

Chapter 7

Patient Pathways

In the reporting of vital statistics about births and infant deaths, outcomes are given; not the rates of conception and how many women may have been pregnant. It is sometimes thought that these are synonymous events, a fact which is belied when the issue of abortion is considered. For this reason while there is an accurate listing of births in Canada, there is little information on the actual extent of pregnancy. The Committee estimated that of every 100 pregnancies, 77.4 percent resulted in live births, with some of these infants dying shortly after birth or within the first year of their lives. The other pregnancies, or 22.6 percent, either terminate spontaneously or are induced. Of this number, 1.4 percent are stillbirths which occur after 20 weeks of pregnancy, 7.9 percent are spontaneous abortions and abortions designated as neither spontaneous nor induced, and 13.3 percent are induced abortions, both legally done, illegally obtained, or performed for Canadian women outside Canada.¹

For many Canadian women the birth of a child is a happy and wanted event. But with changing ideas about the size of families, the birth rate in recent decades has declined along with the average size of families. While it is unknown how many unwanted pregnancies there may have been in the past, this fact now involves a sizeable number of Canadian women. How women see pregnancy before and after conception takes place may change, with no firm decision being reached until a definite outcome—a birth, a stillbirth, or an abortion—occurs. On the basis of its findings the Committee estimates that at least 1 out of 6 women who consider an induced abortion change their minds before this operation is obtained. About half of these women initially wanted to become pregnant, but after much consideration they subsequently decided to terminate their pregnancy. The second group consists of women who did not initially want to conceive, sought an abortion, and prior to a scheduled operation withdrew and subsequently gave birth to a child.

¹ Calculated for 1974 on the basis of: 345,646 live births; 6,345 stillbirths; 35,158 spontaneous abortions and other abortions; 48,136 therapeutic abortions in Canadian hospitals; an estimated 1,441 illegal abortions in Canada; and an estimated 9,627 abortions obtained by Canadian women in the United States. There were 5,192 infant deaths in Canada in 1974. See Statistics Canada, *Vital Statistics 1974*, Ottawa, Information Canada, May 1976.

Decisions about unwanted pregnancies involve heightened emotions and considerable stress. After an unwanted conception has occurred, women may follow one of several courses which in part depend upon their social situation, what they know about different options, and the availability of the health services where they live. Some women obtain directly an abortion in a Canadian hospital. Others who are less familiar with health services turn to community agencies for counsel. Some women by-pass Canadian medical care services altogether and go to the United States. In decreasing numbers a smaller group of women turn for assistance to maternity homes.

In reviewing these options which are taken following conception, three other courses are not dealt with in detail in the Report. Little is known about how many women had unwanted pregnancies, whether they were single or married, or if they gave birth to a child, but at no time sought the assistance of community agencies. Another group about whom little is known are the women who had abortions in Canadian hospitals which were listed as being neither spontaneous nor induced. Finally, a group whose numbers are diminishing are the women who obtain illegal abortions in Canada.

The general pathways which are taken by women who have unwanted pregnancies are: (1) women who are referred directly for abortions in Canadian hospitals; (2) women who turn, or who are referred, to community resources for counsel who may subsequently get an abortion in Canada, go to the United States for this procedure, or may carry their pregnancy to term; (3) women who turn to college and university health services; (4) women who go directly to the United States for an abortion; and (5) women who carry to term and who may turn for assistance to maternity homes and welfare services. The several sources of information about the work of agencies for pregnancy counselling and abortion referral were drawn from the national offices of major voluntary associations, and inquiries sent to a large number of provincial associations and independent groups. The actual work in the field of family planning and abortion counselling of the agencies which were contacted was unknown prior to this survey, and in this sense, the results which were obtained are not a sample. Out of a total of 1,005 agencies which were contacted, 483 or 48.1 percent, returned completed questionnaires.

Agencies Contacted	Information Requested	Replies	Percent Return
Public health departments	254	137	53.9
Child welfare agencies	242	84	34.7
Community agencies	125	42	33.6
Planned Parenthood	76	38	50.0
Séréna	49	18	36.7
College and university health services	211	134	63.5
Commercial agencies	13	2	15.4
Maternity homes	35	28	80.0
TOTAL	1,005	483	48.1

In considering the different routes taken by pregnant women, either seeking an abortion or going to term, information was obtained in the context of two Terms of Reference set for the Committee which stipulated: what is "the timeliness with which this procedure makes an abortion available in light of what is desirable for the safety of the applicant"; and whether applicants for abortion were "being discouraged from obtaining legal abortions in Canada because delays in obtaining medical examinations, decisions by therapeutic abortion committees, and termination of pregnancies where approval has been given, increase the risks to a point which applicants find unacceptable."

Pathway one: Abortion in Canadian hospitals

When a woman recognizes that she may be pregnant, and if she decides to seek an abortion, several factors may influence when the abortion operation is done. These factors are: (1) a woman's social circumstances and how she feels about the issue of abortion; (2) the individuals and agencies to which she may turn for assistance and the nature of the counsel which is given; and (3) the use of health services involving the decisions of physicians, the location of hospitals with committees, and what steps are taken by physicians in the review of abortion applications. These factors do not operate apart. Each to a greater or lesser extent has implications for the length of time which is involved between when a woman decides she wants to terminate her pregnancy and the speed with which this operation is done. The information drawn upon here was taken from the experience of 4,754 women getting an induced abortion who participated in the 1976 national patient survey.

Most of the women in the national patient survey said that their menstrual cycles either were usually (12.4 percent) or always (79.6 percent) regular. While little is known about the accuracy of the timing of missed menstrual periods or the speed with which delayed menses are recognized, 87.8 percent of the abortion patients in the national patient survey suspected they were pregnant before their second missed menstrual period. Some of these women experienced other symptoms associated with pregnancy such as nausea and swollen breasts.

After conception occurred, most of these patients (79.5 percent) initially discussed this fact with members of their families and their close friends. About 1 out of 5 patients (18.5 percent) spoke first about their pregnancy to a physician. Only a handful (2.0 percent) immediately sought out a community agency. Two major resources were used to confirm that conception had occurred. About 3 out of 5 women (59.0 percent) contacted a physician; most of the rest (40.5 percent) had a pregnancy test done either at a drugstore or a clinic. In the course of seeking advice some women (19.5 percent) subsequently turned to one or more community agencies or social service consultants for assistance. Among this group about 1 out of 10 (9.7 percent) met with the staff of two or more agencies.

The average length of time was 2.8 weeks from when a woman realized she was pregnant to when she consulted a physician. Almost 2 out of 5 women

(38.8 percent) said they had seen a physician within the first week of suspecting that they were pregnant; another quarter (26.0 percent) had done so within two weeks. Overall, 2 out of 3 women (64.8 percent) said they had seen a physician within the first two weeks of when they became pregnant, 1 out of 5 (21.2 percent) between 3 to 4 weeks and 1 out of 7 women (14.0 percent) took five weeks or longer to make an appointment with a physician. About half of the patients (52.4 percent) consulted their usual family doctor, a step which was more often followed by married women (61.4 percent) than single females (47.8 percent). Three other sources of medical care were turned to about equally, with 17.0 percent of the patients having first consulted a medical staff member of a hospital or a community clinic, 16.4 percent an obstetrician-gynecologist, and 13.4 percent another family physician who was not their usual practitioner.

The reason most frequently cited by women why they had not seen a physician sooner about their pregnancy was that they had not realized they had been pregnant (35.9 percent). This reason for many of these women may have been a rationalization for why they had delayed consulting a physician or a rejection of the fact of pregnancy itself, for over 9 out of 10 (93.9 percent) women said they suspected they were pregnant within six weeks of the time of conception.² All other reasons were less often given. About 1 out of 10 patients (11.2 percent) were uncertain during this initial period of their pregnancy whether they wanted to have an abortion and 1 out of 12 women (8.3 percent) had initially been afraid to go through with having an abortion. Relatively few women, about 1 out of 20, attributed part of the delay to obtaining the results of their pregnancy tests (6.3 percent). Women seeking an abortion on an average saw two physicians (2.08 per patient) prior to their operation. Among the patients in the national survey, 16.5 percent said they had seen three physicians, 3.9 percent four physicians, and 1.1 percent had seen five or more physicians. Two patients had seen eight physicians.

On an average women took 2.8 weeks after they first suspected they had become pregnant to visit a physician. After this contact had been made there was an average interval of 8.0 weeks until the induced abortion operation was done. The average reported time of 10.8 weeks was somewhat larger than the actual indicated length of gestation at the time of the abortion operation which was 10.0 weeks for the average woman among the 4,754 patients. The average length of time after a physician had been contacted prior to the operation varied across the country and by the social circumstances of women. This average interval involved only those women who had the abortion operation done in a Canadian hospital. It does not take into account what happened to women who went to the United States for this purpose or the experience of women who decided to go to term.

The shortest average interval between the initial contact with a physician and when the abortion operation was done was among women in Quebec where 1 out of 5 patients (18.3 percent) had the operation done within three weeks.

² The proportion of women who suspected they were pregnant by the number of weeks their period was overdue was: 35.7 percent, one week; 30.5 percent, two weeks; 9.8 percent, three weeks; 11.8 percent, four weeks; 3.0 percent, five weeks; 3.1 percent, six weeks; and 6.1 percent seven weeks and over.

This shorter interval for women in Quebec contrasted with other regions where between 3.7 percent to 6.4 percent of the women in the national patient survey had their abortions done within three weeks of their initial consultation with a physician. In keeping with this finding, relatively fewer women in Quebec in the national patient survey waited eight weeks or longer for this surgical procedure than women elsewhere in the country. While 1 out of 4 abortion patients in Quebec (23.0 percent) were in this longer time category (eight weeks or longer after an initial contact with a physician), on an average 2 out of 5 women in Ontario and the western provinces waited this length of time (between 41.9 and 43.8 percent of patients) and in the Maritimes this proportion rose to 3 out of 5 women (62.9 percent).

