Regulating Reproduction: Examining Provincial Responses to the Decriminalization of Abortion Through a Legal Lens

The 1988 R. v. Morgentaler decision decriminalized abortion in Canada, under the Charter of Rights and Freedoms provision for security of the person. The Mulroney administration promptly attempted to replace the legislation with bill C-43 following Morgentaler's Supreme Court victory. The bill would have "recriminalized abortion unless procedures were performed by a doctor and the life and/or health of the mother were threatened" (Overby, Tatalovich and Studlar 383). The bill was defeated in the Senate in a tie vote and no new law has since been implemented to regulate the procedure. Abortion now falls under provincial jurisdiction as a matter of healthcare, rather than federal jurisdiction under the Criminal Code, and every province has regulated abortion differently, often attempting to effectively re-criminalize the procedure by blocking access. The Morgentaler decision is often portrayed as the country's final battle for reproductive rights, but challenges to provincial restrictions on abortion access have resulted in widespread litigation.

Following the decriminalization of abortion the limits of the precedent were tested in court. Where doctors could legally perform abortions, whether women would be required to pay for the procedure themselves, and who had the power to override a woman's decision to terminate her pregnancy were all boundaries tested through litigation. Through an examination of the legal battles and corresponding policy responses this paper will demonstrate the existence of a continuing struggle for women's reproductive rights and health in Canada.

Abortion access is measured not only in gestational limits and the number of facilities that perform the procedure, but the social and political climates women must negotiate to get service. Abortion is not a stand-alone issue of private morality or health, but an issue deeply ingrained in ideals of community membership and equality. This paper will begin by locating the issue of abortion in Canadian political culture utilizing social reproduction and a negotiating citizenship framework. Using these frames three provinces will be examined: Ontario, Quebec, and New Brunswick. Ontario and Quebec are Canada's most populous provinces and have both been the site of court battles and legislation that shaped the legal landscape of abortion in Canada. Quebec is arguably Canada's highest access province, though Ontario also falls at the high end of the access spectrum. New Brunswick is a useful counterpoint to these cases as one of Canada's lowest access provinces, second only to Prince Edward Island. While litigation on the subject of abortion is diverse this paper will focus on three of the most prominent sites of contested access: hospitals, clinics, and women's bodies. Hospitals were included as a contested zone despite a lack of recent legal activity because of their past and present roles in the regulation of abortion access, particularly as a facility needed to supplement a lack of clinic access. Ultimately, it will argue that, while there are similarities between the provinces regarding sites of litigation, New Brunswick has positioned itself as an outlier in its responses to court rulings. The province has operated with a clear intent to blocking abortion services despite progressive legal precedent. New Brunswick has become an anomaly amongst the Canadian provinces by actively working to remove women's agency to negotiate their citizenship.

I have conducted interviews with a variety of actors involved in the abortion access debate, including social movement actors, politicians, lawyers, and medical professionals. These interviews, combined with document analysis, contribute substantially to the analysis in this paper. Interviewees were given the option of being recorded and then transcribed or not being recorded and having their statements paraphrased. Participants were also given the option of having their identities revealed or being referred to in general terms relating to their involvement with the issue (i.e. medical practitioner).

Contextualizing Abortion in Canadian Politics

The importance of abortion access cannot be understood absent the context of women's lived experiences. The impact of pregnancy, birthing, and motherhood on women's lives have long been central to calls for reproductive autonomy, but abortion has also been discussed in the context of moral, political, and legal issues. The idea that abortion can be "somehow divorced from the politics of the welfare state" as an issue of private morality is deeply problematic, as abortion is a highly politicized issue, which impacts many aspects of women's lives. According to one Morgentaler Clinic escort in Fredericton:

> For the general populous it's a moral issue almost in the abstract. That's the problem with the kind of discourse that exists around abortion in this province [New Brunswick]. People talk about it as a black or white moral issue, at least in the public. I think things are different in private, but in the public it's framed as an abstract moral issue in that it doesn't actually seem to relate to actual women who need to get those services. (Toron)

