# No Right to Health, No Right to Abortion:

# The Charter Gaps Undermining Abortion Access in Canada

by

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## Abstract

Abortion is widely recognized under international human rights law as essential to rights to life, liberty, security, health, autonomy, equality, and freedom from discrimination. Despite its legal status in Canada following the Supreme Court's decision in *R. v. Morgentaler*, no constitutional right guarantees access to abortion services, leaving accessibility contingent on provincial policy, local health systems, and political will. This legal gap produces uneven access that disproportionately affects marginalized populations, including Indigenous women, disabled women, migrants, low-income individuals, and those living in rural, remote, or northern regions. Drawing on Supreme Court jurisprudence, including *Morgentaler*, *Gosselin v. Quebec*, *Chaoulli v. Quebec*, and *Eldridge v. British Columbia*, this paper demonstrates that the Canadian Charter of Rights and Freedoms primarily protects abortion as a negative liberty, shielding individuals from state interference without imposing affirmative obligations on governments to provide equitable access. The analysis examines the structural, geographic, and systemic barriers created by provincial discretion, provider limitations, institutional refusals, and stigma, situating Canada within international human rights frameworks articulated by treaty bodies such as CEDAW and CESCR, which emphasize positive state obligations to ensure availability, accessibility, acceptability, and quality of reproductive health services. The central argument contends that Canada's negative-rights framework leaves abortion precarious, legally permissible but inconsistently realized in practice, and vulnerable to political or administrative shifts. The paper concludes that operationalizing a rights-based approach, through the reinterpretation of sections 7 and 15 of the Charter, federal legislation, and provincial policy reforms, could address systemic inequities, expand access, regulate conscientious objection, and mitigate barriers for marginalized populations. Aligning domestic law with international human rights standards

would enhance reproductive autonomy, promote substantive equality, and ensure that abortion is recognized not merely as a permitted service but as a fundamental, actionable human right.

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## Introduction

Abortion is widely recognized in the interpretive practice of international human rights treaty bodies as an essential component of the rights to life, liberty, security, health, autonomy, equality, and freedom from discrimination.[1] Treaty bodies such as the Committee on the Elimination of Discrimination against Women (CEDAW) and the Committee on Economic, Social and Cultural Rights (CESCR) have repeatedly affirmed that States must ensure not only the legal availability of abortion, but also its practical accessibility, particularly for marginalized groups.[2] The Office of the United Nations High Commissioner for Human Rights (OHCHR) has stated that "denying women access to abortion can amount to violations of the rights to health, privacy and, in certain cases, the right to be free from cruel, inhumane and degrading treatment."[3] In this global framework, abortion is not simply a matter of personal choice or medical discretion; it is a substantive human right grounded in dignity, equality, and bodily integrity and autonomy.[4]

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[1] Treaty body General Comments constitute authoritative interpretive guidance on the scope and content of treaty obligations but are not formally binding on states; see Helen Keller and Leena Grover, "General Comments of the Human Rights Committee and Their Legitimacy," in *UN Human Rights Treaty Bodies: Law and Legitimacy*, ed. Helen Keller and Geir Ulfstein (Cambridge: Cambridge University Press, 2012), 129. United Nations Committee on Economic, Social and Cultural Rights, *General Comment No. 22: Right to Sexual and Reproductive Health (Article 12)*, UN Doc. E/C.12/GC/22 (2016), https://docs.un.org/en/E/C.12/GC/22; United Nations Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24: Women and Health (Article 12)*, 1999.

[2] Ibid.; Ibid.

[3] Office of the High Commissioner for Human Rights, *Information Series on Sexual and Reproductive Health and Rights: Abortion* (Geneva: OHCHR, 2020), https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf.

[4] UNFPA, *My Body is My Own: Claiming the Right to Autonomy and Self-Determination* (2021).

Canada, however, occupies a paradoxical position. Since the Supreme Court of Canada's 1988 decision in *R. v. Morgentaler*, decriminalized abortion, the procedure has been lawful throughout the country.[5] Yet no constitutional or statutory right guarantees access to abortion services. The *Canadian Charter of Rights and Freedoms* (the "Charter") protects life, liberty, security of the person, and equality, but it does not explicitly recognize a right to health or to health care.[6] As a result of the Court's "negative conception of the right to health care,"[7] abortion in Canada may be understood as a negative liberty: the state may not implement procedural frameworks for abortion that violate fundamental justice (i.e., "state inaction" or "negative-rights based approach"),[8] but it is under no "positive constitutional obligation" to provide or facilitate access (i.e., no "affirmative duty").[9] This legal vacuum has produced a system in which abortion is permissible in principle but often inaccessible in practice.

The consequences of this gap fall unevenly across the population. While individuals in major urban centers may have timely access to abortion services,[10] many others, particularly Indigenous women, disabled women, migrants, low-income individuals, and those in rural, remote, and northern regions, face persistent structural barriers.[11] These include long travel

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5 *R. v. Morgentaler*, [1988] 1 S.C.R. 30.

6 *Canadian Charter of Rights and Freedoms*, ss 7, 15, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11, https://www.justice.gc.ca/eng/csj-sjc/rfc-dlc/ccrf-ccdl/pdf/charter-poster.pdf.

7 Martha Jackman, "Charter Review as a Health Care Accountability Mechanism in Canada," *Health Law Journal* 18 (2010): 15.

8 Ibid., 18.

9 Ibid., 19; *Morgentaler*, [1988] 1 S.C.R. 30, 53, 63, 73.

10 Action Canada for Sexual Health and Rights, "Access at a Glance: Abortion Services in Canada," September 19, 2019, https://www.actioncanadashr.org/resources/factsheets-guidelines/2019-09-19-access-glance-abortion-services-canada.

11 Abortion Access Tracker, "Barriers to Abortion Access," https://www.abortionaccesstracker.ca/barriers-to-abortion-access.

distances, limited provider availability and training, financial burdens, jurisdictional confusion, anti-choice activities, crisis pregnancy centres (CPCs), belief-based care denial, and faith-based institutions that refuse to offer abortion services.[12] These access disparities mirror broader inequities in the Canadian health system,[13] and without a recognized right to health, governments can continue to permit substantial regional variation in abortion access without violating the Charter.[14] Although these disproportionate impacts align with the kinds of systemic disadvantage that section 15 is designed to address,[15] and indeed section 15 provides the strongest doctrinal basis for requiring governments to take positive measures,[16] the Supreme Court has applied these obligations narrowly,[17] limiting section 15's capacity to secure equitable abortion access across jurisdictions.

This research examines how the absence of a constitutional right to health under the Charter undermines abortion access in Canada. It addresses two central questions: (1) What does the lack of a right to health mean for the legal and practical accessibility of abortion across

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[12] Ibid; Wendy Glauser, "Faith and Access: The Conflict inside Catholic Hospitals," *The Walrus*, December 2022, https://thewalrus.ca/catholic-hospitals/; Abortion Rights Coalition of Canada, *Position Paper #5: The Canadian Abortion Provider Shortage: Now and Tomorrow,* May 2020, https://www.arcc-cdac.ca/media/position-papers/05-Abortion-Provider-Shortage.pdf.

[13] Brenda L. Gunn, "Ignored to Death: Systemic Racism in the Canadian Healthcare System," Submission to EMRIP Study on Health, University of Manitoba, for UN Human Rights Office of the High Commissioner (OHCHR), https://www.ohchr.org/sites/default/files/Documents/Issues/IPeoples/EMRIP/Health/UniversityManitoba.pdf; Canadian Public Health Association, "Addressing Health Inequities in Canada," *Canadian Public Health Association*; Public Health Agency of Canada, "Social Determinants of Health and Health Inequalities," *Government of Canada*, last modified July 18, 2024, https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html.

[14] Jackman, "Charter Review as a Health Care Accountability Mechanism."

[15] *Canadian Charter of Rights and Freedoms*, s. 15; *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624.

[16] *Eldridge v. British*; *Vriend v. Alberta*, [1998] 1 S.C.R. 493; Emmett Macfarlane, "Positive Rights and Section 15 of the Charter: Addressing a Dilemma," *National Journal of Constitutional Law* 38, no. 1 (2018): 149.

[17] *R. v. Sharma*, 2022 SCC 39, [2022] 3 S.C.R. 147.

Canadian jurisdictions? and (2) Should Canada adopt either constitutional or statutory reforms, such as recognizing a right to health, to guarantee equitable access to abortion services? Drawing on Supreme Court of Canada jurisprudence, this paper demonstrates how decisions such as *Morgentaler*, *Gosselin v. Quebec (Attorney General)*, *Chaoulli v. Quebec (Attorney General)*, and *Eldridge v. British Columbia (Attorney General)* entrench a negative-rights framework that limits the state's obligations in the realm of reproductive health.[18] The analysis then turns to the lived reality of abortion access in Canada, highlighting provincial disparities, systemic inequities, and the specific impacts on marginalized groups. To situate Canada within broader normative expectations, this paper draws on international human rights standards developed by UN bodies, which articulate positive obligations to ensure accessible, available, acceptable, and quality abortion services.[19]

The central argument advanced here is that Canada's failure to recognize the right to health leaves abortion access precarious, inconsistent, and vulnerable to political change. While constitutional or statutory recognition of abortion would not automatically guarantee universal access, a rights-based framework (whether through constitutional interpretation, legislative recognition, or explicit incorporation of international human rights obligations) would provide a stronger legal foundation to challenge barriers and hold governments accountable.[20] Without

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[18] *Gosselin v. Quebec (Attorney General)*, 2002 SCC 84; *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35; *Eldridge v. British Columbia*.