The average amount of time between when a woman first contacted a physician and when the abortion operation was done for the 4,754 women at 24 hospitals in eight provinces was directly related to their experience with seeking medical services and how hospital services were organized in different regions. This interval of time increased on an average by one week for each additional physician whom a woman contacted. Women who consulted one physician prior to when the final arrangements were made for the abortion operation waited on an average of between 6 to 7 weeks, while patients who had seen three or more physicians spent between 9 to 10 weeks until the operation was done. Other aspects of how health services were organized also directly influenced the length of the interval between an initial contact with a physician and when the abortion operation was done. These factors included: difficulties which women had had in getting an appointment at a hospital (11.1 percent); consulting a physician who chose not to make a referral either to another physician or to a hospital (5.2 percent); receiving no assistance from a hospital clinic, a medical practice clinic or a community clinic (0.9 percent); or not having an application for the procedure approved by a hospital therapeutic abortion committee (1.2 percent). Overall, about 1 out of 5 women (18.4 percent) in the national patient survey experienced one or more of these factors which served to lengthen their pregnancies prior to when the abortion operation was performed.

The average length of gestation of the women in the national patient survey when the abortion operation was done was 10.0 weeks. The length of gestation in terms of weeks for these patients was 38.8 percent, eight weeks or less; 45.3 percent, 9 to 12 weeks; 5.4 percent, 13 to 15 weeks; 9.9 percent, 16 to 19 weeks; and 0.5 percent, 20 weeks and longer. About two-thirds (65.0 percent) of the patients in Quebec had a gestation of seven weeks or less when they had their abortion operations. The average length of gestation of patients in other regions was between 10.1 and 11.2 weeks. In Quebec and British Columbia 7.7 percent and 7.0 percent respectively of the abortion patients had abortions when their length of gestation was 16 weeks and longer. In Ontario the proportion of patients in this category was 10.3 percent, while it was 14.9 percent among women in the Prairies and 20.8 percent in the Maritimes.

The average length of gestation among the abortion patients varied by their age, their marital status and their level of education. Regardless of what part of Canada they lived in about 1 out of 20 married women (5.5

percent) had a length of gestation of 16 weeks or more at the time of their abortion operation. The experience for single women and women who were separated from their spouses was double this level, with respectively 12.4 percent and 12.7 percent having this length of gestation at the time of the abortion operation.

There were consistent trends across the country when the abortion operation was done by the age of women and their length of gestation. In general, more older patients had a shorter length of gestation while most younger women had been pregnant longer prior to the abortion procedure. In British Columbia for instance which reflected the national trend, 17.9 percent of abortion patients 17 years and younger had their abortions at or before eight weeks of gestation and among this age group 14.7 percent had been pregnant 16 weeks or longer when the operation was done. In contrast, among patients who were 35 years or older in that province, 2 out of 5 (43.1 percent) had been pregnant eight weeks or less and there were none who had the abortion operation done who were 16 weeks or longer in their length of gestation. Similar trends occurred in all other regions. In Ontario, 17.7 percent of the women who were 17 years and younger and 47.9 percent of women who were 35 years and older had their induced abortions done at or before eight weeks of pregnancy. One out of five of these younger women in Ontario (22.6 percent), but only 1 out of 20 of the older women (4.3 percent) had abortions done when they had been pregnant 16 weeks or longer.

As with the effects of age and where women lived, their level of education was also related to when the abortion operation was done. Over half of the women who had been to college or university (52.4 percent) had their pregnancies terminated within eight weeks of the time of conception, while only a third (32.0 percent) of women who had grade 10 schooling or less were in this category. In contrast, five times as many women with less education (15.9 percent) than women who had been to college or university (3.0 percent) had their pregnancies terminated at 16 weeks or longer in their length of gestation. These trends occurred consistently across the country.

When only those patients who had abortions when they had been pregnant 16 weeks or longer are considered, many of these patients (10.4 percent), had had the abortion operation delayed because of difficulties which they had had with finding medical services which would have facilitated their requests for induced abortion. **Among women who had been pregnant 16 weeks or longer when they had an induced abortion, 1 out of 5 of these women said there was no therapeutic abortion committee at the hospital in the community where they lived. Among the small group of women who had induced abortions whose previous applications had not been approved by a hospital therapeutic abortion committee, 1 out of 4 (27.9 percent) had been pregnant for 16 weeks or longer. While 5.2 percent of patients said the physician whom they initially contacted did not refer them to another physician, 1 out of 5 of these patients (19.0 percent) subsequently had abortions when they had been pregnant for 16 weeks or longer. Among the 1 out of 10 patients (11.1 percent) who had had difficulties in arranging a hospital appointment, 1 out of 5 (20.0 percent) subsequently had an induced abortion when they had been pregnant 16 weeks or longer.**

There were two groups of patients among the women who had induced abortions when they had been pregnant for 16 weeks or longer. The first group had seen a physician at least eight weeks before the abortion operation was done. **Three out of four of the women (75.7 percent) who had an induced abortion done between 13 to 15 weeks of gestation had initially consulted a physician at least eight weeks earlier. An equal proportion (76.7 percent) of women who had their abortions when they had been pregnant 16 weeks or longer had also seen a physician some two months prior to the abortion operation.** These women who had a longer length of gestation when they had induced abortions had been seen by physicians in ample time to have had this operation done considerably earlier in their pregnancies. **The average interval of eight weeks resulted from direct delays in how physicians and hospitals handled these patients.**

The second group of women (21.3 percent) who had been pregnant for 16 weeks or longer when they had their induced abortions had waited on an average for eight weeks or more before they had contacted a physician about their pregnancy. The applications submitted on their behalf by physicians to hospital therapeutic abortion committees were processed more rapidly than was the case for the larger group of women who had contacted physicians earlier in their pregnancies. Among the women who had not seen a physician until eight weeks after they became pregnant, and who were between 13 to 15 weeks in length of gestation, most had an induced abortion within five weeks.

Most of the women in the national patient survey (84.1 percent) had an induced abortion done when they had been pregnant for 12 weeks or less. A majority of these women spent some 6 to 8 weeks after they had first contacted a physician before the abortion operation was done. Making an early contact with physicians had not facilitated or speeded up the scheduling of the abortion operation for these patients. Coupled with this delay experienced by most induced abortion patients was the fact that the women who themselves delayed longer than the average patient in consulting a physician obtained an induced abortion faster than the majority of all patients. In these respects the health system responded faster to what was seen as a crisis situation for women who had delayed seeking medical assistance, but in the process of doing this, the needs of those women which were seen to be less immediately threatening were set aside with the accumulative level of the risk of health complications being increased for these patients.

The amount of time taken to get an induced abortion and its relation to the length of a woman's pregnancy was looked at by a different means of analysis, the statistical method of multiple regression. In this analysis the three main contributing factors which were reviewed were: (1) a woman's social circumstances; (2) the persons or agencies which she had consulted; and (3) the provision of health services in terms of the number of physicians who were seen, the length of time which was taken for medical referrals, and the amount of time which elapsed between the initial contact with a physician and when the abortion operation was performed. This analysis dealt with the question of what accounted for the different lengths of pregnancy of women getting an induced abortion. Put differently, what speeded up or what delayed the

obtaining of this operation? Items which accounted for less than 1 percent of the differences were dropped from the regression equation as having too little statistical significance³.

What the multiple regression procedure did was to eliminate the relationship between several events which were associated with each other, such as a patient's age, her marital status, or her level of education. For young women for instance it would be expected that fewer would be married and have somewhat less education than older women. While each of these factors may be related to the length of a woman's pregnancy, they are also closely related to each other. The analysis considered the extent to which all of these factors were related to the length of a woman's pregnancy.

Three events (how much time was taken by a woman to consult a physician, how many physicians she consulted, and the length of time from the initial medical consultation to the abortion operation) accounted for 73.5 percent of the differences in the length of the pregnancies of the women in the national patient survey. While with the information which was available, it was not possible in the regression analysis to account for about a quarter (26.5 percent) of the factors associated with the length of gestation, it is unusual in considering what people do to be able to explain or to account for such a large proportion of what happened.

The decisions which patients made—their fears about abortion, their recognition that they were pregnant, and how long it took them to reach these decisions accounted for 12.3 percent of the delay. The actual time it took to reach a decision was an important factor itself, one which was little influenced by a woman's age, her family circumstances, her religion, her primary language, or where she lived. For the patients in the national patient survey, none of these other aspects of a woman's circumstances as well as the advice given by her family or the counsel which she received from community agencies speeded up or delayed the sequence of obtaining an abortion. These factors undoubtedly influenced the experience of some of these women, but in the aggregate, if the experience of all of the women in the national patient survey is considered, they had a negligible effect. The most significant factor which accounted for women having an abortion earlier or later in their pregnancies resulted from the decisions taken by physicians once these patients had contacted them to request an abortion. Medical decisions and the amount of time which was taken to process and review abortion applications accounted for 61.2 percent of the differences in the length of the patients' pregnancies. When these decisions were promptly made and the requirements of the therapeutic abortion committees were more speedily met, the length of gestation was substantially lower. Where more time was involved in these steps between a woman's initial contact with a physician and the approval of an application, the length of gestation increased.

In considering these results it is relevant to remember that they represented the experience of 4,754 women who obtained abortions in accessible

³ Appendix 1, Statistical Notes and Tables. See Note 1.