Social reproduction is a framework used to conceptualize the processes necessary to reproduce and sustain individuals on a daily and generational basis and helps to put the reality of women's choice into perspective (Luxton and Bezanson 3). The processes include pregnancy and birth as well as the daily maintenance necessary to maintain individuals, including physical and emotional labor (Laslett and Brenner 382). Social reproduction is necessary to human survival but is undervalued and localized exclusively in the private sphere (Luxton 32). The naturalization of women's roles in the private sphere has effectively de-politicized reproductive issues socially while the state continues to legislate reproductive health and autonomy. The lines of the public/private dichotomy blur on the issue of abortion because they have never truly been separate. A woman's reproductive capacity has the power to influence every aspect of her life, both public and private, and reproductive control is a necessary step in allowing women to operate as autonomous citizens.

Citizenship has traditionally been presented as an inclusive, universal concept, but this view is turned on its head in practice. Individuals experience citizenship differently. Bakan and Stasiulis propose a view of citizenship as existing on a spectrum "involving a pool of rights that are variously offered, denied, or challenged, as well as a set of obligations that are unequally demanded" (Bakan and Stasiulus 2). Citizenship encompasses "complex and multifaceted relationships of individuals to territories, nation-states, labour markets, communities and households," and makes simplistic legal

definitions problematic (Bakan and Stasiulus 11). The ability of women to reproduce impacts not only their personal relationships and obligations, but also their perceived and actual responsibilities to their communities and society at large.

The difficulties women face in negotiating different zones of access are further complicated by their own experiences and situation. Location, race, income, age, relationship status, dependents, and a myriad of other factors impact the importance of different sites of access and the ease with which they can be overcome. For instance, a perception of a negative social climate and possible backlash to an individual's actions can be enough to dissuade action. This is one of the reasons that there is such concern over the refusal of medical personnel to refer women for birth control and other reproductive health services when they, themselves, are against it. The power dynamic of the relationship and, in many cases, the fear exposure, means that some individuals feel too ashamed, judged, or confused to persist towards their goal. Thus women do not experience barriers to access in a uniform way.

A framework, which allows for a more complete understanding of the interactions of individuals within larger systems, and the unique barriers they face, could provide individuals and institutions with a more effective understanding of the issues and how they might be addressed. More than simply highlighting the unique experiences, a negotiated citizenship framing, through the lens of social reproduction, makes the links between individuals and their community membership apparent. It is not enough to understand that individuals have differing levels of agency when attempting to access their reproductive rights, the magnitude of importance of these rights within the context of their citizenship needs to be understood. A woman's difficulty in accessing a safe and timely abortion is not an isolated issue that can be corrected at the micro level, it is a manifestation of a systematic mishandling of women's health and autonomy issues and an issue which bridges rights, politics, and health in a unique way.

Contested Zones

Hospitals

Many aspects of the Criminal Code were liberalized in 1969 following the Criminal Law Amendment Act, 1968. The act was introduced by then Minister of Justice Pierre Trudeau but was only enacted when he became Prime Minister in 1969. The bill enacted large-scale changes to the criminal code, including the legalization of homosexuality, contraception and, in some instances, abortion. It was in defense of this bill that Trudeau made his now famous declaration that, "The state has no business in the bedrooms of the nation" (McLaren 135). While the changes to the Criminal Code certainly liberalized abortion, the state had by no means stopped legislating women's bodies.

Abortion was legalized only within strict parameters. The law limited the practice of abortions to accredited hospitals and only once a woman had successfully pled her case in front of a therapeutic abortion committee (TAC) and received approval (Rebick 36). Each TAC consisted of four doctors, none of whom could actually be involved with the procedure, and it was commonplace for anti-choice doctors to volunteer for the committees in order to block women's access to services. TACs were also few and far between, as hospitals were not required to have these committees or regulate how frequently they convened, making them difficult for women to access in a timely manner

if at all. Quebec was particularly resistant to the formation of TAC's, due largely to the stronghold the Catholic Church had on the province before the Quiet Revolution. In 1978 Quebec had "only twenty-four hospitals with abortion committees compared to the 109 in Ontario" (McLaren 137). These committees were also highly varied and known to interpret the law in "dramatically different fashions" (McLaren 137).

