Courage My Friends Podcast Series IX – Episode 1
Lawless: The Complete Decriminalization of Abortion.... Only in Canada

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ANNOUNCER: You're listening to *Needs No Introduction*.
Needs No Introduction is a rabble podcast network show that serves up a series of speeches, interviews and lectures from the finest minds of our time

RESH: How did Canada become the only country in the world to completely decriminalize abortion? And why is this better than legalization? How is abortion a public good and why the silence around it? What does the overturning of Roe v. Wade mean for Canada? And when it comes to equal access to abortion, is decriminalization enough?

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COURAGE MY FRIENDS ANNOUNCER: Welcome back to this podcast series by rabble.ca and the Tommy Douglas Institute at George Brown College.

In the words of the great Tommy Douglas...

TOMMY (Actor): Courage my friends, 'tis not too late to build a better world

COURAGE MY FRIENDS ANNOUNCER: This is the Courage My Friends Podcast.

RESH: Welcome back to the podcast and to the premier episode of Season 9, *Lawless: The Complete Decriminalization of Abortion.... Only in Canada.*

I'm your host, Resh Budhu.

In this episode, we welcome Martha Paynter, nurse, scholar and author of Lawless: Abortion Under Complete Decriminalization, released this month by Fernwood Publishing. We discuss Canada's complete decriminalization of abortion (the only country to do so) the fascinating and often fraught history that brought us to this point, the influence of the anti-choice lobby here and the overturning of Roe versus Wade in the US, and what it takes to make abortion access truly equitable and a public good.

Martha, welcome. Thanks for joining us.

MARTHA: Thanks for having me Resh

RESH: Your book, *Lawless: Abortion Under Complete Decriminalization* will be released this September by Fernwood Publishing. And it is premised on the fact that since 1988, Canada is the only country in the world to completely decriminalize abortion.

What does complete decriminalization mean?

MARTHA: Thanks. It means really that we do not have any restrictions on abortion that interface with criminal law. In many jurisdictions, especially in recent years, we've seen expansion of decriminalization, partial decriminalization. So it's okay, you can have an abortion, as long as you are in the first 20 weeks of pregnancy, as long as you have a reason that the State decides you merit one, for instance, sexual assault, incest, or of course, threat to your physical life. Those kind of things, right? With gestational duration being the most common vector for restrictions...

RESH: And when you say gestational duration, what do you mean?

MARTHA: Weeks of pregnancy. Yeah. I apologize for the clinical terms . Yeah. So here in Canada, we have not put in place a restriction in the law on gestational duration, because according to our Constitution, our Charter of Rights and Freedoms, the pregnant person themselves has that "right to life, liberty and security of the person."

To have security of the person, to have liberty, you have to govern your own body. And it is your own body until it becomes two bodies. It's really that simple in a sense. That is why the way we approach it separates this health service from criminal law. For us working in this field, this is a health service that we provide.

For me, as someone who did a lot of maternity nursing, it's not as if at some point I would say, okay, well, you know, now you're breastfeeding, the baby is now 13 months old, so now you're no longer allowed to have it, my support, my lactation support. It's over, right? There's no clinical ground for that. So that would be an arbitrary State-created distinction. And that's not how we do things; we do things based on what makes sense clinically because this is a health service.

So it doesn't mean that there is no regulatory regime at all. Quite the opposite, and that's kind of the point of the book, this *Lawless* title and then I go on and on and on for like 12 chapters about how there are all these other types of laws.

But when we think about health services, we don't have a law about, let's say hip arthroplasty, right? You have a hip arthroplasty because you need a hip arthroplasty and that's that. You don't get one from someone who isn't equipped to give you one. Don't go seeing someone who doesn't have the appropriate skills. And your care is paid for under the Canada Health Act.

Between the Charter of Rights and Freedoms and the Canada Health Act, those are the laws that cover abortion in this country. And they are not criminal laws.

RESH: At one point way back, we'll get to that, they were, but this has moved it from a criminal justice issue to a reproductive health issue, from criminal justice to reproductive justice. And it is guaranteed, as you say, by " right to life, liberty and security of person", which is Section 7 under the Charter.

Lots of interesting facts in this book. One is that we actually come closest to the World Health Organization definition of abortion. Correct?

MARTHA: Yeah, the WHO recommends against any type of criminalization, any limits on legal abortion at all. And they also recommend that the widest variety of providers be engaged in this work. And so with the introduction of mifepristone which was approved by Health Canada for medication abortion in 2015 and widely implemented and deregulated in 2017, with this we now have nurse practitioners forming a very large and important part of the abortion workforce.

We've also seen movement, with leadership from Quebec, but movement to expand that to include midwives. Of course in my dreams, we would have registered nurses on that roster, pharmacists on that roster. Why not?

So that's what the World Health Organization is getting at, is that abortion is extremely safe, and there's no reason to not expand that clinical support role to as many titles as possible within the realm of safety, right?

Medication abortion is safer than Tylenol. So, of course, we should get to a place where registered nurses and pharmacists can also be supporting patients, advising and yeah.