Canadian hospitals in 1976. These findings did not include the experience of women who tried but did not get abortions, who went abroad for an abortion, or who decided to go to term. While many physicians and nurses have voiced their deep concern about abortion patients who obtain this operation when their pregnancy is more advanced and they attribute this delay to the socially irresponsible behaviour of women seeking induced abortions, the findings are unmistakable and clear. This is not the case for most of these women who had induced abortions. In an almost self-fulfilling prophecy, because there is so much stigma involved with induced abortion and because so many physicians see this procedure with considerable distaste while others wish no part of the abortion procedure, it is these factors that account for most of the delay experienced by women who had induced abortions when they had been pregnant for 16 weeks or longer.

Going beyond who a woman was, where she lived, or with whom she had spoken or consulted, it was medical decisions, not decisions made by patients, which made the most substantial difference in how long it took these patients to get an induced abortion and which extended the length of their pregnancies. The reasons for this delay are rooted in the diversity of views held by physicians about abortion and the amount of time which was taken to meet the various requirements set by hospital therapeutic abortion committees. If medical decisions had been more promptly made for these patients, if on an average they had seen fewer physicians, and if the time taken in the submitting and the processing of abortion applications had been shortened, most of these abortion operations could have been performed earlier and at less risk for these patients.

Pathway two: Community agencies

Approximately 1 out of 5 women in the national patient survey had contacted one of a number of community agencies about their pregnancies. This step accounted for less than 1 percent of the difference in the length of gestation of all of these patients, or in other words, for most of the patients in the survey, this step neither speeded up nor delayed their obtaining an induced abortion in a Canadian hospital. But these community agencies served a broader group of women, some of whom were advised to go to the United States to obtain an abortion, while others subsequently bore children.

The most frequently used source turned to by 1 out of 14 patients in the national patient survey (7.1 percent) were the branches of the Planned Parenthood Federation of Canada. This resource was used somewhat more by single women or women who had been previously married than by married women. The next most frequently used counselling service which had been used by the abortion patients were the various abortion referral agencies whose distribution was limited primarily to Quebec and Ontario. These agencies, used by 1 out of 15 patients (6.5 percent), drew more of their clients from among women who had a college or university education than from women with an elementary school training. The remaining sources of counsel were turned to by

only a handful of the patients, with 4.0 percent turning to general social service agencies; 2.5 percent to school nurses or counsellors; 0.9 percent to Birthright; and 0.5 percent to a religious leader such as a priest, a rabbi, or a minister. What emerges from these findings is that most of the women who decided to have an abortion in Canada did not turn to any of these community resources, but they made their decisions to obtain this operation either by themselves or through discussion with their families and friends. While the contacts made by the patients with community agencies provided some assistance, they served an "expediting" function, that of routing patients to hospitals, advising them on the selection of physicians who should be consulted about an abortion, or recommending that they go to the United States for this purpose. The type of counselling which was provided is illustrated by the experiences of women using these services—some of whom were well satisfied, while others left feeling they had not been fully or well advised.

I was taken to a private room at the back of the offices where I was interviewed by a counsellor. I advised the counsellor that I was frightened and upset as I thought I was pregnant. The counsellor asked me whether I had had a pregnancy test. When I told her I had not, she suggested that I could go to a drugstore, the _____ Clinic (which she advised me was free), or to a doctor. She suggested I should go the next day, but from the description of my symptoms she stated that she thought that I was very likely pregnant.

The counsellor asked me what I planned to do, and I replied that I did not know and that I was confused and scared. She told me that I could: (1) keep the baby, or, (2) have an abortion. I told the counsellor that I knew nothing about abortion and she then proceeded to describe what she called the two basic kinds of abortion:

- (a) D & C—the counsellor referred to this as "dusting and cleaning", and emphasized it was a very simple and commonly used procedure in which the womb was scraped and that there would be no serious repercussions to me.
- (b) Saline abortion—which is the injection of a salt solution into the fluid surrounding the baby. She stated that she would not advise this type of abortion because it was like an actual birth, as one goes into contractions, i.e., labour, but the baby is born dead and the hospital stay is longer.

The counsellor urged that I shouldn't leave it too long, and that if I decided to have an abortion, I should do so very soon—before I was three months pregnant. She further advised me that I would have no problem in getting an abortion in _____ since all major hospitals, except the Catholic ones, performed abortions.

I was also advised that if I went to _____ hospital, they would not use the word "abortion" on my chart, but would use the word "family planning", since she stated that abortion means "planning a family". She also stated that she thought that the _____ hospital does about twelve abortions every two weeks, and that I would be placed in the gynaecology wing and that no one would know me there.

The counsellor then proceeded to fill in a questionnaire in which she recorded my birth date, address, religion, income bracket, education, profession, and type of birth control I had used.

The counsellor next explained the female anatomy and the various methods of birth control—she mentioned specifically the I.U.D., foam, jelly, condom, and the diaphragm. She showed me a chart of the female anatomy and what birth control devices looked like. I found her explanation to be somewhat less than clear. Before I left the premises, the counsellor gave me some pamphlets on birth control.

. . .

I advised the counsellor that I thought I was pregnant and wanted to talk the matter over with someone. The counsellor advised me that I could: (1) keep the baby; (2) have an abortion, and that she could not tell me what to do. I then asked the counsellor what was involved in an abortion and she stated that it was an easy operation and would only take five minutes and that, statistically speaking, it was safer than childbirth. She further stated that it was as easy as having tonsils or an appendix removed, and that my only complication might be feeling "blue" for a few days afterwards. She also stated that abortion was legal and that I did not have to feel guilty about it.

The counsellor advised me that I could either have an abortion at _____ or, at _____ in _____ where I would have to stay overnight. Or, I could go to the _____ in the United States, which she advised me would be preferable in my case since it was faster and I could be in and out in a day.

The counsellor then advised me that if I chose to have an abortion in _____ that the therapeutic abortion committees, in the aforementioned hospitals, were merely a formality and that I could obtain an abortion at _____ in three weeks or less, but at _____ it would take longer since the latter was very busy since it was doing the bulk of the abortions in _____. I then discussed with the counsellor the question of _____ paying for the abortion and my husband finding out about the abortion. She advised me that if I had a tubal ligation performed at the same time as the abortion, the doctor would then not have to record my abortion as such, but that the _____ computer would register the abortion as a sterilization, with the result that my husband would not have to know about my abortion.

The counsellor, then, for a period of approximately 5 to 7 minutes, discussed birth control with me. She described the pill, I.U.D., diaphragm and foam. She also showed me a plastic model of the female anatomy and indicated to me how the birth control devices were used.

The counsellor then completed a form in which she recorded my name, birth date, doctor's name, income, religion, education, place of employment, and type of birth control I had been using.

The counsellor also gave me a list of doctors' names and their addresses. Apart from the time spent discussing birth control and completing the above mentioned form, the entire interview was directed to the discussion of abortion. I was never counselled about the possibility of keeping the child and no other alternative, except abortion, was discussed with me.

The services of the referral agencies were provided in most instances without charge to the women who sought them out. In the national patient survey, women who obtained abortions were asked if they had paid fees for the assistance which they had been given by community services. While most had not been charged for this assistance, 1 out of 10 women (10.7 percent) had paid

for these services, a factor which contributed to the overall expense of obtaining an abortion. Among a group of four agencies (community agencies, Planned Parenthood, Séréna, and commercial agencies), most (79.0 percent) distributed pamphlets to make their services known to the public. A second means of publicizing an agency's services was through listings in telephone directories. Three out of four (73.0 percent) agencies were listed, usually under the heading of family planning, contraception information, birth control, as well as the actual title of the agency. The heading of birth control services is sometimes given in the yellow pages of telephone directories. Advertising in newspapers and public places, such as public transit, was done by half (50.0 percent) of the community agencies. The Planned Parenthood Federation of Canada through a national birth control advertising campaign used this form of publicity. Advertisements in the personal columns of newspapers were widely used by Séréna (82.3 percent) and the commercial agencies. Commercial agencies usually paid for larger advertisements which listed their services. Public meetings including television and radio guest appearances were used by 61.2 percent of the agencies.

Many of the agencies directly contacted other community services to make known their availability and the types of services which they offered. Two-thirds (64.8 percent) of the Planned Parenthood groups, many of the Séréna groups (58.8 percent), and approximately half of the community agencies (42.5 percent) had contacts with other community resources. Additional resources most frequently contacted were social and family service agencies. Of these agencies, 51.0 percent had contacts with social agencies, while 39.0 percent had regular contacts with health agencies including family planning clinics and public health agencies. Other community resources including ministers, churches, Birthright, Children's Aid societies were routinely contacted by 29.0 percent of the agencies.

These centres were asked what difficulties had been encountered by the women seeking abortions who had used their services. Among the 214 agencies the problems listed were: 82.2 percent, length of gestation set by the hospitals; 75.0 percent, consent of minors or spouses; 73.9 percent, requirements set by hospital therapeutic abortion committees; 68.1 percent, the financial difficulties of women; 64.3 percent, obtaining an appointment with a physician or involving the advice given by a physician; and 57.8 percent, the distance travelled by the women seeking an abortion.

In our province many women live in rural areas where they are isolated from access to the therapeutic abortion committee or in many cases isolated from information. Even in 1975 women still called asking if abortion is legal.

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Hospital _____ in our city treats all therapeutic abortion applications as emergencies, but this is just not the case in the other hospitals. For example, Hospital _____ requires all patients to consult a psychiatrist prior to making application.

. . .

In this province the abortion law is not operating. Only a minute minority of hospitals have set up therapeutic abortion committees. Actually, no such

committee has been set up outside of _____. And in City _____ itself, only one hospital performs a sizeable number of abortions.

. . .

Over the last year we have had two instances of local M.D.s telling clients some pretty gross misinformation about abortions. One M.D. told a patient that she would bleed to death if she had an abortion. Another M.D. told a patient that she would be sterile if she had an abortion.