TACs were abolished when the Morgentaler decision struck down the existing regulation of abortion in the Criminal Code. Today, Ontario and Quebec both cover the cost of abortions in hospitals under their provincial healthcare plans. Unfortunately, the majority of hospitals still do not perform the procedure. Whether or not a hospital will perform abortions is at the discretion of their organization boards:

> One hundred percent of these hospitals could provide abortions since most abortions are sufficiently uncomplicated (from a procedural standpoint) that they can be provided even in freestanding clinics with minimal surgical infrastructure. Many hospitals simply refuse to provide abortions because of ideological decisions made by their boards. Since abortion clinics are mostly an urban phenomenon, this lack of provider hospitals leaves many women who live away from urban centers with no ready access to abortion services. (Kaposy 20)

The number of hospitals providing accessible abortion services has also decreased in Ontario, Quebec and New Brunswick. A Canadians for Choice study undertaken in 2006 took stock of the number of hospitals from which women were able to access abortion services, rather than those which claimed availability, in an effort to reflect "the real experiences and difficulties that women have when trying to access an abortion" (Shaw 10). They found that "the amount of hospitals in Canada with accessible abortion services has decreased" and that the distribution of hospitals with service is problematic, with "the majority of providing hospitals are located in urban areas" (Shaw 9).

Access issues in New Brunswick are of particular concern. In 2007 less than 40% of the abortions performed in New Brunswick were done at the Dr. Everett Chalmers Hospital in the capital city of Fredericton, the bulk of the remaining abortions were performed at the private clinic also located in the capital (Canadian Institute for Health Information). New Brunswick averages about 1000 abortions a year, but only those performed in a registered hospital by a gynecologist are covered under Medicare, if the woman first received written permission from two doctors stating that the procedure was medically necessary.

In May of 2006 the hospital announced that it would no longer be performing abortions due to staffing shortages, effectively leaving the province without access to publicly funded abortion services. Public outcry followed and then Provincial Health Minister, Brad Green, was forced to find new hospitals willing to take on the demand. The province now has two gynecologists performing abortions, each at a different hospital, though their identities and location remain discreet for their protection (Shaw 23). In the event that one of them is ill, chooses to take time off, or retires, there is no one to fill in for them or replace them. Despite the outcry following the effective block on public access to abortion procedures the government continues to stand by its policies.

Formal legal action following the decriminalization of abortion has not focused on hospital abortions. Hospitals are a difficult venue to protest and regulate given the variety of services they perform and the anonymity their size often grants. The challenges associated with the provision of abortions in hospitals have manifested quietly. Instead of legal cases, hospitals have simply removed abortions from the list of services provided at their institution or claimed staff shortages to justify its absence. Still, levels of hospital access remain a political issue, which the provinces have largely failed to address, despite having "the power to introduce legislation preventing hospital boards from making ideological decisions to refuse to provide abortion services," (Kaposy 30). Concerns regarding abortion provision are more often centered on clinics, as will be discussed in the next section, but without a fully funded alternative to hospital abortion services women in New Brunswick are particularly affected by a lack of political will to correct the dwindling and unnecessarily bureaucratic abortion services in hospitals in their province.

Clinics

Clinics have been at the center of the majority of legal of action relating to abortion in Canada in the past decade. Clinics present an easy target for resistance because they typically focus their services solely on the safe performance of abortions and counseling for women before and after the procedure. This directed purpose makes them an obvious target for anti-choice resistance. Moreover, Henry Morgentaler, the doctor who successfully challenged the 1969 modifications to the Criminal Code, began his fight for women's autonomy by opening an abortion clinic.

