

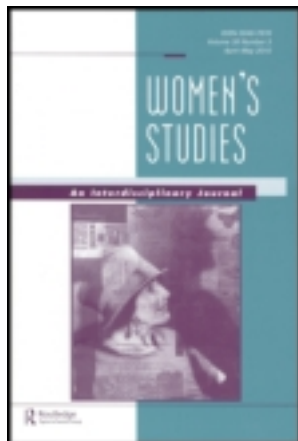
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ACCIDENTAL TOURISTS: CANADIAN WOMEN, ABORTION TOURISM, AND TRAVEL

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“Medical tourism” is fast becoming a subject of major research interest. It is usually understood to be a twenty-first century manifestation of health tourism and refers to travel to access a range of elective or obligatory medical services. Medical tourism is popularly characterized as the solution to rising domestic health care costs and patient wait times in a globalized world that encourages consumer choice (Gray and Poland 2; Cortez 72; Turner 1639). Yet medical tourism is a very complex phenomenon. The term itself is contested; sometimes emphasizing foreign, cross-border or regional travel, travel from wealthy countries to poor countries or travel that combines access to medical services with tourism (Hall 5; Johnston 24; Hopkins 185). The word “tourism” can be misleading (Hannah). Tourism can occur for “non-leisure purposes” involving “the consumption of goods and services” during the period of travel. These goods and services can include medical services (Martin 251) and their consumption is seen as addressing or exacerbating prevailing economic inequities because medical tourism is a global industry worth billions (Vijaya 55; Godwin 3981). Even when individuals travel to access medical services for reasons that have little to do with choice, tourism signifies individual agency, freedom, and mobility (Gilmartin and White 276). These characteristics are often linked to medical tourism despite the fact that legal and extra-legal impediments blocking access to medical services compel individuals to travel (Smith-Morris and Manderson 334).

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Women's access to medical services within a medical tourism framework needs to be investigated because women's choices, especially in regard to reproduction, are limited by gendered structural constraints and globally stratified inequities based on race, class, disability, sexuality, nationality, and age (Colen 380; Lippman 282; Smith 120). Notably, one type of medical tourism that is unique to women is "abortion tourism." The term has an anti-choice slant although it is used generically to indicate the travel women undertake to access abortion services. This kind of travel, which is likened to the Underground Railroad, diaspora, or exile (Nathan; Rossiter), is most familiar to Ireland, where abortion is illegal. Thousands of Irish women travel to Britain annually for abortion services (Human Rights Watch 2). Medical tourism and abortion tourism are profoundly interconnected because they both involve travel to circumvent similar legal and extra-legal impediments to medical and abortion services. However, abortion tourism is rarely acknowledged as part of the broad spectrum of medical tourism (Behrmann and Smith 85). This omission may occur because attention paid to women participating in medical tourism is focused mostly on the use of assisted reproductive technologies (ARTs) in "reproductive tourism," "fertility tourism," or "cross-border reproductive care" intended to induce pregnancy and promote gestation to term (Jones and Keith; Bergmann; Whittaker and Speier). It may also occur because of a general disinterest in women's reproductive health issues (Cook, Dickens, and Fathalla), because abortion is a stigmatized medical procedure (Feldt), or because only travel across international borders is viewed as medical tourism (Johnston 24; Hopkins 186; Smith-Morris and Manderson 331) whereas travel across domestic borders is ignored.

In this article we trace Canadian women's abortion tourism, use government reports documenting its existence, and then turn to studies of non-governmental organizations on abortion access. We argue that travel to access abortion services is a widespread transnational phenomenon in which Canadian women have participated; that it predates the current trend of Canadian medical tourism; and that it must be considered a type of medical tourism whether or not Canadian women's travel to access abortion services occurs across international or domestic borders (Palmer; Sethna and Doull, "Journeys of Choice"; Sethna and Doull, "Far From Home").

Abortion as a Medical Procedure

Abortion is recognized as a vital, time-sensitive health service that is also a remarkably common medical procedure. Still, it remains a contentious practice for many (D. Shaw 634). "Unsafe abortion," defined as "a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both" (World Health Organization), is a leading cause of maternal mortality and morbidity (Grimes et al., "The Preventable Pandemic" 3). While abortion rates are similar in the developing and developed worlds, the vast majority of unsafe abortions occur in the developing world (Sedgh 90). Safe abortion in the first trimester leads to far better health outcomes than does late term abortion (Kiley 446). After 20 weeks of gestation abortion is generally classified as late term and is rare (Centers for Disease Control and Prevention). Abortion rates remain fairly stable regardless of the legal status of abortion. Legal abortion results in significant improvements to women's health (Grimes, "The Silent Scourge" 101). Despite the importance of legal abortion, abortion does not have to be illegal in order to be inaccessible. As the grounds for legal abortion vary widely around the world, access to abortion can easily be compromised (Singh 5).

Women who travel to access abortion services do so because of the illegality of abortion and/or because extra-legal impediments restrict access to abortion services. Extra-legal impediments may include the geographical distance to abortion services, the costs of the procedure, the wait times involved, complicated referral or approval policies, gestational limits, inappropriate or limited facilities, uncooperative or untrained medical personnel, anti-choice harassment, confidentiality issues, and HIV status (J. Shaw; Henshaw). Extra-legal impediments restrict access to abortion even in sectors where abortion is legal (International Sexual and Reproductive Health Law Program).