RESH: And I wanna get to mifepristone and how that has really revolutionized all of this. But just back to the decriminalization, because abortion is decriminalized in Canada, but not legalized, again hence the title *Lawless*. Could you just go a little bit more into what is the difference between decriminalization and legalization?

MARTHA: So, with legalization there would be parameters defining what is legal. So you look for instance at the situation in France where you have a legal right to abortion up to 16 weeks because that is what abortion is in France.

Again, let's go back to my hip arthroplasty. You can have a legal hip arthroplasty, and I'm making this up if you are under the age of 70 right. So you have to make the law have parameters. And so what would those parameters be? They would be inevitably restrictive and subject to change.

Whereas if you just define something as health and leave it to healthcare providers to decide whether or not you meet the clinical criteria. And with abortion, the clinical criteria are, are you pregnant and do you not wanna be?

We have similar types of discourse in relation to sex work and the difference is that people who are working in sex work encounter when something is decriminalized versus legalized. It's legalized within a context. You have to do X, Y, and Z according to the State for your practice in sex work to be legal. As opposed to your work will not be investigated as criminal, will not be sanctioned as criminal inherently for what it is.

RESH: So again, abortion is decriminalized but not legalized. Meaning that we have it as a negative right. The state should not interfere in our ability to access an abortion.

MARTHA: Exactly.

RESH: But not a positive right in that there is no explicit abortion law that could be revoked. And it's easier to revoke a law than it is to amend a constitution in some senses.

MARTHA: Exactly.

RESH: But this is still a continuing debate, right. About whether we need an abortion law in Canada, and you unpack this in the book.

MARTHA: It's certainly not a debate among the abortion movements.

RESH: Okay.

MARTHA: It's rhetoric that is wielded against us by the anti-abortion forces, right. Making a frantic reaction to this absence of a law.

RESH: And sort of inferring that because there's no law, somehow it is illegal, which is inaccurate

MARTHA: Or that it's chaos, right? And that is not the case. We have a very well-orchestrated, machinery and infrastructure for abortion. So we do have to be careful about it because abortion is legal in Canada. Yeah. Right.

RESH: And regulated.

MARTHA: And regulated, even if we do not have the legalization of abortion. I worry so much that this rhetoric confuses the public, especially in this moment.

You know, I probably had to write this book always, but I definitely had to write it after the fall of Roe v. Wade when every source of news and non-news that Canadians are consuming is just this bombardment of US information.

And so in the face of all this US information, the Canadian consumer, the Canadian patient, the Canadian abortion seeker needs to understand that this realm that we are in is completely different. We have a completely different legal regime, a completely different health regime, a completely different finance, et cetera, et cetera, et cetera, right?

So, what I want people to really come away from this with is that abortion is a service. It's normal, it's common, it's almost banal.

And the greatest threat in Canada to me is not some debate about abortion, it's these encroaching and oblique forces of privatization of healthcare, period. Of use of the notwithstanding clause to threaten the rights of the most marginalized among us, like little transgender youth. Those kinds of forces, that's the type of thing that worries me.

RESH: We're gonna get more into that because there are so many inequities within abortion in Canada. But just to get back to the basics, because there's also so little knowledge as, as you're saying. What exactly is abortion and what are the different types?

MARTHA: Oh, thank you, Resh. Okay. So let's start with procedural abortion, which most people know by its old name, surgical abortion. We've moved away from that language because of course there's no cutting into the skin, and that's what people associate surgery with. So, in an abortion procedure it's actually very brief.

The patient is given some medication for anxiety, for pain. They are on an exam table and receive what's called a "bimanual exam" where the provider pushes on the uterus and inserts two fingers into the vagina to feel the location of the cervix and the size of the uterus. Then when they put in the speculum, which is that kind of duck-clip thing that people might know from having a pap smear, which opens and reveals the cervix. They then often freeze the cervix with lidocaine, like when you go to the dentist, a needle that puts lidocaine, local anesthetic. And then a thin tube called a dilator is inserted through the os, the central opening of the cervix. A cervix, if you touch it, it feels like a nose, but there is a central little hole, and we can place the dilator through that. Then we use successively wider dilators to open the cervix enough, and then we put in a tube called the vacurette and attach that to suction. And that suction is used to remove the contents of the uterus. And then all of the instruments are removed and it's finished.

Typically the contents of the uterus are inspected to make sure that it's complete. Because one of the potential complications of procedural abortion is what's called retained tissue, so some tissue that stays in there and that can become infected. That's rare, but we of course wanna prevent it. We often give patients a prophylactic antibiotic, again to prevent that. So the procedure itself takes about seven minutes, and then patients go into recovery and they're watched if they had pain medication. You know, their vitals are monitored to make sure that they're doing well with the pain medication. And then typically they're fine. They'll have minimal bleeding and go back to work the next day. So that's a procedural abortion.

With a medication abortion, the best drug that we have for medication abortion is called mifepristone, and it's used in combination with misoprostol. , Mifepristone is a single tablet that you would take at your house. Nothing really happens, you don't really feel anything typically with mifepristone. But what the mifepristone is doing is it's basically changing your hormones to make the uterus incompatible with the pregnancy. So it's ending the pregnancy, it's done at that point.