Morgentaler opened an abortion clinic in Montreal after encountering women desperate for abortion services in his practice as a family doctor. In 1973 he made a public announcement that he had successfully performed 5,000 abortions (McLaren 137). His declaration was meant to illicit a reaction from the government, and it did. His clinic was later raided and he was taken to court where a jury of his peers found him not guilty. In an unprecedented action February of the same year the Quebec Court of Appeal "quashed the jury finding and ordered Morgentaler imprisoned" (McLaren 137). Morgentaler was brought to trial twice more and is twice acquitted.

Despite the fact that Morgentaler had overtly broken the law, the fact that "three French-Canadian juries should have accepted Morgentaler's argument that his actions were justified because the existing law denied all women equal access to abortion services" is demonstrative of a dramatic shift in attitudes towards women's reproductive autonomy (McLaren 137). The same stories of women's desperation to control their reproduction in the face of poverty, which had propelled Morgentaler to opening his clinic in the first place, had swayed the jury. Perhaps even more critical than concern about discrimination on the basis of sex, "class interests were never absent and often quite transparent" in debates regarding reproduction (McLaren 141).

Quebec's three failed attempts to have a jury convict Morgentaler eventually led the government to declare that it would no longer pursue legal action against Morgentaler, effectively legalizing his practice in Quebec before he achieved success in the rest of Canada (National Abortion Federation). The social climate in Quebec followed suit rapidly and Quebec became a beacon of progress for the rest of Canada.

Morgentaler soon expanded his operations to Ontario to meet demand. His Toronto clinic was also met with resistance, but this time of a more violent nature. The Toronto clinic was firebombed in 1983 while Morgentaler was once again in the court system defending his practice. While the judge in his case dismissed his defense, as in Quebec, a jury acquitted him and doctors Smoling and Scott, who practiced alongside him, in 1984. The Ontario Attorney-General "appealed the acquittal" but, meanwhile, the "clinic reopened, and Ontario filed new charges against Drs. Scott and Morgentaler"(National Abortion Federation). In 1985 the Ontario Court of Appeal "set aside the Toronto jury's acquittal and ordered a new trial" (National Abortion Federation). Morgentaler appealed the decision to the Supreme Court of Canada. The province promised that it would "not seek to shut down the Toronto Clinic while the appeal was pending" (National Abortion Federation). Meanwhile Morgentaler opened a second Toronto clinic in 1986. The clinic was raided and new chargers were laid against Morgentaler. These proceedings were stayed awaiting the Supreme Court appeal. The Ontario government dropped the second set of charges the next year. When Morgentaler's appeal finally reached the Supreme Court the ruling struck down the existing abortion law in Canada. While his previous Supreme Court challenge (1976) had failed, the enactment of the Canadian Charter of Rights and Freedoms provided new avenues to challenge the Criminal Code.

Performing abortions in clinics was illegal before 1988 and the governments of both Quebec and Ontario responded to Morgentaler's actions with litigation. As Morgentaler's intent was to draw attention to the problematic nature of the classification of abortion as a criminal matter, the court cases were an anticipated consequence of his actions and were instrumental in shifting the social perception of the issue. Following the decriminalization of abortion neither the Ontario nor the Quebec government pursued legal action to block clinic access. In fact, Ontario applied for, and was granted, a temporary injunction to prevent women and doctors from harassment (National Abortion Federation). The injunction is limited in scope, only protecting patients outside of some clinics and the homes of some doctors.

Quebec has funded a portion of clinic costs since 1988, but their funding limitations were challenged by doctors Morgentaler and Paquin, both founding members of the Association for Access to Abortion (National Abortion Federation). In 2006 a Quebec court ruled that the province was responsible for the full cost of abortions in private clinics in the province. The province complied with the ruling without appeal.