[19] United Nations Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, UN Doc. E/C.12/2000/4 (August 11, 2000), https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/Health/GC14.pdf; UN CESCR, General Comment No. 22; UN CEDAW, *General Recommendation No. 24*; United Nations Human Rights Committee, *General Comment No. 36: Article 6: Right to Life*, UN Doc. CCPR/C/GC/36 (September 3, 2019), https://docs.un.org/en/CCPR/C/GC/36; Office of the United Nations High Commissioner for Human Rights, *Technical Guidance on the Application of a Human Rights-Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality*, A/HRC/21/22 (July 2, 2012).

such reforms, abortion in Canada will continue to function as a "fragile freedom": available to some, obstructed for many, and never fully realized as a substantive human right.[21]

**The Charter and the Legal Status of Abortion in Canada**

The legal status of abortion in Canada occupies a unique and often misunderstood space within Canadian constitutional law. This landscape changed with the landmark 1988 Supreme Court of Canada decision in *Morgentaler*; abortion was decriminalized, yet no corresponding positive right to access abortion services has been constitutionally recognized. The decision marked a profound shift in Canadian reproductive rights by invalidating the criminal prohibitions on abortion under section 251 of the *Criminal Code*,[22] but it stopped short of affirming a constitutional entitlement to abortion services. This distinction, between freedom from criminalization and a guaranteed right of access, has shaped the trajectory of reproductive rights in Canada over the subsequent decades. Within the framework of the Charter, abortion remains understood as a negative liberty, meaning that the state may not implement procedural frameworks, such as those in s. 251, that unjustifiably interfere with the decision to terminate a pregnancy, but it is under no constitutional duty to ensure that abortion services are accessible or equitably provided.[23] This approach is reinforced by courts that are "highly reluctant to seriously

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[20] Johanna B. Fine, Katherine Mayall, and Lilian Sepúlveda, "The Role of International Human Rights Norms in the Liberalization of Abortion Laws Globally," *Health and Human Rights* 19, no. 1 (2017): 69–80; Joanna N. Erdman, "A Constitutional Future for Abortion Rights in Canada," *Alberta Law Review* 54, no. 3 (2017): 727–752.

[21] Steven Lecce, Neil McArthur, and Arthur Schafer, eds., *Fragile Freedoms: The Global Struggle for Human Rights* (New York: Oxford University Press, 2017).

[22] *Morgentaler*, [1988] 1 S.C.R. 30 (Dickson CJ and Beetz J., majority; Wilson J., concurring).

[23] Jackman, "Charter Review as a Health Care Accountability Mechanism in Canada," 65.

engage with the *Charter* as a health care accountability mechanism."[24] This section examines how Supreme Court jurisprudence, particularly *Morgentaler*, *Gosselin*, *Chaoulli*, and *Eldridge*, constructs this distinction between negative and positive rights and how this interpretive approach undermines abortion access across Canada.

In *Morgentaler*, the Supreme Court of Canada struck down section 251 of the *Criminal Code*, which required women to obtain "a certificate from a therapeutic abortion committee of an accredited or approved hospital" before they could access a lawful abortion.[25] The Court held, in its majority reasoning, that s. 251 created arbitrary, unfair, cumbersome, and burdensome barriers to timely medical care, amounting to a "complete denial"[26] of a woman's rights to "life, liberty and security of the person" under section 7 of the Charter.[27] Chief Justice Dickson, in the majority opinion, emphasized that the procedural requirements subjected women to unnecessary emotional, psychological, and physical stress,[28] infringing their security of the person in a manner that does "not comport with the principles of fundamental justice."[29]

While *Morgentaler* was a decisive victory for reproductive autonomy in Canada, the Court deliberately confined its reasoning to the procedural unfairness of the criminal framework,[30] emphasizing that the determination of social policy and substantive rights surrounding a solution to "the abortion question…must be left to Parliament" rather than the

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24 Ibid., 15.

25 Ibid., 31.

26 Ibid., 183.

27 Ibid., 71-76; *Canadian Charter of Rights and Freedoms*, s. 7.

28 *R. v. Morgentaler*, 56, 60.

29 Ibid., 73, 63–64 (Beetz J., concurring); 184–185 (Wilson J., concurring).

30 Ibid., 32-37

courts, and thus did not recognize a constitutional right to abortion or to health care more broadly.[31] Although the plurality opinions of Dickson C.J. and Wilson J. both recognized the profound implications of abortion for women's autonomy and bodily integrity,[32] Dickson CJ, in the majority opinion, restricted the analysis to the constitutionality of the procedural requirements in s. 251,[33] reflecting the narrow issue before it (whether the criminal law procedure violated s. 7) rather than addressing the broader question of whether the Charter protects a substantive right to abortion or to health care, or whether governments have a positive obligation to provide or fund abortion services.[34] Justice Wilson's concurring opinion came closest to articulating a broader vision of reproductive liberty, grounding her reasoning in a "woman's right to personal autonomy"[35] and moral agency.[36] However, her opinion did not command a majority, and subsequent jurisprudence has treated *Morgentaler* as a case about freedom from state interference, not as establishing an enforceable right to reproductive health care.[37]

The absence of a constitutional right to health or health care in the Charter has meant that abortion access in Canada depends largely on the organization of provincial health systems and political will rather than constitutional mandate. The Supreme Court's reasoning in *Morgentaler*

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31 Ibid., 158-159.

32 Ibid., 36-37, 56-57, 170-174.

33 Ibid., 63-69.

34 Ibid., see "assuming Parliament can act, it must do so properly," 33, see also "In the present case, I do not believe that it is necessary for the Court to tread the fine line between substantive review and the adjudication of public policy," 53.

35 Ibid., Wilson J., concurring, 172.

36 Ibid., 175-180.

37 *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, 587, 618; *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791, 849.

thus laid the groundwork for a negative-rights framework, wherein individuals are protected against unjust state intrusion (negative rights) but not guaranteed state assistance or resources to realize those rights in practice (positive rights).[38] This conceptualization continues to define the limits of Canada's reproductive rights landscape.

The Supreme Court's approach to socio-economic rights in *Gosselin* reaffirmed its general reluctance to interpret s. 7 of the Charter as imposing positive obligations on governments,[39] in contrast to sections such as s. 2(d) and s. 15, which can entail certain positive duties to promote equality or provide services.[40] The case concerned a challenge to a Quebec regulation that reduced welfare benefits for recipients under the age of thirty unless they participated "in one of three programs: On-the-job Training, Community Work, or Remedial Education."[41] The claimant, Louise Gosselin, argued that the policy violated section 7 (life, liberty, and security of the person) and section 15 (equality rights) of the Charter by depriving her of "adequate living standards."[42]

Chief Justice McLachlin, writing for the majority, held that while the Charter does not exclude the possibility of "one day" being "interpreted to include positive obligations," such obligations had not been established on the facts of the case.[43] She emphasized that section 7 had

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38 David Boersema, "The Content and Scope of Rights," in *Philosophy of Human Rights: Theory and Practice* (Boulder, CO: Westview Press, 2011), 72-75.

39 *Gosselin v. Quebec*, "Thus far, the jurisprudence does not suggest that s. 7 places positive obligations on the state."; see *Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 486; *Reference re ss. 193 and 195.1(1)(c) of the Criminal Code (Man.)*, [1990] 1 S.C.R. 1123.

40 *See Dunmore v. Ontario (Attorney General)*, 2001 SCC 94, [2001] 3 S.C.R. 1016; *Eldridge v. British Columbia*.

41 *Gosselin v. Quebec*, para. 7.

42 Ibid., para. 82.

43 Ibid.

historically been "interpreted as restricting the state's ability to deprive people…of life, liberty and security of the person" [i.e. to protect individuals from state interference (a negative right)], not to compel the state "to ensure that each person enjoys life, liberty or security of the person," (i.e. a positive right or a state's positive obligation).[44] The Court reasoned that recognizing "a positive state obligation to guarantee adequate living standards" would represent "a novel application of s. 7," and that it was not warranted absent "sufficient evidence in this case" of a deprivation of life, liberty, or security caused by state action.[45]

*Gosselin* thus entrenched a constitutional dichotomy between negative and positive rights. The Court signaled that while socio-economic deprivations can implicate human dignity and security,[46] such harms do not automatically trigger s. 7 unless they result from "active state interference" (affirmative state actions that restrict liberty or security).[47] The Court left unresolved whether "state omissions,"[48] such as failures to provide adequate social assistance, can ever constitute a s. 7 violation, placing such questions in "the inherent domain of the legislature and not that of the justice system."[49] This reasoning has significant implications for abortion access: because the state is not constitutionally required to guarantee access to health care,[50] disparities in abortion provision, such as the lack of clinics in rural or northern regions,

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44 Ibid., para. 81.