Therefore, women travel, often over long distances and under trying conditions, to access abortion services across international and domestic borders. The further a woman has to travel to access abortion, the less likely she is to obtain one and the more likely she is to be young and underprivileged (Jewell and Brown 118; Lichter, McLaughlin, and Ribar 285; Shelton, Bran,

and Schultz 262). Travel can skew abortion data, making it difficult to establish the need for abortion services in different sectors (Strauss). Indeed, abortion rates fluctuate geographically because of the concentration of abortion services in certain jurisdictions (Gober 230). Birth and abortion rates rise and fall based on the feasibility of travel from regions where abortion access is impossible or difficult to regions where abortion access is available (Harper, Henderson, and Darney 507). Even internet search patterns indicate that areas with limited abortion access show higher use of the internet to search for abortion providers outside those locations (Reis and Brownstein).

Abortion History in Canada

Abortion in Canada has been historically deployed as a back-up method of birth control for women. Abortion was often self-induced using home-made concoctions or commercially sold abortifacients and could also be performed by medical or non-medical personnel. While many women died because of post-abortion infections, most survived. Nevertheless, abortion was a significant contributor to maternal mortality rates (McLaren and McLaren, "Discoveries and Dissimulations"; McLaren and McLaren, "The Bedroom and the State"). Abortion and contraceptives were criminalized in the late nineteenth century when eugenic thought was predominant. Intent on preventing "race suicide," eugenicists sought to increase the numbers of Canadian-born, white, Anglo-Saxon Christians by restricting birth control access overall. However, eugenic concerns over the fertility of immigrants, the disabled and the poor encouraged the development of a birth control movement. While there was support for the legalization of contraceptives, abortion remained a clandestine matter (McLaren, "Our Own Master Race"; Backhouse; Valverde).

Overseas Journeys

Over time, some non-Catholic hospitals formed Therapeutic Abortion Committees (TACs) to deal with abortion requests on a case-by-case basis but the threat of prosecution deterred many

doctors from performing abortions (Brodie, Gavigan, and Jenson 25). Pressure for the reform of birth control laws increased after 1945 when eugenically inspired fears of overpopulation, especially in the developing world, surfaced (Sethna, "The Evolution of the Birth Control Handbook" 101). In the 1960s, illegal abortion was recognized as a leading public health issue. The liberalization of abortion legislation in various countries coincided with an increase in global tourism. Canadian women who could afford the costs or who could raise the money, began travelling to Japan, Poland, Sweden, Mexico, and Switzerland for abortions. One college student recalled her flight overseas:

Because abortions were not legal in Canada, I was taken to Japan [by a parent] where they were. . . . Because of the language problem, I didn't know what was happening or going to happen to me. . . . Although the staff was very kind, my surroundings were unsanitary. . . . I had to borrow a substantial amount for the trip. Financially, this experience set me back a year and more. (Report of the Committee on the Operation of the Abortion Law 186)

The passage of Britain's 1967 Abortion Reform Act (excepting Ireland) spurred even more abortion tourism. The Act allowed for legal abortions if two doctors could agree that there was a risk of fetal anomalies or that the continuation of the pregnancy threatened the woman's life, her physical or mental health, or any of her existing children. Because the Act had no residency requirements, women from all over the world, including Canada, came to Britain to access abortion services (Sethna, "All Aboard" 92). The transportation industries, abortion referral agencies, and doctors directly or indirectly encouraged their travel. Disgust over profiteering that was occurring at the expense of foreign nationals led British authorities to rebuke "commercial entrepreneurs"—ranging from taxi drivers, hotel owners and private sector doctors—for taking financial advantage of these women, bringing the medical profession into disrepute and creating an international scandal (Report of the Committee on the Working of the Abortion Act 131).

Canadian women who did not go abroad relied upon a network of relatives, friends, acquaintances, and sympathetic medical professionals who referred them to local abortionists or to those

in another city or province. A young, pregnant, Toronto woman recollected:

My parents had found out why I was so sick and they were wonderful about it. My dad said he had just read that abortion was legal in Sweden and that somehow they would arrange to send me there. But the next day a cousin of a friend called to tell me of a man in Ottawa who would give me an abortion for \$400. I was told to come alone, bring cash and I would be met at the airport. (Childbirth by Choice Trust 140)

Canadian abortion providers were inundated with requests for abortions from women inside and outside Canada. Vancouver physician Dr. William McCallum had women referred to him “from as far away as Montreal, New York, Miami, Los Angeles, Hawaii, Nome, and from every town and village in British Columbia” (qtd. in Childbirth by Choice Trust 114). After Montreal-based Dr. Henry Morgentaler began performing abortions openly in his clinic in contravention of Canada’s law, women from all over North America besieged him with requests for the procedure (Dunphy 89, 113).

