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Spatial disparities and travel to freestanding abortion clinics in Canada

Christabelle Sethna [a,*], Marion Doull [b]

[a] Institute of Women's Studies and Faculty of Health Sciences, University of Ottawa, 120 University (11030), Ottawa, Ontario, Canada K1N 6N5
[b] School of Population and Public Health, Faculty of Medicine, University of British Columbia, 2206 East Mall, Room 414, Vancouver, British Columbia, Canada V6T 1Z3

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SYNOPSIS

Access to abortion services is uneven throughout Canada. As a result, women cross provincial and territorial borders to garner access to abortion services. In this first-time study, the travel women undertake to access abortion services at freestanding clinics across the country was systematically tracked, mapped, and analyzed using questionnaire-based data. A total of 1186 women from 17 freestanding abortion clinics provided information about their journeys. The mapped data reflect the acknowledged importance of the "spatial turn" in the health sciences and provide a graphic illustration of spatial disparities in abortion access in Canada, namely: 1) the paucity of services outside urban centers; 2) the existence of substantial access gaps, particularly for women living in Atlantic, Northern and coastal communities; 3) the burdensome costs of travel and, in some cases, the costs of the abortion procedure itself, especially for younger women who travel the farthest; 4) the unique challenges First Nations and Métis women face in accessing abortion services.

Introduction

Abortion in Canada was legalized in 1969 but under very restrictive conditions. The Supreme Court struck down this law in 1988. Since then, Canada remains one of the few countries in the world without a federal law regulating abortion. Today, abortion is considered a "medically necessary" service. This phrase has various interpretations; it has not been defined federally but it generally means a service performed by a physician as defined by the Canada Health Act or a service a patient needs "in order to avoid a negative health consequence" (Charles, Lomas, & Giacomini, 1997: 365–94). In Canada, health care is administered by provincial or territorial governments but the federal government holds sway by allocating funds to provinces and territories for health care purposes. The federal government is also responsible for enforcing the Canada Health Act. This Act sets out five principles of public, universally funded Medicare. Health care must be accessible, portable, universal, comprehensive and publicly administered nationwide (Singh Bolaria & Dickinson, 2001). Although the overall intent of the Act is to create a system of equitable access to health care, Canadians have raised concerns about "timely access to existing services, particularly in rural and remote areas, limited progress in advancing primary health care reforms and growing wait lists, especially for diagnostic services" (Final Report of the Commission on the Future of Health Care in Canada, 2002). However, access to abortion services rarely figure in such national concerns despite the fact that it is uneven throughout the country and has been described as a "patchwork quilt with many holes"(Eggertson, 2001: 847).

The most recent data available suggest that Canadian women are obtaining fewer abortions than in previous years, and this decline is most apparent among young women under the age of 20 years (Statistics Canada, 2008a). It is speculated that the drop in abortion is due in part to decreased sexual activity among young people and increased contraceptive use (Rotermann, 2008; Santelli, Linbderg, Finer, & Singh, 2007). However, abortion rates are also closely tied to the accessibility of the procedure (Jones &

* Corresponding author.

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Kooistra, 2011). Data on abortion access in the United States have indicated the rise and fall of abortion rates among neighboring states when restrictive policies are introduced (Santelli et al., 2007) Studies show that the further a women 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 & Brown, 2001; Lichter, McLaughlin, & Ribar, 1998; Shelton, Bran, & Schultz, 1976). Legal or extra-legal obstacles can restrict access to abortion services. Extra-legal obstacles may include institutional policies regulating the delivery of abortion services, the costs of the procedure, the imposition of gestational limits, the lack of confidentiality, anti-choice harassment and violence, and the location of abortion services (Farid, 1997; Gober, 1994; Henshaw, 1991; Palley, 2006).

In Canada, these extra-legal obstacles have coincided with a steady drop in public sector hospitals performing abortions since 1977 (CARAL, 2003; Report of the Committee on the Operation of the Abortion Law, 1977; Shaw, 2006). Currently, only 15.9% of hospitals in Canada offer abortion services and the majority of these hospitals are located in urban centers (Shaw, 2006). Freestanding abortion clinics exist apart from hospitals, operate in the public, semi-private and/or private sectors and are based mainly in urban centers. Such clinics have become attractive options even though private health care services may disadvantage women because they are less likely able to pay for them (Rodgers, 2006) and private health care services have become contested ground in Canada for federal, provincial and territorial powers in an era of financial cutbacks, increased demand for public health care services, and proposals for the reform of Medicare (Browne, 2004; Pro-Choice Action Network, 2002; Taylor, 2006).

As a result, Canadian women attempt to find spatial solutions to an unwanted pregnancy, crossing provincial and territorial borders to garner access to abortion services in jurisdictions outside their home communities. Despite the importance of such travel to access abortion services, the topic has been largely ignored (Palmer, 2011; Sethna, 2011; Sethna & Doull, 2007), underlining the neglect of abortion as a medically necessary service for women in Canada (Fowler & Trouton, 2000; Norman, 2011). In this first-time study, we attempt to fill this knowledge gap by systematically tracking, mapping and analyzing the travel women undertake to access abortion services at freestanding clinics throughout Canada.

Methodology

Our national study was informed by a regional pilot study conducted on women's travels to the Toronto Morgentaler Clinic, a freestanding abortion clinic that operates in the public sector in Toronto, Ontario. The findings from the pilot study revealed that women were travelling considerable distances to access abortion services at this clinic. Moreover, women from lower income groups were more likely to have travelled further to access abortion services and younger women were more prone than older women to report their journey to the clinic as “difficult” (Sethna & Doull, 2007). The pilot study prompted the need for a national study of travel to freestanding abortion clinics. All freestanding abortion clinics were invited to participate in this national study ($n=26$).[1] Seventeen out of 26 clinics agreed to participate; every province with a freestanding abortion clinic was represented in the study, namely Newfoundland and Labrador, New Brunswick, Quebec, Ontario, Manitoba, Alberta, and British Columbia. The province of Prince Edward Island (PEI) has no hospital or clinic facilities for abortion services. In the northern Canadian territories (Northwest Territories, Yukon and Nunavut), in Nova Scotia and Saskatchewan abortion access is hospital-based only (see Table 1). In the urban centers of Toronto, Montreal and Vancouver, where the majority of the country's freestanding abortion clinics are concentrated, more than one clinic participated. The most common reason for non-participation was limited staff resources to commit to the study.