And then you take the misoprostol the next day. And you have four misoprostol pills. You put them typically in your cheeks and they dissolve. And that medication causes contraction-type cramps, which expel the tissue from the uterus.

So drug one ends the pregnancy. Drug two expels the pregnancy.

Now this is a medication. So unlike a procedure, we don't know how long it's gonna take. Ideally, once you take the misoprostol, within been about six hours you've passed most of the tissue. But it can take much longer. Ideally the bleeding resolves quite quickly, but it can continue for weeks.

So when we think about what people will prefer in terms of is a medication or procedural abortion best for you, there are of course clinical factors. So if someone has, you know, a bleeding disorder, severe anemia, then maybe medication abortion where you're bleeding, cramping, bleeding at your house, maybe that's not the best call. Depends.

But we also consider social factors. So maybe you have two kids at home, it's very inconvenient to get into the clinic. Your mother will come over and help watch the kids while you're passing the tissue. Great. Good. And getting to the clinic would be a real pain. Okay, maybe that's a factor.

Maybe you want to have a nurse at your side who's monitoring your pain medication in the procedure room. Maybe you'd rather just buy some Advil at the pharmacy and no thank you, no white coats around.

Right? So it really depends on what you want and your personal circumstances. But by having these two options, well, it creates choice. And that in and of itself when you're able to determine the course of this procedure for yourself, in addition to being able to determine that you can have it in the first place, these are sources of power. And are not only important manifestations of that right to liberty and security of the person, but are also really important for the rest of your life.

Abortion it's often maligned and misunderstood as some traumatic experience and it's usually not that. It's usually a source of great relief and self-confidence and reassurance that you can govern yourself and you can support yourself, perhaps your existing children and, take charge of your direction.

That was a long-winded way of telling you what the difference is between what we call MA, medication abortion or PA, procedural abortion.

RESH: How does one access abortion services, and are these covered under universal healthcare in Canada?

MARTHA: Yes, they're covered. How you access services depends on where you are. And in every province and territory in Canada, there's a clinic that you can call.

You can just pick up the phone and call them and book an abortion. That's what we call "self-referral".

And because of the olden days, how things used to be done, where you were required to have the permission of a therapeutic abortion committee made up of physicians at a hospital, because of this old legacy, people might not know that everywhere in Canada you can just call and book yourself and nobody is going to assess your eligibility. That's not a thing anymore. Hasn't been for a long time.

The problem is how do you know who to call? So you're going to Google Abortion Ontario, if you're in Ontario as you are. And then you're gonna get a whole bunch of stuff. Because a lot of anti-abortion uh, activists, if we can call it that, energy is devoted to misinforming patients. To getting them to go see them at crisis pregnancy centers, to suck them into the orbit of the crisis pregnancy center so that they are delayed in accessing care.

This is the issue, and this is the number one thing that for the last while in my career I've been obsessed with, is helping people understand how to get an abortion exactly where you are.

So if you live in PEI, this is the number for SHORES. If you live in New Brunswick, this is the number for the Moncton City Clinic. It's open every day. Et cetera, et cetera, et cetera, right? Because there's not just one number you call.

Now that said, if you don't know who to call you can call Action Canada for Sexual Health and Rights, which is a very important organization across the country that at least has its finger on the pulse nationwide about who is working where.

Because we don't talk about abortion enough, this is often just not well understood. For instance, where I live in New Brunswick, where abortion takes place at the Moncton City Hospital, there's a lovely clinic . At the Bathurst Hospital there's a clinic and at the Dumont Hospital there is a clinic, but it's not like these clinics have advertising campaigns. So how are you supposed to know, right? This is the problem.

MARTHA: So we need to talk about abortion like the normal thing that it is so that people don't face this like Google mess of misinformation and confusion.

RESH: And we also need to talk about abortion history because a lot of people don't know about abortion history. I was saying to you earlier, I consider myself a reasonably well-informed person and again, there were a lot of facts within this book that were like, oh, really? Right. So the book examines the legal, political and social entanglements of abortion in Canada and the history behind this is fascinating and often quite fraught.

Give us the highlights of how did we get to where we are now? What are some of the really important moments to understand?

MARTHA: So. In 1892.

RESH: Okay.

MARTHA: No, but seriously, we had our first criminal code, federal criminal code. And it was of course, based on the British colonial model. And that criminalized all those things that are so focused on women and women's bodies. It criminalized birth control, it criminalized abortion, it criminalized sex work, right? So that was in place until 1969 when the first Trudeau put forward what was known as the Omnibus Bill. This was a very important suite of legislation that decriminalized contraception, decriminalized homosexuality and partially decriminalized abortion.

RESH: The State has no place in the bedrooms of the nation.

MARTHA: Yes. Dear Pierre Elliott Trudeau. At that point there had been a lot of attention to deaths of patients caused by the criminalization of abortion that was in place at the time.

So post '69, we had this regimen called the Therapeutic Abortion Committee regime. And with this new section in the criminal code, you could have an abortion that wouldn't be criminalized if you had the approval of a Therapeutic Abortion Committee made up of three physicians, and the abortion was going to be performed at a licensed hospital.