Abortion Law Reform and Abortion Tourism

In 1969, the Canadian government succeeded in reforming the country’s birth control legislation such that contraception was decriminalized and abortion was legalized. Once the new law came into effect in August that year, legal abortions could be obtained only under stringent conditions. A woman seeking an abortion had to be referred by a doctor to a Therapeutic Abortion Committee (TAC) in an accredited hospital. The TAC, composed of three or more doctors, determined whether the pregnancy threatened the life or health of the woman. However, accreditation varied according to provincial requirements, hospitals were not obligated to strike TACs, and doctors were not obliged to serve on these committees. Catholic hospitals opted out. And nowhere was the concept of health defined (Muldoon 173–174). Dissatisfaction with the new abortion law was immediate. Nascent feminist groups were particularly irked by the control it ceded to doctors and the unfairness with which it was applied. They discovered that TACs were most likely to approve the abortion

requests of women who were married, white, and middle class. These groups organized to demand the repeal of the new abortion law. In the interim they helped women navigate the stringent requirements for legal abortions, or directed women to abortion providers in the United States (Palmer; Thomson 25; Sethna and Hewitt 470). After some American states legalized abortion, thousands of Canadian women journeyed south of the border for abortion services. After the American Supreme Court declared in 1973 that abortion merited constitutional protection, even more abortion options became available in the United States for women who could afford to travel (Sethna, "All Aboard" 97).

Ongoing opposition to the new abortion law from various quarters led the Canadian government to appoint a Committee on the Operation of the Abortion Law to study how the abortion legislation functioned in practice. Released in 1977, the Committee's report confirmed that the law had not alleviated the need for women to journey to abortion services as only 20.1 percent of accredited hospitals in Canada had TACs. The report provided proof of women's entangled domestic and international border crossings for abortion services. Women who contacted their physicians after suspecting pregnancy had to wait an average of eight weeks for a TAC-approved abortion at a hospital. Women who approached community agencies for assistance were directed to the United States for abortion services, especially if they lived in Ontario, Quebec, or the Maritime provinces. Women who sought help at university student health services were most often sent to hospitals in Canada. However, in a quarter of these cases, they were directed to hospitals out of town or to the United States. The most significant reasons for travel to the United States included gestational limits for abortion imposed by local hospitals in Canada, TAC rejection of an abortion request, confidentiality issues, and the difficulty getting a medical appointment within a reasonable length of time (Report of the Committee on the Operation of the Abortion Law).

The Committee concluded that "a continuous exodus of Canadian women to the United States" was one of the predominant consequences of the 1969 legislation (Report of the Committee on the Operation of the Abortion Law 17). It held two main factors responsible for this exodus: the near impossibility of procuring an abortion in Canada in a timely fashion and

the existence of competitive “abortion referral pathways” to the United States (Report of the Committee on the Operation of the Abortion Law 74). These pathways turned a profit for abortion referral agencies and the transportation industries on both sides of the border. American abortion clinics and hospitals servicing Canadian patients also benefitted financially. In fact, half the American abortion clinics and hospitals the Commissioners surveyed actively solicited Canadian women by providing Canadian doctors with brochures, writing letters to Canadian physicians and referral agencies, listing their services in Canadian telephone directories, and placing advertisements in Canadian newspapers. Some American abortion clinics sprung up near the border deliberately to attract Canadian patients. Based on the available data for the year 1974, 11,194 Canadian women had abortions in the United States (Report of the Committee on the Operation of the Abortion Law).

Domestic Abortion Services

A few Canadian hubs for abortion services emerged due to a concentration of accredited hospitals with TACs and abortion clinics in urban locales. However, clinic abortions were technically illegal under the 1969 law because they were not performed after TAC approval in an accredited hospital. An Ontario study commissioned by this province’s Ministry of Health found that because abortion services were unavailable or limited in smaller centers, the resultant delays led to high rates of second trimester abortion, especially among teenagers. Figures for the year 1985 indicated that one in five Ontario women left their county of residence to have a hospital abortion in another part of the province. Over 50 percent of all abortions in Ontario were performed in hospitals in Toronto, Ontario’s largest city. Hospital abortions for out-of-town women caused hardships such as repeated travel for each step in the referral process and the consequent costs. Five thousand Ontario women went to abortion clinics in Toronto and the United States (Powell 34).

Legal challenges to the 1969 abortion law coalesced around Dr. Henry Morgentaler, who continued to perform abortions in his Montreal clinic. Morgentaler insisted that

abortions up till 12 weeks of gestation could be done quickly and easily in a clinic setting, thereby avoiding TAC-fuelled delays and the complications of later term abortions. In the 1980s, Morgentaler opened a clinic in Toronto and another in the city of Winnipeg, Manitoba arguing that the law “discriminates against the poor who cannot travel to the United States and afford the cost of an abortion there, as well as those living far from the border and women who have difficulty leaving their family behind in order to travel to the States” (qtd. in Pelrine 85). Morgentaler clinics proved to be a draw not only for Canadian women. Abortion referral services in the United States sent American women who lived close to the border northward. In fact, the doctor’s first arrest in 1970 occurred after he performed an abortion on an American teenager who had travelled from Minnesota to Montreal (Dunphy 89).