Data were collected using a self-administered written questionnaire intended to track, map and analyze women's journeys to clinic abortion services. The questionnaire was previously tested in the pilot study and was slightly revised for the national study (Sethna & Doull, 2007). It was available in four languages, English and French as well as Cantonese and Punjabi, the latter two languages common to urban immigrant populations and recommended by clinic stakeholders. Questions posed related to demographics (age of respondent, marital status, nationality, self-defined ethnicity, mother tongue, place of residence, postal codes, employment status), logistics (distance travelled, mode of transportation, expenses incurred), and experiences (reasons for choosing the clinic and assessment of the ease or difficulty of their journey).

The questionnaire was distributed for one month at each participating clinic. The national study was approved by the

Table 1
Locations of freestanding clinics and hospitals with abortion access.

Province/ territory	No. of freestanding clinics and location	No. and percentage of hospitals providing abortion services[a]
British Columbia	4 (Vancouver, Victoria)	26 (29% of hospitals in province)
Alberta	2 (Edmonton, Calgary)	6 (6% of hospitals in province)
Saskatchewan	0	4 (6% of hospitals in province)
Manitoba	1 (Winnipeg)	2 (4% of hospitals in province)
Ontario	8 (Toronto, Ottawa)	33 (17% of hospitals in province), only one in Northern Ontario
Quebec	9 (Montréal, Trois Rivières, Gatineau, Rimouski)	31 (24% of hospitals in province)
New Brunswick	1 (Fredericton)	1 (4% of hospitals in province)
Nova Scotia	0	4 (13% of hospitals in province)
Prince Edward Island	0	0 (no access)
Newfoundland/ Labrador	1 (St. John's)	3 (21% of hospitals in province)
Yukon Territory	0	1 (50% of hospitals in territory)
Northwest Territories	0	2 (67% of hospitals in territory)
Nunavut Territory	0	1 (100% of hospitals in territory)

[a] Source: Shaw J. (2006). Reality Check: A close look at accessing abortion services in Canadian hospitals. Ottawa: Canadians for Choice.

University of Ottawa Ethics Board. The clinic's intake officer offered the questionnaire to women upon their entry into the clinic. The officer explained that participation in the study was voluntary and that the questionnaire was anonymous. Women who agreed to participate filled out the questionnaire while they were waiting to be seen by clinic staff and then returned the completed questionnaires to the intake officer. For confidentiality purposes, the questionnaire did not require the respondent to report her name and an opaque envelope was used to submit her answers. The women's comments are reproduced verbatim.

Analysis

Analysis was completed using SPPS (version 18.0). Simple counts and percentages were calculated for most variables. Where possible, odds ratios with 95% confidence intervals were calculated to quantify trends. Given the acknowledged importance of the "spatial turn" in the social sciences, the humanities and more recently in the health sciences (Dunae, 2008; Pickles, 1999), data emerging from the questionnaires were mapped to provide a graphic illustration of women's travel patterns to abortion clinics. Public health practitioners have long used maps to explain complex health issues stemming back to John Snow's 1854 map that pinpointed a water pump as the source of a London cholera epidemic (Kreiger, 2009). Today, maps are used increasingly to provide visual evidence of spatial disparities and can be a powerful tool to illustrate the variable geographic impact of health care policies (Geraghty, Balsbaugh, Nuovo, & Tandon, 2010; Nykiforuk & Flaman, 2011; Ruiz-Muñoz, Pérez, Gotsens, & Rodríguez-Sanz, 2012). Canadian Census Divisions (CDs) were selected as the primary unit of analysis to provide a high-level overview of patient home community locations appropriate for national as well as provincial scale visualization. A census division is defined as "a group of neighboring municipalities joined together for the purposes of regional planning and managing common services" and can correspond to a county or a regional district depending on the province or territory (Statistics Canada, 2006). In total, patients travelled from 121 of the 288 CDs in Canada. Additionally, this aggregation was selected to ensure that no individual patients could be identified within smaller geographic units. The mapping database creation process began by geocoding patients' self-reported home postal codes (95.6% of participants provided a postal code) using DMTI GeoPinpoint and then locations were spatially joined to CDs using boundary files created by Statistics Canada in 2006. Summary statistics were calculated by aggregating all patient information within each CD. Aggregated data for each CD were then linked to the geographic centroid of each CD and visualized using the proportional symbol tool available in ESRI ArcMap 10 software. All data for CDs with less than five patients were scaled up to be equivalently sized to a CD with 5 patients to ensure clear visualization and protection of privacy.

To produce the maps from these data and visualize patient travel patterns, study clinic locations were first geocoded as above using the address locations. Straight lines were produced to depict women's travel patterns from each CD to the clinic using ArcMap software. All files were then projected into Canada Albers Equal Area Conic to ensure land areas and distances are accurately represented. Finally, each map was exported to Adobe Illustrator for legend creation and cartographic improvements.

Results

A total of 1186 women participated in the national study. The average age of participants was 26.0 years (s.d., 6.4). The ages of the participants ranged from 12 to 48 years with 0.5% of the sample under 16 years old and 14.6% under 20 years old (Table 2). Over 60% of the participants reported that they made less than $30,000 per year (60.5%), 23.8% earned less than $10,000 per year and 9.7% were receiving social assistance. Most were Canadian born (76.7%) and self-identified as "white" (64.3%). However, because the questionnaire allowed participants to self-identify their ethnicity there were 187 distinctive responses that were sorted into eight broad groups for analysis (Table 2). Each group captured an array of responses. For example, participants self-identifying as African, African American, African Canadian, Black, Congolese, Ethiopian, Haitian,

Table 2
Demographic characteristics.

