Beyond Legal: A Feminist Intersectional Analysis of the Policy Landscape Shaping Indigenous Women's Access to Abortion Services in Canada

By

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Abstract

This thesis locates proven barriers in access to abortion services for Indigenous women in Canada within the policy landscape. It points to opportunities for policy reform to improve access and ultimately, reproductive justice for this population. Critical policy studies and feminist and intersectionality-based policy analysis theory were used to assess documents determined through background research to form the policy landscape. This extended to their design, text, and implementation. Studied federal-level documents included the Indian Act, the Constitution Act, the Indian Health Policy, the Health Transfer Policy, the Canada Health Act, and the Non-Insured Health Benefits Program. Manitoba was assessed as a case study of provincial-level policy given its high proportion of Indigenous residents and evidenced issues in access for this population. This is research that has not been conducted before. It makes a valuable contribution to the literature at a time in which significant political attention is being paid to the subject of abortion access in Canada and to the federal framework for Indigenous health care.

Table of Contents

List of Tables

List of Figures

List of Acronyms

2SLGBTQQIA+: Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and additional sexual orientations and genders (YMCA Canada, 2021, para. 2)
AFN: Assembly of First Nations
BNA Act: British North America Act
CHA: Canada Health Act
FIPA: Feminist Intersectional Policy Analysis
FNIHB: First Nations and Inuit Health Branch
HGSA Act: Health Governance System Accountability Act
HTP: Health Transfer Policy
IHP: Indian Health Policy
ISC: Indigenous Services Canada
NDP: New Democratic Party
NIB: National Indian Brotherhood
NIHB: Non-Insured Benefits Program
NWAC: Native Women's Association of Canada
PHA: Provincial Health Authority
RHA: Regional Health Authority
UNDRIP: United Nations Declaration on the Rights of Indigenous Peoples

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I am grateful for the opportunity to have assisted a research team led by Dr. Astrid Vanessa Perez Pinan and Dr. Renée Monchalin in identifying themes in interview data as reported by Indigenous women in Canada on their experiences accessing abortion. These perspectives helped to inform the viewpoint from which I conducted this research. To this end, I would like to acknowledge all of the courageous women and gender diverse individuals who are sharing their stories on their experiences accessing abortion service – despite how difficult – to improve reproductive justice for future generations. Finally, I would like to commend the efforts of all the individuals and organizations that are fighting to secure safe and equitable access to abortion service – an issue critical to the freedom and equality of those with childbearing abilities and important to my personal values and beliefs.

Chapter 1: Introduction

Abortion has been decriminalized in Canada since 1988[1], however, evidence – including the United Nations Committee on the Elimination of Discrimination against Women's 2016 report – points to a lack of equitable access for women[2] across Canada owing to structural and institutionalized barriers (Monchalin, 2021-a; Kirby, 2017; United Nations Committee on the Elimination of Discrimination against Women, 2016). From a geographic standpoint, abortion service is provided by only one in six hospitals across Canada – the majority of which are based in urban centres (OECD, 2020). Constitutionally, provinces and territories hold jurisdiction over health care, resulting in vast discrepancies in access to abortion care nationwide.

1.1 Defining the Problem

Indigenous women in Canada – who access health care within a convoluted system of federal and provincial/territorial authority (Turpel-Lafond, 2020) – face distinct barriers in their access to abortion service. While the bulk of abortion service providers are situated within urban centres, 60 percent of Canada's Indigenous population resides in rural areas (OECD, 2020). Structurally, Canada's framework for health care remains one made by and for European settlers and their descendants. Founded on colonial aims to assimilate Indigenous populations, it disregards their unique needs at best and diminishes their existence at worst (Denny, 2020; Clarke 2021; Browne & Fiske, 2001). Further, given its basis in colonial legislation designed by while males with patriarchal views and colonizing ambitions, Canada's health care framework has specifically and purposefully underserved Indigenous women since its inception (Denny, 2020; Stote, 2015; Bourassa et al., 2004).

In combination with the Indian Act's imposition of patriarchal systems in historically matriarchal Indigenous societies (Halseth, 2013), negative representations of Indigenous women were instituted by colonizers to legitimize their subjugation and serve colonial pursuits (Corbett, 2019). Representations of Indigenous women as unfit mothers specifically, were established to legitimize child apprehension, land acquisition, and population controlling tactics such as forced

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[1] Abortion was made legal in 1969, with caveats which are further explained on pages 6 and 7 of this thesis.

[2] For matters of scope, my research focuses on those with reproductive abilities identifying as "women"; however, I acknowledge that abortion access also impacts two-spirit, transgender, and gender diverse peoples and that such populations often face additional barriers due to gender and sexuality-based discrimination (Monchalin & Paul, 2021-b).

sterilization (Corbett, 2019). Such tactics have resulted in entrenched oppression, stereotyping, and conditions that continue to propel misrepresentations surrounding Indigenous women's mothering abilities, including poverty, domestic violence, and teenage pregnancy (Corbett, 2019). Lasting stereotypes manifested in prejudiced treatment by healthcare workers, combined with a history of reproductive control, severely impact Indigenous women's interpersonal experiences with abortion care (Corbett, 2019). The tragic case of Joyce Echaquan – an Indigenous woman who live-streamed her abuse and mistreatment by hospital staff in a Quebecois hospital, and whose 2020 death was declared by coroners to be a product of racism and prejudice by health care workers (Bilefsky, 2021) – is just one example of how racist and sexist bias towards Indigenous women is not only perpetrated in the health care system structurally, but interpersonally in medical treatment (Denny, 2020; Clarke, 2021; Stote, 2015; Browne & Fiske, 2001).

Together, the compounded barriers preventing Indigenous women in Canada from accessing equitable abortion service provision in Canada contribute to "gross violations of women and trans people's right to bodily self-determination" (Kirby, 2017, para. 2). Considering the definition of reproductive justice[3] as every individual's right to choose to have or not to have a child; to parent one's own child; and to raise one's child in a safe and healthy community (Sister Song, n.d.); such systemic barriers present a significant infraction to Indigenous women's reproductive justice in Canada.

1.2 Importance of the Study

Despite evidence pointing to distinct barriers in access to abortion service for Indigenous women in Canada, findings are limited and the cause of such barriers is understudied (Monchalin, 2021-a). This thesis seeks to uncover the root of such barriers and will investigate whether and how such barriers take form at the policy-level. This includes the way in which barriers stem from policy's lack of consideration of the multiple and intersecting categories of discrimination shaping Indigenous women's lived experiences. I argue that Canadian policymakers have both the capacity and responsibility to combat such barriers through policy

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[3] This term was first introduced by a Black women's caucus at a pro-choice conference in Chicago in 1994, titled, *Women of African Descent for Reproductive Justice* (Sister Song, n.d.). The term combines reproductive rights and social justice in recognition of the specific contexts in which women of colour and other marginalized women and Trans people make reproductive decisions (Sister Song, n.d.).

reform to ensure reproductive justice for Indigenous women. I call for policy justice, which Wiebe and Levac (2020) define as "public policy that acknowledges and aims to address the effects of racism, sexism, colonialism, ableism, heteronormativity, transphobia, and classism … in an attempt to seek equity" (p. 6). An analysis of relevant policy[4] and the way in which such barriers are facilitated through its design and implementation is imperative to generating such reform.

Within the broader context of a history of oppression specific to Indigenous women and their reproductivity, it is imperative that Indigenous women are brought to the table to guide such reform. This thesis does not merely call for reform to the colonial policy landscape, but for decolonized reform; reform that transcends colonial systems and structures and is guided by and reflective of Indigenous women's needs; desires; views; histories, and practices.

This thesis has significant value at this time given the current political climate in Canada: as of May 2022, access to abortion has gained considerable attention amongst the media and public and federal funding has been committed to improving the issue[5]. Accordingly, research pointing to opportunities for reform on the subject is both timely and significant.

1.3 Thesis Goals and Research Questions

The goal of this research is to disrupt existing systems of power that perpetrate barriers to access for Indigenous women for the purpose of ensuring their reproductive justice. It will seek to inform policymakers of the need for reform and of opportunities to do so that consider the multiple and intersecting barriers faced by Indigenous women in Canada. It also seeks to inform the efforts of advocacy groups and inspire further research by academics.

Through applying feminist and intersectionality-based policy analysis theory to the examination of the policy landscape structuring Indigenous women's access to abortion service across Canada – as defined in my conceptual framework – I will seek to examine policy-level barriers inhibiting equitable access. My consequent research questions are as follows:

- *In what ways does the policy landscape shaping Indigenous women's access to abortion service in Canada (including its design and implementation) generate barriers to access?*
- *What are the key policy-level barriers needing reform?*

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[4] "Policy" is used throughout this thesis as an all-encompassing term for policy documents, including legislation, regulations, policy statements, and programs.
[5] This is in reference to the overturning of federal abortion legislation in the United States.

1.4 Positionality Statement

Researcher Identity

As a white, able-bodied female from an urban, middle class socioeconomic upbringing, I am conducting this research from a position of privilege. With the population of Indigenous women whose experiences are the focus of my research, I share the experience of being a female with reproductive capacity. This said, I lack first-hand experience and knowledge on the remaining intersecting categories of oppression shaping their experiences with access to abortion services in Canada.

My past work as a Public Sector Consultant provides me with competencies in research and analysis to bring to this research endeavor; however, my research experience to date has been from a Western, colonial perspective; I have limited experience conducting research about or with Indigenous peoples.

Perspectives

Given my above-described positionality in proximation to this research endeavor, it will be critical that I consider Indigenous perspectives and lived realities as I conduct my research. To this end, my perspectives guiding this research endeavour are shaped by the interpretations I formed while qualitatively analyzing findings shared by Indigenous women on their experiences accessing abortion service in Canada[6]. I am aware of the gendered and colonial bias of the policy landscape shaping abortion service, which is why I will be conducting my research through a feminist intersectional paradigm (Crenshaw, 1989; McPhail, 2003; Hankivsky et al., 2019; Kanenberg et al., 2019). My personal beliefs echo the constructionist epistemological and relativism-based ontological stances of this paradigm; specifically, I believe that knowledge is subjective and context-derived. My intersectional feminist and human rights-based personal values have guided me to pursue this research topic: I believe reproductive justice is fundamentally necessary for all women and assert that intersectional barriers compound gender-based injustices, including in access to reproductive services. I firmly believe that the right to access an abortion – or a woman's right to make choices about her body, physical and emotional health, and future – is a basic human right.

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[6] This was conducted in support of Monchalin et al.'s forthcoming research on Indigenous women's lived experiences accessing abortion services in Canada, as described later in this body of work.

Potential Research Implications

My research examines Indigenous women's access to abortion services funded and administered by the federal and provincial governments[7], in other words – in accordance with colonial structures and Western medical beliefs. On the basis of feminism – including a woman's right to equality and choice – I seek to identify options for policy reform to improve Indigenous women's equitable access to service availability within such colonial structures. I acknowledge that any reform must be guided by Indigenous women and their unique needs and desires. The ultimate aim is for reform that transcends colonial structures and respects self-determination. I also acknowledge that Indigenous women have traditional means of birth control that they have practiced for generations. The scope of my study is limited in that I do not study how Indigenous women can better access abortion options traditional to the culture of their band or people.

Given my own upbringing in colonial systems, I am taking steps to broaden my understanding of Indigenous histories, values, and perspectives, including the multiple and intersecting barriers of oppression faced by Indigenous women in Canada. This includes furthering my understanding of traditional abortion practices and the impact of imposed colonial values on prevailing views towards abortion within Indigenous communities. In acknowledgment of the fact that reflexivity statements change over time as new knowledge is uncovered, I will continue to check my own biases and perceptions as I proceed to plan and conduct my research.

1.5 Structure of Thesis

My thesis follows the traditional format. In the subsequent chapter, I detail all necessary background information the reader needs to know to understand the context of my research. My Literature Review follows this Background chapter, detailing my findings from my review of relevant literature, along with my approach for doing so. In Chapter 4, I detail my research methodology, methods and tasks, and approach to data analysis. In Chapter 5 I detail my research findings and in Chapter 6 I analyze these findings and discuss their meaning in relation to my guiding research questions and goals. My Conclusion sums up my core research findings and points to areas for further research.

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[7] I use the terms "provincial" and "province" in reference to both provinces and territories in various instances throughout this paper for the sake of brevity.

Chapter 2: Background

This chapter provides background context relevant to the scope of my research. The first section provides an overview of abortion policy in Canada, inclusive of its history and of the landscape shaping access to the service today. The second section introduces Canada's history of colonialism and the impact of colonial legislation on Indigenous peoples' and Indigenous women's experiences with health care in Canada. Finally, the third section provides an overview of health care policy in Manitoba – a province I have chosen to examine as a case study of provincial abortion policy. This is given the role of provinces/territories in abortion service provision and proven barriers in access in the province for Indigenous women specifically.

2.1 Abortion Policy in Canada: An Overview

The following section provides an overview of the abortion policy landscape in Canada today, including the overarching health care landscape shaping its provision and its history of decriminalization. This provides necessary context for the reader while also helping to explain the importance of my use of a policy analysis framework that incorporates both feminist and intersectional thinking.