So instantly we experience the problem with this regime, which is very few hospitals had such a committee, and even if they had such a committee, how would you find out? Think about right now in the information internet age, the silly hoops we have to jump through to get factual information about where we go to get an abortion.

In 1969 for you to make the leap from, okay, now I know I'm pregnant. 'cause you couldn't buy pregnancy tests at the dollar store in 1969. So first you have to find out you're pregnant. Then you have to go to your family doctor because we didn't have nurse practitioners blossoming the size of our primary care workforce.

So you go to your family doctor, then you get a referral to the Therapeutic Abortion Committee, if that family doctor will allow It. Then you get to the Therapeutic Abortion Committee and maybe they're going to approve you and maybe they aren't. And maybe at that point, they only approve things up to, let's say 20 weeks and it's taking you 24 to get through all these hoops. So now you're screwed.

This was recognized quite quickly as a massive problem. And obviously it's the most privileged among us who have access to the most information and get through the hoops the fastest.

You know, the Abortion Caravan, that movement in 1970 to really raise awareness across the country, this feminist traveling act that went from the West Coast and

demonstrated very publicly in Ottawa and on Parliament Hill. This was because this immediate change was not enough.

And, you know, the abortion caravan in 1970 was calling for complete decriminalization. They were also calling for access to birth control that we still haven't achieved.

And so in 1970, you know the other person who recognized all this was Morgentaler. Dr. Henry Morgentaler, Holocaust survivor, concentration camp survivor, who finishes his medical school in Canada and sets up family practice in Montreal.

He sees right away that this Therapeutic Abortion Committee regime is not gonna work. And so he opens a private clinic and he just starts doing them, completely illegally with no one's approval. And I think it's so important that we remember that that was what was done at the time. If there was a law that was not just, there was this man incredibly courageous man who just wouldn't obey it.

RESH: Yeah.

MARTHA: It is so just so important when we see creeping fascism all around us that we remember these people who just said, oh, no, thank you.

RESH: Well, it is important. The history I said was fraught, it was dangerous. And you certainly document this in the book. . I was growing up as a teenager at that time. I remember seeing the protests and counter-protests around clinics, the targeting of abortion providers, Morgentaler among them, I remember the firebombing of his clinic in Toronto. I also just wanna mention, since we're on rabble, that Judy Rebick.

MARTHA: Judy!

RESH: Judy Rebick, who's one of the co-founders of rabble, was actually credited at one point with saving his life. But yeah, Morgentaler was such a pivotal figure in this history.

MARTHA: Yeah, and you know, what you just said really illustrates... 'cause you just jumped from 1970 to 1994 in a breath and it shows this 24 year period, and it even went on long beyond that, when this man was just working his fingers to the bone, that's for sure.

So we have this period, he is doing this work and of course he gets arrested. And he is tried three times with the crime of providing abortion, and no jury would convict him. Because like he did, they inherently saw this was just not the law. Yeah, he broke the law, but the law wasn't a good law, the end. And so that made its way up to the Supreme Court of Canada in 1988.

So he'd already been doing this for 18 years. He had already been in prison. He had a heart attack in prison. He was in prison for 10 months at one point. The courage, right the courage!

So 1988 he wins and the Supreme Court of Canada rules no, we can't have this law in place because it violates the Charter.

Now, we only had the Charter in 1982 . And we only had the Canada Health Act in 1984, right? So there were these things that had to happen earlier in the eighties to make it so that in 1988 the court would rule as it did.

Suddenly Morgentaler is free to open his clinics anywhere in Canada and he does, he opens them all across the country.

Then we see in the nineties this real period of violent backlash and that's when the Toronto fire bombing happened. It's when the sniper attacks happened. Although there were no murders in Canada, there were very serious injuries as a result of these sniper attacks. That put a real chill over everything.

Yeah, I was a teenager in the nineties and my mother was incredibly active in this space. And I think it really influenced me seeing this type of on-display sidewalk dispute where you have people screaming at patients.

You know, we all of a certain age watched that Degrassi High episode, right.

RESH: And it, Erica was, who was it?

MARTHA: It was Erica. One of the twins who went in through the fracas and had the procedure. Yeah, but these themes were really important in that show. That was the Canadian adolescent show.

Anyway there were some very principled providers dedicated to doing this work, but they were few and far between because the risks were extreme.

I've spent a lot of time in the past couple of weeks Resh, talking about a mentor of mine who died on July 3rd, Dr. Jacques Desrosiers. He was taught to provide abortions in the early nineties by Dr. Morgentaler. And he took over Dr. Morgentaler's clinic in Halifax. And then he came to run the provincial clinic. And then we came to name the clinic after him, the Rose Clinic, after Jacques Desrosiers.

So I've talked a lot recently about what he did. You know, Jacques was pretty, pretty simple guy to be perfectly honest. And he just believed that it made sense to do this work, and so he just did it through all of the threats. He just kept on coming to work and doing the work basically until he died. That was the kind of person who did the work then. And that continued for quite a long time.