Age	%
12–16 years	2.3
17–20 years	19.5
21–25 years	33.0
26–30 years	21.5
31–35 years	13.4
36–40 years	7.6
41–48 years	2.8
Employment status	
Unemployed	16.7
Full-time	52.2
Part-time	17.3
Full-time student	11.5
Part-time student	2.4
Race/Ethnicity	
White	64.3
Asian	4.9
South Asian	5.3
Black	8.6
First nations/Métis	7.4
Middle Eastern	1.8
Latina	1.6
Mixed race	2.9
Relationship status	
Single	23.1
Boyfriend/partner	59.3
Married	13.9
Separated	2.1
Divorced	1.5
Widowed	0.1
Income	
Less than $10,000	23.8
$10,000–$19,999	23.3
$20–29,999	18.2
$30–39,999	14.6
$40–49,999	8.1
$50–59,999	5.0
Over $60,000	7.1
Education	
None	2.3
Elementary	0.8
High School	38.9
College	32.5
University, undergraduate	17.8
University, graduate	7.8

Nigerian, Somali were grouped into "Black"; those self-identifying as Arab, Lebanese, Syrian were grouped into "Middle Eastern." These broad groups do not capture the diversity of the responses but they do reflect the ethnic diversity of the Canadian population. Nearly 82% of participants lived within 100 km of a clinic located in or near an urban center while 18.1% lived over 100 km from a clinic. The distance to a clinic varied from less than 1 km to 3,558 km (for a national snapshot of travel patterns see Fig. 1). Figure one also reveals that many women bypass hospital-based abortion services in or near their home communities in favor of freestanding clinics. As this study focused solely on freestanding clinic-based access we did not gather data on women's contact with hospitals or reasons for selecting a clinic over a hospital. However, we know that some women (19.2%) reported that the clinic they visited was not the first clinic they contacted. The most common reason they gave for contacting an additional clinic was the absence of appointments at the first clinic contacted (39.9%). Others stated that the first clinic they called was too far from their home (11.8%) or the staff was rude on the phone (11.4%). A sizeable number of women cited "other" reasons (35.5%) for not visiting the first clinic they called. Their hand-written comments indicated that they were discouraged by long wait times (e.g., "appointment was too far away, long wait time"), gestational limits (e.g., "grosses trop avance pour l'hopital, 14.6 semaines [de la grossesse] referee a la Clinique Morgentaler"[2]; "I was too early in the pregnancy"), difficulties getting through to the clinic by phone (e.g., "no one answered the phone"; "phone always busy"; "they never returned my calls"), cost (e.g., "clinic did not take OHIP [Ontario Health Insurance Plan]", "wasn't expensive but it was $50 and don't have that at the moment"), requirements for an ultrasound and resultant delays (e.g., "they insisted on an ultrasound first which I could not get for 3 weeks"), logistical difficulties posed by the journey to the clinic (e.g., "I wasn't sure how to get there by public transportation"; "they [clinic staff] would not let me take a taxi") and, the unavailability of medical as opposed to surgical abortion (e.g., "I was referred here because the other place does not do medical abortions").

In Toronto, Montreal and Vancouver, where women can access abortion services at several freestanding clinics as well as hospitals, the proportion of women travelling more than 100 km to clinics ranged from 0% to 12%, reflecting their proximity to abortion services (see regional maps, Figs. 2–5). In contrast, seventy-three percent of women travelling to the clinic in New Brunswick travelled more than 100 km to access services and approximately a third of women (29–36%) travelling to clinics in Alberta, Manitoba and Vancouver Island travelled more than 100 km to access services. Alberta has clinics in its two biggest cities, Calgary and Edmonton, Manitoba has one clinic in its capital, Winnipeg, and Vancouver Island has one clinic in its largest center, Victoria. Given Canada's vast size and its cluster of populations in Atlantic, northern and rural areas, distances travelled can be considerable. For example, there is a substantial population living in

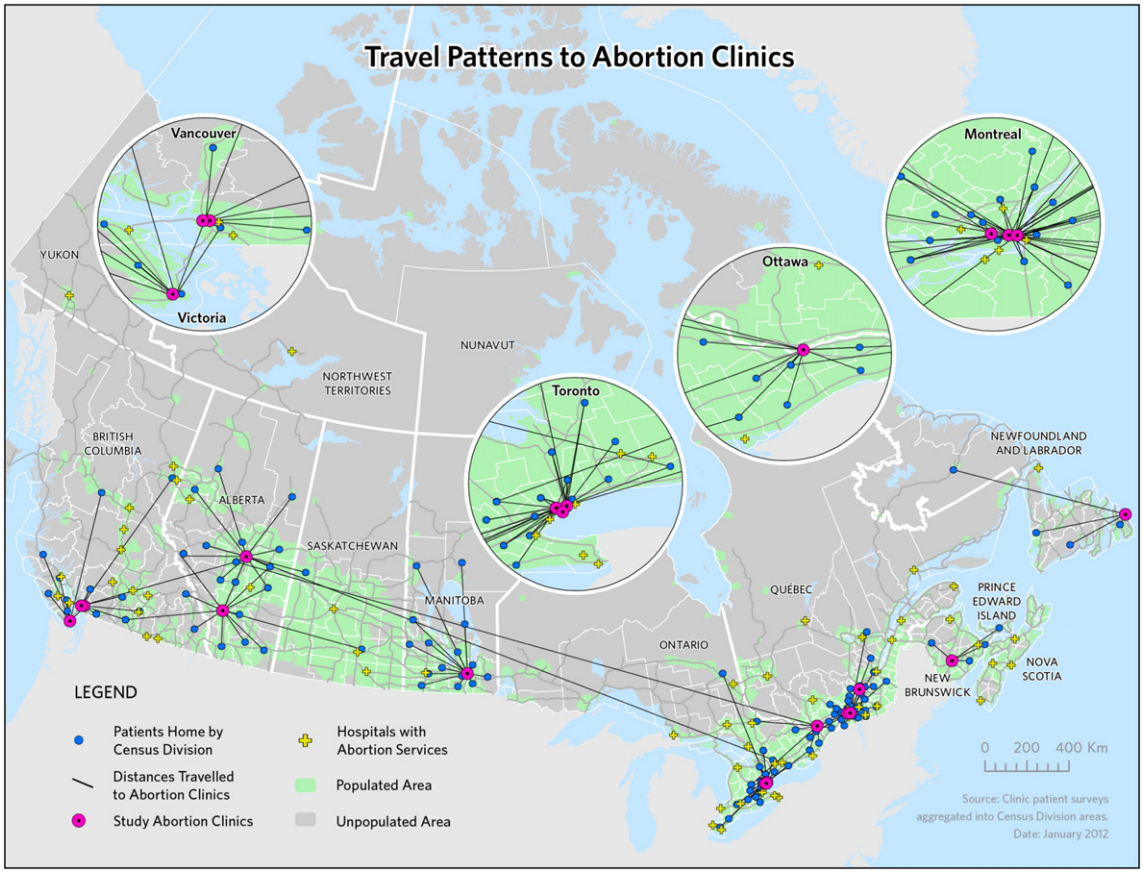

Fig. 1. National map of women's travel patterns to access abortion services.