Abortion in Canada: Second Wave Feminism and the Decriminalization of Abortion

Between 1869 and 1969, abortion was illegal in Canada as per Canada's Criminal Code. Its penal consequence was life imprisonment for anyone procuring or offering the procedure (Dunsmuir, 1998). In 1969, abortion was made legal under the code only if deemed that the pregnancy would cause the individual medical harm, as approval by a "Therapeutic Abortion Committee"[8] (Johnstone, 2017). This amendment was ultimately deemed unconstitutional in the historic case of *R. v. Morgentaler*, effectively decriminalizing abortion and allowing it to be treated as a medical procedure "governed by the laws, regulations, and medical standards that apply to all health services in Canada" (Chapman & Penny Light, 2017, p. 188). Fundamental to its decriminalization was the burgeoning "second wave" of feminist movements across Canada

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[8] Therapeutic Abortion Committees were appointed by hospital boards and formed of three medical doctors at an accredited or approved hospital (Dunsmuir, 1998). The amended law made no requirement that hospitals have these abortion committees, nor did it dictate any criteria for the committee's approval; the decision was ultimately left to physician discretion, which resulted in significant inconsistencies in approvals across the country (Stettner et al., 2017).

and the U.S. in the 1960s and 1970s. These focused on securing women's sexual freedom and the right to choose to birth a child or not. According to Dyck (2017), arguments for the decriminalization of abortion emerged within this "highly charged atmosphere of reproductive politics", with this reaching a "fever pitch" by the early 1970s (p. 75).

Of significance to the movement was the 1982 introduction of the Canadian Charter of Rights and Freedoms into the Constitution – legislation that introduced the right of *security of the person*, referring to one's right to the health, privacy, and integrity of their body (Steps to Justice, n.d.). In 1986, Canadian physician and abortion rights activist Dr. Henry Morgentaler successfully challenged the constitutionality of abortion legislation on the basis of this right. The Supreme Court ruled in favour in 1988, with Justice Bertha Wilson – the only female Supreme Court justice at the time – famously declaring the decision to have an abortion as not only a medical decision, but a profound "social and ethical one as well; one of the whole person, one with psychological, social and economic consequences for the woman" (Action Canada for Sexual Health and Rights, 2020-b, p. 4). Notably, although the Supreme Court's *R v. Morgentaler* decision invalidated the section of the Criminal Code relating to Therapeutic Abortion Committees, it did not enshrine the right to abortion in law. This means that abortion is not protected from the tabling of new bills reintroducing it as a criminal matter.

Health Care Governance in Canada

As per Canada's Constitution Act, the administration of health care services is a power of the provinces and territories, pertaining largely to physician and hospital services and cost coverage for all medically necessary procedures. Abortion service provision is consequently of the purview of provinces and territories. While positive in that provinces and territories can tailor their respective health frameworks to the unique needs of their populations, this division of power also results in significant discrepancies in the administration of health care – and abortion care – nationwide (Long, 2020; Palley, 2006). Particularly, this structure can result in provincial and territorial public health administration being influenced by the political ideology of each province/territory's ruling political party.

The 1984 Canada Health Act and its Canada Health Transfer theoretically offer the federal government a degree of control over provincial/territorial health care delivery in Canada. Given the high cost of public health administration and provinces/territories' limited revenue sources, provincial/territorial governments are reliant on the federal government for funding to deliver such services (Long, 2020; Palley, 2006). This funding – provided through the Canada Health Transfer's federal transfer payments – is conditional to provinces and territories' adherence to the Health Act's five principles, being: universality, comprehensiveness, accessibility, portability, and public administration (Government of Canada, 2021-a). The federal government can withhold funding if a province/territory fails to deliver health care in accordance with these principles. Of these principles, "universality" requires that all residents of a province or territory be entitled to the "publicly funded health services covered by provincial/territorial plans"; "comprehensiveness", stipulates that all "medically necessary health services provided by hospitals and doctors must be covered under provincial/territorial health care insurance plans"; and "accessibility" stipulates that "Canadians should have "reasonable access" to insured hospital and doctor services" (Senate of Canada, n.d., para 2). The federal government deems abortion to be a medically necessary procedure covered by the tenants of the Canada Health Act, and required to be universally accessible to all provincial/territorial residents (Health Canada, 2015; Prime Minister of Canada, 2022).

Abortion Options Today

Today, abortion is available surgically or medically. Surgical abortions can be carried out in either a hospital or private clinic setting. In Canada, the cost of accessing an abortion at a private clinic is covered by provincial/territorial health plans in all province/territories except New Brunswick (Brown, 2022). Health Canada approved medical abortions through the use of the abortion pill, "Mifegymiso", in 2017. Mifegymiso requires a referral from either a practicing physician, nurse practitioner, or midwife (Action Canada for Sexual Health and Rights, 2019-a). It can be dispensed at a local pharmacy or by a prescribing health professional (Action Canada for Sexual Health and Rights, 2019-a).

Health Canada's approval of the drug Mifegymiso was significant for abortion access in Canada for both women at large and those in rural locations specifically. Where women were previously limited to having to travel to a hospital or clinic to access a surgical abortion – most of which are urban-situated – the pill theoretically allows women to stay in their community and abort in the privacy of their home. Notably, the COVID-19 pandemic has helped improve access to the pill through increasing the availability of online telemedicine, consequently allowing women to request a prescription for Mifegymiso from a prescribing practitioner online (Boynton, 2022). Women residing in rural areas where internet access is limited, however, remain dependent on community availability for referral.

While women may access surgical abortions in most provinces/territories at at least 16 weeks gestation[9], Mifegymiso is only approved for use up until 9 weeks of gestation for on-label use and 10 weeks off-label (Action Canada, 2019-b). Currently, all provincial and territorial health plans – with the exception of Nunavut – as well as the federal government's Non-Insured Benefits Program (available to Indigenous persons with "status") cover the cost of Mifegymiso – which can cost between $300 to $450 per package (Boynton, 2022; Action Canada for Sexual Health and Rights, 2019). This said, access to the pill continues to be dependent on physicians' will to prescribe, pharmacists' will to dispense, and its availability in pharmacies (Boynton, 2022).

Relating to surgical abortions, provinces and territories may institute their own rules and regulations surrounding the provision of services within the bounds of the criteria of the Canada Health Act. This includes on: (a) provincial cost coverage for surgical procedures offered in clinic settings (where two-thirds of people seeking surgical abortions choose to have the procedure performed and where Abortion Rights Coalition of Canada deems abortion care to be better delivered (Abortion Rights Coalition of Canada, 2021)); (b) approved gestational limits (which range from 12 to 24 weeks in provinces/territories across Canada); and (c) safe access zone legislation (Action Canada, 2019-a). Safe access zone legislation – currently in effect in five provinces/territories – prohibits any form of anti-abortion protest from taking place within a certain distance of facilities providing abortion services. Such protests represent an additional barrier to access given that they can involve harassment and compounded stigma for both patients seeking abortion and practitioners providing it (Abortion Rights Coalition of Canada, 2022-c).

2.2 Indigenous Health Care in Canada: An Overview

This section details Canada's colonial history and the prevailing impacts of colonial legislation and governance systems – or lack thereof – on Indigenous health outcomes, including for Indigenous women. The Indian Act specifically has resulted in drastic consequences for

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[9] In this context, this term refers to the latest number of weeks of pregnancy one can access an abortion at and that a provider may provide an abortion at.

Indigenous peoples[10]. Beyond creating significant discrepancies in care through its introduction of "status", it has instituted gender inequities between Indigenous women and men; intergenerational trauma; poverty; stigma surrounding what were once traditional birthing practices; and a general – and well-founded – mistrust for the Canadian health care system.

Colonialism and Colonial Legislation

European settlers – hailing from both France and Britain – first arrived in Canada to establish colonies in the 1600s. Their motive of "colonizing" the land involved colonizing its existent populations – Canada's Indigenous people who had been living on the land (referred to by many as "Turtle Island") for centuries. The first attempt by settlers to control the Indigenous population through policy involved the Royal Proclamation of 1763 (Parrot, 2022). The proclamation declared a set of "rights and protections" for Indigenous peoples under the British colonial administration (Parrot, 2022, para. 3). As more settlers came to Turtle Island and sought to build colonies upon the land, Indigenous peoples became portrayed as uncivilized "savages" requiring civilization into the European population to serve colonial ambitions (Government of Canada, 2018-a; Parrot, 2022). Such "civilization" of Indigenous peoples was justified under the "Doctrine of Discovery" – a framework based on official declarations by the Pope that deemed land acquisition by Christian settlers as legal (Assembly of First Nations, 2018-a). In 1857 and 1869, the Gradual Civilization Act and the subsequent Gradual Enfranchisement Act were passed with oppressive assimilating intentions – the concept of "enfranchisement" referring to assimilation through the removal of "Indian status", or rights and protections introduced by the Royal Proclamation. Status was replaced with land and voting rights under the colonial administration in attempt of assimilating Indigenous peoples into European society (Parrot, 2022)[11]. Building off of these two iterations of legislation, colonizers in 1876 introduced an all-encompassing piece of documentation titled, *The Indian Act*, granting the new Canadian state (formed in 1867 through the British North America Act), "sweeping powers with regard to First Nations identity, political structures, governance, cultural practices, and education" (Parrot, 2022, para. 7). Today, the Canadian Encyclopedia defines The Indian Act as an "evolving,

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[10] This is discussed extensively in critical Indigenous studies literature, including in scholars Mary Ellen-Lelm and Glen Coulthard's respective books, 'Colonizing Bodies' (1998) and 'Red Skin, White Masks' (2014).

[11] Note, these rights were made available to Indigenous men only.

paradoxical document that has enabled trauma, human rights violations and social and cultural disruption for generations of Indigenous peoples" (Parrot, 2022, para. 1).

Through introducing stipulations surrounding Indian status – and being developed by white male colonizers – The Indian Act introduced female-centric sexism into Indigenous cultures, where in many, women's traditional role was historically central to the "safety and well-being of all members of Aboriginal communities" (Kenny, 2004, p. 37). The act defined "Indian" as any "male person of Indian blood reputed to belong to a particular band", any "child of such person", or a woman who is "lawfully married to such person" (in accordance with the colonial judiciary system) (Parrot, 2022, para. 13). Women were stripped of their status and consequently their identity.

The Indian Act also created the reserve system, this pertaining to the allocation of plots of generally less valuable land for First Nations bands' inhabitation[12] (Wilson, 2018). This land was (and remains) classified as federal land – First Nations were denied title (Wilson, 2018). It also deemed the use of traditional means of resource distribution on the land illegal. According to Wilson (2018), a "rapid increase in poverty on reserves" followed in the early 1900s (para. 7). Today, as Wilson (2018) writes, "First Nations people still live with the problems created by the reserve system"; there is "often not enough land for all members to have housing; and many reserves are very isolated and do not have basic services, such as electricity or running water" (para. 10). Where most provincially funded abortion care and service providers are located in urban areas, one can interpret how geographic barriers to abortion access are generated by the Indian Act's allocation of "isolated" plots of land.[13]

Colonialism and the Suppression of Indigenous Reproductive Practices and Women's Fertility

In understanding the context of Indigenous women's experiences with accessing Western abortion services today, it is important to understand that (a) Indigenous women practiced preventative and abortive forms of birth control long before settler contact; and (b) colonizers "discounted and made illegal" these practices upon contact while introducing stigma surrounding

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[12] Note, the Indian Act applied (and continues to apply) to First Nations people only, excluding Metis and Inuit individuals.

[13] Here, I detail some of the many oppressive stipulations written in the Indian Act given their relation to abortion access specifically. One can read more on the many stipulations imposed by the Indian Act on Indigenous peoples here: https://laws-lois.justice.gc.ca/eng/acts/i-5/

the procedure that prevails today (Monchalin & Paul, 2021-b, para. 1). As Action Canada, citing the National Aboriginal Council of Midwives (2020-a, p. 2) writes, prior to settler contact, midwives were central to Indigenous communities and “supported all pregnancy outcomes, including abortion”; reproductive practices were deeply embedded in community cohesion and well-being (Burnett, 2017). Such practices were characterized as harmful to communities and labelled as “devil’s work” by the church and state in place of Eurocentric and Catholic norms and beliefs (Burnett, 2017; Monchalin & Paul, 2021-b).

Burnett (2017) rightly describes these actions as a “double-fronted assault that targets both Indigenous bodies of knowledge and Indigenous bodies” (p. 36). In other words, such colonial actions not only suppressed traditional birthing practices and knowledge but oppressed Indigenous women and their bodily integrity. Subsequently, the church and state sought to control the Indigenous population through constraining women’s fertility by way of forced sterilization, forced abortion and child apprehension (Monchalin & Paul, 2021-b). These practices have left a well-founded legacy of mistrust by Indigenous women of Western reproductive health care and health care providers. Further still, Monchalin & Paul (2021-b) write that while knowledge around practicing reproductive freedoms still exists within Indigenous communities today, “many knowledge holders have been made to feel ashamed of it due to stigma that arrived with settlers” (para. 4). This long history of oppression of reproductive practices and freedoms results in “unique and intersectional experiences” for Indigenous women when accessing abortion services today in comparison with the general population (Monchalin & Paul, 2021-b, para. 9).

In more recent history, Indigenous women have been excluded from the fight for abortion legalization in Canada; their voices not sought out and their unique needs not accounted for in resulting policy decisions. In describing the 1970 cross-country caravan for abortion legalization meant to unite women on the issue of gender equality, titled, the “Abortion Caravan”, Action Canada for Sexual Health and Rights (2020-a) writes that the campaign failed to address the “unique concerns facing Indigenous women living in a country that was founded upon the brutal and oppressive colonization of their peoples” (p. 1).