45 Ibid., para. 83.

46 Ibid., para. 18.

47 Ibid., paras. 72, 77, 81, and 319.

48 Ibid., para 325.

49 Ibid., para. 386; see also para. 319 ("[s. 7 rights] may be violable by mere inaction or failure by the state to actively provide the conditions necessary for their fulfilment.")

50 *Chaoulli v. Quebec*, para. 104 ("The Charter does not confer a freestanding constitutional right to health care"); for an example of a right that does impose positive obligations on the state to guarantee access, see *Mahe v. Alberta*, [1990] 1 S.C.R. 342, 393 ("Section 23 of the Charter imposes on provincial legislatures the positive

are framed as access barriers rather than Charter violations.[51] The case affirmed the Court's institutional conservatism in matters involving resource allocation and socio-economic policy,[52] effectively shielding the state from judicial review to address systemic inequities in health care access.

Three years after *Gosselin*, the Supreme Court revisited the relationship between the Charter and health care in *Chaoulli*. The case involved a challenge to Quebec's prohibition "on private insurance for health care services that are available in the public system."[53] The claimants argued that excessive wait times in the public system violated their rights under both the *Quebec Charter of Human Rights and Freedoms* and section 7 of the Canadian Charter.[54]

A four-justice majority struck down the prohibition and held that "in circumstances where the government is failing to deliver health care in a reasonable manner, thereby increasing the risk of complications and death," the prohibition can infringe section 7.[55] Importantly, *Chaoulli explicitly* states that "The Charter does not confer a freestanding constitutional right to health care."[56] Rather, it recognized that once "the government puts in place a scheme to provide health care, that scheme must comply with the Charter."[57] The case therefore carved out a

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obligation of enacting precise legislative schemes providing for minority language instruction and educational facilities where numbers warrant."), a point reaffirmed in *Doucet-Boudreau v. Nova Scotia (Minister of Education)*, 2003 SCC 62, para. 28 ("Section 23 places positive obligations on governments to mobilize resources and enact legislation for the development of major institutional structures").

51 Abortion Access Tracker, "Barriers to Abortion Access."

52 Lawrence David, "Resource Allocation and Judicial Deference on Charter Review: The Price of Rights Protection According to the McLachlin Court," *University of Toronto Faculty of Law Review* 73, no. 1 (2015): 42-43, 56, 2015 CanLII Docs 5514, https://canlii.ca/t/7nd5z.

53 *Chaoulli v. Quebec*, para. 2.

54 Ibid.

55 Ibid., paras. 123-134.

56 Ibid., para. 104.

narrow window through which state failures in health care delivery might attract constitutional scrutiny.

However, *Chaoulli*'s implications for abortion access remain limited. The decision did not impose a positive duty/obligation on governments to provide services; it only constrained the state from creating or maintaining policies that unreasonably restrict access to existing care (i.e. state interference). In practice, this means that provinces and territories can choose the extent to which abortion services are integrated into their health systems, provided they do not erect barriers so severe as to endanger life or security.[58] This creates a very high threshold for constitutional scrutiny. At one end of the spectrum are extreme delays or restrictions that pose a demonstrable risk of serious harm, such as significant increases in the risk of complications, illness, or psychological distress, which may meet both the *Chaoulli* and *Morgentaler* standards for infringing section 7.[59] At the other end are pervasive structural, geographic, or logistical barriers that impede access but fall short of endangering life or security;[60] these are effectively insulated from constitutional challenge and remain treated as matters of policy rather than rights.[61] The *Chaoulli* majority based its decision on the risk of individual harm, including serious physical or psychological suffering caused by waiting-list delays,[62] a focus that has been

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57 Ibid.; See *Cycle Toronto et al. v. Attorney General of Ontario et al.*, 2020 ONSC 1215, paras. 149-153 (noting that while the Charter does not confer freestanding rights, constitutional scrutiny may arise where a government scheme is in place but implemented in a manner inconsistent with Charter protections).

58 Examples of such severe barriers could include prolonged waiting times, lack of providers in rural areas, or administrative hurdles that prevent timely access to care. Such barriers may engage section 7 of the Charter, which protects life, liberty, and security of the person (*Chaoulli v. Quebec*, paras. 38–43, 123–124).

59 *Chaoulli v. Quebec*, paras. 118-124; *R. v. Morgentaler*, 59.

60 Abortion Access Tracker, "Barriers to Abortion Access."

61 *Chaoulli v. Quebec*, paras. 2, 104.

62 *Chaoulli v. Quebec*, paras. 38-43, 112, 117, 123.

described as reflecting an "implicit embrace of a traditional liberal individualist conception of rights"[63] and that could be interpreted as leaving collective or structural barriers, such as the lack of providers in rural communities,[64] outside the Charter's reach.

While *Gosselin* and *Chaoulli* reveal the Court's caution toward socio-economic claims under section 7, *Eldridge* offers a notable, though limited, departure from this trend. The case concerned the failure of the British Columbia Medical Services Commission "to provide sign language interpreters as an insured benefit" for deaf patients in hospitals.[65] The Court held that this failure violated section 15(1) of the Charter because it denied deaf patients equal access to publicly funded medical services.[66]

Justice La Forest, writing for a unanimous Court, found that governments "should not be allowed to evade their constitutional responsibilities by delegating the implementation of their policies and programs to private entities."[67] Where a government chooses to provide a benefit (in this case, health care), "it is obliged to do so in a non-discriminatory manner."[68] *Eldridge* thus represents a rare instance in which the Supreme Court recognized that fulfilling equality rights may "require governments to take positive action."[69] Nevertheless, the Court carefully circumscribed this obligation, grounding it in the removal of discriminatory barriers rather than

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63 Jennifer Llewellyn, "A Healthy Conception of Rights? Thinking Relationally About Rights in a Health Care Context," in *Health Law at the Supreme Court of Canada*, ed. Jocelyn Downie & Elaine Gibson (Toronto: Irwin Law, 2007), 49.

64 Abortion Rights Coalition of Canada, *Position Paper #5*.

65 *Eldridge v. British Columbia*.

66 Ibid., paras. 94-95.

67 Ibid., 42.

68 Ibid., para. 73.

69 Ibid.

in a generalized duty to provide health care, by stating that they could "not purport to decide [whether or not] the matter [is true in all cases]."[70]

For abortion, the *Eldridge* reasoning provides a theoretical foothold for challenging inequities in access that disproportionately affect marginalized groups, such as Indigenous women, disabled women, or those in rural and northern regions. If unequal access to abortion services results in discriminatory effects on the basis of sex, disability, or other protected grounds, governments could be required to take positive corrective action. Yet, the absence of an explicit right to health continues to constrain the scope of such arguments. Without a constitutional framework linking health to equality or security of the person, abortion and reproductive rights advocates face an uphill battle in framing abortion access as a justiciable right rather than a policy question.

These cases collectively illustrate the Supreme Court's enduring commitment to a "negative-rights based approach to the Charter."[71] Section 7 protects individuals from unjust state interference with life, liberty, or security of the person, "except in accordance with the principles of fundamental justice,"[72] but does not obligate the state to provide the means to secure those interests. Section 15, while oriented toward equality, has been interpreted primarily as requiring governments to *avoid* discrimination rather than to *remedy* systemic inequities through redistributive measures, although s. 15(2) permits laws or programs aimed at improving conditions for disadvantaged groups.[73] This jurisprudence reflects a broader "model of liberal

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70 Ibid.

71 Martha Jackman, "Constitutional Castaways: Poverty and the McLachlin Court," *Supreme Court Law Review* 50 (2010): 311.

72 *Canadian Charter of Rights and Freedoms*, s. 7.

73 Government of Canada, "Charterpedia – Section 15 – Equality rights," Department of Justice Canada, https://www.justice.gc.ca/eng/csj-sjc/rfc-dlc/ccrf-ccdl/check/art15.html.

constitutionalism" that views rights as constraints on state power rather than as entitlements to state action.[74]

The practical consequence of this interpretive framework is that reproductive rights in Canada remain precarious and unevenly realized. Provinces and territories retain significant discretion over health service delivery, including abortion, and the federal government's role is limited to enforcing the principles of the *Canada Health Act* (CHA). The absence of a constitutional right to health means that regional disparities, long travel distances, financial constraints,[75] and institutional barriers, such as those imposed by faith-based hospitals,[76] do not typically constitute Charter violations. In effect, the legal system protects the right to choose abortion *in theory* but not necessarily the capacity to exercise that choice *in practice*.

The distinction between negative and positive rights has concrete implications for abortion access in Canada. Following *Morgentaler*, despite attempts to pass new criminal abortion legislation, the federal government declined to enact new legislation,[77] leaving abortion to be regulated through health policy and provincial health systems.[78] While this decriminalization removed the threat of prosecution, it did not guarantee the establishment of abortion services across the country. Access remains uneven, with significant disparities between urban and rural and remote areas, and between provinces such as Ontario, British Columbia, and

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74 Anna Śledzińska-Simon, "Constitutional Framings of the Right to Abortion: A Global View," *International Journal of Constitutional Law* 21, no. 2 (2023): 402, doi:10.1093/icon/moad029.