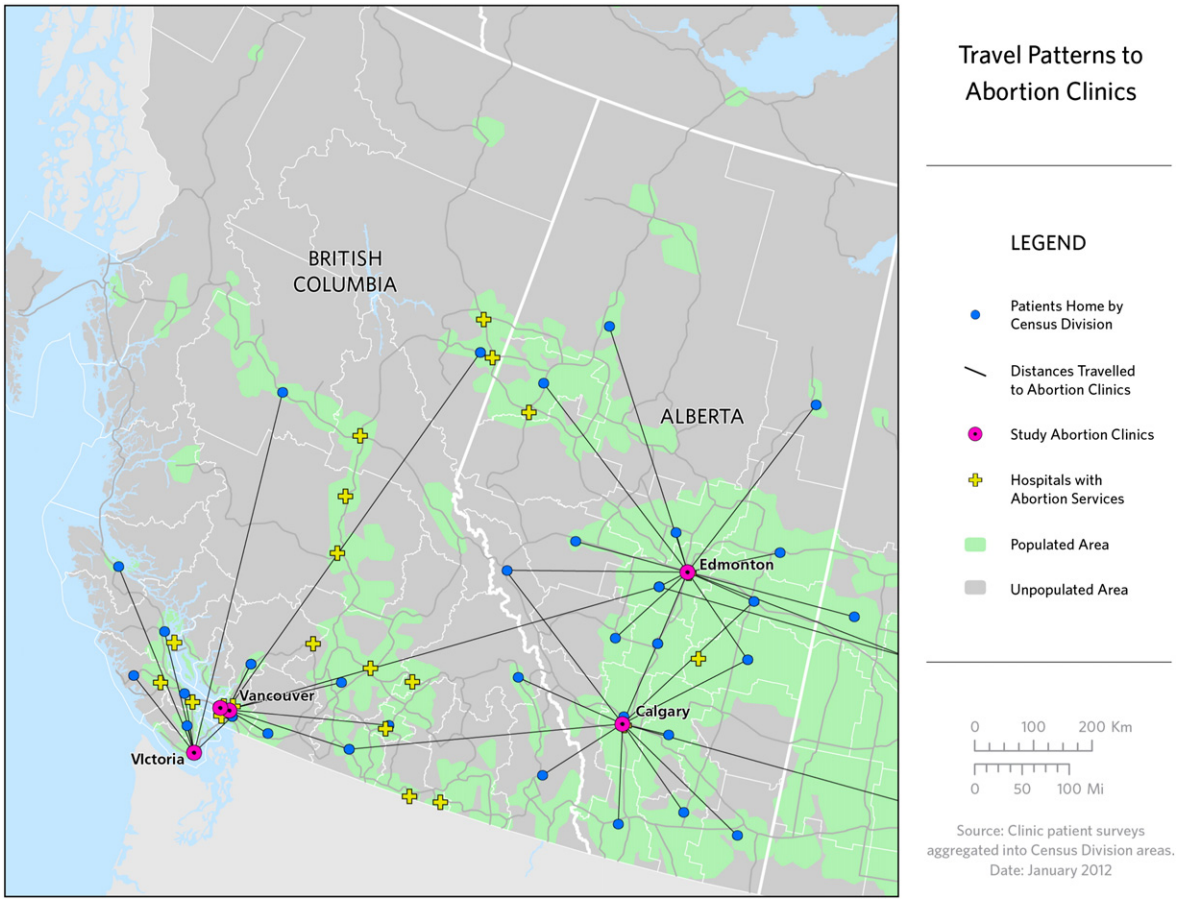

Fig. 2. Regional map of women's travel patterns to abortion clinics — British Columbia and Alberta.

northern Alberta due to lure of the oil and gas industry. This area is approximately 450 km from Edmonton and 755 km from Calgary.

Just under half the participants (44.9%) travelled an hour or more to the clinic where they accessed abortion services with 52.8% of these women stating that this clinic was closest to their home. Again, in many of these cases, women bypassed a nearby hospital-based abortion service. Women's reported travel costs varied from "nothing" (15.6%) to more than $100 (CDN) (5.4%). When asked to detail their transportation costs women reported paying for plane tickets, bus tickets, gas for vehicles, ferries and taxis, often for themselves and a travel companion. In addition to travel costs, some women (38%) incurred other expenses that ranged from less than $10 (CDN) (9.5%) to more than $100 (CDN) (3.1%). These expenses varied but included childcare, car repairs prior to travel, parking costs, food and loss of income due to time off work. Costs were often doubled as the majority of women reported travelling to the clinic with someone (73.1%), most often a boyfriend/partner (42.3%), friend (24%) or husband (15.2%).

Although abortion is supposedly a funded, medically necessary procedure, 22.1% of women reported that they paid for their own abortions. Of these women, 19% paid for the abortion procedure and for travel to the clinic. The bulk of the women who reported paying for their abortion procedure (65.7%) mentioned costs of $50–$100 which suggests, according to clinic fee schedules, that they paid for supplementary expenses such as administrative fees, medication or follow-up contraception rather than for the abortion procedure itself. Administrative fees that clinics may charge range from $60 to $100 (CDN). Clinic fee schedules indicate that the abortion procedure can cost anywhere from $370 to $1300 (CDN) with costs depending on whether the women is from out of the province or country and by gestational age. The 25.3% of women who reported paying more than $300 likely paid for the abortion procedure itself. Whether or not these women would later be reimbursed by their provincial government health care plans for the abortion procedure is unknown. The majority of those women who did not pay for their abortion procedure reported that they used their provincial health care plan cards and noted that their procedure was paid by their own provincial health care system (93.3%).