The Framework for Indigenous Health

The Indian Act remains in effect today – and while amended; and in combination with other pieces of legislation – continues to oppress Indigenous peoples in Canada. Related to health care specifically, Section 73 of the Indian Act gave the "Governor in Council the authority to make certain regulations related to [Indigenous peoples'] medical treatment and public health" (Lavoie, 2013, para. 15). The British North America Act of 1867 similarly defines the architecture through which the Government of Canada presides over Indigenous peoples' access to health services. Concerning Indigenous peoples, the act named Canada's federal government as responsible for matters pertaining to "status Indians"[14], and the provincial and territorial governments as responsible for "non-status Indians" but also the planning and administration of public health. This allocation of powers and the Indian Act's stipulations surrounding status – which remain today – have resulted in a legacy of confusion, convolution, neglect, and severe discrepancies in Indigenous peoples' health outcomes. The Government of Canada publicly states on its webpage that the Canadian health system shaping Indigenous peoples' health outcomes in Canada is a "complex patchwork of policies, legislation, and relationships" (Government of Canada, 2021-c, para. 3).

From a federal policy standpoint, key documents governing the delivery of health care for status Indians[15] include the 1979 Indian Health Policy, the 1982 amended Constitution Act, and the 1988 Health Transfer Policy. The 1979 Indian Health Policy set the foundation for the 1988 Health Transfer Policy. It clarified roles between the federal and provincial/territorial powers relating to Indigenous health – renewing its commitment to improve levels of health in Indigenous communities – and affirmed that both First Nations and recognized Inuit people had a role to play in doing so – namely in adapting the delivery of health services to meet the needs of their community (National Collaborating Centre for Aboriginal Health, 2011-a). This policy set the precedent for various federal funding programs aimed at improving health outcomes, including the Non-Insured Health Benefits Program, described below, and the Clinical Community Care Program – which funds nursing stations in rural and remote areas.

The 1876 British North America Act was amended in 1982, firstly recognizing Indigenous peoples as inclusive of First Nations, Inuit and Metis, and secondly recognizing their inherent right to self-government (National Collaborating Centre for Aboriginal Health, 2011-a.; Government of Canada, n.d.-b). With these movements towards greater self-determination, and

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[14] I use quotations here ironically given the Indian Act's continued use of this derogatory terminology – both the term "Indian" and the archaic, colonial designation of status to Indigenous peoples.

[15] I utilize the term "Indian" in this Chapter only in reference to the language of the Indian Act.

based on calls to action from Indigenous communities across Canada, the Government of Canada introduced the 1988 Health Transfer Policy with the intention of "offering eligible First Nations and Inuit communities a degree of control over community health services" (National Collaborating Centre for Aboriginal Health, 2011-a, p. 17). As per its name, the policy introduced processes for the transfer of health service control to First Nations communities and the federal government's transfer of necessary funding. The policy stipulated three options for service delivery responsibility, including direct service delivery (first level); coordination and supervisory authority (second level); and consultant and advisory authority (third level) (Smith & Lavoie, 2008).

The Health Transfer Policy remains in effect today, and according to the National Collaborating Centre for Aboriginal Health (2011-b), through the policy, the majority of First Nations "design and implement their community health programs and employ the majority of their health services staff" (p. 3). This said, the reporting requirements associated with funding transfers – which have become more stringent in past years in line with the federal government's move towards efficient public service delivery and performance measurement – are complex, and laborious to meet (Lavoie et al., 2005). These measures require First Nations to shift time and resources away from the program planning and management involved in the delivery of health care (Lavoie et al., 2005). As Greenblatt (2009, p. 35) writes, "this trend is at odds with the discourse of devolution in the federal-Aboriginal relationship" – the sole intent of the Health Transfer Policy and the preceding Indian Health Policy.

From a federal governance standpoint, Indigenous Services Canada is the department responsible for funding and directly providing services to registered status First Nations and recognized Inuit peoples living on and off reserve (Government of Canada, 2021-c). This is in supplement to those provided by provinces and territories. They are responsible for overseeing Health Transfer Agreements as per the Health Transfer Policy and for maintaining the *Indian Register*, which is the official record of registered status Indians in Canada (Government of Canada, 2022-a). They also administer a variety of health promotion-based programs in First Nations reserves. According to Indigenous Services Canada, status individuals have "certain benefits and rights and are eligible for a range of federal and provincial and territorial programs and services" (Government of Canada, 2022-a). Compulsory enfranchisement stipulations – such as the loss of status for attending university or for marrying a non-status man – were not eradicated from the Indian Act until 1985. Remaining female-specific sexist stipulations relating to the status of descendants of those who unjustly had their status removed were not fully abolished until 2017 (Government of Canada, 2018-b).

To "registered" Indigenous people, Indigenous Services Canada provides primary health care services, health promotion programs, and un-insured health care benefits through the Non-Insured Health Benefits plan ("NIHB") (Government of Canada, 2021-c). This plan provides coverage for a range of health benefits for those not covered by provincial plans, including for: "prescription drugs and over-the-counter medications; dental and vision care; medical supplies and equipment; mental health counselling; and transportation to access health services not available locally (for registered First Nations living on-reserve only)" (Government of Canada, 2022-b, para. 3). Mifegymiso, the abortion pill, is covered under the plan's approved drug benefit list. Related to transportation, the program's Medical Transportation Policy Framework covers travel costs, living expenses and emergency transportation for those living on-reserve to "attend medically necessary health services that are unavailable on-reserve or in [one's] community of residence", (Government of Canada, 2016, para. 1) theoretically enabling on-reserve First Nations and Inuit women to access funding to cover transportation costs for travel associated with accessing abortion services in urban centres. It must be noted that Indigenous Services Canada maintains no responsibility for Indigenous peoples who have not been allowed registered status as per Canada's colonial system of status designation. Besides Indigenous Services Canada, Health Canada and the Public Health Agency of Canada provide funding for programs that "target, in part, Indigenous peoples who live in urban settings or in northern communities" (Government of Canada, 2021-c, para. 4). This includes the Clinical Community Care Program, through which the Government funds nursing stations in remote communities in which residents cannot "reasonably access"[16] provincial/territorial care. Unlike the Canada Health Transfer, whose formula is protected in legislation, the Government of Canada notes that funding for registered First Nations and Inuit health services is "subject to discretionary increases or reductions" (Government of Canada, 2021-c, para. 4).

As above, provinces and territories are responsible for administering health care to their populations in accordance with the Canada Health Act. First Nations, Inuit, and Metis people are considered to be part of this population; however, the Canada Health Act makes no explicit

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[16] The program provides no definition of "reasonable access".

mention of either (National Collaborating Centre for Aboriginal Health, 2011-a). Provinces and territories enact their own legislation governing health care matters, including the regulation of health care professionals (Government of Canada, 2021-c). As it relates to abortion service provision, provinces may set parameters on matters such as cost coverage and safe access zones. In accordance with the 1979 Indian Health Policy and the 1988 Health Transfer Policy, some provinces and territories have entered into agreements with First Nations organizations for shared models of health care service planning and delivery (Government of Canada, 2021-c).

Inequities Resulting from the Framework for Indigenous Health

Above I detail the "convoluted" system of federal and provincial health care funding and administration shaping Indigenous peoples' access and experiences with public health care in Canada. The Government of Canada itself writes publicly that "a coordinated approach to address the health needs of First Nations, Inuit, and Metis, and health care delivery among all levels of government, including Indigenous governments, remains an ongoing challenge" (Government of Canada, 2021-c, para. 6).

The Indian Act is to blame in large part for such discrepancies in care. According to Palmer et al. (2017), the Indian Act provides "the federal government the *authority* (my italics) to make regulations related to medical treatment and the public health of Indigenous peoples but does not outline an *obligation* to provide services" (Palmer et al., 2017 citing Lavoie, 2013, para. 29). This matter is complicated by the Indian Act's stipulations over status, leaving some Indigenous peoples within the care of provincial governments and others the federal government. Further, the broad and vague language used in the Indian Act results in a lack of accountability from both levels of government over who should pay for health services (National Collaborating Centre for Aboriginal Health, 2011-a, p. 21). Jurisdictional debate results in bureaucratic delays causing long wait times for Indigenous peoples in accessing medications "readily available to non-Indigenous Canadians" (Palmer et al., 2017, para. 6).

The 2002 Romanow Report on Canadian Health care identified "mismanagement of health care funding and a poorly designed system of care" as having left Indigenous peoples "facing serious health inequities" (Palmer et al., 2017, para. 32). According to Katz et al. (2021), the Truth and Reconciliation Commission of Canada's Calls to Action, which, "highlights the striking health disparities between Indigenous and non-Indigenous populations in Canada", (Katz et al. 2021, citing the Truth and Reconciliation Commission of Canada, para. 5) states that these disparities are understood to be a direct result of “previous Canadian government policies” and part of the “continuing impact of colonization and genocidal policies aimed specifically at Indigenous people” (Katz et al., 2021, para. 5). Wiebe (2016) points to the Indian Act’s intentional surveillance, management and control of the Indigenous “body”, such as through the Indian Register and the residential school system, as a core cause of such disparities.

2.3 Abortion Access in Manitoba: A Case Study

Given that health services are administered by provinces and territories, an examination of the policy landscape at the provincial level is necessary for the analysis of policy-level barriers. Consequently, I have chosen to examine the abortion policy landscape in the province of Manitoba in my research – a province with the highest proportion of Indigenous residents in Canada and with proven issues in access to abortion services for Indigenous women (Katz et al., 2021; Action Canada, 2019-a; Monchalin et al., forthcoming). As it relates to the availability of abortion services, Manitoba is far behind other provinces from an access perspective. Until 2005, Manitoba refused to fund abortion provision outside of hospital settings. In 2022 still, according to available data, Manitoba had only three total surgical abortion service providers province-wide (including two hospitals and one clinic); this is compared to a total of 11 in Nova Scotia – a province whose total population is roughly 400,000 less than Manitoba[17]. In 2019, compared to Nova Scotia’s nine medical abortion providers, Manitoba had three (Action Canada, 2019-a). As far as medical or surgical abortion providers in rural areas go, Manitoba had none in 2019, whereas Nova Scotia had nine – this is despite roughly 35-40 percent of Manitoba’s population living in rural or remote communities (Action Canada, 2019-a). Finally, Manitoba lacks safe access zone legislation preventing anti-abortion protestors from protesting within a given distance of abortion services providers, as instituted in BC, Alberta, Newfoundland, and Quebec (Action Canada, 2019-a).

Where access is limited to begin with, preliminary findings by Monchalin et al. (forthcoming) point to distinct barriers for Indigenous women residing in Manitoba. Through conducting interviews with Indigenous-identifying women across Canada on their experiences with accessing surgical abortion services, Monchalin et al. (forthcoming) identified several

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[17] These findings are based on available data. In reviewing these findings, please note that greater data on physicians providing abortion services is available in Nova Scotia than in Manitoba (Action Canada, 2019-a).

widely reported barriers. Interviewees touched on a lack of rural service providers and the challenge and cost associated with having to commute significant distances to access a provider in an urban centre (Monchalin et al., forthcoming). Interviewees also noted negative interpersonal experiences with service providers based on their Indigeneity; having experienced receiving less care in comparison to white female patients and having been subject to racial stereotyping and microaggressions (Monchalin et al., forthcoming). This aligns with findings from McKenzie et al.'s (2022) study of urban Indigenous women's experiences of reproductive injustice in Manitoba; specifically, Indigenous women reported experiencing Indigenous-specific racism and stereotyping surrounding their ability to birth and raise a child and coercion as it pertains to their reproductive autonomy. Separately, in their respective research on distance travelled to access abortion care, Sethna and Doull (2013) found that a third of the studied women in Manitoba travelled more than 100 kilometres to access services.

Altogether, this chapter lays out the background context relevant to my research. It details the overarching frameworks for Indigenous health care and abortion policy in Canada to facilitate my policy analysis. The following chapter provides rationale for such a policy analysis through detailing the existing literature and prevailing gaps, along with the theories and concepts guiding my research.

Chapter 3: Literature Review

I began my review of the literature on this topic by identifying key terms and entering these in logical combinations into UVic Libraries' "Summons 2.0", Google Scholar, and the Google search engine – seeking to locate both scholarly and grey literature. I reviewed available abstracts and executive summaries for relevance and for source credibility (reliability and subject matter expertise) to identify my chosen articles. I subsequently scanned reference lists and searched identified authors' names to locate outlying pieces of literature that didn't appear in my initial key variable search. I searched UVic's thesis and dissertation repository, "UVicSpace" but did not find any documents relevant to my research topic. Key terms I used in my search included, "Indigenous", "Aboriginal", "abortion access", "abortion policy", "abortion service provision", "Canada", "reproductive health", "reproductive justice", "policy barriers", "lived experience", "colonialism", "racism" and "health care". Altogether, I identified 32 pieces of literature relevant to my topic area, including both academic and grey literature. Six of these articles had direct relevance to my research, correlating Canadian policy to barriers in abortion service for Indigenous women, albeit with differing scopes. Outside of these, three categories of literature emerged possessing some measure of relevance to one of these two variables. All four categories of literature are detailed below:

1. The first category includes seven pieces of literature that examine **policy-level barriers** to accessing abortion services **for women in Canada as a whole**.
2. The second category of literature includes six pieces discussing, to some extent, the impact of **Canadian policy** on **Indigenous women's access to abortion services in Canada**.
3. The third grouping includes fourteen pieces of scholarly and grey literature acknowledging **barriers** specific to **Indigenous women in Canada and their social locations,** without a policy focus.
4. The fourth grouping includes six pieces of literature examining **the impact of colonial policies and practices** on Indigenous women's **health outcomes and experiences**. While not focused specifically on abortion care, this literature is relevant to my research questions as it details the systemic barriers shaping Indigenous women's health care experiences and outcomes at large.