75 Abortion Access Tracker, "Barriers to Abortion Access."

76 Glauser, "Faith and Access."

77 Bill C-43, *An Act Respecting Abortion*, 2nd Sess., 34th Parl., 38–39 Eliz II (1989–1990); Abortion Access Tracker, "Abortion and the Law," https://www.abortionaccesstracker.ca/abortion-and-the-law.

78 *Constitution Act, 1867*, s. 92(7) (Canada); *Canada Health Act*, R.S.C. 1985, c. C-6.

Quebec, which integrate abortion into public hospitals and clinics,[79] and others like New Brunswick and Prince Edward Island, which historically restricted or failed to fund clinic-based abortions.[80]

These inequities expose the limitations of Canada's negative-rights framework. Without a constitutional right to health, individuals cannot compel governments to provide accessible reproductive services. The judiciary's reluctance to recognize positive obligations under section 7 has effectively insulated governments from accountability for systemic failures in abortion provision.[81] Scholars note that there has also been a global "shift in the argument on reproductive freedom, from one based on justifications for state interference in women's negative liberty to one based on the failure of the state to fulfill its obligations in the area of reproductive health."[82] While international human rights bodies, such CEDAW and CESCR, have always recognized this concept and have repeatedly urged Canada to address these disparities,[83] Canadian domestic

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79 Abortion Access Tracker, "Barriers to Abortion Access."

80 Joanna N. Erdman, "The Law of Stigma, Travel, and the Abortion-Free Island," *Columbia Journal of Gender and Law* 33 (2016): 29–37, https://digitalcommons.schulichlaw.dal.ca/cgi/viewcontent.cgi?article=2954&context=scholarly_works; Hannah Bryenton, "The History of Abortion Access on Prince Edward Island," *CBC News*, July 3, 2022, https://www.cbc.ca/news/canada/prince-edward-island/pei-history-abortion-access-1.6507176; Jacques Poitras, "Holt Government Repeals Ban on Funding Abortions Outside Hospitals," *CBC News*, November 7, 2024, https://www.cbc.ca/news/canada/new-brunswick/holt-government-abortions-funding-1.7376879.

81 For a discussion on this issue, see below in the section "International Obligations and Domestic Implementation," on pages 26-29.

82 Śledzińska-Simon, "Constitutional Framings of the Right to Abortion," 402.

83 United Nations Committee on the Elimination of Discrimination against Women, *Concluding Observations on the Tenth Periodic Report of Canada*, CEDAW/C/CAN/CO/10, October 30, 2024; Action Canada for Sexual Health and Rights, "Takeaways from Canada's 10th CEDAW Review," November 15, 2024; United Nations Committee on Economic, Social and Cultural Rights, *Concluding Observations on the Sixth Periodic Report of Canada*, E/C.12/CAN/CO/6, March 23, 2016, https://docs.un.org/en/E/C.12/CAN/CO/6; Action Canada for Sexual Health and Rights, "CESCR Day Three: Ups, Downs and Frustrating Moments," February 24, 2016, https://www.actioncanadashr.org/news/2016-02-24-cescr-day-three-ups-downs-and-frustrating-moments.

law continues to conceptualize abortion as a matter of policy discretion rather than constitutional obligation.

From *Morgentaler* through *Gosselin*, *Chaoulli*, and *Eldridge*, the Supreme Court has recognized that government action or inaction can create concrete risks to health or equality, protecting individuals from particular harms, but it has consistently refrained from imposing broad systemic obligations.[84] This judicial restraint reflects both institutional concerns about separation of powers and a deeper ideological commitment to liberal individualism.[85] The result is a legal landscape in which abortion is legally permissible yet materially inaccessible for many, particularly for marginalized populations such as Indigenous and disabled women, migrants, and those living in poverty or remote regions.

The Court's adherence to a negative-rights paradigm thus perpetuates what scholars have called a "fragile freedom."[86] Women's reproductive autonomy is protected from state interference but not from systemic neglect. The right to abortion, in this sense, remains incomplete; recognized in form but not in substance. Although recognizing health as a constitutional right, with corresponding positive duties, would best advance reproductive justice, incremental doctrinal and policy changes grounded in existing Charter guarantees could begin to address the inequities that have produced Canada's "constitutional castaways."[87]

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84 *Morgentaler*, 60, 62, 66, 70-71, 73-74; *Gosselin*, paras. 81, 141, 261, 271, 274, 332, 334-335; *Chaoulli*, paras. 89, 104, 112-118, 123; *Eldridge*, paras. 80, 96 (targeted remedy for sign language interpreters in hospitals rather than a broad systemic obligation).

85 Llewellyn, "A Healthy Conception of Rights?" 49.

86 Lecce, McArthur, and Schafer, *Fragile Freedoms*.

87 Jackman, "Constitutional Castaways," 299.

**Abortion Access in Canada**

Abortion access in Canada exists within a constitutional and policy environment that produces significant regional and demographic disparities. Although the Supreme Court's decision in *Morgentaler* decriminalized abortion, it did not establish a constitutional *right* to obtain the procedure. As a result, abortion is lawful but not guaranteed, leaving accessibility contingent on public health policy rather than enforceable rights.

In the absence of federal abortion legislation, the regulation and organization of abortion services falls primarily under provincial and territorial jurisdiction.[88] The CHA "sets out the nation-wide principles of the Canadian health care system"[89] in order "to facilitate reasonable access to health services without financial or other barriers."[90] Because abortion is considered a medically necessary service, it is covered under this framework as an insured health service.[91] However, the lack of explicit legal protection at the federal level leaves abortion access politically vulnerable, as demonstrated by numerous attempts to introduce anti-abortion legislation.[92] It is far from hypothetical that future governments could introduce funding restrictions or regulatory changes that restrict access, particularly in more conservative provinces, because nothing in federal law prevents such shifts. In other words, while the CHA

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88 National Association of Women and the Law, "Feminist Organizations Support No New Abortion Law in Canada," https://nawl.ca/no-new-abortion-law/.

89 Ibid.

90 *Canada Health Act*, R.S.C. 1985, c. C-6, s. 3.

91 NAWL, "Feminist Organizations Support No New Abortion Law in Canada."

92 Abortion Rights Coalition of Canada, "Anti-Choice Private Member Bills and Motions Introduced in Canada Since 1987," June 19, 2023, https://www.arcc-cdac.ca/presentations-anti-bills/.

establishes national principles, it does not create rights or mandate uniform service availability across provinces.

Given that "provinces and territories oversee how their health care system is managed,"[93] provincial and territorial policies significantly impact the accessibility of abortion services, leading to disparities across the country. New Brunswick illustrates this dynamic particularly well. For decades, the province limited Medicare funding for abortions performed outside hospitals, a policy that "limited the procedure's availability across the province."[94] The federal government repeatedly penalized New Brunswick for violating the CHA, as the province failed to provide equitable access to medically necessary procedures, issuing deductions of $140,216 in 2020 and $64,850 in both 2021 and 2022.[95] Clinic 554, the province's only private clinic, closed in January 2024, leaving surgical services concentrated in hospitals.[96] Although legislation in November 2024 expanded public funding for clinic-based abortions,[97] no new clinic providers have emerged as of late 2025,[98] highlighting that significant challenges persist across Canada, and demonstrating the extent to which access remains contingent on provincial political will.

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93 NAWL, "Feminist Organizations Support No New Abortion Law in Canada."

94 Hina Alam**,** "New Brunswick to Allow Medicare to Pay for Surgical Abortions Outside Hospitals," *The Free Press*, November 7, 2024, https://www.winnipegfreepress.com/arts-and-life/life/health/2024/11/07/cp-newsalert-new-brunswick-to-allow-medicare-to-pay-for-abortions-outside-hospitals.

95 Health Canada, *Canada Health Act Annual Report 2021–2022*, https://www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2021-2022.html#c3.4.

96 Aidan Cox, "New Brunswick's Only Private Abortion Clinic in Fredericton Closes Its Doors," *CBC News*, January 31, 2024, https://www.cbc.ca/news/canada/new-brunswick/clinic-554-fredericton-abortion-1.7100433.

97 Alam, "New Brunswick to Allow Medicare to Pay for Surgical Abortions Outside Hospitals."

98 Jacques Poitras, "New Brunswick Abortion Access a Work in Progress One Year after Policy Change," *CBC News*, November 6, 2025, https://www.cbc.ca/news/canada/new-brunswick/nb-abortion-access-one-year-after-policy-change-9.6968150.

These province-by-province discrepancies have led scholars to describe abortion access in Canada as a "patchwork quilt with many holes," with "huge discrepancies in the availability of reproductive services, including abortion, from province to province and…within provinces."[99] Since most abortion clinics are "located only in the largest cities[,] most of which…clustered along Canada's southern border,"[100] abortion access in rural, remote, and northern communities is particularly inconsistent, with individuals often having to "travel long distances and have substantial wait times to reach abortion services."[101] For example, surgical abortion seekers in Nunavut may need to travel hundreds or even thousands of kilometres to access care in Iqaluit or in southern cities,[102] and travel from remote areas often comes at great personal expense.[103] Although some provinces offer travel assistance programs for medical procedures,[104] these

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[99] L. Eggertson, "Abortion Services in Canada: A Patchwork Quilt with Many Holes," *Canadian Medical Association Journal (CMAJ)* 164, no. 6 (2001): 847, https://pmc.ncbi.nlm.nih.gov/articles/PMC80888/pdf/20010320s00042p847.pdf.