Even though the violence the threat of the violence had really dissipated, cultural norms were changing, it wasn't really until 2015 with Health Canada's approval of mifepristone and deregulation, so that medication abortion became a normal prescription you can get in any family physician's office, any general nurse practitioner's office, that made it so that you didn't have the target of the abortion clinic. You didn't have the mantle of being the one abortion provider in town with a target on your back. Basically you could get an abortion from anywhere.

You could be going into your family practice office because you have strep throat. Or because you have osteoarthritis. Or because you need an abortion. Nobody outside is gonna know and nobody's going to protest you. As well as the bubble zone legislation that's also happened.

But we've seen that targeted harassment that providers feel, it's really dissipated. And the fear that patients feel has really changed.

RESH: It's an interesting history and as you said, you've been so connected to it through your family as well.

Could you speak a bit more about your background and also what inspired you to write *Lawless* and what inspires you to pursue reproductive justice? Because this really has been sort of the core of so much of your work.

MARTHA: Yeah, thank you Resh. You know living here in Fredericton now again, I'm from Fredericton and I came back after I got my PhD and I work here at UNB.

I was raised in an environment where this was just very straightforward. My mother was very professionally engaged, she was the head of Planned Parenthood in New Brunswick. But it was more that it was just the norm in our home. That reproductive health and experiences were normal and important.

Why did I write this? What inspired me? I write about this in the beginning of the book. I was at this conference in Alberta. You know, Lethbridge small place in Alberta. And in Lethbridge access to abortion, because the procedural clinics are in Calgary and Edmonton, access to abortion relies very heavily on the work of a very small number of volunteers.

Women who just have their ears to the ground. They know what's going on. You can call them and they will figure out where to get you an abortion. And I think I was at a conference in 2023 and I just thought, you know, we are at this point where this is still how we do things. This is so unsophisticated.

People do not know in a place like Alberta with a billion, multi-billion dollar health budget, we're relying on women to do this volunteer, feminized work of figuring out, just like, you know, abortion, underground. It's so strange and unnecessary. I mean, I deeply admire these women, that's not what I'm communicating. It's just that we don't have a very good system.

And part of that is because we're afraid to talk about this. And so we don't talk about it. We don't learn about it. I teach in nursing schools, I teach in medical schools. I obviously went to one. This is not part of the normal conversation. It's more common than diabetes. But what do you think, it's 20 hours of curriculum, right? Also diabetes is very important.

So I wanted to write the book to clarify the way things are right now and how we got here. And this is not an okay place to be. It's not okay that we're relying on this feminized volunteer labour that's subject to, you know what, if somebody goes on vacation for a month? We can't have things that are that precarious. That's not a system. And so we need to have better, more conversations about abortion so that we're not so haphazard. That's kind of why I wrote the book.

And we really need to understand the potential of our unique regime. This is what people around the world are dying to have. And we've had it since 1988. So come on, now we can do better given that we've achieved this situation.

RESH: Obviously as we said, this goes beyond clinical procedure or legal decision. You write that, "Abortion is healthcare, but abortion is political too. Abortion is foundational, not fringe.It is normal, not special. And it is power, not shame." So could you speak more about what is the political significance of abortion and why is it, as you say, an "essential need" and a "public good"?

MARTHA: As an abortion care provider, as somebody who would sit bedside with a patient. Hold their hand, give them fentanyl. I really had a profound horror that the fear that patients come into the space with, the shame that they're intended to experience. Like I said, they usually leave feeling very different, but they come into the space full of fear, full of shame.

And it made me so angry that this is obviously an act that takes two and all of the burden of this... The physical pain, because it is kind of painful. Of course, we're gonna give you fentanyl, but it's still gonna hurt.

The physical pain, the massive inconvenience, and the social and emotional burden of having to feel like you're doing something bad, all of this rests on women and people with a uterus. And it's just so ridiculous that it would be so inequitable.

You know, sometimes I would be with patients and they would be expressing this shame and then, you know, their boyfriend wouldn't even show up to pick them up.

And I just thought, how, how can this be the society that we live in? That we have so much strength and responsibility and bravery from these women and gender diverse people who are coming into this clinic.

Regardless of this, they're leaving the clinic, having been treated with respect and compassion and having their whole lives reopen to possibility. They're leaving the clinic feeling loved and full of power. And so not only does this make abortion work

so profoundly fulfilling, it's just such good work. But it really shows how this is just incredibly important, it's essential. Not because it's gonna keep you healthy, but it is going to keep you healthy.

RESH: Well, you write about the benefits go from the individual to the community. Because people who don't get an abortion when they want one, there can be so many cascading negative effects from that.

MARTHA: Yeah. There's a beautiful and incredible study outside of California by Diana Green Foster that shows over 10 years of tracing what happens to patients in the US who were unable to get the care they needed because of these restrictions, for instance, gestational duration restrictions. Those patients, the patients who cannot get the abortion care that they wanted, who are turned away, it's called the Turn Away study, they are more likely to live in poverty, to experience domestic intimate partner violence, for their children to be unwell. And frankly, they're more likely to die. So this is something that we need to understand what the risk is to a society if we do not have this care readily available. Quickly available.