Findings from my review of the literature are detailed below according to the four above-described categories. Notably, all six articles of direct relevance to my research are theoretically focused as opposed to empirically based. Of the remaining articles, four reported original research – two on Indigenous women's experiences with accessing abortion services in Canada and two on Indigenous women's experiences with the Canadian health care system at large. The bulk of the literature consisted of scholarly analytical pieces, pointing to a gap in the literature in terms of original research on the subject of my study.

3.1 Policy-Level Barriers for Women in Canada at Large

Within the first grouping of relevant literature, authors detail how current and historical policy and legislative frameworks in Canada contribute to issues of access for women at large (as opposed to for Indigenous women specifically). Palley (2006) and Long (2022) point to Canada's federal structure and provincial jurisdiction over abortion policy as responsible for inequities in access to abortion services across the country. Abortion is a highly political issue and provincial and territorial approaches to abortion care differ vastly in large part due to political ideology (Long, 2022; Palley, 2006). Generally, the number and location (urban versus rural) of service providers, along with gestational limits differ drastically between provinces and territories (Schummers & Norman, 2019; Long, 2022). Some provinces have, in recent years, refused to provide medical coverage for abortions provided outside of hospital settings (Long, 2022). Action Canada (2019-a) provides a factsheet on their website highlighting the discrepancies in abortion service provision nationwide. It compares province-specific policies and the number and location of service providers across each jurisdiction (including urban and rural). Data from a 2014 survey on abortion providers points to a complete lack of surgical service providers in rural Manitoba (Action Canada, 2019-a). From a medical standpoint, those who have to travel greater distances to access abortion services commonly have abortions later in the gestational term (Schummers & Norman, 2019). This then results in a higher risk of health complications (Schummers & Norman, 2019).

Regarding federal intervention, there is agreement that the federal government has a greater role to play in ensuring universal service delivery across the country; however, Palley (2006) notes a lack of sufficient political implementation resources at the federal government's disposal. The federal government may withhold health care transfer payment funding if it finds a province to be out of compliance with Health Act principles of accessibility/universality; however, doing so lessens the ability of provinces to fund health services in accordance with the principles of the Health Act (Palley, 2006). Largely, the polarizing subject of abortion service has caused the federal government to refrain from implementing any significant action since its decriminalization in 1988 (Long, 2022). Long (2022) and Johnstone (2017) explain how the right to abortion in Canada is not protected by legislation, leaving it open to recriminalization through new legislation; however, both authors note the improbability of such given its politically polarizing nature.

Following their 2016 periodical review, the United Nations Committee on the Elimination of Discrimination Against Women ("the Committee") released a comprehensive report citing "disparities in access to [abortion] services and to affordable contraceptives" in Canada (United Nations Committee on the Elimination of Discrimination Against Women, 2016, p. 15). The Committee's three associated recommendations for the Government of Canada included: (a) ensuring access to legal abortion services in all provinces and territories; (b) ensuring that affordable contraceptives are accessible and available to all women and girls, "in particular those living in poverty and/or in remote areas"; and (c) ensuring "the invocation of conscientious objection[18] by physicians does not impede women's access to legal abortion services" (United Nations Committee on the Elimination of Discrimination Against Women, 2016, p. 15). Regarding the Committee's first recommendation to ensure legal access, Action Canada in 2016 cited incidences of provinces denying coverage for abortion provision in clinics, refusing to require hospitals to perform abortions, and setting gestational limits. These result in individuals having to travel longer distances to access abortion services that meet their needs at their own expense (Action Canada, 2016). Further, Action Canada (2016) cited a lack of access to the abortion drug Mifegymiso. On the Committee's third recommendation to ensure that the exercise of conscientious objection does not impede women's access, Action Canada (2016) notes that many provincial Colleges of Physicians and Surgeons have failed to "amend their policies in line with human rights obligations to include effective referrals" (para. 4). On service availability, Kaposy (2010) references a lack of hospitals providing abortion service, a lack of trained doctors, and a lack of education on abortions in Canadian medical schools. In the context

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[18] Conscientious objection refers to a practicing physician's refusal to "perform a legal role or responsibility" – in this case provide an abortion – due to their personal beliefs or values (Shanawani, 2016, para. 1).

of such limited-service availability, “women who are poor, geographically isolated, especially young, addicted, abused, disabled, or otherwise vulnerable” will be less able to overcome existent barriers to access (Kaposy, 2010, p. 21).

3.2 Canadian Policy and Barriers to Abortion Access for Indigenous Women

All six pieces of scholarly and grey literature discussing the impact of Canadian policy on Indigenous women’s experiences accessing abortion services reported barriers rooted in colonial policies and practices. The literature concludes that existent barriers to abortion access for women at large are compounded for Indigenous women based on social locational factors; meanwhile, Indigenous women experience distinctive barriers unique to their social locations and identities. On the former, the literature concludes that Indigenous women experience systemic socioeconomic issues as a result of colonial policies (Minacci-Morey, 2020; Nelson, 2017; Shaw, 2013). Such socioeconomic issues act as social determinants of health[19], including determining Indigenous women’s experiences with and access to abortion services. Unsafe housing on reserves, as well as a lack of basic infrastructure and sanitation and food insecurity are all examples of systemic issues compounding barriers to access (Minacci-Morey, 2020; Nelson, 2017; Shaw, 2013). Indigenous women also face higher rates of unemployment and have lower median incomes by $5000 than non-Indigenous women in Canada (Minacci-Morrey, 2020). Amongst the landscape of abortion access at large, general barriers that are compounded by factors unique to Indigenous women include: a limited number of safe and legal abortion service providers (including clinics specifically, which provide more positive care experiences and aftercare supports than hospitals); a scarcity of service providers outside urban centres and the costs associated with travel from rural areas; vast discrepancies in regulations between provinces, including on gestational limits and insurance coverage; and, a lack of information as well as misinformation on service availability (Minacci-Morrey, 2020; Nelson, 2017; Bollinger, n.d.).

Related to the latter of the above two conclusions, barriers specific to Indigenous women include, for one, on-reserve privacy issues: while Indigenous women can access government funding to cover the cost of travel and accommodation through NIHB, they must receive

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[19] According to the Government of Canada (2022-g), social determinants of health are the “personal, social, economic and environmental factors” that determine health outcomes and inequities. These include factors such as income, education, employment, housing, and social inclusion/exclusion (Government of Canada, 2022-g).

permission through their band council to do so, compromising their confidentiality and privacy (Minacci-Morrey, 2020; Action Canada for Sexual Health and Rights, 2020-b). Beyond a lack of privacy, Indigenous women on reserve face the risks of community stigma and shame – products of the church and state's colonial indoctrination of Catholic values. Further, they are subject to Indigenous-specific racism and stereotyping in interpersonal experiences with Western service providers (Minacci-Morrey, 2020; Shaw, 2013; Bollinger, n.d.). On reserves, maternity services available to Indigenous women are limited, having been declared by the Society of Obstetricians and Gynecologists of Canada as being in a "state of crisis" (Nelson, 2017, p. 722). The majority of primary care providers on reserves are registered nurses, meanwhile only registered physicians, nurse practitioners, and midwives are legally allowed to provide abortions in Canada (Action Canada for Sexual Health and Rights, 2020-b).

Looking at the federal policy landscape, it is agreed that (a) discrepancies in access across the country are a result of Canada's jurisdictional division of powers as it relates to Indigenous health care; and (b) that abortion services across Canada are not provided in accordance with the principles of the Canada Health Act (Nelson, 2017; Shaw, 2013). Nelson (2017) cites the lack of legislated health authority for Indigenous peoples in both the Constitution Act and Indian Act – along with the Indian Act's institution of status – as manifesting in a convoluted system of health governance and gaps in care – both of which result in discrepancies in access to reproductive health care for Indigenous women. Nelson (2017) calls for greater collaboration between federal and provincial/territorial powers as it pertains to health care delivery to Indigenous populations, and a more cohesive policy agenda as it relates to federal sexual and reproductive health care service provision.

From a provincial policy landscape standpoint, Stevenson and Taylor (2020) detail the legislative documents forming the legal basis for entitlement to abortion services in Nova Scotia, including for Indigenous peoples. At the international level, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) secures the right to reproductive choice (Stevenson & Taylor, 2020); the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) declares that Indigenous individuals have the right to access all social and health services without discrimination (Stevenson & Taylor, 2020); and the United Nations Convention Against Torture declares that the delay or denial of abortion services may amount to torture or inhumane treatment (Stevenson & Taylor, 2020). At the federal level, the Canadian

Charter of Rights and Freedoms and the Canada Health Act guarantee the right to life, liberty, and security of the person and set out requirements for the provincial/territorial administration of health services (Stevenson & Taylor, 2020). Stevenson and Taylor (2020) also cite examples of Canadian common law which establish rights applicable to abortion access, including the right to timely access to abortion services without state interference, and the right to medical self-determination. As it relates to coverage for abortion services, Stevenson and Taylor (2020) describe how the federal government's Non-Insured Health Benefits Program refers Indigenous peoples to mainstream abortion service providers, limiting Indigenous patients' access to traditional abortion medicines.

3.3 Barriers Specific to Indigenous Women and their Social Locations

The third grouping of articles details barriers specific to Indigenous women and their social locations, without a policy focus. Identified barriers included a lack of service providers on or near reserves and rural Indigenous communities; the cost and time associated with travelling from a reserve or rural community to an urban clinic or hospital; racial stereotyping and mistreatment by service providers; negative experiences in hospital environments versus clinics; a lack of information on service availability; and stigma by community and family members (Sethna & Doull, 2013; Monchalin, forthcoming; Monchalin & Paul, 2021-b; Monchalin, 2021-a). Monchalin (2021-a) describes how barriers in access to abortion services are compounded for Indigenous women by historic and ongoing colonialism and resultant disparities in social determinants. Historically, Indigenous women have been subject to centuries of violence and sexual and reproductive control by the church and state (Monchalin, 2021-a). Today, they remain subject to systemic and interpersonal racism, stereotyping, and mistreatment in the health care system and to a legacy of abortion-related stigma (Monchalin, 2021-a). There is a lack of abortion providers on reserve, let alone culturally safe abortion services (Monchalin, 2021-a). Further, socioeconomic factors and a lack of privacy challenge women's ability to access funding for travel (Monchalin, 2021-a).

Monchalin (2021-a) writes how the COVID-19 pandemic created new barriers to abortion access for Indigenous Peoples in Canada. Physical distancing restrictions imposed by the government caused abortion clinics (already scarce) to close or decrease their hours while also contributing to shortages in Mifegymiso supply (Monchalin, 2021-a). More recently, Monchalin et al. (forthcoming) conducted interviews with Indigenous women and Two-Spirit individuals on experiences with accessing abortion care in Canada[20]. In line with Monchalin's 2021 report, key themes from the interviews included challenges accessing services from rural and reserve locations; stigma and shame by family and community members on reserves and in small communities; and Indigenous-specific racial stereotyping and mistreatment by service providers, particularly in hospital settings (Monchalin et al., forthcoming).

From a geography standpoint, Sethna and Doull (2013) mapped travel patterns of those accessing an abortion in Canada based on questionnaires with 1186 women. Women self-identifying as First Nations or Metis were "three times more likely to report travelling over 100 kilometers to access a free-standing clinic as compared with white women and more likely to report their journey was "difficult" as compared to a white woman" (Sethna & Doull, 2013, p. 57).

As referred to in my introduction, the U.S. Supreme Court in June 2022 overturned legal precedent that restricted the prohibition of abortion – this resulting in significant media attention being paid to issues of access to abortion services in Canada. Consequently, I conducted a supplementary grey literature review of news articles focusing on access to abortion in Canada for Indigenous women in late June 2022 – this following my approach to my literature review as detailed above. I entered the above-described key words into Google News and UVic Libraries Summons 2.0 (filtered for news articles only), through which I discovered seven relevant articles from major Canadian news outlets written in the first week of May 2022 and the last week of June 2022 (in line with an initial news leak on the proposed decision on May 3rd and the ultimate decision on June 24th). Writing for major news outlets, including CTVNews, the Toronto Star, the Globe and Mail, CBCNews, The Province, and Yahoo!News, authors assert that Canada's population of Indigenous women are inequitably disadvantaged in their access to abortion services in Canada. The authors cite Canada's history of colonialism, including historic and ongoing interpersonal and systemic Indigenous-specific racism and violence, along with geography, as key causes. Wyton (2022), writing for the Tyee, asserts that abortion care is "stratified along gender, race and class lines" (para. 10) in both B.C. and Canada. Beyond

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[20] Note that I assisted in the qualitative analysis of these interview transcripts, providing me with an early interpretation of key themes. Where findings from Monchalin et al.'s (forthcoming) research have helped to inform this thesis and my overarching researcher perspective, this thesis will help to inform Monchalin et al.'s work.

geography and systemic racism, she references the historical context of violations to reproductive freedom that Indigenous women have been subject to by the colonial administration, along with issues of stigma and a lack of privacy in smaller communities.

