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The Gender Gap: Reproductive and Sexual Health Services in Southern Alberta

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I Gender Equity and Reproductive Freedom

Between August 2008 and June 2009 there was a 12,800 net increase in employment of women in Alberta over the age of 20. Contrastingly, in the same period, 29,000 men lost jobs. While women gained employment ahead of men they remain over represented in lower paying jobs with the average median hourly earnings during the first six- months of 2009 being \$19.52 for women compared to \$25.43 for men over the age of 20 (Hamilton and Summer, 2009). Gender wage differentials are “particularly severe in Alberta for those women who have gone on to graduate from non-degree programs in post-secondary institutions. In 2009, women working full-time, full-year with a post-secondary diploma or certificate earned 63.2% of what men earned, despite having the same level of education”(Parkland, 2012).

In 2012 Bailey definitively linked women’s wage gains that began in the 1990s with an increased access to oral contraception (Hansen, 2012 sa Bailey et al, 2012). When women are able to defer or control the timing of motherhood, economic and educational advancement follows although a woman’s decision whether to pursue an education, a career or to use contraception is mediated by cultural variations as illustrated in case studies of Chinese, Inuit and Mennonite women many of whom have low rates of birth control usage (Billson and Stapleton, 1994:357; sa Kulig et al, 2009) “Theoretically,” Billson and Stapleton determined “contraception should play an important role in women’s lives because it carries the potential to allow us greater control over our bodies, reduces the chances of accidental motherhood, and affords greater choice in participating in the public sphere of educational and occupational opportunity”(357). Further, women’s opportunities are enabled by available and affordable childcare. However, *gender asymmetries* impede women’s progress, as “men have failed to enter the domestic sphere as extensively as women have crossed over into the public sphere . . . [a]symmetrical cross-over means that childbearing has drastic implications for women who wish to participate in the public as well as domestic spheres. Children are the main factor deterring women from seeking employment” (ibid, 358). Women largely remain the primary caretakers for children and household affairs as “the domestic imperative that emanates from [women’s] biology has become crystallized in the social institution of motherhood which idealizes the woman who caters to her children to the exclusion of everyone (even herself)” (ibid 358). When faced with unwanted or accidental pregnancy, women and the children in their care may suffer inordinately because the woman’s ability to earn is undermined. It follows therefore that reproductive freedom allows greater economic equity for women and correspondingly may reduce, or offset, child or family poverty.

II Historical Background

Reproductive freedom across variations in a woman’s class or culture in addition to a social and cultural revolution in how Canadians understood the concept of *sexuality* and *family*, has resulted since 1969 when birth control and access to abortion was decriminalized under *Section 251* of Canada’s Criminal Code (Weir 1994). But *Section 251* was not ideal for women (Palmer 2011). In the 1970s, the Calgary Birth Control Association referred many Albertan

women to clinical services in Seattle (Palmer, 2011; MacKinnon, 1994). Under *Section 251*, abortions in Canada required the written consent of a therapeutic abortion committee consisting of a least three physicians; and approvals occurred only if pregnancy endangered the life or health of the woman. Alternatively, in the United States, the landmark Supreme Court decision known as *Roe v Wade* (1973) used the 14th constitutional amendment to guarantee a woman's right to privacy should she wish to seek an abortion. In January 1988, a Canadian Supreme Court verdict declared *Section 251* unconstitutional enabling women to privately decide, in consultation with their physician, on the matter of an abortion.

In essence, however, between 1969 and 1991 procreation was unshackled from sexuality, and sexual relationships between men and women were transformed. Reliable methods for family limitation such as the birth control pill afforded women greater freedom to engage in sexual activity without the risk of unwanted or accidental pregnancy. The pill also reduced women's dependency on men for other means to prevent pregnancy. Today oral contraception is the dominant means of pregnancy prevention for women in Canada (43%); women are extremely aware of the value of the condom as a barrier against HIV/STIs as well as an extra barrier against pregnancy; and married women, 35-44, frequently use sterilization as a method of birth control (10% women/14% male partners). On the other hand, sexually active adolescent girls while more aware of emergency contraception are less familiar with time limit efficacy of such methods; and condom use decreased among adolescents who employ oral contraception (CIHI, 2004:51).

III Social Conservatism and Reproductive Health

Fortunately more men, in the 21st century, are actively parenting and increasingly aware of reproduction as a shared responsibility. Yet women remain consistently subject to harsh and moral condemnation if they wish to limit birth or need access to timely and safe abortion services or counseling. Men are less subject to the social imperatives to parent and are not scrutinized or judged in the same way as women when it comes to decisions about reproduction.