. . .

Women do not even know what the legal procedures are or how involved they are. Learning about the red tape and following along it is one more difficulty for a woman with already more difficulties than she can handle.

. . .

The _____ Hospital has placed geographic and residency restrictions on therapeutic abortion cases. This has put a great hardship on women in the south of the province as the committees in _____ have always been extremely harsh in their judgments. Many _____ women have found it necessary to give a false residence and apply through the _____ committee or to fly to the United States after having spent prior time unsuccessfully applying to the _____ committee.

. . .

Our follow-up on abortions shows that in general women who have abortions are placed on the maternity ward and that they are treated unsympathetically, if not downright ignored by nursing and service staff.

. . .

We have found that in general, M.D.s are reluctant to discuss abortion as an alternative to unplanned/unwanted pregnancy, either because of moral stance or lack of time.

. . .

Quite a few of the social agencies and doctors we have talked with are very concerned about the "backlash" they are expecting from hospitals in _____. That hospital is starting to resent being called an "abortion mill", and rightfully so. The hospital committee in _____ is, at best, a hit and miss effort, depending on the personal beliefs of whatever doctors happen to be on the committee in any three month period. As all doctors are required to serve at one time or another, it is conceivable to have a couple of anti-abortionist doctors serving together, thereby allowing no abortions for a three month period. _____ doctors don't use _____ Hospital.

. . .

We have learned directly of one doctor in particular in this province who forced his abortion patients to sign sterilization papers, or no abortion.

. . .

We have found women who come in for an abortion past 12 weeks are invariably from out-of-town, particularly from _____. Several

of these women have talked about the difficulty getting an abortion in that city, i.e., doctor will not refer, doctor refers to another doctor who will not perform the abortion, doctor charges \$250 for a D&C (although this is covered by _____).

. . .

This Hospital has geographical limits and out-of-town women must lie about their address to be considered by the therapeutic abortion committee. There is only one doctor that I am aware of, that does abortion past 12 weeks . . . he will perform prostaglandin abortions.

The 214 agencies which variously provided for pregnancy and abortion counselling (125 community agencies, 76 Planned Parenthood, and 13 commercial agencies) were located in 86 cities across Canada.

TABLE 7.1
POPULATION SERVED BY COMMUNITY RESOURCES
FOR PREGNANCY COUNSELLING AND ABORTION REFERRAL*

COMMUNITY AGENCY SURVEY

Province	Number of Resources	Number of Communities Served	Proportion of Population Served* percent
Newfoundland	8	4	20.2
Prince Edward Island	1	1	17.1
Nova Scotia	7	4	31.0
New Brunswick	12	10	33.1
Quebec	32	11	52.5
Ontario	62	24	60.4
Manitoba	15	2	57.3
Saskatchewan	18	9	40.6
Alberta	13	3	54.2
British Columbia	38	15	55.9
Yukon	5	1	61.0
Northwest Territories	3	2	25.3
CANADA	214	86	53.2

* Based on the size of the communities in which the agencies were located; 84.3 percent of the individuals who were served came from within a radius of 20 miles. These resources were located in communities which made up 53.2 percent of the population and their distribution varied from province to province. The proportion of the Canadian population that had immediate access to these agencies was the highest in Ontario. It was below the national average in the Maritimes. There were 62 agencies in 24 Ontario communities serving 60.4 percent of that province's population. In New Brunswick, 12 agencies in 11 communities reached an estimated 33.1 percent of the population. Seven of these agencies in four communities in Nova Scotia served 31.0 percent of its population. In Prince Edward Island, an agency operated in one city which had 17.1 percent of the province's population. Newfoundland had eight community agencies in four cities which totalled 20.2 percent of its population. The proportion of the population in the western provinces which had immediate access to these agencies for abortion counselling and referral varied little from the national average. In British Columbia, 55.9 percent of the population had access to 38 resources in 15 centres. In Alberta, 13 programs operated in three cities which had 54.2 percent of the population. With 18 agencies in nine cities, 40.6 percent of Saskatchewan's population had immediate access to these agencies.

The majority of the community agencies were located in large cities where hospitals had established therapeutic abortion committees, while their distribution was negligible in cities where no abortions were done by local hospitals, except in Quebec where most therapeutic abortions were done in two cities and the agencies were located in 11 centres. As a rule counselling and referral agencies served their local community first. On the average 84.3 percent of their clientele came from within 20 miles, while the remainder (15.7 percent) came from smaller towns in the immediate vicinity. There were no significant provincial variations in this respect. Only one agency in Saskatchewan and four in Quebec reported there was a trend involving more women coming from other large centres.

When the profile of the women who were served by these agencies is seen from the perspective of the full range of their clients, a somewhat comparable trend emerges which is similar to the experience of the women in the national patient survey. Among the women who had contacted an agency in 1975, 63.8 percent were single and most were young women; 72.9 percent of the women seen by the agencies were under 25 years, and 1.2 percent were under 15 years. Two out of five (38.8 percent) were between 15 and 19 years; 32.9 percent, between 20 and 24 years; and 27.1 percent were 25 years and older.

Among the community referral agencies surveyed by the Committee, 45 agencies had referred a total of 4,700 women to Canadian hospitals in 1975. This group included some of the larger referral agencies which accounted for two-thirds of the abortion referrals to Canadian hospitals. These agencies may have made an estimated total of 7,500 referrals for abortion in 1975 to Canadian hospitals. Among the agencies which provided family planning information, 83.7 percent routinely referred women to hospitals in the communities where they were located. The level of contact between community agencies and local resources for abortion was the same across Canada, except in Quebec and Saskatchewan where the rates were slightly lower. In Quebec 62.5 percent of the agencies had contacts with local resources and among the agencies in Saskatchewan, 66.7 percent referred women to local hospitals. Among all of these agencies, 47.8 percent had no contact with hospitals in other areas, while 52.2 percent dealt occasionally with out-of-town physicians or hospitals.

Most of the community agencies (66.1 percent) at least occasionally referred women to out-of-country abortion facilities. Compared to the national average, fewer agencies in the western provinces, where the reported rates of therapeutic abortions were higher, followed this procedure. In comparison, community agencies in Ontario, Quebec and the Maritimes more often referred women to clinics in the United States. In British Columbia 55.5 percent of the agencies which were surveyed directed clients to clinics in the United States, and this was done by 40.0 percent of the agencies in Alberta, 37.5 percent of the agencies in Saskatchewan, and 40.0 percent of the agencies in Manitoba. In Ontario, 82.4 percent of the agencies referred women across the border, as did a similarly high proportion of all of the agencies in Quebec and the Maritimes.

Pathway three: Student health services

About 1 out of 5 Canadians between the ages of 18 and 24 years are students in post-secondary institutions and about 40.0 percent of this number are women who are studying at colleges or universities. The student health services of 211 post-secondary institutions (56 universities and 155 community colleges) were surveyed, with replies being received from 75.0 percent of the university health services and from 59.3 percent of the community colleges. While most academic institutions had standard health services, 12 of the colleges and universities in British Columbia, Alberta, Saskatchewan, Manitoba, Ontario and Newfoundland had one or more additional clinical or counselling services for female students administered by students' councils.

The majority of the student health services (86.5 percent) operated during regular office hours. A few (11.6 percent) could be reached in the evening, and the remainder were available on a part-time basis. Their services included: 82.8 percent, pregnancy counselling; and 80.6 percent, abortion referral. Among the health services which were reported to be inadequate were: 44.4 percent, abortion facilities; 27.8 percent, pregnancy counselling; 22.2 percent, sexual and contraceptive information; and 5.5 percent, abortion counselling. The majority of the schools (76.4 percent) suggested that such services should be paid for by government. Approximately one-fifth (28.6 percent) felt that these services were best provided by trained volunteer counsellors in a family planning centre. Three out of four of the colleges and universities had made some abortion referrals during 1975. Most of these referrals were made by student health services in 26 large universities in British Columbia, Alberta, Ontario, and Quebec, and community colleges in two metropolitan centres. These schools accounted for 78.0 percent of all referrals for abortion in Canada reported by student health services. The results of the national patient survey found that a minority (7.4 percent) of the students who had an induced abortion in Canadian hospitals had gone to these health services and twice as many (16.7 percent) had contacted a community referral agency. The majority had directly contacted a physician.

Among the students who said they had seen a college or university counsellor about their pregnancy, the largest group was between 20 and 24 years (54.9 percent), followed by students between 18 and 19 years (37.3 percent). Students over age 25 were the group which least used these services (7.8 percent). The reluctance of students to use student health services for abortion counselling and referral stems from a concern to preserve their privacy and from fear that their academic standing may be affected. In particular, students attending small institutions may prefer to discuss their pregnancy elsewhere. For students attending larger institutions, the health services of these universities may be one of a number of sources of referral for abortion which are available.

It is my impression that fewer students are using university resources in the last two years. In that time period, community resources have become more numerous and more visible.

In 1975 I received approximately 15 requests for information about abortion facilities. I know and hear of many students who have taken action on their own. It is very difficult to assess the numbers of women at this university who have sought an abortion from just official reports.

• • •

My experience has been that a community referral agency in our city does an excellent job. I know that there are less reputable referral sources that the students use. I often hear about their experiences 6 or 8 months after the fact. That is why I believe it is extremely important that abortion be readily obtainable. One of the major difficulties I have with students is their concern over parental reactions. Because of this, they sometimes refuse to use a hospital in our province, because of fears with billing and therefore possible information to their parents.