On May 11th, 2022, the Government of Canada produced a news release announcing $3.5 million in funding for projects to improve access to abortion services in Canada to be administered by both Action Canada for Sexual Health and Rights and the National Abortion Federation Canada. The funding is designed to remove barriers such as a lack of service availability and a lack of financial and logistical resources required to access the services (Government of Canada, 2022-c). They acknowledged that “previous experiences of discrimination within the health care system” have created “access barriers for minority and marginalized groups, such as Indigenous and racialized people” (Government of Canada, 2022-c, para. 3).

Prior to 2022, news articles on the topic are limited aside from Violet Lee and Spillet’s 2017 CBCNews piece on issues of abortion access for Indigenous women in Saskatchewan, and Smith’s 2010 article for the Toronto Star. Like written by Wyton, Smith points to geographic distance; stigma perpetrated by the church and state; a long-history of abuse towards Indigenous women and their sexual identity; and a lack of confidentiality on reserves as resulting in key barriers to access.

3.4 Indigenous-Specific Structural and Systemic Issues in the Canadian Health Care System

The last category of literature examines the prevalence of colonial practices, policies and behaviours in Canada’s health care system and their impact on Indigenous women’s general health outcomes. Health and social status indicators report that Indigenous women in Canada experience major discrepancies in health outcomes compared to non-Indigenous women (Browne & Fiske, 2001; Clarke, 2021; Denny 2020; Bourassa et al., 2004). According to Bourassa et al. (2004), Indigenous women in Canada have a lower life expectancy and elevated disease and suicide rates compared to non-Indigenous women. Chronic diseases are also higher in prevalence amongst Indigenous women than men, which epidemiologists suggest are a result of “forced acculturation imposed on Aboriginal people” (Bourassa et al., 2004, p. 1). The identified literature concurs that such health outcomes are shaped by interpersonal and institutional discrimination and intersecting oppressions resulting from colonial policies. The Indian Act is referenced by Denny (2020), Clarke (2021), and Bourassa et al. (2004) as the root cause of Indigenous women's poor health outcomes, having purposefully instituted the subjugation of Indigenous women, both legally, socially, and culturally. There is a consensus amongst all authors that Indigenous women's identities, rights, and reproduction were undermined to serve colonial aims (Browne & Fiske, 2001; Clarke, 2021; Denny 2020; Bourassa et al., 2004; The National Inquiry into Missing and Murdered Indigenous Girls, 2019). As leaders of their communities, bearers of knowledge, and carriers of new generations, Indigenous women are viewed by colonizers as threats to their goals of population control, assimilation, and land and resource acquisition (Clarke, 2021; Denny, 2020). The removal of rights and the establishment of negative stereotypes enabled colonizers to justify their systemic oppression. Bourassa et al. (2004) describe how colonial discourse, including the term "Indian", has been used to frame non-white populations as inferior to justify their inequitable treatment and exclusion, including how this ultimately "contributed to poor health conditions in the oppressed group" (p. 24). Historic sexual sterilization policies and the continued forced sterilization of Indigenous women are examples of how Indigenous women's reproduction has and continues to be controlled by the state to serve "eugenically guided" goals (Clarke, 2021, p. 1; Denny, 2020).

Browne and Fiske's 2001 conclusions on the above were informed through interviews with rural First Nation women on experiences with mainstream health care. Interviewees reported negative experiences characterized by dismissal and belittling; vulnerability and marginalization; and negative stereotyping, including denigration over their roles as mothers. Browne and Fiske (2001) concluded that mainstream health care in Canada is shaped by colonial policies which contribute to "racialized and gendered stereotypes and economic privation" for Indigenous women (p. 126). Such policies contribute to the marginalization of Indigenous women from "the dominant systems of care" (Browne and Fiske, 2001, p. 126). Similarly, the National Inquiry into Missing and Murdered Indigenous Girls' 2019 findings are based in reportings from survivors of systemic and interpersonal violence specific to Indigenous women and girls, and their family members. Finally, the literature asserts that neglect is not only prevalent at the federal level but at the provincial level: reporting on findings from her review of Indigenous-specific racism in B.C.'s provincial health care system, Turpel-Lafond (2020) identified “largely disconnected efforts amongst federal and provincial governments” regarding Indigenous women’s reproductive health (p. 77).

3.5 Summary of Key Findings

The reviewed literature points to the inequitable nature of abortion access in Canada; to lesser health outcomes for Indigenous women as a result of systemic barriers within the health care system; and altogether, to distinct barriers to abortion service access faced by Indigenous women in Canada. Ten academic publications and ten news articles explicitly concur that Indigenous women face unique systemic and interpersonal barriers to accessing abortion services in the country. Barriers for women at large (compounded for Indigenous women based on their social locations) as determined through my literature review are detailed below:

- Provincial/territorial jurisdiction over abortion service provision resulting in varying regulations and health coverage dependent on political interests;
- A scarcity of service providers and their urban-centric geographic distribution;
- A scarcity of information on service availability and options;
- Conscientious objection by physicians and pharmacists; and
- Stigma and shame from pro-life communities.

In addition to the above, Indigenous women are subject to the following additional barriers:

- Enduring colonial policies and practices designed to assimilate and contain Indigenous populations; policies that:
  - Disregard traditional Indigenous approaches to health;
  - Disregard the distinct needs and social locations of Indigenous women; and
  - Result in systemic racism.
- Widespread Indigenous-specific interpersonal racism and bias amongst health care workers, manifesting in mistreatment and abuse.
- A history of systemic neglect and violence, and a specific history of controlled fertility resulting in well-founded fear and mistrust of mainstream reproductive health care amongst Indigenous populations.
- A convoluted and overcomplicated patchwork of governance pertaining to Indigenous peoples’ health and wellbeing, and in association, a lack of accountability resulting in systemic socioeconomic disparities.

- Prevailing stigma amongst Indigenous communities surrounding abortion, instigated by colonizers' indoctrination of Eurocentric beliefs and religious values.
- A lack of privacy from other community members in the context of on-reserve care.

As I describe in my introduction, my thesis will seek to locate said barriers within Canadian public administration and identify areas for reform.

3.6 Gaps in the Literature

As is evidenced above, and as Monchalin (2021-a) states, "there is virtually no literature available surrounding Indigenous women's and Two-Spirit Peoples' experiences with abortion in Canada" (p. 1). Further still, there is a lack of methodologically-sound empirical research in the subject area and a lack of useful policy analyses to inform policy reform more specifically. The context I have provided above points to a need for deeper examination of how the policy landscape shapes and impedes Indigenous women's experiences with accessing abortion services in Canada in order to generate reform. A closer examination of the impact of historic legislation such as the Indian Act, Canada's constitution acts, the Canda Health Act, and the 1979 Health Transfer Policy is necessitated. Applying an intersectional lens will be crucial to understanding the extent to which key policy documents consider the intersecting categories of oppression faced by Indigenous women in Canada.

3.7 Theoretical and Conceptual Frameworks

As above, Canada's health care system has and continues to disadvantage Indigenous women in Canada. I assume this to be based on the system's colonial foundations and its continued lack of consideration for the intersecting dimensions of discrimination faced by Indigenous women in Canada. Through this research, I seek to uncover how the current framework's failure (in design and implementation) to consider Indigenous women's multiple intersecting identities and oppressions results in distinct barriers for Indigenous women's access to abortion services today. Accordingly, my research is founded on the paradigm of "intersectional" theory.

Theoretical Framework

Kimberlé Williams Crenshaw coined the term "intersectionality" in 1989 in reference to the "interconnected nature of social categorizations" that create "overlapping and interdependent systems of discrimination or disadvantage" for a person or a group of people (Oxford English Dictionary, 2018, para. 1); or as Rodriguez (2018) writes, "are created and perpetuated as part of systems of power and inequality that sustain privilege and disadvantage in everyday life" (para. 1). Crenshaw coined this theory to describe the compounded discrimination Black women experienced in the mid-to-late twentieth century, including racism in the feminist movement, sexism in civil rights, combined with other potential categories of discrimination such as sexual orientation, age, class, and disability (Rodriguez, 2018). This said, Clark (2016) notes that the concept of intersectionality is not new to Indigenous communities and was practiced "long before the writings of the early African American women activists" (p. 49). According to Clark (2016), the Indigenous ontology is "inherently intersectional and complex in its challenging of the notions of time, age, space, and relationship" (p. 49); prior to colonization, Indigenous communities had "multiple categories of gender, holistic understandings and approaches to health" (p. 49). Intersectionality as a research paradigm consequently has significant relevance for my thesis.

In research, intersectionality facilitates the examination of "people's overlapping identities and experiences … to understand the complexity of prejudices they face" (YW Boston Blog, 2017). Crenshaw (1989) describes "political intersectionality" as linked to the "exploration of public policies" and the ways in which intersectionality is "embedded in their articulation", including in their design, implementation, and outcomes (Crenshaw, 1989 as cited by Rodriguez, 2018, para. 13). As it relates to my objective of generating policy reform outside of traditional colonial structures, Hankivsky et al. (2012) write that "the inclusion of colonized people's traditional knowledges in the production of knowledge generated by policy analysis can work to shift dominant colonial or racialized discourses in policy and can thus have a decolonizing effect" (p. 37). Dhamoon (2011) similarly notes that "including the perspectives and worldviews of people who are typically marginalized or excluded in the production of knowledge" can work to "disrupt forces of power that are activated through the production of knowledge" (p. 240). Accordingly, I will utilize intersectionality as a paradigm to analyze the extent to which current abortion policy fails to consider the multiple categories of discrimination forming Indigenous women's lived realities.

Conceptual Framework

According to Hankivsky et al. (2019), applying an intersectional lens to policy analysis encourages critical reflection “that allows researchers and decision-makers to move beyond the singular categories that are typically favoured in equity-driven [policy] analyses” (p. 135). Through utilizing “intersectionality-based policy analysis”, analysts commit to “ameliorating inequitable relations of power that maintain inequity” – those typically unquestioned in “dominant public health research and policy approaches” (Ferlatte & Oliffe, 2019, p. 265). Building off of intersectional theory, and given the gendered nature of abortion policy and he fundamentality of abortion access to women’s equality and freedom, my analysis utilizes a “Feminist Intersectional Policy Analysis Framework”, incorporating both Hankivsky et al. (2019)’s intersectionality-based policy analysis theory and feminist theory.

At its core, feminist theory is a movement for justice; it is about giving women choice and freedom (Crocket, 2017). The right for a woman to make choices about her own body – including to choose whether or not to birth and maintain responsibility for a child (which then has profound social, economic and emotional consequences for the woman) – is fundamental to her freedom and equality. Accordingly, so is her right to access an abortion in a safe, timely and legal manner. A feminist approach to the analysis of the abortion policy landscape, and one that incorporates intersectional theory for the reasons cited above, has profound significance to my research.

McPhail’s (2003) original Feminist Policy Analysis Framework incorporates concepts of feminism into traditional policy analysis, founded on the belief that mainstream policy development and analysis is conducted without regard for gender (McPhail, 2003). It was developed through a review of the feminist policy literature to determine “which questions feminist policy analysts ask of policy to determine its effects upon the status of women … and how well [the policy] fits with the goals and values of feminist ideology” (McPhail, 2003, p. 42.). Specifically, it provides a framework for a researcher to examine the extent of alignment of any policy with the goals and values of feminist ideology[21]. This said, in consideration of advancements in feminist theory and policy analysis to date – namely in the incorporation of intersectional theory – Kanenberg, Leal and Erich (2019) have refined McPhail’s original

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[21] It should be noted that McPhail’s framework considers the various viewpoints of feminism, taking a “both/and” as opposed to an “either/or” perspective (McPhail, 2003, p. 46). The framework is “inclusive of questions and perspectives that can be shared by many feminist perspectives in an effort to honor multiple feminist identities and to enhance the product of the analysis” (Kanenberg et al., 2019, p. 8).

framework. They've broadened the original assumption of McPhail's framework to that of mainstream policy development and analysis's lack of consideration for not only gender, but of the intersecting categories of oppression shaping Individuals and groups' lived experiences. Kanenberg, et al.'s Feminist Intersectional Policy Analysis framework (2019) – which I will utilize specifically in my research – provides a series of questions that can be asked of any policy to examine the extent to which it considers gender along with other intersecting discriminations, including race and systems of colonialism. The framework is to be used at multiple points of a policy intervention, including in its design and implementation.

Core to my research methodology, I will apply this framework to conduct an in-depth examination of the way in which current policy considers – or fails to consider – intersecting categories of oppression shaping Indigenous women's realities, and the resulting inequities. McPhail, and Kanenberg et al. write that questions can be selected from the framework and applied in analysis as relevant; the specific questions I will utilize in my analysis, and the core principles guiding one's use of the framework are detailed in Appendixes A and D.