You know, most abortion patients are already parents and they're trying to govern their lives, their families, in a way that they can protect their children from poverty and from violence. I mean, violence is a huge part of this. As a nursing educator, we don't talk enough about how gendered violence causes injury and mental anguish, which is this enormous source of illness, harm. This is why we need a lot of healthcare because of gendered violence. And that's why we do need a lot of abortion services.

RESH: Now in your first book, Abortion to Abolition: *Reproductive Health and Justice in Canada*, you discussed the liberatory potential of abortion. Really what we're talking about here. And you looked at abortion access through the prism of prison, for people who are incarcerated, a very underserved population, and they aren't the only ones. Access to a safe and timely abortion is still a struggle for many. What are some of the persistent barriers to abortion and who are some of the groups that are most impacted and how.

MARTHA: I think that we've done a little bit of very important work to address the gender exclusion that is pervasive in reproductive health services. For example, our changing of the name of the Nova Scotia Women's Choice Clinic to the Rose Clinic, these deliberate acts to communicate an intention to be gender inclusive. It's a necessary first step.

These are the kind of things that you can worry about if you're not worrying about the safety of yourself coming into the clinic doors. When you're not worried about your patients being screamed at. You get to start worrying about like, okay, does our form say your pronouns on it? Right? You can make some thoughtful progress in your practice.

So we're doing some work there, but of course that's a huge project. Gender inclusivity is a huge project all across reproductive health services.

We have as a country, not only underserved, but deliberately and violently harmed Indigenous women, girls, and two-spirit people. And with the legacy and ongoing threats of eugenic forced sterilization. To compliment that with this affirmation that you obviously, have the right to and should have culturally safe abortion care, while we are reckoning with forced sterilization...

RESH: W hich was a feature of the residential school system as well.

MARTHA: Yes. And it's all part of this genocidal, Canadian colonial cultural project, right? So that's a huge thing.

And we continue to have almost no discussion or thoughtfulness about inclusion of patients with disabilities. We have almost no research, no guidelines, no movement to be better in that domain. And of course, we know that disabled women are much more likely to be subject to intimate partner violence.

We have fat phobia that we're dealing with in reproductive health spaces. We don't really know what we're doing there. And there's starting to be understanding that emergency contraception Plan B doesn't work so great for people who are over 175 pounds. And so then you're gonna increase your need for abortion.

We just need to be doing things that are more sensitive. And we can now. We have the space.

So those are patients who are all covered.

The other huge issue here is that we do not have coverage, we do not have public funding for people without papers.

International students are very likely to not have coverage unless they go through the motions and are able to go through the motions of applying for and receiving Medicare. Migrant workers.

MARTHA: These are people that we rely on. Certainly as a university educator, I'm relying on international students and it should be universities that are taking some leadership and making sure that all of their students are safe and able to access covered abortion services while they're here. All of us require migrant labour work so that we have food to eat.

So recognizing that we have these connections and responsibilities towards each other. And we do not have pathways for these people to have paid for care.

RESH: And all of this , it takes time, right? This is a very time-sensitive issue in terms of the best time for you to get an abortion as well.

MARTHA: And this is another source of a lot of confusion. So we do not have a gestational limitation in law in Canada, but 95% of abortion in Canada is in the first trimester.

So for that little bit that's left, you have to find a provider who knows what they're doing, who's willing to do it, who's organized and they are few and far between. It's not that it's illegal, it's the people who do this work just aren't everywhere. Have to go to Toronto, you're gonna have to go to Montreal, you're gonna have to go to Vancouver. And that's gonna cost a fortune.

The procedure is covered. The provincial government might even pay your hotel and your flight, but there's more to life than that. Right? All your days of lost work. So the earlier that we can ensure someone has access... And we've already seen with the introduction of mifepristone, and democratizing across primary care, we're seeing that the need for second trimester services is falling.

People are in general getting care even earlier. But we're always going to need later care. And not that every hamlet is going to have a provider, no. But we need to know the pathway to the provider who does do this work. That needs to be less shrouded in secrecy and bureaucracy.

RESH: Absolutely. Now I wanna get into that because to quote the book again, "1 in 3 women or people with a uterus will have an abortion in their lifetime, and 100,000 abortions occur in Canada each year." Yet abortion and the history abortion in Canada remains, as you say, shrouded in secrecy or shrouded in silence.

That Canada is the only nation to completely decriminalize abortion, as we were discussing earlier, was news to me, it was news to a lot of the people that I was speaking to. Why this lack of knowledge and this silence around abortion?

MARTHA: Well, I mean, we're so silent about so many things that are about gender justice, right?

It's 2025 and apparently people are just discovering that menopause is a thing and can be treated right now.

RESH: It's interesting that you bring that up because we had done an episode on menopause a couple seasons ago, and it was around a report that the Menopause Foundation had come out with called Menopause, the Silence and the Stigma.