Extra-Legal Impediments

On January 28, 1988 the Supreme Court of Canada invoked the *Charter of Rights and Freedoms* and struck down the 1969 abortion law in the landmark case *R. v. Morgentaler*. The Court recognized that the law was unfair because it forced women to bear the hardships of travel to access abortion services:

If women were seeking anonymity outside their home town or were simply confronting the reality that it is often difficult to obtain medical services in rural areas, it might be appropriate to say ‘let them travel.’ But the evidence establishes convincingly that it is the law itself which in many ways *prevents* access to local therapeutic abortion facilities. The enormous emotional and financial burden placed upon women who must travel long distances from home to obtain an abortion is a burden created in many instances by Parliament. (*R. v. Morgentaler* 71)

The striking down of the abortion law did not solve the problem of lack of access to abortion services (Rodgers 111). In the post-1988 era, anti-choice opposition to abortion and the failure of the federal government to assert its authority over provinces and territories where abortion access was problematic, undermined access to abortion services (Palley). For example, women from Nova Scotia who sought abortions in the province’s hospitals before *and*

after the Supreme Court decision continued to experience long delays. They waited anywhere from two to six weeks for a hospital abortion due to the lack of physical space, competing demands for other medical procedures and the small number of abortions performed daily. In contrast, women who left Nova Scotia for abortion services reported that they could get an appointment at an abortion clinic in Toronto or Montreal within a week (CARAL-Halifax Chapter). Ten years after the Supreme Court decision, Atlantic Canadian provinces were some of the most troublesome spots for abortion access in the country. Prince Edward Island banned abortions in its hospitals. Women heading to the mainland for abortion services incurred high costs for travel, accommodation and child care. Prince Edward Island, Nova Scotia, New Brunswick, and Newfoundland would not fund clinic abortions even when hospital abortions in those provinces were unavailable. One New Brunswick woman reported:

The Supreme Court decision has had very little real impact in my region. Before 1988 women travelled six to ten hours for a costly clinic abortion in the United States. Since 1988, women travel six to ten hours for a somewhat less-costly Canadian clinic abortion. (CARAL, "Access Granted" 33)

Geographical disparities surfaced throughout the country. Abortion access in big cities improved. However, as these cities were located primarily in the south, women from rural and northern regions had to make long journeys to them. Such travel placed considerable financial burdens on women who were young and poor. Aboriginal women in the Northwest Territories were hard hit. A review of abortion services available between 1986 and 1991 detailed the travel challenges the women in this region faced. As the Northwest Territories "cover one third of the Canadian land mass, have a majority Aboriginal population and are composed of communities with limited or no road access," the Department of Health earmarked 11.2 percent of its budget for medical travel because "the movement of patients to services is an enormous component of the Northwest Territories health care system and has shown consistent large increases from one year to the next" (Report of the Abortion Services Review Committee 9).

The difficulty of abortion access for women in this large and remote region was compounded by the fact that women seeking

abortions had one main point of access into the medical system, namely a physician, a nurse, or a nurse practitioner. Their refusal to give a woman seeking abortion a letter of referral for a medical travel warrant authorizing government payment for a commercial flight for medical treatment meant that the woman would be unable to have the costs of travel for abortion services covered. A woman could appeal the referral or purchase a regular airline ticket out of pocket and ask for reimbursement later. When non-medical caregivers made medical travel warrant referrals, a woman seeking an abortion had to sign a confidential statement declaring her pregnancy, her desire for counseling and/or her need for an abortion before a witness. These statements had to be sent to the Department of Health, thereby compromising her privacy. During the time period under investigation, 1,332 women, the majority of whom were Inuit, Indian, or Métis, had abortions at Stanton Yellowknife Hospital. Only 481 of these women lived in Yellowknife; the remaining 851 women travelled from the Kitikneot region, Inuvik, Baffin, and Keewatin to the hospital. During this same time period, an additional 656 women travelled from the Northwest Territories to Montreal, Ottawa, or Winnipeg for their abortions. Notably, a number of women who had abortions at Stanton Yellowknife Hospital protested that they received insufficient pain relief during or after their abortions and that medical staff treated them in a disparaging manner (Report of the Abortion Services Review Committee).

The Decline in Hospital Abortions

In 1977 only 20.1 percent of hospitals across Canada had established TACs as required by the 1969 abortion law (Report of the Committee on the Operation of the Abortion Law). Yet in 2003, 15 years after this law was struck down, the Canadian Abortion Rights Action League (CARAL) calculated that one in five hospitals, or just 17 percent, were providing abortion services. Neither Prince Edward Island nor the newly created territory of Nunavut in northern Canada provided any abortion services. Quebec and Ontario had the highest number of hospitals providing abortion services, while the Western provinces of Alberta, Manitoba, and Saskatchewan, had the lowest. In addition to these

geographical disparities, access to hospital abortion was compromised by restrictive gestational limits, approval procedures, consent policies, wait times, misinformation, confidentiality issues, and anti-choice medical staff, counseling centers, and harassment and violence (CARAL, "Full Report").

One of the biggest extra-legal impediments to abortion access was reported to be the necessity of travel, especially for women in smaller communities. For example, Nunavut women seeking abortion first had to travel to the capital of Iqaluit, which could take up to three days, and then fly to Ottawa or Montreal for abortion services. For some women, travel to another province for abortion services was even more onerous because of deficiencies in reciprocal billing agreements between some provincial and territorial governments. The *Canada Health Act* regulates the conditions provincial and territorial health insurance plans must meet in order for the federal government to provide them with the health care transfer payments necessary for the full coverage of medically necessary services. All provincial and territorial health insurance plans must be publicly administered, comprehensive, universal, portable, and accessible. Because abortion is considered a medically necessary service, provincial and territorial health insurance plans should theoretically cover all abortion costs. However, some plans refuse to cover abortion if it takes place outside the woman's province or territory of residence. CARAL also singled out four provinces—Nova Scotia, New Brunswick, Manitoba, and Quebec—which did not provide coverage for abortions performed in clinics as opposed to hospitals. CARAL concluded "there is no other medical procedure in Canada today that remains open to such state interference and has to be negotiated by women in need of medical treatment" (CARAL, "Summary" 5).