In the 1990s, transnational (Canada & U.S.) groups who self-identify as "pro-family" and "pro-life" emerged as vocal proponents of conservative views on the family and on the reproductive rights of *women*. Researchers, studying seven "pro-family" groups, and their inter-organizational alliances with "pro-life" groups and politicians in Calgary over the course of a single year, noted their rising popularity and influence. Founded in the 1980s and 90s groups such as *The Alberta Women of Worth* (later Alberta Federation of Women United for Families, or AFWUF) introduced the rhetoric of "family values" to the public sphere with the promotion of "the virtues and efficacy of the heterosexual nuclear family" and "opposition to extending the legal definition of marriage to include gay and lesbian couples" (Anderson and Hartford, 2001:38). The AFWUF, and others, reportedly influenced conservative elites and parties including *The Canadian Alliance* and its predecessor *The Reform Party* (the Alliance eventually merged with the *Progress Conservative Party of Canada*) (ibid). The political influence of "pro-life" or "pro-family" organizations continues to strengthen as recently exemplified by, for example, a motion to re-examine the status of the "fetus." proposed by backbench Conservative MP Stephen Woodworth, who employs arguments consistent with "pro-life" ideology. In response to Woodworth's proposition that government intervene in women's fertility by re-conceiving the "fetus" as separate from the female body, 250 conference delegates of the Canadian Medical Association asked to retain that section of the Criminal Code declaring a child becoming a human being at the moment of birth rather than at conception (Kirkey, 2012). Dr. Genevieve Desbien claims Woodworth's motion "constitutes a recriminalization, not only of abortion, but any form of contraception" and asked CMA delegates to "recognize that women must retain their full and complete rights" (ibid).

Whereas most clinically-based public reproductive health service providers aspire towards ideological neutrality in order to serve public health, “pro-life” organizations are more polemical or ideologically-charged and often are rooted in religious fundamentalism. *Lethbridge & District Pro-Life* typifies organized social conservatism in their mission to “proclaim the inherent value of human life from conception until natural death” (www.lifelethbridge.org/). “Pro-life” and “pro-family” rhetoric conceives abortion as wrong under most or all circumstances including pregnancies occurring from non-consensual sex or violent rape. Certain “pro-family” constituencies, moreover, disapprove of women’s independence from motherhood and may define family as exclusively heterosexual and nuclear against social trends reshaping family formations in contemporary society.

One study determined that individual opposition to legalized abortion was more likely among respondents who disapproved of married women working outside the home. Anti-abortion views also prevailed among those with strong religious commitments and lower levels of education. (Hartnagel, Creechan and Silverman, 1984) The study employed ten variables—religiosity; denominational affiliation (Protestant and Catholic); education; age; ancestry; sex; church attendance; number of children; approval for married women working; and of childlessness—to predict or indicate approval or disapproval for legalized abortion (ibid). While women aspire towards economic and social security—with their waged and unwaged labour inside and outside the household critical to family survival—“pro-family” and “pro-life” values revive antiquated concepts of femininity and appear to wish to keep women harnessed to a domestic imperative.

Many women’s groups and reproductive rights advocates are necessarily guarded in light of the retrenchment of conservatism or misogyny into all tiers of government and the public sphere. As Palley noted, both federalism and organized anti-abortion groups “negatively affected the delivery of abortion services in the provinces and territories.” (2006: 566). But, as he insists, following the decision against *Section 251*, abortion became “a procedure that, in Canada, must be performed by a medical doctor . . . and . . . should be covered as a “medically necessary service” by Canada’s Medicare in compliance with the five principles of that act (public administration, comprehensiveness, portability, universality, and accessibility).” Regional service disparities remain however as “provinces routinely limit abortion access, either directly through public policy or indirectly by allowing local health systems to limit such access” (ibid, 568). A recent report shows a reduction in accessible abortion services nationwide from 17.8% in 2003 to 15.9% in 2006 with the following trends observed: a decrease in hospitals providing accessible abortion services; services are poorly dispersed across Canada with the majority of services restricted to urban areas; a woman’s experience obtaining reproductive health services regionally varies and easy access may be impeded; and wait times, gestational limits and availability of counselling also varies widely (Shaw, 2006:1). In Alberta, 6% of hospitals provide abortion services in 2006 a much lower percentage than northern hospitals in Nunavut who provide between 100% or 67% in the Northwest Territories. In Catholic-dominant Quebec 24% of hospitals provide abortion services whereas Prince Edward Islanders lacking any access to hospital abortions must travel off island for “safe and timely abortion care” (ibid, 2).