And when I'm reading your book, I'm like, yeah, this all sounds very familiar because again, it's not just about the knowledge gap within the general public, but in policy and really disturbingly around medical training programs and so, so yeah, continue

MARTHA: We don't know what we're doing. Yeah, so this is just part of a very long list of things that we do poorly for women and people with a uterus.

Also though, this has been a allowed to be in our cultural discourse as this thing that is a source of shame. In, for example, TV shows it might be hinted at, but most of the time people choose not to have the abortion.

You know, *And Just Like That* wrapped a couple days ago, and we all remember when Miranda was gonna have an abortion. She went into the clinic, the door closed behind her, and then lo and behold, Brady was born. Right?

So we have these major cultural forces that just reiterate this idea that abortion is rare and hard. And it's not, it's very normal. It's very common and it takes seven minutes. And actually it will allow you to follow your dreams. Whether that dream is to escape a violent relationship or to finish your graduate degree or whatever.

So, we do need to have this shift in the way we talk about abortion. And we need to understand abortion, not just as healthcare, but as this force of good in our society.

Yes, of course we need to do a better job treating endometriosis. We need to do a better job treating menopause. But abortion is, it's part of democracy. And so I really want that value, that core to be appreciated. Especially now when we look at rising fascism and what's happening south of the border, we need to recognize our position on abortion, this is celebratory. This is something that defines us and has a lot to do with the way our culture works.

Is our culture perfect? Absolutely not. But there are things that are only possible because we are allowed to govern our bodies.

RESH: When I'm thinking about the sex education that I had growing up, there was a lot of education that was around when you are reproductive and when you are going to give birth, or how you get to that point of giving birth.

But when it comes to making the decision not to, no education about that abortion when it comes to after your reproductive years, nothing about that. So there's also such an obsession with just birthing as well.

When abortion does enter into popular discourse is when it becomes a political football. We've seen it here, we've seen it in the United States, we see it in Ireland. We see it in so many contexts. And going back to the United States. So again, the federally protected right to abortion under the Supreme Court decision of Roe versus Wade, guaranteed since 1973 was revoked by the Supreme Court in June of 2022.

Abortion is now decided by various state laws in the US and as of now, abortion is banned in 12 of those states with various degrees of limitation and access in others. So go a bit more into what you see happening in the United States. And does it have a bearing on Canada? And has it galvanized the anti-abortion movement or anti-choice movement in Canada? So what are the impacts of what is happening in the United States?

MARTHA: I think one of the things that is misunderstood about what's happened in the US is the reality on the ground is that there is more abortion now in the US than there was before. The banning of abortion has increased the numbers of abortion by a lot.

And so what we see happening, of course, you're not having the abortions in Texas, but you're having them somewhere. And so yes, there's going to be more migration to those few States that remain, that are so overburdened with this work and the incredible dedicated providers who are doing this work.

But people are not going to choose to have children in a regime where they are so poorly treated. So this is driving up the abortion rate.

In Canada the rate of abortion was already way lower than in the US and it's only going down. And we're seeing the complete opposite happen in the US.

I really think it's important for listeners to understand that's what happens if you ban abortion, abortion will go up.

Has it galvanized them? Sure. I mean, they're driven by something that is, you know, it's not logical and it's not factual. And it's not clinical. Like it just... I won't ever be able to really understand it. Right.

RESH: No, but they are such a powerful force.

MARTHA: They're a very powerful force.

RESH: As a lobby, as a movement. And the book delves into many of the tactics that the anti-choice movement, lobby has been putting forth over the years. Talk about some of those tactics.

MARTHA: Well, certainly the crisis pregnancy center, right? Yeah. Which was invented in Toronto. And the book gets into that.

RESH: Canada's the head of so many things, right? Decriminalization and crisis pregnancy centers.

MARTHA: And we have a lot of them.

RESH: More than clinics.

MARTHA: Yes. Way more than clinics. But again, clinics are no longer the unit that we count, right? Because we have medication abortion throughout primary care. So we don't wanna be doing that, and we really wanna move away from that. But regardless, crisis pregnancy centers are a problem.

And we can counter this by being public. By advertising. We should have billboards paid for by the province that say, medication abortion is available. Call one 800-M-abortion and get yourself one. Like we can counter this because this is an advertising war that we are losing. And so that's the thing. We can only do so much through..., i mean, I love doing like a podcast or an interview. But we need billboards!

We need algorithmically sophisticated, top of the Google hits for our real abortion providers so that patients are not stumbling into becoming prey for the crisis pregnancy center.

RESH: Which parade as clinics. I mean, it's interesting how they set them right next to clinics.

MARTHA: Illegally!

RESH: Illegally, yeah. One of the frequent targets of anti-abortion groups are university and college campuses. You've probably seen them at your university. I've seen them at my college. Why campuses?

MARTHA: Campuses make sense because there's a lot of young people here. People are coming of age and coming into understanding what matters to them philosophically.

And that's why so much of the Left had this early period in the student union movement, right that then evolves into involvement with labour. It's a galvanizing time for youth politically.

The campaigns that sometimes happen on university campuses can be grotesque and they can be misinforming.