Several important spatial disparities emerged in relation to the age, ethnicity and geographic location of the participants. Women under the age of 30 were more likely to have travelled over 100 km to access a clinic (OR = 1.57 [95% CI: 1.08, 2.28]) (see Fig. 6 for an illustration of travel patterns by age) and were also almost twice as likely to report that their journey to the clinic was "difficult" (OR = 1.83 [95% CI: 1.06, 3.15]) compared with women over the age of 30. Women

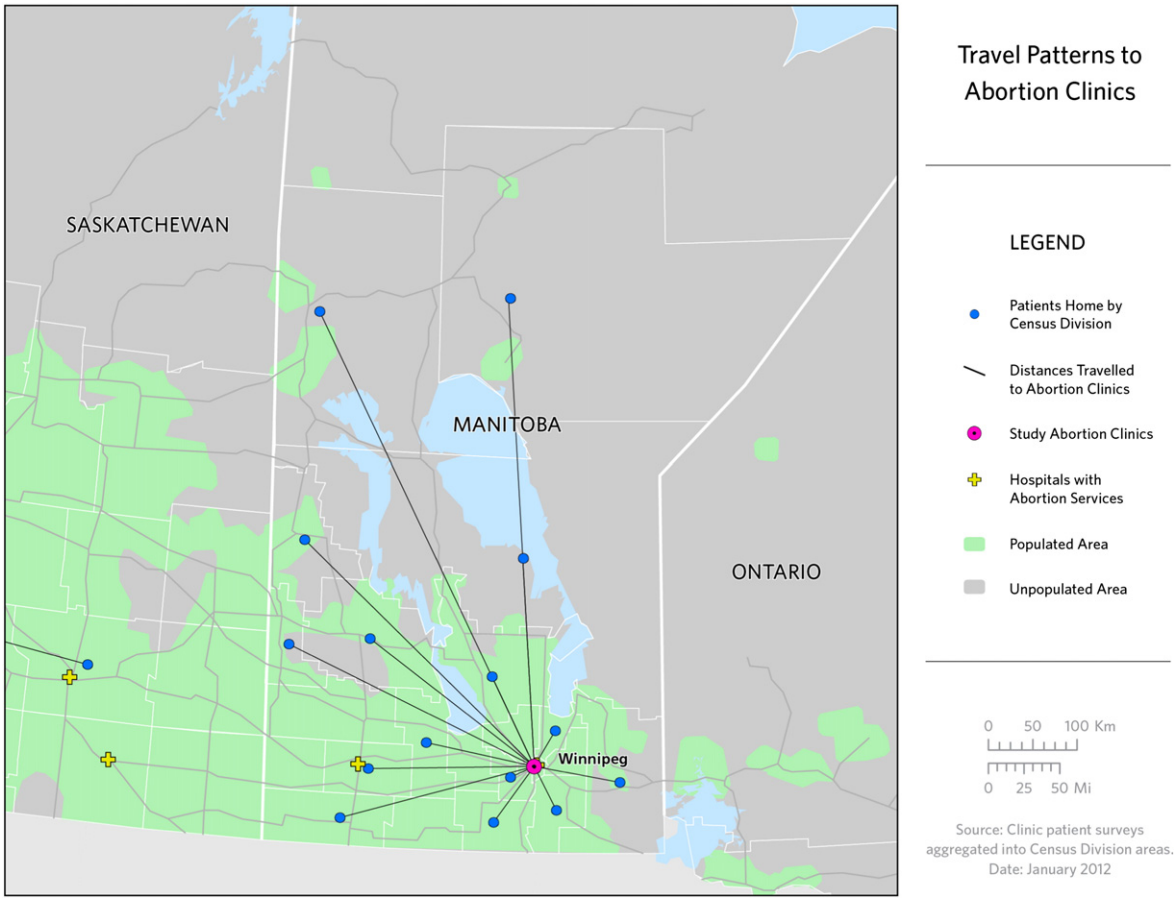

Fig. 3. Regional map of women's travel patterns to abortion clinics — Saskatchewan and Manitoba.

who self-identified as First Nations or Métis were almost three times more likely to report travelling over 100 km to access a clinic as compared with white women (OR = 0.33 [95% CI: 0.20, 0.53]). Not surprisingly, these women were also more likely to report that their journey was difficult as compared with white women (OR = 0.41 [95% CI: 0.22, 0.79]). Women who lived more than 100 km from a clinic were also more likely to report that they would have preferred to have their abortion earlier compared with women living less than 100 km from a clinic possibly reflecting delays or hardships created by travel (OR = 0.67 [95% CI: 0.48, 0.93]).

Finally, despite the considerable distances travelled in some cases, the majority of women in this study stated that their journey to the clinic was "easy." Most illuminating were the narrative responses to the open-ended question which asked women to describe why they felt their journey to the clinic was "easy" or "difficult."

Those who described an easy journey focused on logistical reasons such as accurate directions from the clinic and good public transit to the clinic. Supportive staff, no anti-abortion protestors at the clinic and a positive sense of their decision to abort were also cited:

> "Office was easy to locate, gave myself enough time to arrive a few minutes early (therefore not rushed, not stressed being late), staff very efficient and physician excellent; caring environment."
> "Accessible to bus or transportation""All the staff at the clinic are great. They make you feel comfortable and at ease about the situation. The clinic is only 2 minutes drive from my house."
> "I came with a friend, it was fairly easy to find and there were no [anti-abortion] protestors here."
> "Because I was already comfortable with my decision and it was easy to get to, except the parking was difficult to find."

More than one quarter of the sample (28.2%; $n = 329$) reported that their journeys were easy because, having been to same clinic for a previous abortion, they were familiar with the route. There were no significant patterns by age or income when this variable of a previous abortion was examined; however, women who self-identified as First Nations or Métis were more likely to report a previous abortion as compared with white women (OR = 0.52 [95% CI: 0.32, 0.84]).