[100] Dorothy Shaw and Wendy V. Norman, "When There Are No Abortion Laws: A Case Study of Canada," chapter 4 in *Abortion: Global Perspectives and Country Experiences* (Issue #1), Special Issue of *Best Practice & Research: Clinical Obstetrics & Gynaecology*, May 12, 2019, 11, https://researchonline.lshtm.ac.uk/id/eprint/4654994/20/When-there-are-no-abortion-laws.pdf.

[101] Laura Schummers and Wendy V. Norman, "Abortion Services in Canada: Access and Safety," *Canadian Medical Association Journal (CMAJ)* 191, no. 19 (2019): E517–E518, https://doi.org/10.1503/cmaj.190477.

[102] Martha Paynter, "How To Access Abortion Care In Every Province And Territory," *Chatelaine*, July 19, 2022, https://chatelaine.com/health/abortion-care-canadian-province-territory/.

[103] Shaw and Norman, "When There Are No Abortion Laws," 10.

[104] See Abortion Access Tracker, "Nunavut: Travel support" (medical travel benefits under the Medical Travel Policy include coverage for transportation expenses as outlined in the Financial Administration Manual); "Northwest Territories: Travel support" (the Medical Travel Policy includes benefits for patients insured under the NWT Health Care Plan who have a valid medical referral); "Yukon: Travel support" (the Medical Travel Program includes subsidies for some patient travel expenses); "Manitoba: Travel support" (a patient traveling outside of Manitoba to access abortion care may be eligible for a transportation subsidy from Manitoba Health's Out-of-Province Transportation Subsidy Program), among others.

supports are frequently insufficient and the reimbursement processes overly complex,[105] particularly for patients already navigating financial, geographic, or linguistic barriers.[106]

Quebec maintains a relatively broad network of hospital- and community-based services,[107] while British Columbia, Alberta, Saskatchewan, Manitoba, and Ontario show pronounced urban clustering of their points of service.[108] In Alberta, "nearly all procedural abortions" occur in Edmonton and Calgary, leaving rural residents to travel long distances (more than 3 hours/more than 200 kilometres).[109] Even federal support programs, such as the Sexual and Reproductive Health Fund, which "supports community-based organizations that improve access to abortion and other SRH care for under-served communities" with "a total investment of $81 million between 2021 and 2027,"[110] cannot adequately offset these geographic and logistical barriers.

Access to abortion is further constrained by provider-dependent gestational limits.[111] Medication abortion (Mifegymiso) is generally available only in the first ten weeks of pregnancy,[112] while aspiration/surgical/procedural abortions may be offered later, sometimes

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105 See *Health Care Insurance Plan Regulation*, YCO 1971/275 (Yukon).

106 Abortion Access Tracker.

107 Government of Québec, "Finding a Resource Offering Abortion Services: Search results," (shows that Québec offers 75 abortion service points of access), https://sante.gouv.qc.ca/en/repertoire-ressources/resultats-recherche/?theme=avortement&ch_code=&ch_rayon=0&ch_choixReg=0&bt_rechCode=.

108 Abortion Access Tracker, "Access at a Glance," https://www.abortionaccesstracker.ca/.

109 Erin A. Brennand, Beili Huang, Natalie V. Scime, Jadine Paw, and Erin L. Nelson, "Abortion Care in Alberta, Canada, from 2012 to 2023: A Population-Based, Cross-Sectional Analysis of Use and Geographical Access," *The Lancet Public Health* 10, no. 3 (March 2025): e246, https://doi.org/10.1016/S2468-2667(25)00010-6.

110 Government of Canada, "Sexual and Reproductive Health Fund," Health Canada, https://www.canada.ca/en/health-canada/services/funding/sexual-reproductive-health-fund.html.

111 See Action Canada for Sexual Health and Rights, "Common Myths About Abortion," April 5, 2023, https://www.actioncanadashr.org/campaigns/common-myths-about-abortion; and "Abortion," https://www.actioncanadashr.org/sexual-health-hub/abortion.

extending up to 24 weeks in select urban centres.[113] These gestational limits can disproportionately affect individuals who must travel long distances to reach a facility capable of providing care within their allowable gestational window.[114] The combination of geographic isolation, limited provider availability, and gestational restrictions creates a compounded barrier, delaying care and increasing both logistical and health-related risks.[115]

These geographic and structural barriers intersect with systemic inequities experienced by marginalized populations. Both international and domestic analyses confirm that Indigenous peoples, Black people and people of colour, people living in poverty, people experiencing intimate partner violence, adolescents, 2SLGBTQ+ individuals, migrants, disabled people, and incarcerated people all "experience greater barriers to access."[116] From an intersectional lens, it is clear that "people who belong to multiple groups experience increased negative impacts,"[117] compounding structural, economic, and social disadvantages. For those in rural, remote, and northern communities (many of whom belong to multiple marginalized groups) the requirement to "travel long distances, which causes delays in getting care and adds extra costs" functions as a significant barrier to timely and equitable access.[118]

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112 Action Canada for Sexual Health and Rights, "FAQ: The Abortion Pill Mifegymiso," April 6, 2019, https://www.actioncanadashr.org/resources/factsheets-guidelines/2019-04-06-faq-abortion-pill-mifegymiso.

113 Abortion Access Tracker, "Access at a Glance," and "Jurisdictions: British Columbia," (British Columbia has one point of service that "offers services up to 25 weeks [and] may offer services up to 27 weeks + 6 days in certain cases, but for B.C. residents only.")

114 Schummers and Norman, "Abortion Services in Canada," E517.

115 Ibid.

116 Abortion Access Tracker, "Barriers to Abortion Access"; Amnesty International, "Europe: Existing Barriers to Abortion Access Compounded by Alarming Attempts to Roll Back Reproductive Rights," 6 November 2025, https://www.amnesty.org/en/latest/news/2025/11/europe-existing-barriers-to-abortion-access-compounded-by-alarming-attempts-to-roll-back-reproductive-rights/; Guttmacher Institute, *Abortion Worldwide 2017: Uneven Progress and Unequal Access* (March 2018), https://www.guttmacher.org/report/abortion-worldwide-2017.

117 Abortion Access Tracker, "Barriers to Abortion Access."

Indigenous women face additional "unique threats to their health" rooted in Canada's colonial legacy,[119] including widespread medical racism,[120] the historical trauma of coerced sterilization,[121] the use of birth alerts,[122] intergenerational trauma,[123] and the disproportionate travel they must undertake to access abortion services.[124] Disabled women confront inaccessible clinic environments, provider bias, and limited availability of practitioners trained to meet their needs,[125] challenges that are compounded by the increased "importance of timely access to abortion services," since disabled individuals are "at a higher risk of facing serious complications during pregnancy and childbirth."[126] Migrants, undocumented people, newcomers, and refugees

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118 Ibid.

119 Ibid.; Carrie Bourassa, Kim Mckay-McNabb, and Mary Hampton, "Racism, Sexism, and Colonialism: The Impact on the Health of Aboriginal Women in Canada," *Canadian Woman Studies* 24, no. 1 (2004): 24.

120 Mary Ellen Turpel-Lafond, *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care* (British Columbia Ministry of Health, November 2020), 72-73, https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report-2020.pdf.

121 Native Women's Association of Canada, "Forced Sterilization," *NWAC*, https://nwac.ca/academics-policy/forced-sterilization/; Abortion Access Tracker, "Barriers to Abortion Access."

122 IndigiNews, "Birth Alerts," https://indiginews.com/deep-dive/birth-alerts/; Abortion Access Tracker, "Barriers to Abortion Access."

123 Amy Bombay, Kim Matheson, and Hymie Anisman, "Intergenerational Trauma: Convergence of Multiple Processes among First Nations Peoples in Canada," *International Journal of Indigenous Health* 5, no. 3 (2009): 6-47; Abortion Access Tracker, "Barriers to Abortion Access."

124 Christabelle Sethna and Marion Doull, "Spatial Disparities and Travel to Freestanding Abortion Clinics in Canada," *Women's Studies International Forum* 38, May-June 2013: 60, https://doi.org/10.1016/j.wsif.2013.02.001; Public Health Agency of Canada, *Healthcare for Indigenous Women* (May 10, 2024) https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/aboriginal-health/healthcare-indigenous-women/healthcare-indigenous-women.pdf; Renée Monchalin, Astrid V. Pérez Piñán, Madison Wells, Willow Paul, Danette Jubinville, Kimberly Law, Meagan Chaffey, Harlie Pruder, and Arie Ross, "A Qualitative Study Exploring Access Barriers to Abortion Services among Indigenous Peoples in Canada," *Contraception* 124 (2023): 1–5, https://doi.org/10.1016/j.contraception.2023.110056; Abortion Access Tracker, "Barriers to Abortion Access."