The majority of the student health services (76.0 percent) handled requests for abortion on a local basis. The remainder (24.0 percent) directed requests to out-of-town hospitals or to abortion facilities in the United States. The proportion of institutions sending students outside of their communities for an induced abortion was lower than average in the western provinces and Ontario. It rose in Quebec and New Brunswick, where over half of the institutions surveyed used facilities which were not located in their own communities. A majority of the health services of colleges and universities knew of the activities of community referral agencies in their own communities or in their region. One out of ten (9.7 percent) referred students to such agencies for abortion counselling or referral.

Based on the findings of the national patient survey, many students who had contacted their health services felt they had been given practical information about abortion or they had been sent to a physician who would refer their request to a hospital with a therapeutic abortion committee (55.8 percent). For 16.2 percent of the students, arrangements had been made at a hospital by the student health services. Approximately 1 out of 7 of the students were referred to a community agency for counselling and referral.

Approximately 2 out of 3 academic health services (66.2 percent) mentioned the length of gestation and the requirements set by hospital therapeutic abortion committees as problems which they routinely encountered. Over half (58.1 percent) of the referring health services said there were financial problems for the students seeking an induced abortion. Two out of five of the institutions complained about the distribution of resources for abortion (41.8 percent) or their lack of availability (40.5 percent), although some of these universities were affiliated with teaching hospitals which did a sizeable proportion of all abortions which were performed each year. The need for consent from a husband or a parent ranked lowest in the listing of difficulties which were cited, with 39.4 percent of the academic institutions reporting it caused problems when abortion referrals were made.

Pathway four: To the United States

Two-thirds (66.1 percent) of the community agencies surveyed by the Committee had advised some of their clients to get an abortion in the United States. Community agencies recommended this course to women if: (1) they felt their pregnancy exceeded the gestation limits of local Canadian hospitals (77.8 percent); (2) their application had been refused by a therapeutic abortion committee (75.8 percent); and (3) they did not want to be identified by staff or other patients in a hospital (71.4 percent). Other reasons which were less often cited for these out-of-country referrals were: 67.6 percent, faster procedure and close to the United States; 53.3 percent, problems of consent; 53.1 percent, repeat abortion; 47.1 percent, difficulty in obtaining a medical appointment; 40.0 percent, financial difficulties; and 39.4 percent, no therapeutic abortion committee established at local hospitals.

Those women who go by referral from us do so because:

- (a) they have already had an abortion and are afraid to apply again.
- (b) they have enough money and prefer to avoid the time and inconvenience involved in seeing three doctors and awaiting a Committee decision.

. . .

It is impossible for one hospital in a province to handle the total number of requests. A great number of women in our province are forced to seek abortions in the U.S. This is costly and excludes the women under a certain income.

. . .

Women who choose not to submit to the humiliation and red tape, and who have funds, often opt for a clinic in the United States. Women who were turned down by the therapeutic abortion committee here and who could afford to do so travelled to the United States. Total cost for air fare, lodging and medical fees was over \$300 and could amount to \$1000 in the case of saline termination requiring hospital stay.

. . .

Since _____ abortions are only \$75, it often makes sense for women who will have to pay at least \$50 in our city to go to the U.S. where it is done without waiting and red tape.

. . .

It is much easier on the woman concerned to go to the States which is probably why the law exists the way it is anyway. Statistics don't look so bad for Canada that way. However, that discriminates against women who cannot afford an abortion outside of Canada.

. . .

There are occasions when a patient cannot book an appointment for nearly a month because the nurse states that the doctor is too busy. Of course, the chances of the client receiving safe, early abortion then are practically zero,

and our agency has no choice but to refer the woman to a clinic in the United States. We have been experiencing these kinds of difficulties for several years but the hospitals do not appear to have any particular desire to change their procedures to lessen the time for an abortion.

• • •

When a woman is too far advanced to go through the long process of having all the tests and filling in all the forms to be done here before she passes the time limit, we give her several referrals in the U.S. from which to choose.

• • •

One problem we face constantly is that almost all doctors in our city doing abortions overbill the woman anywhere from \$50 to \$200 cash on top of medical coverage. This delays abortions, takes time and causes more risk to the woman. We have only one doctor who does not participate in this extortion.

Although to a lesser extent than community referral agencies, the health services of colleges and universities also used out-of-country abortion facilities. The circumstances when student health services referred students to the United States included: 47.5 percent, non-approval for abortion by a therapeutic abortion committee; 46.2 percent, the preservation of anonymity; 43.6 percent, difficulty in obtaining a medical appointment; 40.7 percent, length of gestation; 40.0 percent, faster procedure and close to the United States; 29.1 percent, no local hospital with a therapeutic abortion committee; 24.5 percent, consent of parents; and 23.1 percent, repeat abortion.

A portrait of Canadian women who went to the United States to get an abortion was obtained from a small number of patients who were treated at eight clinics in five states. These 237 women came from seven provinces and the Northwest Territories. In comparison with patients who had abortions in Canadian hospitals there were fewer women who were younger (16.1 percent under 18 years) or older (8.9 percent over 35 years). Most of these women were single (68.8 percent), fewer were married (18.6 percent), and some were divorced, separated, and engaged to be married. The experience of these women with induced abortion provides an insight into why a substantial number of Canadians leave the country for this procedure. While they were only a handful of the several thousand women who went abroad for this purpose each year, the information which they gave the Committee concurred well with its general findings related to induced abortion. Like other Canadian women who had had induced abortions, most of these patients found it difficult to discuss openly their experience, and some were afraid their opinions and the fact they had left the country might become known.

Among a small group of women from whom information was obtained, most (85.8 percent) who went to the United States would have preferred to have had an abortion in Canada, if they had known or had been told this option was available. Going to the United States was expensive in terms of travel costs and the fees which they were charged for an abortion. Most of the patients (94.4 percent) paid for this operation themselves. Only a few indicated that they planned to seek reimbursement under national health insurance. In some

instances the trips involved several hundred miles, sometimes several thousand miles in the case of patients in the survey who lived in Newfoundland or the Northwest Territories who went to New York City. The main reason why these Canadian women went to the United States for an induced abortion was that they did not know how to obtain an abortion in Canada. The agencies or individuals whom they contacted either dissuaded them from trying to get an abortion in this country, told them it was too difficult or illegal, or inaccurately advised them on the procedures and practices involved in getting an abortion in Canada. From the perspective of patients who went to the United States to get an abortion, the counsel they got from physicians and agencies was a mixture of professional advice, moral values, and personal opinion.

Once they had made the decision to terminate their pregnancy, most of these women had turned to physicians for further counsel and for information as to how an abortion might be obtained. Three-quarters (75.2 percent) said they had a usual family doctor, but fewer than half (40.8 percent) had consulted these physicians whom they had already known. The remainder who had seen physicians consulted other family physicians or obstetrician-gynaecologists whom they had not known before, or went to clinics.

Most of these patients (74.4 percent) had seen one or more physicians in Canada about their pregnancy. Likewise, most of the patients had asked their doctors for assistance and advice in getting an abortion. Some of the patients had consulted more than one physician about their request, with 20.0 percent having seen two physicians, 5.1 percent three physicians, and 6.0 percent four or more physicians. The opinion of their physicians and the advice they gave was the single factor most responsible for the decision by most of these women to go to the United States for an abortion. A small number had found it difficult to get appointments for this purpose at hospital clinics, and 12.0 percent said that applications made on their behalf to hospital therapeutic abortion committees had not been approved.

The counsel given by physicians to these women included a gamut of different courses of action. A fifth of the patients (22.0 percent) going to the United States said it had been difficult to make an appointment with a physician. Many physicians gave more than one piece of advice. Taking all these reasons together, **over half (53.6 percent) of this small group of women who went to the United States to obtain an abortion said that their doctors felt they had little chance of getting an abortion in Canada, were morally opposed to assisting them, or were unwilling to refer them to a hospital where this procedure was done in this country.** The specific reasons included: physicians who would not refer patients to other doctors or to hospitals (13.4 percent); told by a physician that an abortion was illegal (22.6 percent); told an abortion could not be obtained at a Canadian hospital (41.5 percent); told pregnancy was too advanced (9.2 percent); no medical reasons (10.6 percent); abortion involved a risk to health (6.5 percent); told to go to term (14.7 percent); and told there were no doctors who would do the abortion procedure (8.8 percent). While most family doctors and obstetrician-gynaecologists referred patients to hospital committees, or if they were morally opposed to abortion, made patient referrals to other physicians, some physicians wanted no involvement at any

stage in the abortion procedure. Patients who turned to this small group of physicians, not knowing beforehand their views on abortion, either were given no assistance or in some instances were inaccurately counselled.

Pathway five: Childbirth

Child welfare agencies and maternity homes across Canada were contacted to obtain information about their experience with women seeking abortions and pregnant women who went to term for whom they provided services. Out of a total of 242 regional and local branches of child welfare agencies and 33 maternity homes (two additional homes which were contacted were closing) from whom information was requested, *complete* replies were received from 56 welfare units (23.1 percent) and 27 maternity homes (81.8 percent). In addition to providing information about the scope of their services, eight of the child welfare agencies and 24 of the maternity homes participated in a survey involving 203 women for whom they were providing assistance.

Private organizations in Manitoba, Ontario, and Nova Scotia operated child welfare services. The Manitoba Department of Health and Social Development operated 12 child welfare branches; services in that province were also provided by four Children's Aid societies and the Jewish Child and Family Service. All of the 53 child welfare agencies in Ontario were run on a voluntary basis, but worked within the framework of provincial legislation. The majority of these programs were non-sectarian (49); three were affiliated with the Catholic Church of Canada, and one was a Jewish welfare agency. While 5 out of 17 agencies in Nova Scotia were privately run, the provincial Department of Social Services supervised much of the scope of their programs.