RESH: And intimidating I have to say

MARTHA: intimidating, intimidating. But one of the things that I caution in the book is how incredibly important Freedom of Assembly and Freedom of Expression are as other elements of our Charter. And we saw with the reaction to our solidarity work with Palestinians on campus. For those of us I committed to international solidarity, reproductive justice work, you want to be able to speak out. And so I'm cautious, very cautious about, too much restriction on where we can be and what we can say. Because it's so important for the Left to also be able to speak out, to be present, to be public.

There are some things that are very reasonable, right? Like the bubble zone legislation that I talk about in the book that was created to create a moat around the abortion clinic to prevent physical harm and like right there pressed against your ear, verbal confrontation, between anti-abortion terrorists, frankly, and abortion patients.

That is a very reasonable compromise, right?

But criminalizing all protests outside of all health facilities. I don't know. I don't know about that. Yeah. Increasing criminalization of public demonstration really worries me. Not everybody agrees with me either. But that's, part of what the book addresses and it's not entirely figured out.

Even the university thing. Is the university public space?

RESH: It's a good question, and one we're trying to figure out now,. Well, the first floor is, but I know it's a deeper question than that.

Though Canada is ahead in the decriminalization of abortion, decriminalization, as you said, is not enough when it comes to guaranteeing access to safe, supported, and timely abortion for everyone who wants to get it. In building a truly equitable approach to abortion what are some of the current priorities that the country should have, the reproductive justice movement has?

MARTHA: So reproductive justice, let's talk for a second beyond abortion, right? it's so disappointing how we had this opportunity last year that so many of us worked so hard for, for public funding for contraception for everyone. This was a piece we needed and we didn't get it. The Yukon, PEI, Manitoba, and BC orchestrated agreements with the Feds. They will get to have publicly-funded contraception.

Most recent data out of BC shows that there was a 50% increase in the use of long-acting reversible contraception, which is the most effective type of contraception and the most cost effective type of contraception, once BC implemented its free contraception program.

So some Canadians get to have this benefit and some do not. That is profoundly unfair. And not having free contraception. I trained as an economist long before I trained as a nurse, and it is just such bad math. That is some really bad math.

You can have a publicly-funded abortion every month for the rest of your life, but can you have a $30 pack of birth control pills paid for by the province?

No, you cannot.

So this is foolishness. And when we spend billions on weaponry and we cannot find the $100 million that we need for a province to have free contraception, it is infuriating.

And any province that claims that it cares about gender equity, that it cares about violence against women, and hasn't implemented this policy, which is so smart and so easy, um, no. They're just basically lying. There's so much that we need to do, but that we can do so easily. So that's number one.

And of course we need to be doing a better job in terms of our education of healthcare professionals. Contraception too, menopause too, routinizing

reproductive health as part of very normal, basic. This is the basics. And if you don't have this, then you don't really have anything else. And we treat reproductive health as this, like special add-on when it is literally the core of how we got here.

In Canada what we have achieved in terms of improvements to sexual and reproductive health outcomes, it's because of better education for young people, for all people.

The quality of sexual health education is deeply under threat. Danielle Smith has implemented opt-in sexual health education. Ooh, wow! The implications of this 10 years from now are dire.

So those are some very big places to start that will be incredibly efficacious if we have attention to those areas.

RESH: Finally, Martha, who is this book for and what do you want readers to get from *Lawless*?

MARTHA: I think like my first book, this book is for the 18-year-old who wants to know what is going on and what is important.

I want parents to read this book so that they can be like, okay, I know how to take care of my kid. I'm good. And know the reality, feel really powerful that they are a source of factual, helpful information in the age of TikTok disinfo.

I want healthcare providers across the country to read it because we kind of operate in our little silos. Me too. Like, I don't know what you need if you have hypertension, oh my goodness, who am I gonna refer you to? So these kind of things that we need to be better informed about this because it is so, so profoundly basic.

I want young people to read it and to feel like they understand and are proud of where they live.

And I want people internationally to read it, to understand that decriminalization is actually just the beginning. You know, I was in Sweden a couple months ago, and they're working on decriminalization right now. And they're very hung up, very hung up on the idea of not having gestational duration limits. And I think the international reader can read this and realize, it's not going to cause all this chaos. You're still gonna have 95% of your care is gonna be in the first 12, 14 weeks.

I want, educators to read it so that they know where to send people.

It's,really the number one reason I want people to talk about abortion so that they know how they can get whoever it is who texted them for help, help within five minutes.

I just want people to feel really powerful. There's so much information that makes us feel so threatened. I just want us to feel power.

RESH: *Lawless: Abortion under Complete Decriminalization* by Martha Paynter will be released in September by Fernwood Publishing. It is a compelling read and in these times a quite necessary read as well.

Martha, thank you. It has been a pleasure.

MARTHA: Thank you. Resh.

RESH: That was nurse, public scholar and rauthor, Dr. Martha Paynter. The link to her latest book, *Lawless: Abortion Under Complete Decriminalization*, released this month by Fernwood Publishing, can be found in the show notes to this episode.

And this is The Courage My Friends podcast.

I'm your host, Resh Budhu. Thanks for listening.

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