125 Jessica L. Gleason, Jagteshwar Grewal, Zhen Chen, Alison N. Cernich, and Katherine L. Grantz, "Risk of Adverse Maternal Outcomes in Pregnant Women with Disabilities," *JAMA Network Open* 4, no. 12 (December 15, 2021): e2138414, https://doi.org/10.1001/jamanetworkopen.2021.38414; Abortion Access Tracker, "Barriers to Abortion Access."

may face gaps in provincial health insurance, language barriers, or fear engaging with state systems that "could lead to their immigration status being exposed, resulting in potential consequences from the authorities."[127] Low-income individuals must manage not only the procedural aspects of accessing care but also the "indirect financial costs," which include childcare, transportation, and unpaid time off work.[128] This becomes even more difficult for people experiencing homelessness, who often "lack access to basic resources like food, shelter, and transportation, making it difficult to get preventative care and to seek urgent care, including abortion."[129]

Stigma, whether perceived, internalized, or enacted, further restricts access.[130] Persistent stigma affects individuals, communities, and service providers,[131] and can cause delays in seeking timely care,[132] as well as causing "anxiety, depression, increased physiological distress, and social withdrawal and avoidance."[133] Abortion providers in Canada have "expressed strong

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126 Abortion Access Tracker, "Barriers to Abortion Access"; *Access for Everybody: Disability Inclusion in Abortion and Contraceptive Care* (Ipas, 2018), https://www.ipas.org/wp-content/uploads/2020/07/AEDIOE18-AccesForEveryone.pdf; Gleason et al., "Risk of Adverse Maternal Outcomes in Pregnant Women with Disabilities."

127 Abortion Access Tracker, "Barriers to Abortion Access."

128 Ibid.; Human Environments Analysis Laboratory, *Understanding Health Inequities and Access to Primary Care in the South West LHIN* (London, ON: University of Western Ontario, 2016), 8, https://theheal.ca/wp-content/uploads/2022/08/SouthWestLHIN_PCPReport_2016_09_08.pdf.

129 Abortion Access Tracker, "Barriers to Abortion Access."

130 Franz Hanschmidt, Katja Linde, Anja Hilbert, Steffi G. Riedel-Heller, and Anette Kersting, "Abortion Stigma: A Systematic Review," *Perspectives on Sexual and Reproductive Health* 48, no. 4 (December 2016): 169-170, https://www.guttmacher.org/sites/default/files/research_article/file_attachments/4816916.pdf.

131 Sarah Hyde, *Reducing Abortion Stigma: Global Achievements since 2014* (International Planned Parenthood Federation, January 2021), 3, https://www.ippf.org/sites/default/files/2021-02/Reducing%20abortion%20stigma%20-%20Packard%20summary%20report%20-%20English.pdf.

132 Ibid.; Hanschmidt et al., "Abortion Stigma," 175.

133 Ibid., 170.

concerns that stigma interfered with their abortion provision,"[134] with one provider describing "being 'forced out' of practice while another was not able to offer surgical abortions, creating access gaps for their local communities."[135] As a result, stigma operates both as a social barrier and as a structural constraint that shapes the distribution of services across the country.

Despite Canada's progressive stance on abortion rights compared to many other countries, the absence of explicit statutory protections leaves abortion access vulnerable to political shifts, and this vulnerability is not merely theoretical. In the 1990s, Ontario's Progressive Conservative government under Mike Harris "made sweeping cuts to health care" that included "limiting new IHF licences" and restrictions on "funding for abortion care."[136] Anti-abortion advocacy groups like the Canadian Centre for Bio-Ethical Reform (CCBR) have lobbied for increased restrictions, and the Alberta government was found to have funded them a grand total of $142,612 for the period of 2010-2017.[137] These examples underscore that even without criminal prohibitions, reproductive rights in Canada remain susceptible to erosion through regulatory, fiscal, and administrative decisions, and that "the absence of legal restrictions does not inevitably result in ready access."[138]

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134 Madeleine Ennis, Regina M. Renner, Bimbola Olure, Wendy V. Norman, Stephanie Begun, Lisa Martin, Lisa H. Harris, Lauren Kean, Meghan Seewald, and Sarah Munro, "Experience of stigma and harassment among respondents to the 2019 Canadian abortion provider survey," *Contraception* 124 (August 2023): 1, https://doi.org/10.1016/j.contraception.2023.110083.

135 Ibid., 3.

136 Jasmine Pazzano, "On the Brink: Why Abortion Access in Ontario Is Under Threat," *Global News*, December 6, 2022, https://globalnews.ca/news/9280268/abortion-access-ontario-under-threat/.

137 Abortion Rights Coalition of Canada, "Grants from Canada Summer Jobs Program Support Political Attacks on Human Rights," April 10, 2017, https://www.arcc-cdac.ca/media/2017/04/10/arcc-cdac-release-apr-10-17/.

138 Brennand et al., "Abortion Care in Alberta, Canada, from 2012 to 2023," e255.

Taken together, these dynamics highlight the structural fragility of abortion access in Canada. While abortion is legal and, in theory, publicly funded nationwide, in practice access remains uneven, geographically concentrated, and heavily conditioned by intersecting forms of inequality. Without explicit federal protections or recognition of a constitutional right to health, abortion access continues to depend on provincial policy choices, institutional discretion, and the broader socio-economic contexts shaping individuals' lived realities.

**International Obligations and Domestic Implementation**

International human rights law provides a more expansive and substantive framework for understanding reproductive autonomy than Canada's domestic legal system currently recognizes. Unlike the negative-rights orientation of the Charter, which primarily protects individuals from state interference, international human rights law conceptualizes reproductive health as a human right – a legal entitlement – requiring a range of proactive state measures.[139] The obligations articulated by treaty bodies such as CEDAW and CESCR make clear that decriminalization alone is insufficient: States must guarantee that abortion is available, accessible, acceptable, and of adequate quality,[140] with special attention to marginalized populations.[141] This framework emphasizes the State's duty "to take affirmative measures to eradicate legal, procedural, practical and social barriers to the enjoyment of the right to sexual and reproductive health,"[142] and to

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139 United Nations Population Fund (UNFPA), Office of the United Nations High Commissioner for Human Rights (OHCHR), and the Danish Institute for Human Rights (DIHR), *Reproductive Rights Are Human Rights: A Handbook for National Human Rights Institutions* (2014), 78, https://www.ohchr.org/sites/default/files/Documents/Publications/NHRIHandbook.pdf.

140 UN CESCR, *General Comment No. 22*; UN CEDAW, *General Recommendation No. 24*.

141 UN CESCR, *General Comment No. 14*.

address "social inequalities" that "prevent individuals from effectively enjoying in practice their sexual and reproductive health."[143]

CEDAW is central in this regard. Article 12 obligates States Parties "to eliminate discrimination against women in the field of health care" and "to ensure…access to health care services, including those related to family planning."[144] The CEDAW Committee's General Recommendation No. 24 elaborates that States must remove "all barriers to women's access to health services… including in the area of sexual and reproductive health."[145] Importantly, the Committee emphasizes that States have a duty "to ensure…access to health-care services" and "an obligation to respect, protect and fulfil women's rights to health care."[146] In its periodic reviews, the Committee has repeatedly critiqued Canada for failing to "ensure access to legal abortion services in all provinces and territories,"[147] particularly for "women from disadvantaged groups, women in remote and rural areas and undocumented migrants."[148] These critiques underscore that disparities resulting from provincial variation are incompatible with Canada's international obligations and highlight that structural barriers, intersecting inequalities, and systemic discrimination exacerbate inequitable outcomes.

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142 UN CESCR, *General Comment No.* 22, *22*.

143 Ibid., 3, (social inequalities referring to "poverty, income inequality, systemic discrimination and marginalization")

144 *Convention on the Elimination of All Forms of Discrimination against Women*, adopted 18 December 1979 by UN General Assembly resolution 34/180, New York, 18 December 1979, art. 12(1), https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women.

145 CEDAW, *General Recommendation No. 24*, para. 31(b).

146 Ibid., para. 13.

147 UN CEDAW, *Concluding Observations on the Tenth Periodic Report of Canada*, para. 28(e); UN CEDAW, *Concluding Observations on the Combined Eighth and Ninth Periodic Reports of Canada*, UN Doc. CEDAW/C/CAN/CO/8-9 (25 November 2016), para. 41(a).

148 UN CEDAW, *Concluding Observations on the Tenth Periodic Report of Canada*, para. 37(e)

CESCR provides an equally robust framework through its interpretation of the right to health under Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).[149] In General Comment No. 22, CESCR identifies sexual and reproductive health as "an integral part of the right to health,"[150] affirming that States must remove "all barriers interfering with access by women to comprehensive sexual and reproductive health services,"[151] and address the "social determinants of health,"[152] including "poverty, income inequality, systemic discrimination and marginalization."[153] The Committee also emphasizes that equality is not merely formal but substantive,[154] and States have obligations to train health-care providers,[155] ensure the availability of services "within safe physical and geographical reach for all,"[156] and address discrimination against marginalized groups,[157] who "may be disproportionately affected by intersectional discrimination."[158] CESCR further emphasizes that refusals "to provide services based on conscience must not be a barrier to accessing services"[159] and that States must regulate

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149 *International Covenant on Economic, Social and Cultural Rights*, adopted 16 December 1966 by UN General Assembly resolution 2200A (XXI), art. 12(1), https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights.