In British Columbia, Alberta, Manitoba, and Quebec, child protection services were provided together with social welfare and health activities respectively by branches of the departments of Human Resources, Social Services and Community Health, Health and Social Development, and the Ministry of Social Affairs. Traditionally, these services had been directed toward adoption programs and the assistance of pregnant women. In recent years the scope of their services has been extended to provide for the needs of youth in general.

From the information which was given by the agencies which supplied statistics, there was a decrease between 1973 and 1975 in the volume of all individuals who were being assisted. If the number of women who were seen in 1973 is taken as an index equalling 100, then there was a 16 percent drop in the number of single pregnant women between 16 and 18 years who were seen over this three-year period and a 20 percent decline among women who were 19 years or older. The proportion of infants who were given for adoption compared to the number of babies who were brought up by their mothers during this three-year period decreased from 77.5 percent in 1973, 70.4 percent in 1974, to 60.0 percent in 1975. These trends based on incomplete information suggest what many physicians and health and welfare administrators told the

Committee, namely that fewer women were giving their infants for adoption than in the past.

About half of the pregnant women who contacted provincial child welfare agencies were in the third trimester of their pregnancies. These women had decided to carry their pregnancies to full term and had contacted these resources either to make arrangements for adoption or for their support during the last phase of their pregnancy and after childbirth had occurred. Some of the directors of these agencies commented on this aspect of their work.

Abortion is raised as an alternative plan to consider, where appropriate. Counselling involves an examination of sexual activity, goals and possible referral to family planning clinics.

. . .

Since the most basic right of all human beings is the right to life, it is therefore incumbent upon us to uphold this right for all children: those already born as well as those about to be born. Our Society will not give permission to one of our wards to obtain an abortion, nor will we be involved in counselling a woman to have an abortion.

. . .

Currently, there is no policy regarding abortion. The practice has been to discuss the matter with anyone wishing to do so, make referral and provide information as requested, stressing that decision-making rests with the individual.

. . .

Difficult cases involving matters such as serious marital problems, abortion and sterilization, may be referred to the Moral Issues Advisory Committee for advice and direction. Referrals for abortion by staff may not be undertaken under any circumstances.

. . .

We have no written policy. Our procedure is to provide professional case-work services to assist clients in reaching their own decisions about family planning. Depending on the client's needs and wishes, this could include information giving and referrals to resources such as family planning clinics.

. . .

Responsible family planning within the framework of Catholic moral teaching is encouraged. Abortion is not considered to be an acceptable planning alternative but the adult client's right to self-determination is respected in this regard.

. . .

We have a policy. Social work staff is given authority to offer counselling to any client who wishes to discuss abortion and, if the client so desires, a consultation with senior staff provides support for the need to actively support a referral to our appropriate medical or hospital resource.

. . .

We have a committee developing a policy. Currently, we recommend abortion in cases where the mother's situation makes it unlikely that she will be able to care for her child for physical, emotional, or mental reasons.

. . .

No set policy exists. We attempt to work with each pregnant client on an individual basis in order to find the best solution to her particular problem considering her social and medical conditions.

Of the 27 maternity homes (out of a total of 33 identified across Canada) which provided information on their services, two were located in British Columbia, two in each of the Prairie provinces, 12 in Ontario, four in Quebec, and three in the Maritime provinces. The first maternity homes were established toward the end of the last century to aid young pregnant women. Through the years, the Salvation Army Corps has had a strong commitment to these services. Its work has gradually been joined by other denominations in providing services to unwed mothers. Of the maternity homes in the survey, three had been founded before 1900, 10 between 1900 and 1950, and the remainder since 1950. The impetus to open maternity homes rose following World War II. In 1976, the Salvation Army operated 14 maternity homes, seven were under the auspices of other Protestant denominations, and eight were managed by the Catholic Church.

As with the child welfare agencies, the traditional role of maternity homes has changed in recent years—from providing care for women wishing to relinquish their babies for adoption to providing residential services for many other young women. For these reasons many of the maternity homes which had been established in the past either have closed or re-aligned their policies to serve other needs. Based on the reports given by the directors of these maternity homes, the decline in the use of their services by pregnant women has accelerated since 1970. There were 1,852 residents served by the 27 maternity homes in 1975. Approximately half (48.1 percent) of the homes had 50 or fewer pregnant residents during that year, while the remainder accommodated between 60 to 180 women. The average length of stay in each home ranged from 1.5 to 4 months. Most of the homes (62.9 percent) accommodated residents for more than 2.5 months. Half (51.8 percent) of the institutions accommodated only single pregnant girls and overall, most of the residents in maternity homes were single, the remainder usually had only one or two married residents and about the same number of women who were divorced, separated, or widowed. In 1975 there were 32 married and previously married women who had stayed in these homes, a proportion which never exceeded 4 percent of the total number of residents.

Most of the residents were young women who were experiencing their first pregnancy. Over half (57.5 percent) were under 17 years old and 81.9 percent were below the age of 20 years. For 6 out of 7 of these women (86.4 percent) the conception had been their first pregnancy. Of the remainder, 4 out of 5 (82.1 percent) had carried one previous pregnancy to term and 17.9 percent had had two or more childbirths. A small number of these women (3.7 percent) had had an abortion.

According to several administrators of these maternity homes, the women who carried their pregnancies to term and had come to these homes had opted for this pathway because it was the only alternative available to them. Among the factors which were seen to influence their choice, in the opinion of the administrators, their opposition to abortion was the most important consideration. The second major reason for spending the last months of their pregnancy in a maternity home was that many of these women wanted to raise a child, but could not cope with their circumstances at home or at work. A third motivation for carrying a pregnancy to term in a maternity home was seen to result from strong pressure to do so which had been voiced by a woman's partner, her family, or her close friends. Problems associated with the availability of abortion services seldom were cited by maternity home directors as reasons why these women sought out this assistance.

Information was obtained directly from 203 pregnant women living in 24 maternity homes or who were being served by eight child welfare agencies. The majority of these women (82.3 percent) were under 20 years of age; the remainder (17.7 percent) were in their twenties. Over half of the women were 17 years or younger, with 18.8 percent under 16 years and 38.1 percent between 16 and 17 years. When birth occurred a majority of these young women would be single mothers as only 17.1 percent were married when conception occurred. These women in about equal numbers were Protestant (48.2 percent) or Catholic (42.7 percent.)

When they became pregnant, 2 out of 3 of these women (68.5 percent) had been living with their parents, while a few had their own homes (16.0 percent) or lived with a male partner (15.5 percent). In the interval between when conception occurred and when they took part in the survey, most of these women had made alternative living arrangements, with 3 out of 4 (71.7 percent) residing in maternity homes, 14.1 percent living with relatives, 7.8 percent working as "live-in" help for a family, and a few (6.4 percent) living in a boarding house. The proportion of these women who had been living with their parents when conception occurred declined with their age from 97.1 percent of females under 16 years to 47.2 percent of women who were over 20 years old. Prior to their pregnancy, 42.5 percent of these women had attended school, 35.8 percent had had jobs, and 1 out of 5 had been unemployed. At the time of the survey a majority of these women were attending school (52.2 percent), 1 out of 10 was working (10.3 percent), and the remainder were unemployed.

Although all of these women had decided to carry their pregnancy to term, half of them (50.2 percent) had initially considered the possibility of an induced abortion. For these women this option had been supported by some of their close friends (43.9 percent), their parents (25.3 percent), or their male partners (22.0 percent). About 1 out of 10 (8.8 percent) said that a physician had urged them to consider an induced abortion. The influence of their parents was greater among young teenagers, with 2 out of 5 (42.1 percent) who were 16 years or younger reporting that their families had advised them to obtain an abortion. The influence of a family in this respect declined among slightly older

women, with 1 out of 4 of these women (25.6 percent) saying that their parents had urged them to get an abortion.

Among a small group of women who were carrying their pregnancies to term 1 out of 4 (27.6 percent) had at one time considered having an induced abortion, but they had not taken this course because of a lack of accessible services for therapeutic abortion or because of delays which had been involved in applications submitted on their behalf to hospitals. Some of the factors which were involved were: 25.5 percent, physicians had told these women the length of their pregnancy went beyond the limits set for this procedure by hospitals; 30.4 percent, paying the additional costs was beyond their means; 8.9 percent, a physician had refused to refer them for this procedure; and 14.3 percent, did not know how to apply for an induced abortion. One out of five of these women thought that getting an induced abortion was illegal under any circumstances.

Among the women who had once considered having an abortion, 45.2 percent were Catholic, an equal number were Protestant, and the remainder either were members of other religious faiths or gave no affiliation. There were no trends by age among the women who had considered or not considered this alternative. There was a trend by age and the length of gestation, with more younger females, in particular those who were 16 years and younger (40.9 percent), having not sought an abortion on the grounds that their pregnancies were too advanced. Among the small group of married women who were living in maternity homes or who were assisted by child welfare agencies, 2 out of 3 (64.7 percent) had rejected the possibility of an abortion on moral grounds, 29.4 percent said that they had been unable to obtain an abortion, and 5.9 percent said they had reached this decision too late in their pregnancies to make an abortion feasible.

Two-thirds of the women who had considered having an abortion (69.9 percent) planned to give their babies for adoption, a proportion higher than the half of the women (46.9 percent) who had never considered that course. Among the women who had intended but had not had an induced abortion because their pregnancy was too far advanced to apply for one, 84.6 percent had planned an adoption. In contrast, among the women who were morally opposed to abortion, 72.2 percent planned to keep their children. Of the women who had had procedural difficulties involving the abortion procedure, 66.7 percent planned adoption. Among the women who had rejected an abortion following their partner's wish, 22.2 percent planned an adoption and 77.8 percent intended to raise their child. In reaching their decisions about adoption or retaining the custody of their newborn children, these women were influenced by their families and friends about what they decided to do. More of the women who had partners who supported their decisions, had made plans to keep their children. Among the women who had this type of support, half (52.0 percent) planned to keep their children, instead of considering an adoption. In comparison with married women more single women planned to give up their children for adoption. In each instance the decisions of these women might change after childbirth.

