly available to all women in Canada.

Although the number of abortions has decreased over time, with a corresponding decrease in the birth rate, ensuring affordability and access to contraception and emergency contraception and improving public education could further minimize the need for therapeutic abortions. Most therapeutic abortions are the result of unintended pregnancy, and health care professionals must counsel women and provide effective contraception to those who do not wish to conceive.

Worldwide, restrictive laws on abortion contribute significantly to morbidity and mortality in women. In Canada, abortions have been decriminalized. They are safe, and often publicly funded. However, there remain several

Table 2. Potential access barriers to abortion and their consequences[68]

Provider Barriers	Lack of Trained Providers: geographical disparity, lack of adequate training
	Unnecessary Provider Restrictions: restricted to gynaecologists, failure to train or authorize midwives and mid-level providers
	Provider Refusal or Objection: fear of criminal prosecution, threat of violence, and conscientious objection
	Failure to Refer: failure to refer in good faith, deliberate delays
Facility Barriers	Geographical Disparity in Facility Availability: limited access in rural areas or outside major urban centres
	Failure to Certify or Accredit Sufficient Number of Facilities
	Lack of Available Operating Room Time
	Facility Restrictions: restricted to hospitals, gynaecology wards or specialized health centres
	Hospital Policies: gestational limits, age of consent, options counselling
Procedural Barriers	Mandatory Wait Periods
	Mandatory Pre-abortion Counselling
	Rape Administrative Protocols
Authorization Barriers	Restrictive and Inconsistent Interpretation of Statutory Authorization Provisions: failure to define policy respecting legal abortion, failure to provide guidance on exercise of discretion respecting authorization
	Mandatory Provider Authorization: committee or multiple providers
	Judicial Authorization
	Spousal and Parental Authorization: notification or consent
	Lack of Mechanism for Review of Denied Authorizations
Economic Barriers	Affordability: service costs, additional patient fees, extortion, lack of exceptions
	Exclusionary Private and Public Insurance Policies
	Government or Public Resources: failure to commit adequate public resources
Information Barriers	Lack of Knowledge among Providers on Legal Status of Abortion and Related Administrative Regulations: fear of criminal persecution
	Lack of Knowledge among Women on Legal Status of Abortion
	Failure to Disseminate Public Information on Available Legal Abortion: to counter use of euphemisms, ensure information provided in a manner that respects privacy of providers
	Failure to Develop Standards and Protocols for Abortion Service Delivery and Technologies: permitted abortion technologies, providers and facilities
	Gatekeepers that Seek to Block Access: switchboard operators, nurses, counsellors
Stigma Barriers	Community Norms and Attitudes
	Mistreatment in Clinical Setting: paternalistic tradition in delivery of health services
	Provider, Peer and Public Disapproval
Consequences of Access Barriers	
Long Waiting Periods: receive abortion services later in gestation with attendant health risks or denied or limited access due to gestational limits	
Require Women to Seek Services from Private Facilities: higher and private fees	
Require Women to Seek Services in Other Jurisdictions: results in unnecessary costs, delay and time away from work or family obligations.	
Require Women to Seek Services Outside the Formal Health-Care System	
Require Women to Carry Pregnancy to Term	

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areas of concern. Medical abortions are safe and effective, but they are not widely available and they may be associated with a fee. Despite abortion being recognized as a medical procedure, medical education does not routinely cover this topic. It may be associated with a personal financial cost to the patient. The geographical disparity in availability of abortion services continues to be a challenge for our country. Finally, inconsistent reporting hampers the production of reliable statistics and the provision of safety.

The SOGC, as a leader in women's rights to reproductive and sexual health, and all health care professionals involved in the care of women must continue to address these apparent and local issues related to therapeutic abortion in order to ensure ongoing comprehensive women's health care.

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