3.8 Theoretical and Conceptual Frameworks in the Literature

Above, I detail my use of a Feminist Intersectional Policy Analysis framework in my research. In my review of the literature, I found no similar applications of this framework – likely given the framework's recent date of creation. Notably, given that many of the pieces of relevant literature I discovered lacked an empirical basis, very few included a guiding theoretical or conceptual framework. Of the six pieces of literature with direct relevance to my research paper, Minacci-Morey (2020) discusses the value of Critical Race Theory and personal narrative for analyzing access issues for Indigenous women from a legal perspective. She describes this paradigm as relevant to the study of Indigenous women's experiences with accessing abortion services in Canada given that it "recognizes the constantly-fluctuating "multiple consciousness" of oppression that may come from numerous systems of oppressions" (p. 285) – alike to my application of an intersectional paradigm to my research. Stevenson and Taylor (2020), separately, define their article on access to abortion services in Canada as being from a feminist perspective, noting that their feminism strives to be "intersectional and recognizes that barriers to abortion access can have disproportionate effects on some communities" (p. 1). My research incorporates theories of both intersectionality and feminism – outlined by these two authors as important to the study of Indigenous women's access with the abortion service landscape.

Chapter 4: Methodology, Methods and Data Analysis

4.1 Methodology

In conducting my research, I employed a qualitative, postpositivist critical policy studies approach to determining the key policy-level barriers impeding Indigenous women's just access to abortion services in Canada. Through this approach, I interpreted findings inductively in line with the epistemology of my feminist intersectional paradigm, all while continuously reflecting on my own subjectivity and biases in relation to my positionality.

As critical policy studies and specifically, intersectionality-based policy analysis, calls for, my inquiry followed an emancipatory approach focused on justice and equity. Following intersectionality-based policy analysis, I sought to interpret how the policy landscape's[22] current formation generates barriers to equitable abortion access for Indigenous women. This includes for those with and without Indian status as per the Government of Canada's Indian Register. I sought to interpret any "harmful biases, assumptions, stereotypes, exclusions, and oppressive effects" specific to Indigenous women and their social locations (Hankivsky et al., 2019, para. 8). This included inquiry into the landscape's prevailing power structures, the values and emotions associated with its creation and implementation, and its intersection with "hegemonic structures", including colonialism, racism, and patriarchy (Yousefi, 2017, para. 4).

4.2 Methods and Tasks

My approach was dual phased, beginning with a policy document analysis of the policy framework structuring Indigenous women's experiences with accessing abortion services in Canada and its "context, text, and consequences" (Taylor, 1997, p. 33), as defined below. This critical policy analysis provided insights on the values, forces, and power structures underpinning the policies of study and their implementation.

Building off preliminary findings from this first phase, I conducted a more specific inquiry into the identified policy framework and its impact on Indigenous women in my second phase of research through a Feminist Intersectional Policy Analysis framework. I specifically

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[22] I use the terms policy "landscape" and "framework" interchangeably to describe the relevant governance structure and suite of policies structuring Indigenous women's access to abortion services, including their content and implementation.

examined how the policy framework and its structures of power consider, or fail to consider, Indigenous women and their social locations.

The policy framework of examination was determined through my background research, an overview of which is provided in my Background chapter[23]. As noted in this Background chapter, I selected the province of Manitoba as a case study of provincial-level policy and governance structuring Indigenous women's experiences with access.

Below, I describe the methods and tasks involved in this dual-phased approach.

Phase 1: Analyzing the Policy Framework Through a Qualitative Policy Document Analysis

According to Ball (1994), policy is both "text and action, words and deeds" and "what is enacted as well as what is intended" (p. 10). Cardno (2018) describes policy document analysis as a method of critical policy studies which seeks to investigate the "nature of a policy document" and "what lies behind it and within it" (p. 625). To highlight power relations as per critical policy studies theory, Taylor (1997) underlines the importance of analyzing policy documents in terms of their "context, text and consequences" (p. 33).

In this phase, I conducted a policy document analysis of the policy documents forming the policy framework, including at both the federal and Manitoba-provincial level. I examined the policy documents' context, text, and consequences, specifically examining the power structures underpinning and generated by each document's design, text, and implementation. At the federal level, the documents I examined included the Indian Act (including its original 1876 edition and its 1985 amendment); the 1982 Constitution Act and the former 1867 British North America Act; the 1979 Indian Health Policy; the 1988 Health Transfer Policy as manifested in its health transfer handbook; the 1985 Canada Health Act; and the Non-Insured Health Benefits Program (ongoing) and its associated Medical Transportation Policy Framework (2019). At the Manitoba-provincial level, the analyzed documents included The Health System Governance and Accountability Act, and its preceding Regional Health Authorities Act, and the College of Pharmacists of Manitoba's Code of Ethics and Obligations.

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[23] Greater detail on my rationale for each policy document's inclusion in the policy framework, including how they directly impact abortion access for Indigenous women in Canada, is included in Appendix B.

In analyzing the policy “context”, I sought to understand the forces and values that “[drove] the policy into being” (Cardno, 2018, p. 628, citing Bell et al.). This is inclusive of the values of the “powerful people” responsible for its design; the broader socio-political environment; and influential preceding policies, and the extent of consultation with stakeholders and Indigenous and female populations specifically (Cardno, 2018, p. 628, citing Bell et al.). In examining the policy “text”, I drew inferences on the policy’s content, including its use of language in regard to power structures, its framing of Indigenous peoples and Indigenous women, and policy silences in the context of Indigenous women (Cardno, 2018). Finally, in examining the policy “consequences”, I examined power structures surrounding its implementation, including how and by whom the policy is interpreted and implemented; what processes exist to ensure its effectiveness (evaluation and reform); and amendments resulting from evaluation or reform (Cardno, 2018).

Findings and interpretations from this phase set the foundation for deeper inquiry through a feminist intersectional policy analysis, as in phase 2.

Phase 2: Examining the Landscape through a Feminist Intersectional Policy Analysis Framework

In this phase, I analyzed the above-reviewed policy documents utilizing Kanenberg et al.’s 2019 Feminist Intersectional Policy Analysis Framework and its underpinning feminist and intersectional theory. I structured this analysis in line with the approach taken in phase 1, specifically applying this critical inquiry to each policy’s design, content, and implementation (or “context”, “text”, and “consequences”). Building off of insights from phase 1, I critically assessed the ways in which the landscape considers Indigenous women and the intersecting categories of discrimination forming their realities, including gender, race and colonialism. I sought to expose hegemonic biases and power relations generated through the policy framework and any resulting inequities specific to Indigenous women and their social locations (Kanenberg et al., 2019). As noted in my conceptual framework, Kanenberg et al.’s framework contains various lines of questioning to allow an analyst to analyze policy (inclusive of its design, content, and implementation) through a feminist intersectional paradigm. I selected 22 questions from this framework's lines of questioning based on their relevancy to the scope of my research[24][25].

4.3 Data Analysis

In line with my methodology, I conducted my analysis inductively, in other words, interpreting meaning and drawing conclusions from my interpretations. As called for in interpretive data analysis, I continuously reflected on my positionality throughout my analysis, along with my: research questions and goals, methodology and associated epistemology and ontology, and my theoretical and conceptual frameworks. In following my above-defined approach, I recorded my inferences and interpretations across each step, with this then becoming my data. As written above, my inferences from phase 1 guided my analysis in phase 2. As I proceeded to collect data, I organized my data into *domains* – or groupings of core ideas – as they arose, and from there, into categories of meaning (Elliot & Timulak, 2005). I managed my data collection and analysis activities through the use of an Excel spreadsheet, along with a more detailed and corresponding table in Microsoft Word. I also applied file management best practices to manage the policy documents identified through my analysis.

4.4 Strengths and Limitations

My research methodology has several limitations and strengths that require acknowledging.

Limitations

As above, my feminist research approach allows for subjectivity in interpretation and analysis. According to Haraway (1988), the feminist epistemology underlines the importance of "situated knowledge" and "passionate detachment" (p. 585) so long as one continues self-critical acknowledgment of their position and partiality, and commits to seeking perspectives from other points of view (p. 585). Throughout my research and analysis, I sought to consistently reflect on my partiality and positionality; however, my research is limited in that I failed to gather other's points of view to counter my own subjectivity. This said, as I note in my literature review, prior

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[24] The specific framework of questions I will be using can be found in Appendix A.

[25] A definition of the framework's principles, including one's application of the framework in analysis is detailed in Appendix D of this paper.

to conducting this research, I contributed to the analysis and review of findings from Monchalin et al.'s (forthcoming) primary research on such experiences. This has helped to inform the perspectives guiding my research. Additionally, the focus of my research was to map out the federal policy landscape structuring Indigenous women's access to abortion care in Canada from a public administration perspective. This included an analysis of policy at the Manitoba provincial level in connection to reported barriers in the province. Through my research, I learnt of the decentralized nature of health care delivery at the provincial level. Gestational limits for example, are determined per medical institution. An analysis of medical policy documents would bolster the findings of this thesis and is an area for further research.

Strengths

In my background chapter, I detail the significance of this study in the context of broader political attention being paid to issues of abortion access in Canada at this current time. Further, I note the scarcity of literature in this particular subject area. This research represents a novel and timely contribution to understandings of access to abortion service for Indigenous women in Canada within the political, academic and public spheres.

My research respects Indigenous women's own experiences and worldviews. I suggest opportunities for reform within the current colonial landscape of abortion service to inform the development of options for positive change. I assert that I am not in a position to provide policy recommendations on a matter which does not impact me or for a population which I am not a member of and, importantly, that any ultimate reform be guided by the voices of Indigenous women.

Finally, my three years of experience conducting research initiatives as a Public Sector Management Consultant and my learnings from UVic's MPA program provide me with the necessary expertise and credibility to conduct this research initiative soundly and effectively.

Chapter 5: Results

5.1 Introduction

This chapter summarizes the findings from my research as collected in accordance with my above-defined research approach. Consolidated findings from each phase of analysis are detailed per policy document, beginning at the federal level and then moving to the Manitoba-provincial level. Further context on each policy document, including its purpose and my rationale for its inclusion in the policy landscape, can be found in Appendix B, which I encourage the reader to review in conjunction with these findings. As per my methodology, I analyzed each policy document through a research framework comprised of two distinct and complimentary frameworks of analysis to establish an understanding of each document's "context" (values and forces underpinning its design, including in relation to Indigenous women, Indigenous peoples, and women in general; the broader socioeconomic environment in which it came into force; relevant policy documents preceding the policy; and demographics consulted in its design); its "text" (power structures established by the document; its framing of women and Indigenous peoples; its consideration of equitable outcomes; its consideration of differing social locations; and its policy silences); and its "consequences", referring to power structures surrounding its implementation in practice; consideration of intersectionality in its implementation; its processes for evaluation and reform the effectiveness of checks on power; and the form of resultant amendments[26]. Accordingly, this chapter structures my consolidated findings from my analysis of each policy document in sections pertaining to its "context", "text" and "consequences". Table 1 below summarizes the scope of each section in the context of my research framework (including both two frameworks of analysis) at a high-level. My complete research framework, outlining the analytical lines of questioning upon which these results are based, can be found in Appendix A. I encourage the reader to review this to supplement their interpretation of these results.

Table 1: Research Framework Overview

	Policy Document Analysis (Taylor, 1997)	Feminist Intersectional Policy Analysis (Kanenberg et al., 2019)

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[26] For clarity, I note that "consequences" refers to "how the policy is taken up and to what end" (Taylor, 1997), and not the consequences of the policy itself, which are discussed in the context of "barriers created" in my Background chapter and my Discussion and Analysis.

Context:	The context in which the policy was designed, including values of those with policymaking power, the socioeconomic political environment, preceding policy document, and extent of engagement with stakeholders	Consultation and involvement of women, Indigenous peoples, Indigenous women in the policymaking process; consideration of intersectionality, including social locations, in the policymaking process
Text:	Key elements of the policy problem it is addressing, use of language in terms of structures of power, framing of Indigenous peoples, women, Indigenous women	Consideration of intersectionality, consideration of feminist principles; consideration of equity; policy silences
Consequences:	Power structures behind the policy's interpretation and implementation; processes for evaluation and reform and effectiveness of checks on power; and subsequent reform	Consideration of intersectionality; power structures, involvement of women, Indigenous peoples, and Indigenous women in policy implementation, evaluation, reform

5.2 Findings: Federal Analysis

As in my Methodology, I conducted an analysis of eight federal policy documents identified through my background research as forming the framework structuring Indigenous women's access to abortion services in Canada. My research pointed to three levels of documents structuring this framework, as depicted in Figure 1 below. The first level of "foundational" documents includes those that form the basis of the structure and shape all ensuing policies. These include the 1867 British North America Act and the 1876 Indian Act. The second level of "transformational" documents are based in these two prior documents, and all arose in the same political environment, spanning 1979 to 1985 – one of significant societal transformation and reform. These more specifically structure the operational context through which Indigenous women access abortion services across Canada today, and include the 1979 Indian Health Policy, the 1982 Constitution Act, the 1984 Canada Health Act, and the 1985 Indian Act. The third "operational" level includes the documents that dictate operational-level access to federal care for status Indigenous peoples. These include the 1988 Health Transfer Policy and its subsequent 1999 Health Transfer Program Handbook, and the Non-Insured Health Benefits Program (updates ongoing) and its associated Medical Transportation Policy Framework (2019). Findings per these three levels are detailed below.