150 UN CESCR, *General Comment No. 22*, para. 1.

151 Ibid., para. 28.

152 Ibid., para. 8; World Health Organization, Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health – Final Report of the Commission on Social Determinants of Health* (2008).

153 UN CESCR, *General Comment No. 22*, para. 8.

154 Ibid., para. 26.

155 Ibid., para. 27.

156 Ibid., para. 16.

157 Ibid., para. 24.

158 Ibid., para. 30.

159 Ibid., para. 14.

such refusals to ensure timely service delivery.[160] By interpreting the right to health as both a negative (respect) and positive (protect and fulfil) obligation,[161] CESCR situates reproductive rights within a broader vision of State responsibility, contrasting sharply with Canada's current approach, where provincial discretion and provider refusals can produce inequitable outcomes.

While "Canada presents itself as a champion of human rights,"[162] its compliance with these standards is uneven at best.[163] The absence of a constitutional right to health means that provincial disparities are seldom subject to legal redress, allowing inequities in reproductive health care to persist largely unchecked.[164] International treaty bodies have expressed concerns that Canada's "complex" decentralized federal structure and "extensive provincial jurisdiction" exacerbate these inequities.[165] Although Canada is formally committed to implementing ICESCR and CEDAW obligations,[166] the domestic constitutional framework does not provide a strong mechanism for enforcement.[167] This leaves many individuals, particularly those facing

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160 Ibid., para. 43.

161 Ibid., paras. 39-48.

162 Action Canada for Sexual Health and Rights, "Takeaways from Canada's 10th CEDAW Review," 15 November 2024, https://www.actioncanadashr.org/news/2024-11-15-takeaways-canadas-10th-cedaw-review.

163 UN CEDAW, *Concluding Observations on the Tenth Periodic Report of Canada*, para. 37(e).

164 UN CESCR, *Concluding Observations on the Reports Submitted by Canada under Articles 16 and 17 of the Covenant*, E/C.12/1/Add.31, 10 December 1998, para. 12: "unless a right under the Covenant is implicitly or explicitly protected by the Charter through federal-provincial agreements, or incorporated directly in provincial law, there is no legal redress available to either an aggrieved individual or the Federal Government where provinces have failed to implement the Covenant."

165 UN CESCR, *Concluding Observations on the Reports Submitted by Canada under Articles 16 and 17 of the Covenant*, paras. 2, 12; Standing Senate Committee on Human Rights, *Who's in Charge Here? Effective Implementation of Canada's International Obligations with Respect to the Rights of Children: Interim Report* (Ottawa: Parliament of Canada, November 2005), 40, 52.

166 Government of Canada, "Canada's Appearance at the United Nations Committee on Economic, Social and Cultural Rights," Canada.ca, last modified October 24, 2017, https://www.canada.ca/en/canadian-heritage/services/canada-united-nations-system/reports-united-nations-treaties/commitments-economic-social-cultural-rights/canada-appearance.html.

intersecting forms of disadvantage such as Indigenous, racialized, low-income, rural, or migrant populations,[168] without meaningful recourse when access is denied or delayed,[169] contributing to what scholars have referred to as "the implementation gap."[170] International reporting and monitoring mechanisms, including shadow reports and universal periodic reviews,[171] provide some external accountability, yet their impact depends on domestic responsiveness.

International human rights law also situates abortion within broader frameworks of equality and freedom from discrimination.[172] The UN Special Rapporteur on the right to health has highlighted abortion as a freedom "in the context of sexual and reproductive health,"[173] and as a necessary component of "non-discrimination, equality and privacy, as well as the integrity, autonomy, dignity and well-being of the individual."[174] Similarly, UNFPA emphasizes that reproductive rights must be "respected, protected and fulfilled for all without discrimination of any kind" and that they require "equitable access to affordable, acceptable and quality sexual and

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167 Alex Neve, *Closing the Implementation Gap: Federalism and Respect for International Human Rights in Canada*, IRPP Study No. 90 (Montréal: Institute for Research on Public Policy, 2023), 3: "Canada takes a dualist approach to international law, meaning human rights treaty obligations are not directly enforceable until they have been explicitly incorporated into Canadian law, which rarely happens."

168 UN CESCR, *General comment No. 22*, para. 30.

169 Ibid., 22.

170 Ibid., 8.

171 Action Canada for Sexual Health and Rights and Sexual Rights Initiative, *Submission to the UN Committee on the Elimination of Discrimination Against Women* (2024); Action Canada for Sexual Health and Rights and Sexual Rights Initiative, *Submission to the UN Committee on the Elimination of Discrimination Against Women* (2019); Office of the High Commissioner for Human Rights, *Universal Periodic Review (UPR)*, OHCHR, https://www.ohchr.org/en/hr-bodies/upr/upr-home.

172 UN CESCR, *General comment No. 22*, para. 10.

173 Paul Hunt, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur*, Commission on Human Rights, UN Doc. E/CN.4/2004/49 (2004), para. 25.

174 Ibid., para. 9.

reproductive health services…in particular for women and disadvantaged and marginalized individuals and communities," ensuring that such "services are physically and economically within reach."[175] These interpretations underscore that barriers to access, whether legal, geographic, economic, or systemic, disproportionately affect marginalized populations, limiting the practical enjoyment of reproductive rights.

Moving Canada toward a rights-based framework for abortion would further implement these international obligations by confronting structural limitations in the domestic legal system and ensuring that reproductive autonomy is substantively realized. Such a framework would recognize abortion as "an integral part of the right to health,"[176] linking access to dignity, equality, and practical availability. Scholars such as Martha Jackman and Bruce Porter "advocate for the recognition of positive rights under the Charter"[177] by arguing that a purposive interpretation of section 7 of the Charter would "ensur[e] effective implementation of international human rights through the interpretation and application of domestic law," and would allow "Canada's legal culture…to better align with the views and expectations of civil society and Indigenous peoples."[178] Section 15 also provides a mechanism to address inequities,[179] as the Supreme Court's equality jurisprudence recognizes that facially neutral laws and policies can create discriminatory effects, disproportionately harming marginalized

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175 United Nations Population Fund (UNFPA), *Human Rights–Based Approach to Family Planning: UNFPA Support Tool*, 14, https://wcaro.unfpa.org/sites/default/files/pub-pdf/human_rights-based_approch_fp.pdf.

176 UN CESCR, *General comment No. 22*, para. 1.

177 Simon's Megalomaniacal Legal Resources (Ontario/Canada), "Charter – s.7 'Life, Liberty and Security of the Person' (3)," *Is That Legal?*, http://www.isthatlegal.ca/index.php?name=charter.7-legal-rights-3.

178 Martha Jackman and Bruce Porter, "Social and Economic Rights in Canada," in *The Oxford Handbook of the Canadian Constitution*, ed. Peter Oliver, Patrick Macklem, and Nathalie Des Rosiers (Oxford: Oxford University Press, 2017), 860, https://www.socialrights.ca/2019/Handbook-mjbp.pdf.

179 *Canadian Charter of Rights and Freedoms*, s. 15(1), "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination."

groups.[180] As Jackman and Porter note, the Court's early section 15 decisions "played a leading role…in affirming and developing a notion of substantive equality that includes important dimensions of socio-economic rights and places positive obligations on governments to remedy disadvantage,"[181] a principle directly relevant to abortion access.

Federal and provincial measures could operationalize these obligations by establishing baseline national standards, regulating conscientious objection,[182] expanding provider availability, integrating abortion into primary care,[183] supporting telemedicine,[184] and mitigating financial and geographic barriers.[185] Targeted strategies are particularly necessary for Indigenous women, racialized communities, migrants, low-income individuals, and people with disabilities,[186] ensuring that legal access translates into practical, equitable access for all.

By combining proactive Charter-based measures with federal and provincial reforms, Canada could transform abortion from a legally permissible service into a constitutionally and

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180 See *Fraser v. Canada (Attorney General)*, [1985] 2 S.C.R. 1; *Eldridge v. Quebec*.

181 Martha Jackman and Bruce Porter, "Canada: Socio-Economic Rights Under the Canadian Charter," in *Social Rights Jurisprudence*, (Cambridge: Cambridge University Press, 2009), 212, doi:10.1017/CBO9780511815485.013.

182 Wendy Chavkin, Laurel Swerdlow, and Jocelyn Fifield, "Regulation of Conscientious Objection to Abortion: An International Comparative Multiple-Case Study," *Health and Human Rights* 19, no. 1 (2017): 55–68.

183 Regina M. Renner, Madeleine Ennis, Damien Contandriopoulos, Edith Guilbert, Sheila Dunn, Janusz Kaczorowski, Elizabeth K. Darling, Arianne Albert, Claire Styffe, and Wendy V. Norman, "Abortion services and providers in Canada in 2019: results of a national survey," *CMAJ Open* 10, no. 3 (2022): E856–E864, https://doi.org/10.9778/cmajo.20210232.