Litigation in New Brunswick relating to clinics is an outlier because it began long after the procedure's decriminalization. The province did not have an abortion clinic before abortion was decriminalized. The first and only abortion clinic ever run in the province was located in the capital city of Fredericton and opened its doors on June 28th, 1994. The New Brunswick government, then headed by Premier Frank McKenna and his unprecedented entirely Liberal cabinet, convened the same day to invoke a 1985 amendment to the Medical Services Payment Act that prohibited the performance of abortions outside of "approved medical facilities" of which the province counts only registered hospitals (Government of New Brunswick). The New Brunswick College of Physicians and Surgeons suspended Morgentaler's license. The clinic was forced to shut down pending the court case launched by Morgentaler challenging the government's action.

On September 14th of the same year the New Brunswick Court of Queen's Bench ruled that the province did not have legitimate grounds to block the clinic. The court found that the anti-clinic regulations enacted by the province were not meant to ensure quality of care as the New Brunswick government had suggested, but to, "prohibit the establishment of a free-standing abortion clinics and, particularly, the establishment of such a clinic by Dr. Morgentaler" (Morgentaler v. NB para. 44). Dr. Morgentaler's license was restored. The McKenna administration was forced to allow the clinic to remain but refused to change the amendment to the medical act. The government appealed the ruling but it was upheld (National Abortion Federation). A second appeal was made to the Supreme Court but the court refused to hear it (National Abortion Federation).

The rationale for this forceful opposition by the government seemed to be a combination of perceived opposition from an active branch of the electorate and Mckenna's personal views. Former leader of the New Brunswick New Democratic Party, Allison Brewer, suggested that McKenna was responsible for the creation of some of the most prominent barriers to access:

> The really big barriers started with Frank McKenna. In fact, Hatfield had created a hole in the legislation you could drive a truck through, and at the time he had been cornered in Hansard. Hatfield was a smart man and a lawyer and he had recorded in Hansard that he was setting a bill against setting up a Morgentaler clinic. You can't set up a piece of legislation that is directed at one person, and Hatfield would have known that, but, at the same time, he was a political animal and he was pandering to a certain portion of the electorate. (Brewer)

McKenna threatened to give Morgentaler the "fight of his life" if he tried to set up a clinic in the province:

> McKenna put a regulation in the Medical Services Payment Act, which stipulated that abortions would not be paid for except in an approved medical facility. Absolutely brilliant because, in order for a medical facility to be approved, it has to be approved by the province. The province won't approve the Morgentaler clinic as a medical facility and, to this day, no one has been able to overturn that regulation. (Brewer)

There has since been no political will to alter the regulation. The problems with a lack of access have not been discussed in the legislature in any productive capacity. Abortion access is not merely stalled, but actively contested. In 2002 Morgentaler announced his plans to sue the New Brunswick government to force them to cover the costs of abortions performed in private clinics (National Abortion Federation). The case went to trial in 2007 but was stalled by the government, who claimed that Morgentaler did not have the authority to bring a case against the government regarding abortion access because he was not a woman. The court ruled that Morgentaler did, in fact, have the right to bring the case forward in 2008 (Morgentaler v. The Province of New Brunswick.- 2008 NBQB 258). Morgentaler's standing was immediately appealed but the verdict was upheld in a

court of appeal (Province of New Brunswick v. Morgentaler, 2009 NBCA 26). The case is still pending as the government continues to stall proceedings. The government seems to be effectively waiting for Morgentaler to die (Burwell) (Hughes). Former Morgentaler clinic manager in Fredericton, Judy Burwell, believes that that's what the government is hoping for: "He keeps winning, they keep appealing" but, if Morgentaler dies, the whole process will have to start over. According to Peggy Cooke, former Fredericton clinic worker, if " he [Morgentaler] dies we have to start from the start again and that would involve a woman coming forward and that's going to be really difficult".

Women's bodies

Women's bodies have also been a contested zone of abortion access. Immediately following the R. .v. Morgentaler case men in Ontario and Quebec sought out injunctions to place on their pregnant partners to prevent them from getting abortions. Both men were granted injunctions. Quebec's Tremblay v. Daigle proved to be the most influential of the two cases when it set precedent in the Supreme Court.