Figure 1: Three Levels of Federal Policy Documents

Level 1: Foundational Documents
The British North America Act, The 1876 Indian Act (1867 – 1876)

Established the foundation of the policy landscape

Level 2: Transformational Documents

The Indian Health Policy, The Constitution Act, The Canada Health Act, and 1985 The Indian Act
(1979 – 1985)
Came into force amidst an environment of sociopolitical transformation; structures operational access

Level 3: Operational Documents

Health Transfer Policy & Health Transfer Program Handbook, Non-Insured Health Benefits Program & Medical Transportation Policy Framework
(1988 – 1999)
Based in level 2 documents, dictate operational access for status Indigenous peoples

Level 1: Foundational Documents

1867 British North America Act.

Context. The British North America Act ("BNA Act") was conceptualized by "the Fathers of Confederation": thirty-six men – largely hailing from the United Kingdom – who represented the British North American colonies prior to Canada's confederation. This included Sir John A. Macdonald, who became Canada's first Prime Minister. At the time of confederation, these men were concerned with uniting the provinces into one powerful entity, and relatedly, establishing systems of power and control over the land, its resources and agricultural potential, and populations. As a colony of the United Kingdom, Canada's parliamentary and judicial systems were styled in close alignment to that of the United Kingdom. Canada's federalist system was of new design for British powers, however, given the United Kingdom's status as a unitarian state.

Towards Indigenous people specifically, the Fathers held "dismissive, paternalistic views" (The Canadian Encyclopedia, 2019, Indigenous Peoples and Confederation section). Their sense was that Indigenous peoples were irresponsible and incapable of governing themselves. Their belief was that Indigenous peoples were culturally as opposed to biologically inferior and could become members of Canadian society through training and education of European ways of living (The Canadian Encyclopedia, 2019; Smith, 2021). The 1857 Gradual Civilization Act preceded the BNA Act regarding colonial efforts to control Indigenous populations and assimilate them into Canadian society. It was introduced by the "United Province of Canada" (the precursor to contemporary Canada, comprising Quebec and Ontario) to encourage Indigenous peoples within the region to forgo their treaty rights in exchange for property rights and entrance into the Canadian economy (The Canadian Encyclopedia, 2019). The BNA Act's declaration of federal authority over Indians and Indian lands followed on this preceding policy and associated sentiments towards Indigenous peoples. Indigenous peoples were not consulted in discussions leading up to confederation, nor were women at large, where broader sentiments towards women were dismissive, and society and politics largely patriarchal (The Canadian Encyclopedia, 2019).

The BNA Act's provision of health care to provinces stemmed from a societal view that health care was a private matter as opposed to a matter of public health (Kue Young, 1984). At this time in history, most Canadian hospitals were private and managed by Christian religions institutions, where in both the British and British North America context, the Church was highly influential (Kue Young, 1984). Further still, Canada's provinces and territories were highly divergent from a cultural and linguistic (with respect to French and English) perspective at the time (Kue Young, 1984). They had been operating as individual entities prior to the BNA Act; therefore, assignment of power over the establishment and management of hospitals was to provide provinces and territories the authority to deliver health care in line with the distinct needs of their population (Kue Young, 1984). Keeping with this privatized structure, Indigenous communities maintained their own knowledge, practices and traditions along with access to some health care services available through religions institutions (The Canadian Encyclopedia, 2020-b).

Text. Under the BNA Act, the British Crown was provided all-encompassing authority over the composition of the federal parliament, provincial legislatures, and the judiciary and privy council. The act also contains reference to the power of the Church, writing that it is enacted "by and with the advice and consent of the Lords Spiritual and Temporal and Commons"; the "Lords Spiritual" referring to the Church of England (British North America Act, 1867, para. 6). Besides dictating each order of government's jurisdictional powers, the act provided significant autonomy to the provincial and territorial legislatures. It includes no centralized stipulations to mandate consistency in the carrying out of these powers between provinces/territories. Where health care was seen as a private matter within the sociopolitical context, the act makes no explicit mention of the term, but rather, in vague language, writes that provincial and territorial legislatures have powers relating to "The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions[27] in and for

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[27] The term "Eleemosynary Institutions" refers to charitable organizations.

the Province” (British North America Act, 1867, section 92). No stipulations are made surrounding the management and administration of hospitals by provinces/territories.

In similar vagueness to the above, the act allocates power to the federal parliament over “Indians and lands reserved for Indians” (British North America Act, 1876, section 91). It does not specify what this entails, including whether this pertains to matters of health. No provisions related to responsibility for the health of Indigenous peoples are included. The act makes no further reference to Indigenous peoples.

Consequences. The act was both designed and implemented by white males, generating significant repercussions for reproductive health. It includes no provisions regarding its review or evaluation. Regarding future amendments, the act vests sole power to the Crown and the Parliament of the United Kingdom. No requirement is included for consultation with Canada’s executive powers nor any segment of the population. Ultimately, Canada’s constitution act was patriated and amended in 1982, as detailed in the below contextual analysis of the 1982 Constitution Act.

1876 Indian Act.

Context. The BNA Act laid the foundation for the Indian Act’s implementation through granting the federal government all-encompassing power over Indigenous peoples and their lands. It led to the development of the Department of Indian Affairs and enabled the conglomeration of assimilation-based policies previously specific to provincial contexts. Similar to the BNA, the Indian Act was implemented by an all-male, white government. Like with the BNA, Indigenous peoples or governments were not consulted in the design or implementation of the act.

Like at the time of the BNA Act’s implementation, white men in power were concerned with control over Canada’s newly expanded land mass, including its economic potential. Where Indigenous peoples continued to be viewed as a barrier to this aim, assimilation into the Canadian state through means such as mandatory enfranchisement (or the removal of one’s Indian status in exchange for property rights and entrance into the new Canadian economy) was seen as a solution (The Canadian Encyclopedia, 2016). Those not yet assimilated were thought to be “unsophisticated, and incapable of managing their own affairs” (Indigenous Corporate Training Inc., 2022, para. 4). These viewpoints were maintained by colonizers to justify the creation of the Indian Act and its oppressive and controlling policies. Also significant in justifying its assimilative and oppressive stipulations was the “Doctrine of Discovery”. As noted in my Background chapter, this was a legal concept which proclaimed that immersion into European market systems and the Christian religion was to the benefit of uncivilized peoples and lands (Smith, 2021).

As above, the BNA Act allowed for the conglomeration of previous province-specific assimilating polices into the Indian Act. Most significantly, the Indian Act subsumed the 1869 Gradual Enfranchisement Act. This act implemented distinctions surrounding Indigenous peoples’ rights or “status” as specified in the previous Royal Proclamation 1763. With the intent of total assimilation of the Indigenous population – including generations to come –, and in alignment with patriarchal views amongst European male politicians, the act tied Indian status to male lineage (Halseth, 2013). This was in disregard for Indigenous peoples’ historically matriarchal society, where “women were the head of the household and descent was traced through the maternal line” (Halseth, 2013). Through these stipulations, an Indigenous woman’s status was removed if she married a non-status or non-Indigenous man or if her status husband abandoned her or died; the same applied if she left her husband (Wilson, 2018). Similarly, Indigenous men lost status if they were accepted into a University or became a doctor, clergyman or lawyer (Wilson, 2018). Further, when a man lost status through such enfranchisement, his wife and children automatically did too (Wilson, 2018).

Text. The act vested supreme power over Indigenous peoples and their lands into the hands of the Minister of Indian Affairs, beholden to the Governor in Council. The act defines the Minister as being “responsible for the control and management of the reserves, lands, moneys, and property of Indians in Canada” (The Indian Act, 1876, para. 3). In establishing the reserve system, the act sets aside tracts of land for the “use and benefit” of bands of Indians, of which the legal title for – inclusive of its “trees, wood, timber, soil, stone, minerals, metals, and other valuables” – is vested in the Crown (The Indian Act, 1876, Terms section).

The 1876 Indian Act imposed the prior Gradual Enfranchisement Act’s establishment of a band council and chief governance system for Indigenous peoples across Turtle Island and introduced the reserve system. Regarding health care, the act stipulated that Chiefs or Chiefs in Council within the newly imposed governance system, “may set rules and regulations relating to the care of the public health” subject to confirmation from the Governor in Council (The Indian Act, 1876, Councils and Chiefs). It gave the Minister of Indian Affairs the power to “furnish sufficient aid from the funds of the band for the relief of sick, disabled, aged, or destitute Indians who are not provided for by the band of which they are member" (The Indian Act, 1876, para. 10). It should be noted that neither of these stipulations set an obligation for the Governor General to provide health care aid or approve of councils' regulations regarding health care. Rather, these stipulations were framed as being subject to the Governor General's discretion. In the context of various epidemics on Indian reserves – in part due to the cramped and squalid living conditions Indigenous peoples were subject to within the instituted reserve system – the Indian Act was amended in 1906. This granted the Minister of Indian Affairs power to make regulations as deemed necessary for the prevention or mitigation of disease, including the supply of medical aid and medicine, and "any other matter which, in the opinion of the Superintendent General, the general health of the Indians of any locality may require" (The Indian Act, 1906, Management of Indian Moneys section). As above, this stipulation did not mandate the Superintendent to act, but rather gave the Superintendent the power to take action as they see fit. Finally, in 1951, the Indian Act was amended to include a provision enabling the Governor General to authorize the use of lands in a reserve for the purposes of "Indian Health projects" and make regulations "to provide medical treatment and health services for Indians" (The Indian Act, 1951, Regulations section)[28].

The language of the Indian Act is inherently racist and sexist. It infers white, cisgender, heterosexual, able-bodied male dominance. It defines "person" as an individual other than an Indian, and "Indian" as "any male person of Indian blood reputed to belong to a particular band; any child of such person; any woman who is lawfully married to such person" (The Indian Act, 1876, Terms section). The act removed women from governance systems declaring political participants and those with voting powers to be "male members of the [Indian] band of the full age of twenty-one years" (The Indian Act, 1876, Surrenders section). The act vests full power in the British North American male colonizers implementing the act, and then in Indian[29] council and chiefs, comprised fully of men. It refers to Metis individuals as "half-breeds", declaring that "no half-breed in Manitoba who has shared in the distribution of half-breed lands shall be accounted an Indian" (The Indian Act, 1876, Terms section). The act utilizes male-gendered pronouns only in reference to those in which it applies to, enshrining male superiority despite its

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[28] Further background on the Indian Act can be found in Appendix B (pp. 105-107 and pp. 109-110).

[29] The term "Indian" is used throughout this section in keeping with the terminology of the act.

intended application to both sexes. The act gives the Minister authority over determining Indigenous peoples' status; it writes that the Minister may cease the payment of annuity and interest money to any Indian who is guilty of deserting their family, including to the woman and children deserted. This includes an extra provision specific to women, writing that a woman without children who deserts her husband to "live immorally with another man" will also be subject to these penalties (The Indian Act, 1876, Disabilities and Penalties section). On enfranchisement, the act states that the Minister shall authorize "some competent person to report whether the applicant is an Indian who … appears to be qualified to become a proprietor of land", framing Indians as incompetent (The Indian Act, 1876, Enfranchisement section).

Consequences. The 1876 Indian Act includes no provisions relating to a review of its effectiveness or impacts. Regarding amendment, the act gave power to the Crown and Governor in Council to amend the act as they saw fit. As detailed above, the act was amended several times in its first 100 years of creation by the Crown with the intent of continued control and assimilation. The 1982 patriation of Canada's constitution set the framework for the act to be revised by the federal government. Amendments by Canadian parliament – in the context of significant advocacy by Indigenous peoples – ensued to remove some oppressive stipulations, as is detailed below in my analysis of the 1985 Indian Act.

Level 2: Transformational Documents

1979 Indian Health Policy.

Context. Canada took up a greater role in public health in the first quarter of the twentieth century, particularly as the public and government's awareness of the importance of public health grew following the Spanish Flu (Maclean's, 2018). The federal government established a Department of Health in 1919, and later formed a Medical Services Branch within the Department of Indian Affairs in 1927 (The Canadian Encyclopedia, 2020-b). In 1945, the department of Indian Health Services was subsumed by the federal Department of Health. Further, in 1951, the Indian Act was amended to include the provision that the Governor in Council could make regulations to authorize the use of lands in a reserve for the purposes of "Indian Health projects" (Government of Canada, n.d.-b S.C. 1951, Reserves section). Similarly, the Governor in Council was provided the power to make regulations "to provide medical treatment and health services for Indians" (Government of Canada, n.d.-b S.C. 1951, Regulations section). Throughout this time period, the federal government continued to abdicate responsibility for Indian health while providing some funding to religious institutes for their private management of Indian hospitals (Kue Young, 1984).

