Commentary: Adolescents, Marginalization(s) and Abortion Care in Canada

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TOBIN LEBLANC HALEY, PhD
Assistant Professor of Sociology
University of New Brunswick
Saint John, NB

GHAZAL MOTAMEDI
Bachelor of Health Student
University of New Brunswick
Saint John, NB

Abstract

Abortion access in Canada has improved in the past 37 years. However, as healthcare delivery is primarily a provincial/territorial responsibility, there are divergences in the administration and operation of abortion care, including coverage in rural areas, access to telemedicine for medication abortion and the laws and policies governing medical consent for minors. In addition, the access and experience of care are often conditioned by raced, classed and gendered inequalities. When considering abortion care in Canada, it is vital to consider the complexities of federalism, the realities of rural and semi-rural life and intersecting forms of marginalization impacting service users, especially adolescents.

Résumé

L'accès à l'avortement au Canada s'est amélioré au cours des 37 dernières années. Cependant, puisque la prestation des soins de santé relève principalement de compétences provinciales ou territoriales, il y a des divergences en matière d'administration et de fonctionnement des services d'avortement, notamment la disponibilité en milieu rural, l'accès à la télémédecine pour l'avortement médicamenteux ainsi que les lois et politiques au sujet du consentement aux soins des mineurs. De plus, l'accès et l'expérience des soins sont souvent conditionnés par les inégalités de races, de classes et de genre. Lorsqu'on examine les services d'avortement au Canada, il est essentiel de tenir compte des complexités du fédéralisme, des réalités de la vie rurale et semi-rurale ainsi que des formes croisées de marginalisation qui touchent les utilisatrices des services, en particulier les adolescentes.

Introduction

From the Morgentaler decision to the widespread medicare coverage for Mifepristone, abortion access in Canada has changed significantly in the past 37 years (Carson et al. 2022; Lebold and MacDonnell 2020), no doubt, for the better. What remains unchanged, however, are interprovincial/territorial differences in the administration and operation of abortion care. Key areas of difference include care coverage in rural and urban areas, access to telemedicine for medication abortion (Abortion Access Tracker n.d.) and, as Cattapan et al. (2025) point out, the laws and policies governing medical consent for minors. These differences are the result of both governmental and non-governmental factors, including, but not limited to, provincial/territorial responsibility for healthcare in Canada, service delivery across vast, sparsely populated geographical areas and uneven abortion training opportunities for medical professionals (Abortion Access Tracker n.d.; Carson et al. 2022). This is not to suggest that abortion is largely unavailable in Canada but rather that there are interprovincial/territorial differences (and even sometimes intraprovincial/territorial differences) in what is available, how care is provided and what barriers to care individuals might encounter. For example, a lack of rural coverage for procedural abortions (Schummers and Norman 2019), coupled with a lack of telemedicine medical abortions in some provinces and territories (e.g., Yukon [Government of Yukon n.d.], Northwest Territories [Government of Northwest Territories n.d.], Prince Edward Island [Government of Prince Edward Island 2024]) can require patients to undertake significant travel to access care (Abortion Access Tracker n.d.; Lebold and MacDonnell 2020; Paynter 2023). At the same time, a lack of trusted and accessible information, for example, in the province of New Brunswick, can create uncertainty and stress (Hughes et al. 2023). Within Canada's complex healthcare system, the experience of accessing an abortion, similar to any other healthcare service, is clearly conditioned by the availability of the service in a given geographical area (Carson et al. 2022). It is also often conditioned by persistent raced, classed and gendered inequalities, which can compound "disparities in abortion access and family planning services," although research on the impact of these social inequalities is "under-researched in Canada" (Carson et al. 2022: 56).

When considering the healthcare needs of adolescents, including abortion, an intersectional framework (Hankivsky 2011; Motley et al. 2023) can support a deeper understanding of barriers to care. It is recognized that for adolescent patients, organizational factors impacting healthcare access generally, such as long wait times and uncoordinated youth care, alongside individual-level factors such as low health literacy, cultural beliefs and the need for parental consent, can produce barriers, leading to poor health outcomes in adolescents (Garney et al. 2021). Marginalized adolescents report an overall lower health status and are more likely to experience multiple chronic conditions than non-marginalized youth (Robards et al. 2020). A meta-analysis of Canadian, American, British and Australian studies (Kearns et al. 2021) found that gender minority youth, for example, can fear that disclosure of gender identity may lead to negative, complex family dynamics, resulting in avoidance and fear when seeking care.

When it comes to reproductive healthcare needs – including abortion care – adolescents are at a heightened risk of unintended pregnancies and sexually transmitted infections arising from a lack of knowledge/developing knowledge of safer sex (Louie-Poon et al. 2021). An adolescent's gender, age and sexual activity change their perception of care; similarly, social support and resources determine care-seeking behaviours (Salehi et al. 2014). Immigrant youth seeking reproductive healthcare have a heightened sense of mistrust surrounding confidentiality, as familial, intergenerational, cultural and religious stigmas exist within many communities (Louie-Poon et al. 2021). Seeking appropriate reproductive healthcare is harder for youth who have poor access to sexual health information and services, often encountering cultural biases and language barriers; this highlights the need for further education and consultation on sexual health and services for newcomer adolescents (Louie-Poon et al. 2021). Youth living with lower socio-economic status in the suburbs and rural areas may struggle to travel to clinics, often located in urban centres, therefore creating barriers to abortion care (Salehi et al. 2014). These barriers for adolescents are likely compounded by ambiguity in the public information about rules governing the age of consent for healthcare (Cattapan et al. 2025) in Canada's diverse abortion landscape. Welcoming spaces that create a sense of safety and accessibility to adolescents while respecting their personhood and autonomy are needed to destigmatize abortion access (Lowik 2025), as there is clear and easily accessible information about what services are available and what (if any) third-party consent might be needed.

While Canada has fully decriminalized abortion, there remains much to be done to ensure equitable access, especially with the growing anti-choice sentiment in North America (Gordon and Johnstone 2024). The overturn of *Roe v. Wade* in the US (Supreme Court of the United States 2022) and the rise of right-wing populism in Canadian politics (Budd 2021; Graves and Smith 2020) will likely result in even greater abortion stigma, making young people in Canada feel less secure in talking about and accessing abortion care. In this context, it is vital that the inconsistent information about minors' medical consent in Canada be swiftly addressed and laws and policies requiring parental consent for reproductive healthcare be eliminated so that young people have access to autonomy over their reproductive lives. These changes are especially important when we consider the additional barriers to reproductive healthcare, especially abortion care, for marginalized youth.

Correspondence may be directed to Tobin LeBlanc Haley by e-mail at tobin.haley@unb.ca.

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