In 2006, Canadians for Choice (CFC) conducted a follow-up study that recorded a further decrease in hospital abortion access, down to 15.9 percent nationally (J. Shaw 1). The study attributed the drop to abortion providers' fear of anti-choice violence, the lack of medical school training in abortion techniques, and budget-conscious hospital mergers between Catholic hospitals and secular hospitals. Hospitals that are the product of such mergers usually adopt the Catholic Health Ethics Guide, thereby restricting access to contraceptive and abortion services. This

study also identified the necessity of travel as a chief barrier to abortion access. However, some positive changes were recorded. Abortion services became available in Nunavut. Manitoba agreed to fund all abortion procedures whether or not they took place in a hospital or clinics. The Quebec government encouraged women to file class action suits regarding the reimbursement of abortion fees they paid up front (J. Shaw 33).

Anti-Choice Climate

On January 28, 2008 speakers who gathered at a University of Toronto symposium to mark the twentieth anniversary of *R. v. Morgentaler* agreed that abortion access in Canada had ameliorated over the last two decades. Still, they lamented the stubborn existence of various extra-legal impediments. Although abortion is legal in Canada and is considered a medically necessary service, abortion access remains grossly uneven due to extra-legal impediments. Morgentaler, the guest of honor, reminded those present that Prince Edward Island still does not have any abortion facilities and that his legal battles against the government of New Brunswick for refusing to fund abortions taking place in clinics is ongoing (Morgentaler 6). The presence of Dr. Garson Romalis, a Vancouver abortion provider who was shot in 1994 and stabbed in 2000 was a somber symbol of anti-choice violence (Romalis). In 2009, Dr. George Tiller, a provider of late term abortions in Wichita, Kansas was assassinated. The closure of his clinic after his murder eliminated one of the few options for American and Canadian women seeking pregnancy termination after 20 weeks of gestation (Harding).

Moreover, although Canadian pro-choice organizations have long asked the federal government to punish provinces or territories that violate the *Canada Health Act* for restricting abortion access, the government of Canada has been reluctant to take on the issue. Its reluctance is played out against a growing anti-choice climate. Politicians in Parliament have introduced bills restricting abortion access (MacCharles). Activists have petitioned provincial governments to release confidential information about hospital abortions under Freedom of Information legislation (Craine, "BC Hospitals Refuse"). Groups on university campuses compare

abortion to the Holocaust of the Jews (Craine, “Five Canadian Pro-Life”). Rallies demand that abortion be delisted as a medically necessary service (Craine, “2,300 Ontario Pro-Lifers”). Crisis pregnancy centers attempt to trick women into bringing a pregnancy to term by disseminating misinformation about the negative mental and physical consequences of abortion (Arthur).

In 2010, Prime Minister Stephen Harper caused an international firestorm after he announced that Canada’s plan for alleviating maternal mortality—a laudable Millennium Development Goal—would not include abortion access. Harper’s actions were roundly condemned not only because unsafe abortion is a leading cause of maternal mortality and morbidity, but also because they appeared to confirm the existence of a domestic anti-choice “hidden agenda” resembling oppressive American policies such as the “global gag rule” (Holmes and Sethna). Dismay over the Prime Minister’s actions in terms of best medical practices to improve maternal health globally should not obscure the very real lack of access to abortion services many Canadian women face at home (Peritz). Before 1969, women who could afford to do so, travelled to access abortion services in other countries because abortion in Canada was illegal. After 1969, the year abortion was legalized, women travelled inside and outside Canada to access abortion services because of the inequitable application of the abortion law. Since the Supreme Court struck down the abortion law in 1988, marginalized populations of women—Aboriginal women, young women, women from the North, women from rural areas, and women from Atlantic Canada—have tended to travel farthest within Canada to access abortion services (Rodgers).

Conclusion

Abortion is a common but contentious health service that is inaccessible to various women. Abortion tourism is seldom acknowledged as part of the broad spectrum of medical tourism even though it is a widespread transnational phenomenon that is unique to women. Canadian women have participated in abortion tourism for decades across international and domestic borders in order to circumvent legal and extra-legal impediments to abortion access. Clearly, abortion tourism acts as a safety valve relieving

pressure to provide abortions within a country, province, state, county, or jurisdiction. As a result, politicians do not have to court controversy by dealing with abortion issues. Hospitals do not have to allot space for abortion services. Medical schools do not have to include abortion training in the curriculum. Doctors do not have to provide abortion referrals, perform abortions, or face anti-choice harassment violence.