Women who described a difficult journey similarly highlighted logistical reasons such as a time-consuming travel, costs or complicated arrangements:

> "I had to travel 8 hours the day before so that I was at the hospital in time this morning and I have to drive 8 hours back today."

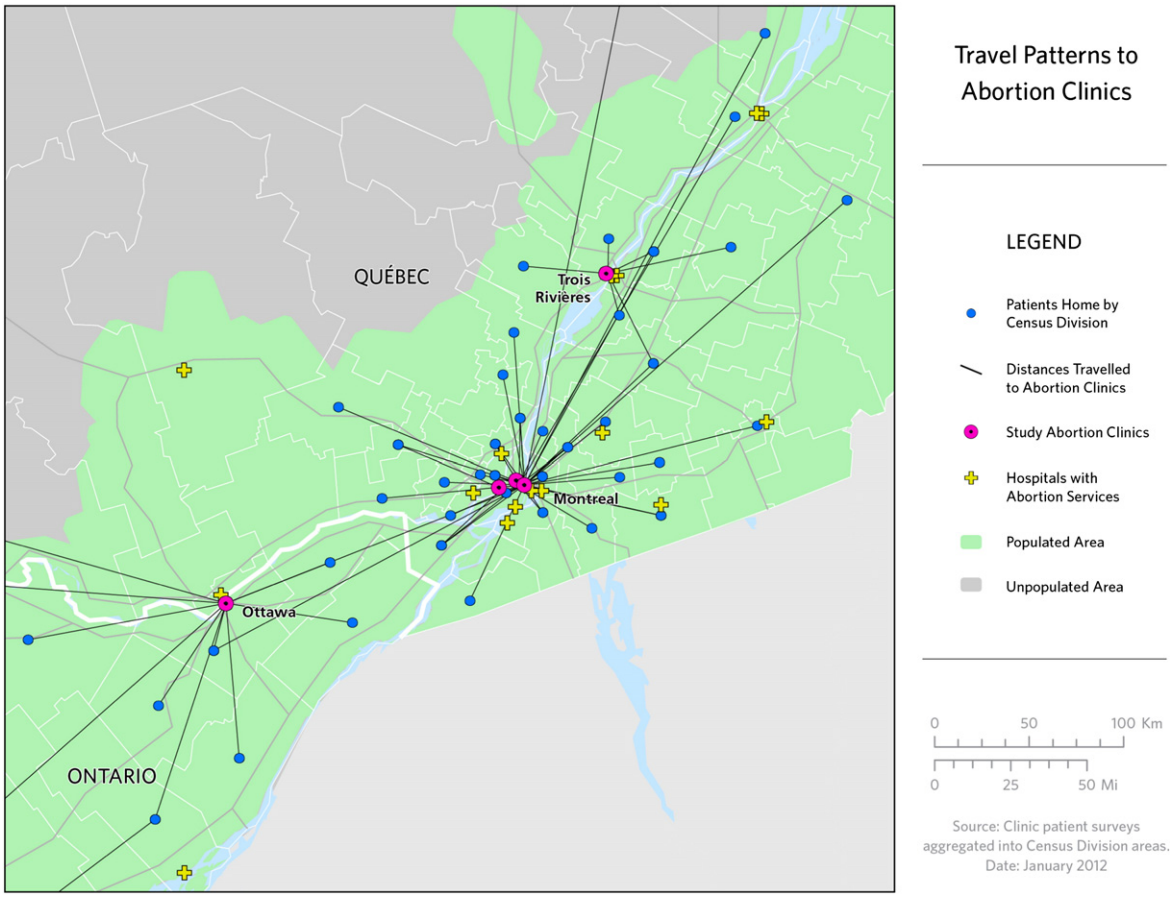

Fig. 4. Regional map of women's travel patterns to abortion clinics — Ontario and Quebec.

> "It was expensive to travel, very difficult to arrange transportation and accommodations."

They also expressed tensions associated with the journey, the pregnancy and the abortion procedure itself:

> "Because I feel very sick. My body is feeling very bad. I am a physical and emotional wreck."
> "Emotional. I'm going through a lot right now and this is just something to add to the list. I am very stressed out and I am hoping things get better soon."
> "Far from home. Got lost on the way. Feeling emotionally and psychologically uneasy."
> "It is emotionally and psychologically uncomfortable because the long wait period [for an abortion] causes anxiety and panic attacks."

Discussion

Mapping the data on women's journeys to freestanding abortion clinics raises four important concerns about spatial disparities in abortion access in Canada: 1) the paucity of services outside urban centers; 2) the existence of substantial access gaps, particularly for women living in Atlantic, Northern and coastal communities; 3) the burdensome costs of travel and, in some cases, the costs of the abortion procedure itself, especially for younger women who travel the farthest; 4) the unique challenges First Nations and Métis women face in accessing abortion services.

Urban centers serve women best because of the existence of numerous freestanding abortion clinics (and hospital-based abortion services) available to them, increasing the chances of a timely appointment in a location that is reached easily, quickly and at low cost. The concentration of abortion clinics in these centers explains why women who live at a distance must travel to access abortion services. Importantly, the maps indicate that in many cases women from outside urban centers bypass hospital-based abortion services in or near their home communities in favor of freestanding abortion clinics. Hospital-based abortion services are essential to women living in some rural and remote communities as they may be the only point of health care access in their community (Shaw, 2006). They may also provide women seeking abortions with a level of safety that can be jeopardized by protesters at freestanding abortion clinics. Yet women may wish to avoid hospital-based abortion services because of confidentiality issues, particularly in smaller centers, or because of the multiple appointments, use of general anesthesia and dearth of counseling services involved (Shaw, 2006). Anti-abortion hospital staff may also deliberately mislead women about the availability of local abortion services or take a judgemental approach to women seeking abortions