Family income and pregnancy experience

The relation between a person's level of income and how he works and lives has been extensively documented in Canada and elsewhere. It is on the basis of reducing these distinctions and ameliorating the situation that much of the intent of social policy hinges, and such national programs as hospital and medical care insurance were enacted. In the field of health care it has long been known that the rates of infant mortality, the distribution of certain diseases, and the accessibility to health services are not the same for all individuals, but vary directly by their social circumstances and on occasion by their level of income. As the economic standard of living has risen and as broad national programs of social security have been in operation for a period of time, a number of these disparities have been narrowed, in some cases, eliminated. Despite the extensive benefits provided by national and provincial programs, sharp social and economic disparities persist. While the social meaning of poverty and the types of services mounted to serve low-income individuals and families change and reflect the social purpose of each era, the culture of poverty remains entrenched. It molds a different way of life than that experienced by middle-income Canadians and in terms of the outcomes of pregnancy contributes to different social choices being taken between seeking an induced abortion or bringing to term an unwanted pregnancy.

As the economic standard of living of Canadians has risen in recent decades, making this nation one of the most affluent countries in the world, there has been a growing search for social indicators which, it has been hoped, would document more fully the essence and quality of how Canadians live, what they seek to do, and to further our understanding of disease which can be prevented, of the nature of social alienation, and the reduction of illegal behaviour. The quest for these new measures whose clarification is still on the horizon makes no less relevant the need to understand at present how an individual's economic lot affects his usual way of life. While there is no official national statement on the concept of poverty, a number of different measures have been developed which have sought to assess the extent and the social implications of poverty in Canada. In the past decade several reports on income indicators have been put forward by groups such as the Special Senate Committee on Poverty, the Social Development Council, Statistics Canada, and the Economic Council of Canada. Because of broad regional disparities in the lifestyles of Canadians, the divided nature of civic responsibilities, and the complexity of developing appropriate quantitative measures which are socially valid, there has been no agreement as yet about the utility of these indicators, how they may be used, or their social policy implications.

Statistics Canada has developed a measure of low income for individuals and families which takes into account the number of persons who are supported in a family and the size of the community where individuals live.⁴ The 1975 revised low-income cut-off levels rose with the number of individuals in

⁴ Statistics Canada, *Income Distribution by Size in Canada: Preliminary Estimates, 1974* (Ottawa, October 1975), pp. 6-7, 16-18. (This report deals with family size.)

families and were scaled to increase by the size of communities. Individuals or families whose annual income fell below these designated cut-off levels spent on an average 62 percent or more of their incomes on food, shelter, and clothing. For this reason they were considered to live in straitened economic circumstances.

The low-income measure developed by Statistics Canada was used in the review of the family income levels of three groups of women who had been pregnant and two groups of single women. The three groups of *females who had children* from whom information was obtained in the national population survey were: (1) all married women who had children; (2) married women who had had induced abortions and the number of their children; and (3) single or unmarried mothers and the number of their children. In addition to the three categories of women who had had children, the two groups of *single women* who were considered were: (1) single women who had no children and who had not had an abortion; and (2) single women who had no children but who had had an abortion. In the analysis of the incomes of married women, the denominator which was used was the size of the family. The experience of all five groups of women was evaluated in terms of the low-income cut-off levels developed by Statistics Canada which take into account income levels by the size of the family and the size of the community where individuals lived.

TABLE 7.2
INCOME AND ABORTION EXPERIENCE OF FEMALES WITH CHILDREN
NATIONAL POPULATION SURVEY

Level of Income	Marital Status and Abortion Experience		
	Married Women: No Abortion	Married Women: Had an Abortion	Single Mothers No Abortion
	percent	percent	percent
—\$ 4,000	8.7	7.7	15.6
\$ 4,000— 5,999	8.0	0.0	3.1
\$ 6,000— 7,999	8.3	7.7	12.5
\$ 8,000— 9,999	9.3	19.2	25.0
\$10,000— 12,999	17.9	17.3	12.5
\$13,000— 14,999	13.3	21.2	6.3
\$15,000— 19,999	16.4	9.6	6.3
\$20,000+	18.1	17.3	18.7
Total	100.0	100.0	100.0
Proportion below Low-Income Levels*	18.6	15.4	25.0

* Based on size of family and size of community of residence, according to Low Income Lines used by Statistics Canada, 1975.

Among *married women* in the 1976 national population survey who had had children but who had not had abortions, a quarter (25.0 percent) had

family incomes of \$8,000 or less; 27.2 percent had family incomes between \$8,000 and \$12,999, and almost half (47.8 percent) had family incomes which were above \$13,000. The distribution of family income of married women with children in this survey undertaken by the Committee closely paralleled the 1974 proportional distribution of family incomes reported by Statistics Canada which was: 23.2 percent, \$8,000 or less; 25.5 percent, \$8,000 to \$12,999; and 51.4 percent, \$13,000 or above. The average family income in 1974 was \$14,485. Different population sampling procedures may account for the observed differences as well as the fact that the information for the 1976 survey was calculated on a basis of families with children, thus excluding childless couples. The married women in the 1976 survey who had not had abortions had an average of 2.2 children, while those females who were widowed, separated, or divorced had on an average 2.3 children.

Based on the 1975 revised low-income cut-off levels developed by Statistics Canada, 18.6 percent of married women with children but who had not had abortions were below these income levels. What this means was that almost a fifth of these married women spent 62 percent or more of their family incomes on food, clothing, or shelter. In terms of the standard of living of the average Canadian family, these families were the poor of the nation.

In a number of reports which were submitted to the Committee and in some of the comments made by physicians in the national physician survey, the availability of the abortion procedure and income were linked together.

It is unfortunate that frequently the factors which determine whether or not a patient gets a therapeutic abortion are economic or geographic. It is difficult for rural dwellers and for those in the lower income levels. The economic disparity in particular is great.

. . .

As long as Canadian women can go to New York State ... for abortions on demand (and all wealthy women have this option), it would appear discriminatory to reject reasonable indications in Canada and make them second-class citizens.

. . .

Penalizes the poor—especially in “holier than thou” areas.

. . .

There is nothing basically wrong with the present abortion committee set-up, except that such committees should be instructed to take a serious view of repeat therapeutic abortions, and cases in which there is evidence of improvidence, carelessness or irresponsibility. Such a serious or unsympathetic view towards abortion on demand requires a parallel development of facilities for the care of children from unsuitable parents or from women who are not likely to make good mothers. At the present time we probably do not know whether children born of such poor mothers will inevitably be a liability to the state, or an asset to the country. A thorough study of this question might help clarify the position. If the record of such children is no worse than the average, we should not be tempted (as we are at present) to grant an abortion to avoid

bringing into the world children who would be unwanted and the offspring of unsuitable mothers, who would become a liability rather than an asset to the country.

. . .

Abortion as it is practiced in Canada does not deserve the notation "therapeutic" because it cures nothing. Social ills cannot be cured by abortion on demand as has been proven in other countries ... Poverty cannot be cured by killing poor people. Undesired and unwanted pregnancies are a reflection of other problems and abortion should never take the place of contraception.

. . .

Therapeutic abortion should be performed outside of prepaid health care facilities. The economic cost should be borne by those requiring it. Everyone should bear a responsibility for their own health care, and in the light of today's knowledge, abortions should not be used as a method of contraception. Society as a whole should not be expected to pay for it. It will be argued that the poor will suffer—but it must be accepted that they should be just as responsible for their health care as anyone else. I am sure that relatively painless methods of payment can be devised.

. . .

The situation at present is a disaster. People in lower socio-economic groups are often at a disadvantage with respect to obtaining abortion, other people have a physician who will not give them the option of therapeutic abortion committee review.

Among *married women with children who had had abortions*, 15.4 percent had annual family incomes of \$8,000 or less; 36.5 percent were between \$8,000 and \$12,999; and 48.1 percent had family incomes of \$13,000 or more. Because there were few married women with no children who had had abortions, this group was excluded from this review. In contrast with married women with children who had not had abortions, 9.6 percent fewer married women who had had abortions had annual family incomes of \$8,000 or less. More of these women than the former group were in the middle-income category of \$8,000 to \$12,999, and the proportions of both groups who had family incomes above \$13,000 were comparable. When the family incomes of married women with children who had had abortions were calculated on the basis of Statistics Canada low-income cut-off levels, 15.4 percent of these families were below these minimum standards.

What this information indicates for the two groups of married women with children, a sample which represented a national cross-section of the population, is that while some married women who had abortions had low family incomes, as a group more of these women were from families in the middle-income levels. Slightly fewer of the married women who had abortions than other married women were economically poor. These findings contradict the belief which is sometimes held, that it is the poor more than the rich who turn to abortion to terminate unwanted pregnancies. The reverse situation is the case. It was the married women who were economically better off who tended to have abortions more often than the married women who were poor.

The definition of the family followed in this review of income and pregnancy experience used the guidelines of Statistics Canada which considered a family as "a group of individuals related by blood, marriage, or adoption, who shared a common dwelling unit at the time of the survey".⁵ Included in this definition are families consisting of both parents and children, extended families which may have grandparents or relatives, and single-parent families involving women and men who either were once married (e.g., widowed, divorced, or separated) or who were never married and who had children living with them. It is the level of family income of single women who have had children, but who have not had abortions, which is compared here with the experience of all married women who have had children and married women with children who have had abortions.