On an international scale, improving access to abortion services may require a public accounting of what individual countries are doing to address women's reproductive health, especially when nations like Canada are signatories to international conventions protecting women's health (Davies). On a domestic level, the integration of comprehensive sex education curricula, the provision of contraceptives, and accessible abortion services might ensure that the reproductive health of diverse populations of women, regardless of geographical location, can be better protected (Canadians for Choice and Fédération du Québec pour le planning des naissances). The journeys of women seeking access to abortion services in a timely fashion signal how profoundly gendered structural constraints and globally stratified inequities can shape women's reproductive choices. Therefore, it is imperative that researchers not only pay more attention to abortion tourism but also to the participation of women in medical tourism across international and domestic borders.

Works Cited

- Arthur, Joyce. "Exposing Crisis Pregnancy Centres in British Columbia." ARCC, 2009. Web. 10 Sept. 2010.
- Backhouse, Constance. "The Celebrated Abortion Trial of Dr. Emily Stowe." *Canadian Bulletin of Medical History/Bulletin canadien d'histoire de la médecine* 8 (1991): 159–187. Print.
- Behrmann, Jason, and Elise Smith. "Top 7 Issues in Medical Tourism: Challenges, Knowledge Gaps, and Future Directions for Research and Policy Development." *Global Journal of Health Science* 2.2 (2010): 80–90. Print.
- Bergmann, Sven. "Fertility Tourism: Circumventive Routes That Enable Access to Reproductive Technologies and Substances." *Signs* 36.2 (Winter 2011): 280–289. Print.
- Brodie, Janine, Jane Jenson, and Shelley Gavigan. *The Politics of Abortion*. Toronto: Oxford UP, 1992. Print.
- Canadians for Choice and Fédération du Québec pour le planning des naissances. *Focus on Abortion Services in Quebec*. Montreal: CFC, 2010. Print.

- CARAL. *Protecting Abortion Rights in Canada: A Special Report to Celebrate the 15th Anniversary of the Decriminalization of Abortion: Full Report*. Ottawa: CARAL, 2003. Print.
- CARAL. *Protecting Abortion Rights in Canada: A Special Report to Celebrate the 15th Anniversary of the Decriminalization of Abortion: Summary*. Ottawa: CARAL, 2003. Print.
- CARAL. *Access Granted: Too Often Denied: A Special Report to Celebrate the 10th Anniversary of the Decriminalization of Abortion*. Ottawa: CARAL, 1998. Print.
- CARAL-Halifax Chapter. *Telling Our Secrets: Abortion Stories from Nova Scotia*. Halifax: CARAL, 1998. Print.
- Centers for Disease Control and Prevention. "Abortion Surveillance, United States, 2005." *Morbidity and Mortality Weekly Report* 57.SS13 (2008). Print.
- Childbirth by Choice Trust. *No Choice: Canadian Women Tell Their Stories of Illegal Abortion*. Toronto: Childbirth by Choice Trust, 1998. Print.
- Colen, Shellee. "Like a Mother to Them': Stratified Reproduction and West Indian Childcare Workers and Employers in New York." *Conceiving the New World Order: The Global Politics of Reproduction*. Ed. Faye D. Ginsburg and Rayna Rapp. Berkeley: U of California P, 1995. 78–102. Print.
- Cortez, Nathan. "Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care." *Indiana Law Journal* 83.1 (2008): 71–132. Print.
- Cook, Rebecca, M. Bernard, and Mahmoud Fathalla. *Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law*. Oxford: Clarendon Press, 2003. Print.
- Craine, Patrick. "Five Canadian Pro-Life Students Arrested for Setting up Display." Life Site News, 12 Feb. 2011. Web. 10 May 2010.
- Craine, Patrick. "B. C. Hospitals Refuse to Release Abortion Data." Life Site News, 12 Feb. 2011. Web. 10 May 2010.
- Craine, Patrick. "2,300 Ontario Pro-Lifers Rally to 'Defund Abortion!'" Life Site News, 24 Oct. 2011. Web. 25 Oct. 2011.
- Davies, Sara, E. "Reproductive Health as a Human Right: A Matter of Access or Provision?" *Journal of Human Rights* 9.4 (2010): 387–408. Print.
- Dunphy, C. *Morgentaler: A Difficult Hero*. Toronto: Random House of Canada, 1996. Print.
- Feldt, Gloria. *The War on Choice: The Right-Wing Attack on Women's Rights and How to Fight Back*. New York: Bantam Books, 2004. Print.
- Gilmartin, Mary, and Allen White. "Interrogating Medical Tourism: Ireland, Abortion, and Mobility Rights." *Signs* 36.2 (Winter 2011): 275–280. Print.
- Gober, Patricia. "Why Abortion Rates Vary: A Geographical Examination of the Supply of and Demand for Abortion Services in the United States in 1988." *Annals of the Association of American Geographers* 84.2 (1994): 230–250. Print.
- Godwin S.K. "Medical Tourism: Subsidising the rich." *Economic and Political Weekly* 39.36 (2004): 3981–3983. Print.
- Gray, Harriet Hutson, and Susan Cartier Poland. "Medical Tourism: Crossing Borders to Access Health Care." Scope Note 47. *Kennedy Institute of Ethics Journal* (June 2008): 1–8. Print.