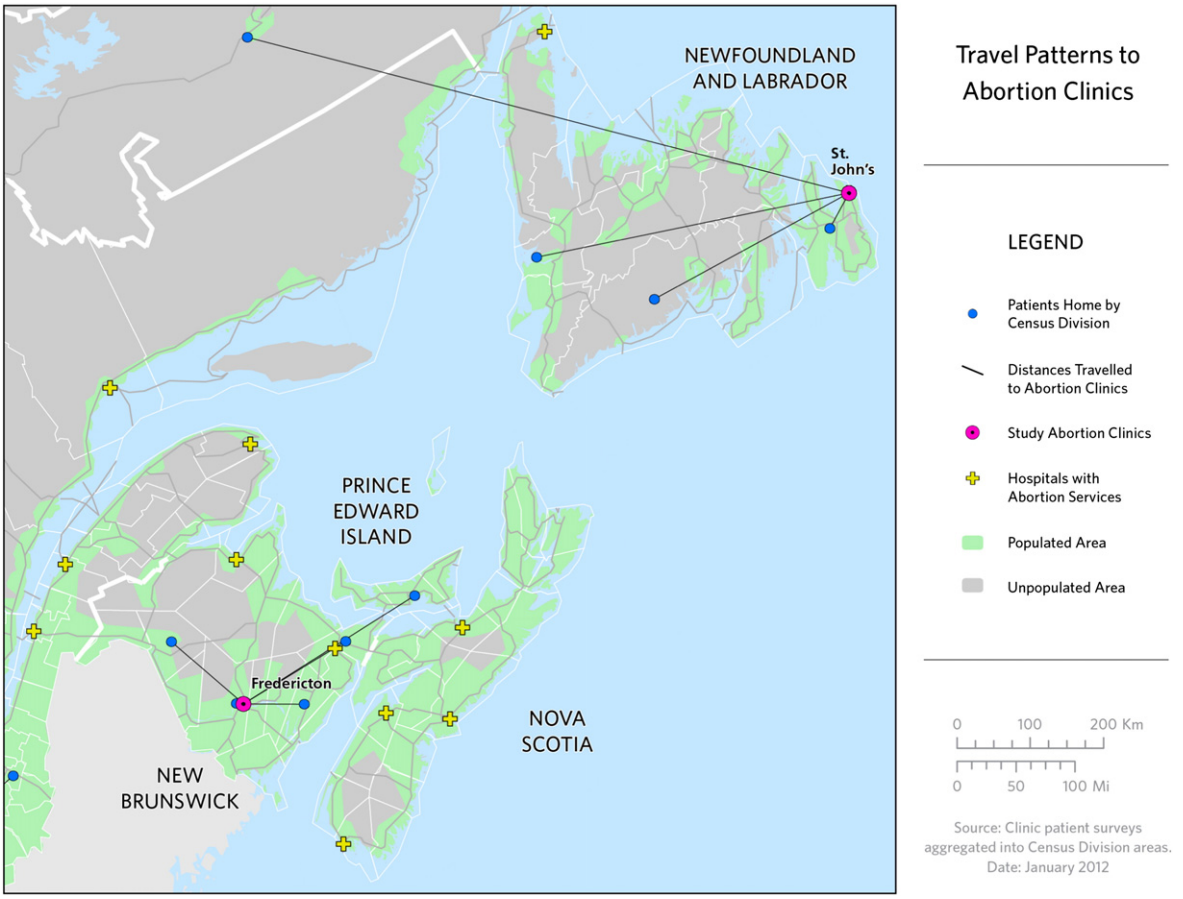

Fig. 5. Regional map of women's travel patterns to abortion clinics — Maritimes.

(Shaw, 2006). Furthermore, hospital-based abortion services are usually provided in a surgical suite, meaning that wait times can be lengthy as other surgical procedures are given priority (Dube, 2007). Although abortion clinics are located in urban centers, the clinic model tends to lead to shorter wait times, less invasive procedures and sympathetic staff. It also provides cost savings to the health care system and allows for onsite counseling and contraceptive provision (Norman, 2011).

There are substantial regional gaps in access to abortion services. Women in the Atlantic provinces of Newfoundland and Labrador, Nova Scotia, Prince Edward Island (PEI), and New Brunswick have the lowest access to abortion services in the country while women living in Canada's rural, Northern and coastal communities are also underserved, compounding social disparities that already exist. Research has consistently shown that young people living in rural and Northern communities have poorer sexual health outcomes, such as sexually transmitted infections and inadequate access to sexual and reproductive health services (Deering, Tyndall, & Koekoorn, 2010; Maticka-Tyndale, 2007; Shoveller, Johnson, Prkachin, & Patrick, 2007). Data also suggest that the proportion of sexually experienced youth is higher in Newfoundland and Labrador and New Brunswick as compared with the national average, pointing to a real need for a range of accessible sexual and reproductive health services including sex education, contraception and abortion (Canadian Federation for Sexual Health, 2007). PEI, another Atlantic province, can be considered in direct violation of the Canada Health Act because of its government's refusal to fund abortions within the province through public health care. Clearly some women must travel because of a scarcity of abortion services close to home. While provincial and territorial governments provide financial assistance for patients who must travel outside their home communities to access various medical services, similar support generally does not exist for women travelling for abortions (see exception for Aboriginal women below). However, there is a general sense that women will not complain about waiting or travelling for access to abortion services as long as they are able to get access (Nykiforuk & Flaman, 2011). Thus the stigmatized nature of abortion services clouds all policy discussions.

The majority of the women accessing clinic abortion services are in their mid-twenties and have low income, compounding the burden of paying out of pocket for abortions and/or associated travel costs. These women are also most likely to fall through the cracks created by the federal government's reluctance to enforce the principles of the Canada Health Act and rarely feature in policy discussions. Abortion is one of just 16 medical procedures exempt from the "portability" requirement permitting reciprocal billing when the procedure is obtained outside of their province of residence with their home province health coverage. This restriction is particularly critical for students