In Tremblay v. Daigle case Jean-Guy Tremblay, former boyfriend of Chantal Daigle, was granted an injunction to prevent her from accessing a legal abortion. The courts ruled in Tremblay's favor both in the original case and on appeal. The first rulings were based on the language of choice and the argument that Daigle willingly became pregnant because she had reluctantly stopped taking birth control at the request of her partner (Kaposy and Downie 298-299). The notion of choice absent context is an issue Kaposy and Downie identify as a serious concern in rulings associated with reproductive choice. The judges in the case did not take into consideration the abusive nature of the former-couples relationship when taking her apparent decisions into account.

The case was eventually taken to the Supreme Court, though Daigle traveled to the United States to get an abortion before the trial was over. The court nonetheless decided to rule on the case, despite Daigle's actions rending the verdict in this specific case moot, because of the importance of the issue. The court found in favor of Daigle, ruling that the fetus has no legal status in Canada.

Attempts to control women's bodies when they continue with their pregnancies have also faced litigation. Perhaps the most famous Canadian case took place in Manitoba. In Winnipeg Child and Family Services (Northwest Area) v. D.F.G. the Supreme Court ruled that "an addicted woman could not be detained against her will in order to protect the health interests of her fetus" (Kaposy and Downie 300). There was dissent in this case by Justice Major who argued that "once a woman has chosen not to have an abortion and to continue her pregnancy, she must be responsible for the fetus's well-being, and the state may justifiably act to ensure the fetus's health if the woman cannot or will not do so" (Kaposy and Downie 300). The problem with this reasoning is the assumption that "women who continue to be pregnant must have rejected the abortion option" or that the decision to remain pregnant requires the forfeit of bodily autonomy (Kaposy and Downie 300).

A similar case in New Brunswick, in which the son of a woman was attempting to sue her for injuries sustained in utero as a result of a car accident she was in while pregnant, were likewise dismissed. In each case, "the judge declined to impose an order restricting the behavior of a pregnant woman in order to protect the supposed interests of her fetus" (Kaposy and Downie 288). Women's bodies are the only contested zone that

the provinces all responded to in a similar way, respecting the Supreme Court precedent in Tremblay v. Daigle.

Outlier

The decriminalization of abortion in Canada has not signified its accessibility or the realization of freedom of choice, even in the sense of ensuring negative liberty. Since 1988 the "courts began testing the implications of the [Morgentaler] ruling, and applicants began testing the willingness of the courts to place restrictions on a woman's rights with respect to abortion" (Kaposy and Downie 285). Precedent has since been set which protects women's bodily autonomy and the right of freestanding abortion clinics to operate openly and receive funding, but obstacles to access persist.

While Ontario and Quebec have not been exempt from legal proceedings challenging the limits of their legislation, New Brunswick remains an outlier, not for the rulings that come out of the province, but for the political responses to them. Litigation surrounding clinics has been at the forefront of their resistance, though the areas they choose not to address also speak volumes, such as the issue of hospital access they fail to acknowledge.

When challenged on clinic payments Quebec conceded after losing a court battle. They did not attempt to appeal or alter legislation to change the nature of their support. Quebec and Ontario both took legal action to block then illegal clinic operations by Morgentaler, but Quebec ceased after numerous failed attempts to convict him, and Ontario when abortion was decriminalization in Canada. The track records of both provinces with regard to access is not rooted in the absence of legal challenges relating to government obligation to provide and fund reproductive health services, rather, it is measured by their responses to court decisions and social progress.

New Brunswick is an anomaly because it has operated with a clear intent to blocking services regardless of legal precedent or changes to social progress. Arbitrary political action defended unsuccessfully through litigation by the province has not created an environment of thoughtful reflection and improved access, rather, it has resulted in an increasingly out-of-touch legislature known for ignoring court rulings and a legal team strongly devoted to preventing cases from being brought forward, rather than defending government policy on legal grounds. The motivations for the province's actions began with clashes between individuals and small, concentrated interest groups and continue to this day. Abortion has been the responsibility of the provinces for over twenty years and should be handled like any other healthcare concern; unfortunately, it is not (Erdman 1093).