184 Regina M. Renner, Madeleine Ennis, Ama Kyeremeh, Wendy V. Norman, Sheila Dunn, Helen Pymar, and Edith Guilbert, "Telemedicine for First-Trimester Medical Abortion in Canada: Results of a 2019 Survey," *Telemedicine and e-Health* 29, no. 5 (2023): 686–695, https://doi.org/10.1089/tmj.2022.0245.

185 Action Canada for Sexual Health and Rights, *Trends in barriers to abortion care*, prepared with the National Abortion Federation Canada (2022), https://www.actioncanadashr.org/resources/reports-analysis/2022-12-14-trends-barriers-abortion-care.

186 Health Canada, "Government of Canada Strengthens Access to Sexual and Reproductive Health Services for Indigenous Communities," news release, August 9, 2023, Vancouver, British Columbia, https://www.canada.ca/en/health-canada/news/2023/08/government-of-canada-strengthens-access-to-sexual-and-reproductive-health-services-for-indigenous-communities.html.

legislatively protected right that is accessible in practice. Situating abortion within this integrated framework underscores the imperative for both international and domestic accountability, ensuring reproductive autonomy is protected in law and realized for all, particularly those most marginalized.

## Conclusion

Canada's legal and policy landscape governing abortion illustrates a persistent tension between constitutional principles and the lived realities of reproductive health care. While abortion has been legal since *Morgentaler*,[187] the absence of a constitutional right to health under the Charter has left access uneven,[188] revealing that legality alone does not guarantee substantive reproductive autonomy. Provincial discretion,[189] the patchwork distribution of services,[190] institutional refusals,[191] and structural inequities continue to shape who can exercise reproductive autonomy and under what circumstances,[192] highlighting the limits of a negative-rights

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187 *R. v. Morgentaler*.

188 Abortion Access Tracker, "Barriers to Abortion Access"; Erdman, "Law of Stigma"; Bryenton, "History of Abortion Access"; Poitras, "Holt Government Repeals Ban."

189 NAWL, "Feminist Organizations Support No New Abortion Law in Canada"; Alam, "New Brunswick to Allow Medicare to Pay for Surgical Abortions Outside Hospitals"; Cox, "New Brunswick's Only Private Abortion Clinic in Fredericton Closes Its Doors."

190 Eggertson, "Abortion Services in Canada: A Patchwork Quilt with Many Holes"; Shaw and Norman, "When There Are No Abortion Laws"; Schummers and Norman, "Abortion Services in Canada."

191 Glauser, "Faith and Access"; Abortion Access Tracker, "Barriers to Abortion Access."

192 Abortion Access Tracker, "Barriers to Abortion Access"; Abortion Rights Coalition of Canada, *Position Paper #5*; Amnesty International, "Europe: Existing Barriers"; Guttmacher Institute, *Abortion Worldwide 2017*.

framework that protects individuals from state interference but does not compel affirmative action to ensure meaningful access.[193]

Supreme Court jurisprudence, including *Gosselin*, *Chaoulli*, and *Eldridge*,[194] reinforces these constraints. While these cases articulate protections for security of the person and equality,[195] they operate within a paradigm that does not recognize positive socio-economic rights.[196] Consequently, health services (including abortion) remain contingent on provincial policies, local practices, and administrative discretion, leaving vulnerable populations, particularly Indigenous women, rural and northern residents, low-income individuals, migrants, racialized communities, and people with disabilities, disproportionately affected.[197] Geographic concentration of services in urban centers, provider-dependent restrictions, and financial barriers exacerbate inequities,[198] reflecting systemic discrimination under section 15 of the Charter.[199]

Stigma further entrenches these disparities. Abortion-related stigma, whether perceived, internalized, or enacted, affects both patients and providers, limiting who can offer services and under what conditions.[200] Reports of providers being forced out of practice or constrained by

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193 Jackman, "Charter Review as a Health Care Accountability Mechanism in Canada"; Lecce, McArthur, and Schafer, *Fragile Freedoms*.

194 *Gosselin v. Quebec*; *Chaoulli v. Quebec*; *Eldridge v. British Columbia*.

195 *Gosselin v. Quebec*, para. 81; *Chaoulli v. Quebec*, paras. 102-104; *Eldridge v. British Columbia*, para. 80.

196 Jackman and Porter, "Social and Economic Rights in Canada," 850.

197 Abortion Access Tracker, "Barriers to Abortion Access."

198 Abortion Access Tracker, "Barriers to Abortion Access," and "Access at a Glance"; Action Canada for Sexual Health and Rights, "Access at a Glance," "Common Myths About Abortion," and "Abortion"; Schummers and Norman, "Abortion Services in Canada."

199 Government of Canada, "Charterpedia – Section 15"; See *Fraser v. Canada (Attorney General)*, [1985] 2 S.C.R. 1; *Eldridge v. Quebec*.

200 Hanschmidt et al., "Abortion Stigma"; Hyde, *Reducing Abortion Stigma*; Ennis et al., "Experience of Stigma and Harassment."

institutional and societal pressures illustrate how social and structural barriers intersect to restrict access.[201] A comprehensive rights-based framework must therefore include strategies to mitigate stigma, including public education, provider protections, and policies ensuring access is not curtailed by social or moral pressures.

International human rights law provides both a lens and normative standard for evaluating Canada's domestic framework. Treaties bodies such as CEDAW and CESCR emphasize that reproductive autonomy is inseparable from substantive equality, dignity, and freedom from discrimination.[202] Disparities in access, whether due to geography, socio-economic status, or systemic marginalization, constitute violations of international obligations even where abortion is legally permitted.[203] Canada's reliance on negative rights and provincial discretion falls short of these international standards, highlighting an "implementation gap" between domestic practice and global commitments.[204]

A rights-based framework in Canada would involve interrelated reforms. Purposive reinterpretation of sections 7 and 15 could establish positive state obligations to ensure meaningful access.[205] Federal legislation could codify abortion as a guaranteed health service, set baseline standards for availability and gestational limits, and regulate conscientious objection to prevent access gaps.[206] Provinces could expand provider networks, integrate abortion into

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201 Ennis et al., "Experience of Stigma and Harassment," 3.

202 UN CEDAW, *Concluding Observations on the Tenth Periodic Report of Cana*; Action Canada for Sexual Health and Rights, "Takeaways from Canada's 10th CEDAW Review"; UN CESCR, *Concluding Observations on the Sixth Periodic Report of Canada*; Action Canada for Sexual Health and Rights, "CESCR Day Three"; UN CESCR, *General Comment No. 22*; UN CEDAW, *General Recommendation No. 24*.

203 UN CEDAW, *Concluding Observations on Canada's Tenth Report*; UN CEDAW, *Concluding Observations on the Combined Eighth and Ninth Periodic Reports of Canada*.

204 Neve, *Closing the Implementation Gap*.

205 Jackman and Porter, "Social and Economic Rights in Canada."

primary care, support telemedicine, and address structural determinants that impede equitable access.[207] Policies should be intersectional, addressing the compounded vulnerabilities of marginalized populations.[208]

Operationalizing such a framework in order to address disparities requires accountability, monitoring, and evaluation through data collection, transparent reporting, and stronger enforcement mechanisms. Legal recognition alone is insufficient if access continues to vary dramatically across regions or populations.[209] Programs that provide logistical and travel funding for rural and remote residents,[210] accommodations for rural and remote patients,[211] and inclusive service provision could translate rights into tangible access.[212] Without these measures, reproductive autonomy remains aspirational rather than real, undermining equality principles and international obligations.

Ultimately, the contrast between Canada's legal permissibility of abortion and the structural reality of access underscores the limitations of Canada's negative-rights paradigm; abortion is recognized in form but not in substance. A rights-based approach grounded in health,

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206 Chavkin, Swerdlow, and Fifield, "Regulation of Conscientious Objection"; UN CESCR, *General Comment No. 22*.

207 Renner et al., "Abortion services and providers in Canada"; Renner et al., "Telemedicine for First-Trimester Medical Abortion"; Action Canada for Sexual Health and Rights, *Trends in Barriers to Abortion Care*; UN CESCR, *General Comment No. 22*.

208 Abortion Access Tracker, "Barriers to Abortion Access"; UN CESCR, *General Comment No. 22*.

209 Abortion Access Tracker, "Barriers to Abortion Access."

210 Government of Canada, "Sexual and Reproductive Health Fund." For example, the SRHF supports Action Canada for Sexual Health and Rights' project *Access for All*, as well as the NAF Canada in providing "financial and logistical support to people travelling for abortion services."

211 Renner et al., "Telemedicine for First-Trimester Medical Abortion."

212 Government of Canada, "Sexual and Reproductive Health Fund." For example, one of the SRHF's medium term goals is that "Healthcare providers will have the knowledge to deliver inclusive SRH care" which they aim to accomplish "by expanding educational materials" that help "enhance cultural safety and inclusion when accessing services and programming related to gender and SRH."

equality, and dignity offers a coherent vision to ensure abortion is not merely a service that exists on paper but a fundamental component of reproductive autonomy, meaningfully accessible to all. Aligning domestic law with international human rights standards would enhance Canada's credibility as a global advocate for gender justice while addressing persistent inequities within its own borders, transforming abortion from a legally permitted service into a substantive right realized in practice.

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