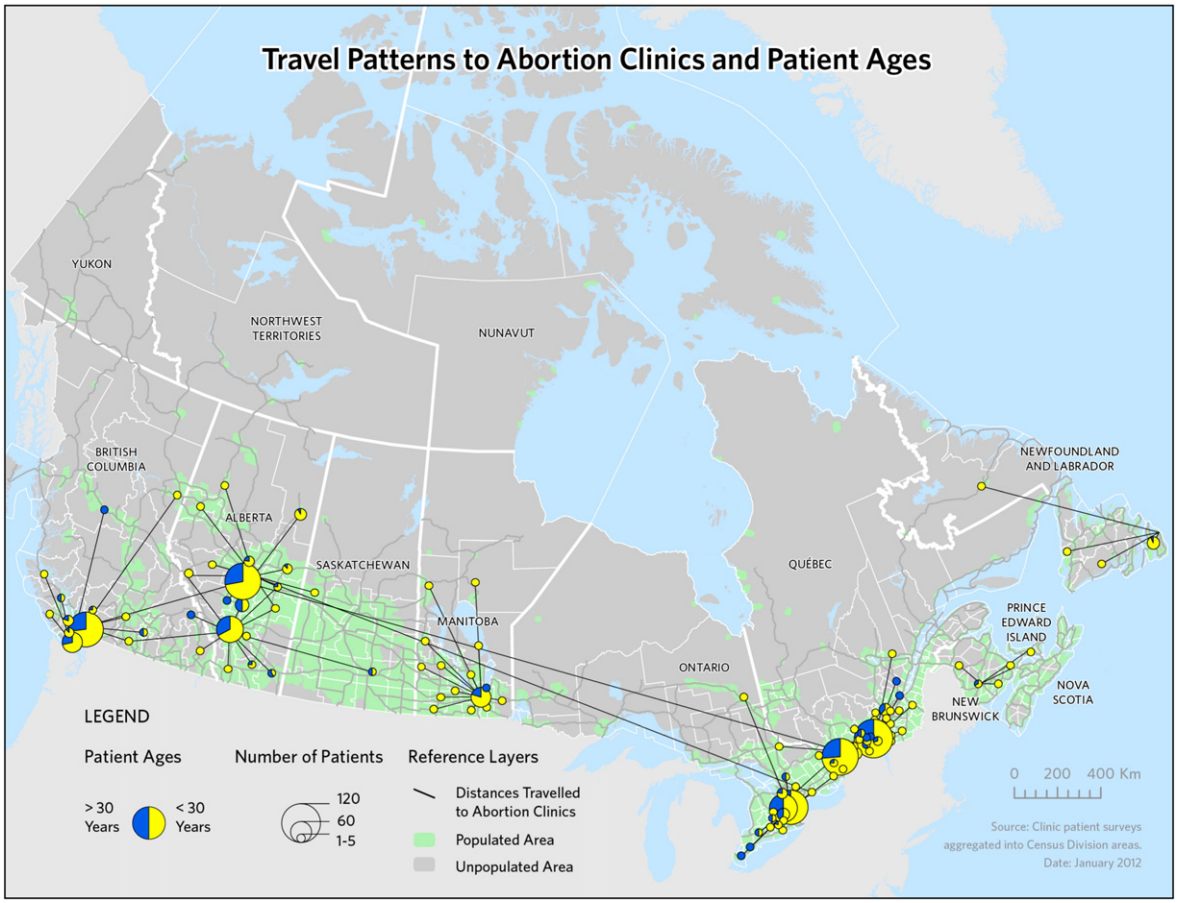

Fig. 6. Women's travel patterns to abortion clinic by age.

who often live outside their home province while attending university or college and because they are temporary residents in that province or territory, are not required to obtain new health coverage. In practice, some provinces have set up ad-hoc agreements to pay for services in a neighboring province but this is not system wide. Removing abortion from this list of exempted services is a simple policy change that recognizes the porous nature of Canada's provincial and territorial borders and provides support for the women who have to travel outside of their home community to access abortion services.

Finally, the data reveal that First Nations and Métis women, particularly those living in rural and remote communities, face several intersecting barriers to accessing abortion services. Forty percent of Aboriginal people in Canada live on reserves, with 60% living off reserve in communities of various sizes (Statistics Canada, 2008b). The establishment of reserves, along with residential schools and a classification system for "Indians" under the Indian Act (1876) has resulted in a negative health legacy for Aboriginal women (Bourassa, McKay-McNabb, & Hampton, 2004). Reserves are most often located in rural, remote or Northern communities. The women who self-identified as First Nations and Métis were almost three times as likely to report travelling more than 100 km to access abortion services, suggesting that they do not reside in urban centers. In addition to the complications of distance, Aboriginal women must endure a formal approval of funds system for off-reserve travel or else must pay for their own travel expenses (Smith, 2010). This system can create lengthy delays and confidentiality is difficult to maintain. However, accessing an abortion outside this system is an even greater challenge (Government of Northwest Territories, 1992; Smith, 2010).

This study had three main limitations. First, due to the nature of the questionnaire distribution at each clinic a total response rate could not be calculated. It is possible that the women who participated in this study are not representative of the population at each clinic as a whole. Second, this study focused solely on freestanding abortion clinics. Therefore, we did not gather information about women who accessed abortion services at hospitals or the reasons why women bypassed them in favor of those offered at freestanding abortion clinics. Other Canadian studies have focused specifically on hospitals indicating that the abortion services they offer are difficult to access (CARAL, 2003; Shaw, 2006). A study that combines women's travel to access hospital- and clinic-based abortion services would be a valuable future endeavor. Finally, we are unable to determine if particular groups (e.g., younger women; unemployed women; First Nations women) are overrepresented in our sample due to the poor quality and lack of similar comparable detail in Canada's national abortion statistics.

Conclusion

This first-time national study on Canadian women's travel to freestanding abortion clinics is an illustrative example of spatial disparities in regard to abortion access. The maps provide convincing visual evidence that women living in Canada's rural, Northern and coastal communities are underserved. Therefore, freestanding abortion clinics can be attractive options for women even when women have to travel considerable distances to access them. Such clinics provide important lessons for policy discussions about health care and health care reform in relation to populations marginalized by geographic location, age, income and Aboriginal background. However, they rarely feature in such discussions, even when Canadians express concerns about their national health care system. Thus, it is likely that freestanding abortion clinics (alongside hospital-based abortion services) will continue to offer women a medically necessary service that remains at the edges of policy discussions.

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Endnotes

[1] This number is based on recent data and does not include community health centres in Quebec which represent a unique access point in that province.

[2] Translation: "Pregnancy too advanced for the hospital, 14.6 weeks [of pregnancy] referred to the Morgentaler Clinic."

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