Among all single women in the national population survey who had not had an induced abortion, 10.5 percent had had one or more children. In comparison among single women who had had an abortion, 23.1 percent had had one or more children. When the average family income of *the single women who had had children* is considered, more of these women had lower family incomes than all married women who had had children and married women with children who had had abortions. Double the number of single women who had had children (15.6 percent) than the other two groups of women had family incomes of \$4,000 or less. Among the women in these three groups, 31.2 percent of single women who had children had incomes which were \$8,400 or less; 15.4 percent of married women who had had abortions; and 25.0 percent of all married women who had had children were in this income group. In the highest bracket of average family incomes which were above \$13,000, the proportional distribution was 31.3 percent of single-parent females, 48.1 percent of married women who had had abortions, and 47.8 percent of all married women who had children.

Based on the 1974 index of low incomes of Statistics Canada, 25.0 percent of single women who had had children were below these minimum cut-off levels. In comparison with the two other groups of women, the group of single women who had had children had lower incomes and more had poverty incomes.

There were comparable trends by level of income among the two groups of single females who had not had children. Almost a fifth of single women (19.5 percent) who had not had children had annual incomes of \$6,000 or less. None of the single women who had had an abortion were in this income category. In contrast, over double the proportion (36.4 percent) of the single women who had had abortions had incomes between \$6,000 and \$9,999 than all single females (15.3 percent). The number of women in both groups who had incomes above \$10,000 was comparable. As with married women with children, fewer single women who were poor had had abortions and there was a higher number among this group in the middle-income bracket.

When the annual incomes of *single women who had had abortions* and *single women with children who had not had an abortion* are compared, there was a sharp contrast in income levels. Almost a third (31.2

TABLE 7.3

INCOME AND ABORTION EXPERIENCE
OF SINGLE WOMEN WITHOUT CHILDREN

NATIONAL POPULATION SURVEY

Level of Income	Abortion Experience of Single Women	
	No Abortion	Had an Abortion
	percent	
-\$4,000	14.2	0.0
\$ 4,000- 5,999	5.3	0.0
\$ 6,000- 7,999	8.2	18.2
\$ 8,000- 9,999	7.1	18.2
\$10,000-12,999	16.0	18.2
\$13,000-14,999	12.1	18.2
\$15,000-19,999	17.0	9.0
\$20,000+	20.1	18.2
TOTAL	100.0	100.0

⁵ Ibid., page 7.

percent) of single women with children had incomes of \$8,000 or less. In contrast, 18.2 percent of single women who had had an abortion had this income level. Almost equal proportions of both groups (37.5 percent and 36.4 percent respectively) had incomes between \$8,000 and \$12,999. Among the highest income group of \$13,000 or above, there were 31.3 percent of single women who had had children and 45.4 percent of single women who had had an abortion.

The opinions of women and men about abortion across the country varied by their level of income. While just about a third (32.3 percent) of the women with family incomes of \$4,000 or less said it was legal to obtain a therapeutic abortion, almost half (47.0 percent) with family incomes of \$20,000 or higher gave this reply. Somewhat fewer rich women (43.5 percent) than poor women (52.0 percent) had no comment on how accessible treatment services were for abortion, while the proportion who felt it was too difficult in each income bracket was comparable (18.1 percent and 16.4 percent).

Both women and men who had higher incomes knew more women who had had an abortion than individuals with lower incomes. Slightly over a quarter (28.8 percent) of women with family incomes of \$4,000 or less knew someone who had had an abortion, while somewhat less than half (44.6 percent) of women with incomes of \$20,000 or more were familiar with such individuals. The proportions for men in similar income categories were 22.3 percent and 35.8 percent respectively.

Slightly fewer men than women felt the current abortion legislation was too liberal or "about right". More men than women (36.5 percent versus 26.5 percent) said this law was too restrictive. Overall, 16.2 percent of women and 12.7 percent of men said the law was too liberal and 24.9 percent and 23.0 percent respectively endorsed the status quo. The remainder of women and

men (32.4 percent and 27.7 percent) had no opinion on this point. There was little difference among women by their level of family income in the proportion who felt the law was too liberal or who endorsed the present legislation. The proportion of women who were undecided on this issue dropped substantially as family income rose from 40.0 percent of women who had incomes of \$4,000 or less to 16.5 percent of women whose family incomes were \$20,000 or higher. Counterbalancing this trend, twice as many women (34.0 percent versus 17.3 percent) who were rich compared to individuals who were poor said the law was too restrictive.

What these findings on the knowledge and opinion of the Abortion Law indicate is that there were consistent trends in these replies by the level of income of women and men. In each instance individuals with higher incomes, whether the basis of their knowledge was accurate or not, held more definite views on the abortion issue. More women and men with higher incomes than individuals with lower incomes said the abortion legislation was restrictive, knew someone who had had an abortion, and said it was legal to obtain an induced abortion.

The use of health services involves a number of related factors. These components include whether health personnel and facilities are available, the type of disease an individual has and the extent to which the symptoms of an illness are known or recognized, and a knowledge of how to go about using treatment services. It is in this last respect, the knowledge of the law and of other women who have had abortions, that the poor or individuals with lower incomes had less information about abortion and the treatment services than women who had higher family incomes. This difference in knowledge about abortion and the availability of treatment services represents a much broader trend involving people with different incomes in their knowledge and their use of health services.

Women as a whole in different social and economic circumstances made different choices about the outcome of pregnancy. The information requires replication; it is but a step toward the documentation of a fuller understanding of how and why these choices are made. Among married and single women in the national survey, fewer females who were poor obtained induced abortions than middle-income and rich women. It is not known how many of the single and poor women who became pregnant were married immediately before or just after childbirth. What is known from the national population survey is that **a substantially higher proportion of single women who had had children were poor. Fewer poor women who were single or married had had abortions. In contrast, more middle-income women had had abortions and fewer of these women and those females with still higher incomes were unmarried mothers.** These broad and distinctive social choices, when the trends are considered in aggregate, represent fundamentally different ways of life and of reacting to a pregnancy. In the context of the "rich-poor" issue, these social choices have profound social and ethical implications which go well beyond the scope of this inquiry.

Alternative choices

A fuller understanding of the several options which pregnant women take would require an extensive review over a longer period of time than was available to the Committee. These options include wanted and unwanted childbirth occurring within marriage. The Committee did not deal with the effects of unwanted births on children or their parents. Little is known about the childrearing of unwanted children, their emotional capabilities, the state of their physical health, what constitutes child abuse and the extent to which it occurs, or what the life chances are of these children. The potential consequences of this course when an unwanted conception occurs are a matter for a separate inquiry. Little is also known about the emotional well-being or the physical health of women who give their infants up for adoption.

When a woman has an unwanted pregnancy, she must reach a decision about one of two alternatives. Either she must go to term, or obtain an induced abortion. From the information obtained by the Committee dealing with the experience of a small group of women who were carrying their pregnancies to term and from the results of the more comprehensive national population survey, a substantial number of single mothers who had unwanted pregnancies had low incomes and many lived in poverty. Because they were less well educated and less familiar with the workings of health services, a number of these women would have preferred to have had an abortion if they had known how to proceed. In contrast to these women, a significantly higher proportion of women who had higher incomes had induced abortions when unwanted pregnancies occurred.

In taking the alternative of obtaining an abortion, women may select one of several courses. Based upon the fragmentary information obtained by the Committee, little can be concluded about women who obtain illegal abortions in Canada. The evidence which is available from the national population survey, the personal accounts of women, reports given by physicians and the prevalence of complications resulting from illegal operations indicate that in the past several years there has been a substantial decline in the volume of illegal abortions. As the occurrence of therapeutic abortions has risen coupled with a still extensive use by Canadian women of abortion facilities in the United States, fewer women now than before take this option. Because there is more public awareness of the risks involved, women if they decide upon an abortion, are now more likely to obtain this operation in a Canadian hospital or to go abroad. In the opinion of a number of senior physicians who were consulted by the Committee, most of the relatively few illegal abortions which are now done are performed during the earliest phases of a pregnancy by means of menstrual extraction in physicians' offices. This is a step about which both the patients and the physicians involved are secretive, with this procedure in many instances being done under the guise of a minor curettage. There appear to be few guidelines governing the purchase or the importing of the required medical equipment which is readily available.

The idea of gatekeepers to health care cuts across the experience of women who by various means obtain induced abortions. While the decision to

take one course or another is always a difficult and intensely personal choice, who these pregnant women turned to and what type of counsel they received profoundly affected the steps which they subsequently took. Among the sizeable number of women who obtained abortions in Canadian hospitals, the main factor which served to lengthen their pregnancies was the amount of time taken after a woman had initially contacted a physician. Many of the women who went to the United States for an abortion either had been given no assistance or had been given inaccurate information by the physicians whom they had consulted. The findings indicate that most patients and most physicians tried to resolve the difficult issue of abortion. But where this was not the case, the timing of the abortion operation was delayed or women by-passed their local physicians and went elsewhere. These delays and the advice which was given resulted in some women going to term who should have preferred to have had an abortion.

About 1 out of 5 women turned to one of a number of community agencies for assistance. The aid given by these agencies involved counsel and the expediting function of making arrangements where abortions might be obtained. Essentially, these agencies were used by women seeking abortions who did not know how to go about getting this information themselves. These agencies often knew little about each other's work. It was the exception, not the rule, when spokesmen for one or another of these programs endorsed the work of other agencies. There was little effective coordination between the efforts of these agencies, hospitals, physicians, or public health units. Each of these groups tended to establish their own domain of services and to regard the work of other agencies as an intrusion. This duplication of effort often resulted in much bitterness and hostility whose side effects meant that the women who turned to these resources were not always well served. In some instances they were given misleading advice about the accessibility of health care services for therapeutic abortion in the community or the province where they lived. For their part, local public health units by ignoring this situation did little to redress what was happening or to move toward the coordination of pregnancy and abortion counselling and referral services.