- Grimes David et al. "Unsafe Abortion: The Preventable Pandemic." *The Lancet* 368.9550 (2006): 1908–1919. Print.
- Grimes, David. "Unsafe Abortion: The Silent Scourge." *British Medical Bulletin* 67 (2003): 99–113. Print.
- Hall, Michael. "Health and Medical Tourism: Kill or Cure for Global Public Health?" *Tourism Review* 66.1/2 (2011): 4–15. Print.
- Hannah, Freya. "Canada Embraces Medical Tourism: The Reasons and Risks." *Medical Tourism Mag.* 22 Feb. 2010. Web. 2 July 2010.
- Harding, Kate. "Where Will Women Go Now?" Salon, 28 July 2010. Web. 1 June 2009.
- Harper, Cynthia, Henderson, Jillian and Darney, Phillip. "Abortion in the United States." *Annual Review of Public Health* 261 (2005): 501–512. Print.
- Henshaw, Stanley K. "The Accessibility of Abortion Services in the United States." *Family Planning Perspectives* 23 (1991): 246–52. Print.
- Holmes, Dave, and Christabelle Sethna. "Financement de l'avortement a l'étranger: Gestion (bio)politique de l'avortement." *Le Devoir* 29 Apr. 2010. Print.
- Hopkins, Laura et al. "Medical Tourism Today: What is the State of Existing Knowledge?" *Journal of Public Health Policy* 31.2 (2010): 185–198. Print.
- Human Rights Watch. *A State of Isolation: Access to Abortion for Women in Ireland*. Washington: Human Rights Watch, 2010. Print.
- International Sexual and Reproductive Health Law Program. *Access to Abortion Reports: An Annotated Bibliography*. 12 Feb. 2011. Web. 13 Mar. 2011.
- Jewell, Todd, and Robert Brown. "An Economic Analysis of Abortion: The Effect of Travel Cost on Teenagers." *Social Science Journal* 37.1 (2000): 113–124. Print.
- Johnston, Rory et al. "What is Known About the Effects of Medical Tourism in Destination and Departure Countries? A Scoping Review." *International Journal for Equity in Health* 9.24 (2010): 1–13. Print.
- Jones, C. A., and L. G. Keith. "Medical Tourism and Reproductive Outsourcing: The Dawning of a New Paradigm for Healthcare." *International Journal of Fertility* 51. 6 (2006): 251–255. Print.
- Kiley, Jessica et al. "Delays in Request for Pregnancy Termination: Comparison of Patients in the First and Second Trimesters." *Contraception* 81 (2010): 446–451. Print.
- Lichter, Daniel, Diane McLaughlin, and David Ribar. "State Abortion Policy, Geographic Access to Abortion Providers and Changing Family Formation." *Family Planning Perspectives* 30.6 (1998): 281–287. Print.
- Lippman, Abby. "Choice as a Risk to Women's Health." *Health, Risk and Society* 1.3 (1999): 281–291. Print.
- MacCharles, Tonda. "Women's Groups Accuse Tories of Anti-Abortion Agenda." *The Star*. 12 Feb. 2010. Web. 13 Feb. 2010.
- Martin, Lauren Jade. "Reproductive Tourism in the Age of Globalization." *Globalizations* 6.2 (2009): 249–263. Print.
- McLaren, Angus. *Our Own Master Race: Eugenics in Canada, 1885–1945*. Toronto: McClelland and Stewart, 1990. Print.
- McLaren, Angus, and Arlene Tigar McLaren. *The Bedroom and the State: The Changing Practices and Politics of Contraception and Abortion in Canada, 1880–1996*. Toronto: Oxford UP, 1997. Print.

- McLaren, Angus, and Arlene Tigar McLaren. "Discoveries and Dissimulations: The Impact of Abortion Deaths on Maternal Mortality in British Columbia." *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries*. Ed. K. Arnup, A. Lévesque, and R. Roach Pierson with the assistance of M. Brennan. London and New York: Routledge, 1990. Print.
- Morgentaler, Henry. "Reflections on My Struggle to Make Abortion Legal and Available in Canada." University of Toronto, Toronto, ON. 28 Jan. 2008. Keynote Address.
- Muldoon, Maureen. *The Abortion Debate in the United States and Canada: A Source Book*. New York and London: Garland Publishing, 1991. Print.
- Nathan, Debbie. "The New Underground Railroad." *New York Magazine*. 12 June 2010. Web. 4 Dec. 2005.
- Palley, Howard A. "Canadian Abortion Policy: National Policy and the Impact of Federalism and Political Implementation on Access to Services." *Publius: The Journal of Federalism* 36 (2006): 565–86. Print.
- Palmer, Beth. "'Lonely, Tragic, but Legally Necessary Pilgrimages': Transnational Abortion Travel in the 1970s." *Canadian Historical Review* 92.4 (2011): 637–664.
- Pelrine, Eleanor Wright. *Morgentaler: The Doctor Who Couldn't Turn Away*. Canada: Gage Publishing Ltd, 1975. Print.
- Peritz, Ingrid. "Despite Being Legal, Abortions Still Not Accessible for All Canadians." *Globe and Mail*. 20 June 2010. Web. 18 June 2010.
- Powell, Marion. *Report on Therapeutic Abortion Services in Ontario: A Study Commissioned by the Ministry of Health*. Ottawa: Ministry of Health, 1987. Print.
- R. v. Morgentaler. 1988. Dr. Henry Morgentaler, Dr. Leslie Frank Smoling and Dr. Robert Scott v. Her Majesty The Queen [1988] 1 S. C. R. 30, 63 O. R. (2d) 281, 37 C. C. C. (3d) 449, 31 C. R. R. 1, 62 C. R. (3D) 1, 26, O. A. C. 1.
- Realizing Choices: The Report of the British Columbia Task Force on Access to Contraception and Abortion Services*. Victoria: Government of British Columbia, 1994. Print.
- Reis, Ben. Y., and John S. Brownstein. "Measuring the Impact of Health Policies Using Internet Search Patterns: The Case of Abortion." *BMC Public Health* 10 (2010): 514–519. Print.
- Report of the Abortion Services Review Committee*. Northwest Territories: Government of Northwest Territories, 1998. Print.
- Report of the Committee on the Operation of the Abortion Law*. Ottawa: Minister of Supply and Services Canada, 1977. Print.
- Report of the Committee on the Working of the Abortion Act* Vols. 1–3. London: Her Majesty's Stationery Office, 1974. Print.
- Rodgers, Sanda. "Abortion Denied: Bearing the Limits of the Law." *Just Medicare: What's In, What's Out, How We Decide*. Ed. C. Flood. Toronto: U of Toronto P, 2006. 107–136. Print.
- Romalis, Garson. "Why Do I Do This? Being a Provider." University of Toronto, Toronto, ON. 28 Jan. 2008. Keynote Address.
- Rossiter, Ann. *Ireland's Hidden Diaspora: The "Abortion Trail" and the Making of a London-Irish Underground, 1980–2000*. IASC Publishing, 2009. Print.
- Sedgh, Gilda et al. "Induced Abortion: Estimated Rates and Trends Worldwide." *The Lancet* 370.9595 (2007): 1338–1345. Print.