New Brunswick has worked to actively remove abortion access since the McKenna administration. McKenna was known to have a personal dislike of Morgentaler, which likely impacted his political actions. Perhaps more importantly, his personal beliefs may have influenced his actions, combined with pressure from the small but organized anti-choice lobby.

The number of anti-choice advocates in New Brunswick is influential but largely exaggerated. Anti-choice activists are highly organized in Canadian politics and driven by a singular focus. This focus on the re-criminalization and social demonization of abortion by lobbyists is difficult to counter, as the goals of the pro-choice movement cover a spectrum of issues surrounding reproductive choice from birth control to day

care. The division of focus combined with a lack of perceived urgency on behalf of the pro-choice movement, given the legal precedent on their side, has meant that the anti-choice movement has become a strong lobbying group, which operates subtly without strong opposition. As Rosella Melanson, former executive director of the Status of Women for New Brunswick, which was abolished by the New Brunswick government on April 1, 2011, explains: "They're probably a small group, but they're very fixated, so they can raise a lot of ruckus and make their voice heard, even though they don't represent that many voices" (Melanson).

It does not seem to be the social makeup of New Brunswick that has influenced its regressive policies. The rural nature of the province is unable to explain its policies. According to a social activist in the province: "It doesn't necessarily fall along the divide of urban/rural, young/old, who's going to be pro-choice and who's going to be anti-abortion" (Toron). These alleged divisions are used to explain policies, which do not necessarily parallel the social climate. Generalizations of conservatism are assumed both within and outside of the province largely because of a lack of public discourse on the issue. Still, even the former manager of the Fredericton Morgentaler Clinic, Judy Burwell, who had to deal with the anti-choice movement on a daily basis, suggests that the majority of New Brunswickers are likely pro-choice:

> Sometimes you think, it must be overwhelmingly anti-choice, but, really, it's the same eight or nine people here [outside the clinic] all the time and, do they have that much power? What's their voting power? I don't understand it. I truly don't. (Burwell)

These groups have members in the provincial parliament in both the Conservative and Liberal parties. These members of the legislative assembly have openly shown their support at anti-choice rallies on the steps of the legislature. While these politicians are still in the minority vocal members of the anti-choice movement back their influence. A further concern comes in the form of financial support. University of New Brunswick Law professor Jula Hughes recounts a conversation with politicians in the province:

> I had long discussions at one point with a number of politicians here [New Brunswick] who self-identified as being pro-choice about what was holding up the move forward and I think it' s a donor base kind of issue, it's not democratic objection but party funding [both parties]. That was what I came away with, but no one explicitly said that it was it is, this is my take on these conversations. (Hughes)

The convictions of anti-choice lobbyists and members of parliament on a subject which is still socially taboo but presumed safeguarded has allowed the anti-choice movement strong footholds in New Brunswick. The constant threat to women's autonomy that has resulted means that New Brunswick women lack the agency Ontario and Quebec women possess on issues of abortion access.

Abortion must be understood contextually. As Justice Wilson's 1988 ruling highlights, a woman's decision to terminate her pregnancy:

> [I]s one that will have profound psychological, economic and social consequences for her. It is a decision that deeply reflects the way the woman thinks about herself and her relationship to others and to society at large. It is not just a medical decision; it is a profound social and ethical one as well. (R. v. Morgentaler)

A woman's reproductive capacity has the potential to deeply impact all areas of her life. While the legal landscape is varied it is the political responses to it that differentiate the provinces. The inability of women to control their bodies is an issue of dire importance that was not resolved through the decriminalization of abortion. Women's ability to exercise their citizenship rights varies by province and continues to be under threat in New Brunswick.

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