Organized, or individual, opposition to women’s independent, or sovereign, choices regarding family, motherhood and birth control is not historically new (McLaren, 1992). Between 1900 and 1940, a variety of professional and politicians, many proselytizing eugenicist beliefs, felt justified in the endeavour to “police” or socially manage women’s bodies and to intervene in women’s sexual and social decisions. Then, as now, it was consistently women’s fertility that was scrutinized or monitored (ibid, 21). Between 1928 and 1972, Alberta’s *Sexual Sterilization Act* targeted those perceived as feeble-minded or socially inadequate (Grekul,

2008). In light of the current climate of neoliberalism and the political embrace of socially conservative, non-secular, values women's right to reproductive self-determination and economic independence is tenuous. One should never assume, therefore, that access to politically-neutral, safe, affordable reproductive and sexual health services are guaranteed. Documents show that rural women confront greater barriers to services than urban residents. Gender equity is founded on women's reproductive freedom.

III Southern Alberta Services

Women, or men, who require birth control education, counseling, or prescriptions; or clinical services for sexually transmitted infections (STIs), or abortion/adoption options or counseling find services in various ways: from family physicians or other health providers such as public health nurses in schools or community clinics; or from family or friends. Any Albertan, seeking anonymity or confidentiality, may choose to travel to sexual health clinics in higher density urban cities such as Calgary or Edmonton. Phone book listings or websites also usefully enumerate services. Mothers concerned about adolescent pregnancies might direct their daughters to available services.

Funded by Alberta Health Services and in existence for over thirty years, *The Lethbridge Reproductive and Sexual Health Program* provides a wide range of counseling, health advocacy, and education for all ages and clinical services for male or female clientele that is age specific (up to, and including, age 24). Clinical services include pregnancy tests, pelvic exams, pap smears, STI/HIV testing and treatment, as well as prescriptions and supplies. They are staffed by 2 full-time, 2 half-time registered Public Health Nurses and 6 doctors on rotation for clinical services. All RN's are active educators serving high schools, colleges, and the university as well as other unique clientele such as *Lethbridge Immigrant and Family Services*. Half-time RN's dedicate half their time to Sexual Health and half to Outreach Nursing Services, caring for homeless and those at risk for homelessness from a clinic space at the *Lethbridge Resource Shelter*. Guidance and educational resources are available to all and to teachers who seek class lesson plans on sexual health (www.teachingsexualhealth.ca is also recommended). All services are free and confidential.

Founded in 1992, Calgary's *The Kensington Clinic* is a free-standing clinic funded by Alberta Health. At the time the clinic opened, only three hospitals performed abortions in Alberta with one turning away approximately 50 women a week. During this same era, women frequently travelled to the U.S. for abortion services and *Kensington* required police protection to restrain protests and protect clinic staff against bomb and death threats (MacKinnon, 1992: 7). Today, client access to *The Kensington Clinic* is eased through the ability to self-refer, with physician referrals no longer essential. Blood work and ultrasound is conducted at the *Clinic* (formerly the client would get those services elsewhere) *Kensington* provides a range of services including: medical and surgical abortions, pre- and post-abortion counseling, STI testing and treatment, emergency contraception and affordable birth control. Services are covered by Alberta or Saskatchewan health care, but fees are charged if the client is partially insured, without insurance, or from other provinces. Their website lists services and guides users; offers a section on Frequently Asked Questions (FAQ) and links to other useful websites. No information regarding transportation, places to stay in the city are provided for clients from outside Calgary.

Reproductive and Sexual Health Services

Kensington Clinic, 2431-5th Ave NW Calgary Alberta T2N 0T3 (403) 283-9117
www.kensingtonclinic.com/

Lethbridge Sexual and Reproductive Health Program Clinic, 300-740 4 Avenue S. Lethbridge, Alberta T1J 0N9 (403)-320-0110 <http://www.albertahealthservices.ca/services.asp?pid=saf&rid=1046256>

"Pro-Life"

Lethbridge and District Pro-Life Association, 1805 9th Avenue N. Lethbridge, Alberta. T1H 1H8 (403)320-5433 Services include: Educational Information (& Resource Library), Pro-Life Training, Alternatives to Abortion, Awareness Activities and Presentation, Referrals for Pregnancy Support and Post-Abortion Counseling, & Media Campaigns.

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