- Sethna, Christabelle. "All Aboard? Canadian Women's Abortion Tourism, 1960–1980." *Women's Health History in North America*. Ed. Cheryl Krasnik Warsh. Waterloo: Wilfred Laurier UP, 2011. 89–108. Print.
- Sethna, Christabelle. "The Evolution of the Birth Control Handbook: From Student Peer Education Manual to Feminist Self-Empowerment Text, 1968–1975." *Canadian Bulletin of Medical History/Bulletin canadien d'histoire de la médecine* 23.1 (2006): 89–118. Print.
- Sethna, Christabelle, and Marion Doull. "Far from Home? A Pilot Study Tracking Women's Journeys to a Canadian Abortion Clinic." *Journal of Obstetrics and Gynaecology Canada* 27.8 (2007): 640–647. Print.
- Sethna, Christabelle, and Marion Doull. "Journeys of Choice? Abortion, Travel, and Women's Autonomy." *Critical Interventions in the Ethics of Healthcare: Challenging the Principle of Autonomy in Bioethics*. Ed. Stuart J. Murray and Dave Holmes. Surrey, England: Ashgate Publishers, 2009. 163–179. Print.
- Sethna, Christabelle, and Steve Hewitt. "Clandestine Operations: The VWC, the Abortion Caravan and the RCMP." *Canadian Historical Review* 90.3 (2009): 463–496. Print.
- Shaw, Dorothy. 2010. "Abortion and Human Rights." *Best Practice & Research Clinical Obstetrics & Gynaecology* 24.5 (2010): 633–646. Print.
- Shaw, Jessica. *Reality Check: A Close Look at Accessing Abortion Services in Canadian Hospitals*. Ottawa: Canadians for Choice, 2006. Print.
- Shelton, James, Edward Bran, and Kenneth Schultz. "Abortion Utilization: Does Travel Distance Matter?" *Family Planning Perspectives* 8 (1976): 260–2. Print.
- Singh, Susheela et al. *Abortion Worldwide: A Decade of Uneven Progress*. New York: Guttmacher Institute, 2009. Print.
- Smith, Andrea. "Beyond Pro-Choice Versus Pro-Life: Women of Color and Reproductive Justice." *NWSA Journal* 17. 1 (Spring 2005): 119–140. Print.
- Smith-Morris, Caroline, and Lenore Manderson. "The Baggage of Health Travelers." *Medical Anthropology* 29.4 (2010): 331–335. Print.
- Strauss, Lilo et al. "Abortion Surveillance—United States 2001." *MMWR Surveillance Summaries* 53.SS09 (2004): 1–32. Print.
- Thomson, Ann. *Winning Choice on Abortion: How British Columbian and Canadian Feminists Won the Battles of the 1970s and 1980s*. Canada: Trafford, 2004. Print.
- Turner, Leigh. "Medical Tourism: Family Medicine and International Health Related Travel." *Canadian Family Physician* 53. Oct. (2007): 1641. Print.
- Valverde, Mariana. *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885–1925*. Toronto: McClelland and Stewart, 1991. Print.
- Vijaya, Ramya. "Revenue Generation or International Transfer of Healthcare Problems?" *Journal of Economic Issues* 44. 1 (2010): 53–69. Print.
- Whittaker, Andrea and Speier, Amy. "'Cycling Overseas': Care, Commodification, and Stratification in Cross-Border Reproductive Travel." *Medical Anthropology* 29.4 (2010): 363–383. Print.
- World Health Organization. *Preventing Unsafe Abortion*. 2011. World Health Organization. Web. 24 October 2011.