In the 1960s, there was a growing awareness amongst the Canadian population of the poor health outcomes of Indigenous peoples in Canada (Kue Young, 1984). Further still, a greater emphasis amongst the media, academia and the public was placed on the federal government regarding its service delivery effectiveness. Specifically, attention was given to its provision of health services to Indigenous populations, where there was a growing awareness of the severe health inequities Indigenous communities were experiencing (Kue Young, 1984). In 1966 and 1969, two reports, titled the "Hawthorn Report: A survey of the contemporary Indians of Canada"[30] and the "Booz-Allen-Hamilton report on Indian health services"[31], were commissioned by the federal government to review the federal delivery of health care to Indigenous peoples and their health statuses (Kue Young, 1984). According to Kue Young (1984), these reports were revolutionary in communicating: the dismal living conditions on reserves; vast disparities in health outcomes between Indigenous and non-Indigenous populations; a lack of clarity on federal-provincial responsibilities for the health care of Indigenous populations; a greater need for federal government involvement in prevention efforts; and a need for greater engagement with Indigenous communities regarding health services to improve health outcomes. The results of the two aforementioned reports coincided with the release of the 1966 Medical Act, which resulted in the provision of health care insurance by all provinces and territories. They also coincided with the federal government's 1969 White Paper, through which it attempted to relinquish its role towards Indigenous people in place of provincial authority. Indigenous peoples and organizations met the introduction of this paper with mass resistance, advocating for greater self-determination as well as resistance to the erosion of the federal government's role in health care delivery. In 1970, provincial Indian associations banded together to develop the "Red Paper" in response to the White Paper, through which they declared the "right to receive, without payment, all health care services without exception and paid by the Government of Canada" (Kue Young, 1984, p. 262). This set the precedent for the formation of the (all male) National Indian Brotherhood ("NIB") in 1972, which later became the Assembly

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[30] Found here: https://publications.gc.ca/collections/collection_2014/aadnc-aandc/R32-1267-1-1-eng.pdf

[31] Found here: https://archive.org/details/HCStudyOfHealthServicesForCanadianIndians1969/mode/1up

of First Nations ("AFN"). The Native Women's Association of Canada ("NWAC") was established by Indigenous women in 1974 following the establishment of the NIB, which they felt wasn't representative of their views (Barker, 2020).

While Indigenous advocacy efforts were successful in preventing the implementation of the White Paper, the federal government issued a policy in 1974 titled the "Policy of the Federal Government Concerning Indian Health Services" – this with the similar intent of abdicating federal responsibility in place of provincial service provision. In this policy – and citing the language of the BNA Act (or lack thereof) – the federal government declared that it had no constitutional or legal obligation to provide health services to Indigenous peoples, but rather would do so as a matter of policy or benevolence (Kue Young, 1984). It offered to provide services when not provincially available along with financial assistance to "indigent" Indians to pay for services when not otherwise provided (Kue Young, 1984). Throughout the remainder of the 1970s, Indigenous people and organizations advocated for recognition of self-government and historic treaty rights; this in the related context of proposed amendments to Canada's constitution in the late 1970s. Indigenous women were separately organizing around the abolishment of sexist stipulations in the Indian Act. Based on such advocacy efforts, in 1978, the government funded the NIB to lead the National Commission Inquiry on Indian Health, which sought to define the concerns and priorities in Indian health care through consultations with representatives of provincial Indigenous organizations (Kue Young, 1984).

Ultimately, taking into account demands by Indigenous populations and the results of the three aforementioned reviews, a newly elected Progressive Conservative government introduced the 1979 Indian Health Policy ("IHP") in place of the former 1974 policy. No Indigenous organization was directly consulted in the policy's development. In notifying the NIB of its new policy on behalf of Indigenous peoples, then Health Minister David Crombie wrote, "I would personally have wished to consult with you prior to this announcement, but the urgent need to inform our Assembly of the Federal Government's decision regretfully makes this impossible" (Government of Canada, 1979, p. 3).

Text. After almost a century of abdicated responsibility for Indigenous health, through the IHP, the federal government finally and officially acknowledged its role in the delivery of health services for Indigenous people. It also clarified roles between federal and provincial powers. Fundamentally, it acknowledged the importance of Indigenous peoples' provision of tailored health services to their communities. The government's acknowledgement of its role is evidenced through text such as, "The Federal Government is committed to maintaining an active role in the Canadian health system as it affects Indians", "[the federal government] is committed to encouraging provinces to maintain their role and to filling gaps in necessary diagnostic, treatment and rehabilitation services" and:

> The most significant federal roles in this interdependent system are in public health activities on reserves, health promotion, and the detection and mitigation of hazards to health in the environment. The most significant Provincial and private roles are in the diagnosis and treatment of acute and chronic disease and in the rehabilitation of the sick. (Government of Canada, 1979, pp. 2-3)

Its acknowledgement of Indigenous communities' own role in health service provision is evidenced through text such as, "Indian communities have a significant role to play in health promotion, and in the adaptation of health services delivery to the specific needs of their community" and "The Federal Government realizes that only Indian communities themselves can change these root causes and that to do so will require the wholehearted support of the larger Canadian community" (Government of Canada, 1979, pp. 4-5).

Despite the significance of its statements based on the aforementioned historic context, the policy is steeped in racist and colonial bias and absent of any specific commitments tied to measurable actions on its "renewed role". To begin with, while the policy recognizes the government's role in the health framework for Indigenous populations, it continues to frame its role in doing so as an act of benevolence. It fails to acknowledge that the inequitable health outcomes specific to Indigenous populations are in fact the result of its own assimilatory actions and inaction (neglect) contributing to poor social determinants of health and inadequate health care service provision. Rather, the policy, "recognizes the intolerable conditions which affect many Indians" and the "intolerable low level of health of many Indian people, who exist under conditions rooted in poverty and community decline" (Government of Canada, 1979, pp. 4-5). Further, the policy states that the federal government realizes that "only Indian communities can change these root causes and that to do so will require the wholehearted support of the larger Canadian community"; again, the government relinquishes any responsibility and instead frames themselves and the Canadian community as heroes or saviours (Government of Canada, 1979, p. 5). In line with colonial narratives, it frames Indigenous peoples as wards or "savages" requiring enlightenment through Western systems. Similarly, it refers to them as apathetic and lacking initiative: it cites the need for government intervention to “remove the conditions of poverty and apathy which prevent the members of the community from achieving a state of physical, mental, and social well-being”. It writes that it is committed to “promoting the capacity of Indian communities to play a more active, more positive role in the health system”, as if they lacked the will to do so themselves. Further, while the policy recognizes the importance of Indigenous peoples’ autonomy in providing health services to improve their health outcomes, it later emphasizes this within the context of “Canadian institutions”: “to promote the ability of Indian communities to pursue their aspirations within the framework of Canadian institutions”, contrary to self-determination (Government of Canada, 1979, p. 5).

In line with its aforementioned colonial bias, the policy inaccurately frames the “traditional relationship of the Indian people to the Federal Government” as one in which the Federal Government “serves as advocate of the interests of Indian communities to the larger Canadian society and its institutions and promotes the capacity of Indian communities to achieve their aspirations” (Government of Canada, 1979, p. 5). Further, the policy is vague and unspecific in relation to the federal government’s role in health care delivery to Indigenous peoples, including for “public health activities on reserves, health promotion, and the detection and mitigation of hazards to health in the environment” (Government of Canada, 1979, p. 5). It fails to make any specific commitments tied to goals or outcomes, resulting in a lack of accountability for Indigenous health outcomes. In Minister Crombie’s accompanying communique on the IHP as sent to the NIB, roles for status Indians living off-reserve are clarified (such people “should receive health services from the province or municipality of residence, but such services are denied, the federal government will attempt to ensure their provision”), with the word “attempt” intentionally used to lessen federal responsibility (Health and Welfare Canada, 1979, p. 2). Finally, the policy is directed towards status Indians only and does not account for Inuit or Metis people. It makes no specific mention of women and is gender neutral in its language.

Consequences. Minister Crombie’s accompanying communique describes the intention of the IHP as being to “promote consultation and participation in the administration and delivery of health programs with respect to registered Indians permanently” (Health and Welfare Canada, 1979, p. 1). This said, the text of the IHP does not commit to any future consultations or establish structures for achieving this. In his communique, Minister Crombie commits to a fundamental review of issues involved in “Indian Health” upon the completion of the NIB and other Indian associations’ ongoing health studies, namely the National Commission Inquiry on Indian Health (Health and Welfare Canada, 1979). He writes that the policy may be reviewed and amended upon the results of the study (Health and Welfare Canada, 1979). This said, the policy itself was never altered, nor did the policy result in a concrete implementation strategy tied to actions and objectives. The policy itself committed no person or agency to carrying out any actions based on its statements.

Despite the above, the IHP was nonetheless pivotal in shaping the framework of health care administration through which Indigenous peoples with status access federal health care today (and accordingly, abortion service). Directly following the policy, a system of health liaisons was established to facilitate dialogue between provincial Indigenous organizations and the federal government on a new structure for health care delivery (Kue Young, 1984) as I detail in my contextual analysis of the Health Transfer Policy, below. The IHP was highly significant in achieving greater self-determination for Indigenous people in the delivery of health care services and a greater role by the federal government in the provision of health care funding and support to status Indigenous individuals. The operational delivery of health care today is very much structured around the pillars of the IHP: in addition to funding self-determination of health care service delivery through the 1988 Health Transfer Policy, the government funds the delivery of health services for status Indigenous peoples through the NIHB, as detailed below, and the Clinical Client Care program, which funds nursing stations in remote First Nations communities. This said, while such programs stem from this policy, there is a lack of a legislative or regulatory basis for these programs’ delivery (Parliament of Canada, 2019). According to the Office of the Auditor General of Canada this “limits the delivery of public services to First Nations communities and hinders improvements in the living conditions on reserves” (Auditor General of Canada, 2011, p. 2). Such programs continue to be delivered on a policy rather than a legislative basis, resulting in “poorly defined essential services and confusion about what is considered adequate funding” (Parliament of Canada, 2019, Delegation and Devolution section).

1982 Constitution Act.

Context. The 1982 Constitution Act came about as a result of multiple forces. As above, until this point, amendments to Canada’s constitution remained within the control of the British

Crown. For more than five decades prior, executive branches at the federal and provincial/territorial level sought out a means to gain authority to amend the constitution; this amongst disagreement between powers on what form a new act might take (Elections Canada, 2022). The potential for constitutional amendment, and in the context of historic systems of oppression, incited activism from Canadian women, Indigenous peoples, and Indigenous women specifically. Indigenous peoples understood that the proposed Constitution would fail to affirm their traditional rights, thus, Indigenous peoples and organizations were advocating to have these enshrined. Such efforts included cross-national demonstrations, protests at Parliament Hill and in London, England, along with lobbying, petitions, written submissions and crowdfunding for international and national support (Elections Canada, 2022). Efforts were ultimately successful in securing the enshrinement of Indigenous treaty rights in the revised constitution.

Separately, the Charter of Rights and Freedoms was being proposed as an addition to the constitution as a means of federally recognizing linguistic rights in the context of separatist propositions by Quebec (The Canadian Encyclopedia, 2020-b). Preceding the Charter from a rights perspective was the Canadian Bill of Rights, however, this bill was not incorporated into the constitution and did not apply in the provincial/territorial context. As detailed in my introduction, the 1960s and 70s saw a burgeoning women's movement – one based in the decriminalization of abortion and securing legal guarantees against widespread sex-based inequities and discrimination faced by women at the time. Women saw the Charter as an opportunity to have their rights guaranteed in equal standing under the law and advocated for this as such through national campaigns, conferences, lobbyism, and protests to Parliament. Canada had also just signed the United Nations Convention on the Elimination of all forms of Discrimination Against Women in 1980 (The Canadian Encyclopedia, 2020-b). It must be noted that while women were ultimately successful in shaping the Charter of Rights and Freedoms, the approach and result reflected heteronormative thinking. The goal was to achieve equality between men and women as opposed to equitable outcomes, and without regard for gender diversity.

Text. This version of the Canadian constitution does not use gendered pronouns but rather refers to individuals with the pronouns "they/them". As per the above, it treats women and men as equally deserving of the same rights, without acknowledging the specific biological and social contexts of women, or the compounded factors faced by specific groups of women.

Regarding its consideration for the historical contexts of Indigenous peoples and Indigenous women, the Charter redundantly writes that it is intended to be "interpreted in a manner consistent with the preservation and enhancement of the multicultural heritage of Canada" (Constitution Act, 1982, Part I, section 27). The Charter guarantees equal treatment under the law and the Constitution Act specifically and commits Canada's Parliament and government to "promoting equal opportunities" (Constitution Act, 1982, Part III, section 36). The act, in vague terms, commits Parliament and the Government of Canada to "providing essential public services of reasonable quality to all Canadians" but does not secure the right to health care specifically (Constitution Act, 1982, Part III, section 36). In 1988, the section of the Criminal Code criminalizing abortions except with the approval of therapeutic committees was invalidated in the case of *R. vs. Morgentaler*. This was on the basis of the Charter right to "Life, liberty and security of the person" (Constitution Act, 1982, Part I). This said, the Charter does not protect the right to access or provide an abortion, nor does it protect abortion from the passing of new decriminalising the procedure. In 1989, for example, a federal bill was introduced in Parliament in attempt to criminalize abortion unless in cases in which the woman's life was threatened. While this bill passed in the House of Commons, the bill was defeated upon a tie in the Senate (The Canadian Press, 2013). No amendments were introduced to the Constitution Act's distribution of legislative powers, such as clarification surrounding responsibility for health care for Indigenous peoples. This is despite it coming into force only three years following the 1979 Indian Health Policy and its acknowledgement of a renewed federal role for Indigenous health, and its distinctions in federal/provincial/territorial roles surrounding Indigenous health care.

Consequences. Unlike the BNA Act, this act clearly stipulates a time period for its review and means for its amendment. For its review, the act stipulated a constitutional conference composed of the Prime Minister and premiers fifteen years following its initiation; however, it did not include reference to the inclusion of Indigenous governments or organizations in this constitutional review. As per Part V of the Constitution Act, the general procedure for amending the Constitution of Canada requires approval by Parliament and the Senate and by legislative assemblies of at least two-thirds of the provinces and territories that have at least fifty percent of the population of Canada (Constitution Act, 1982, Part V). Supplementary amending formulas are attributed to specific sections of the act. For example, the amendment of provisions relating to some but not all provinces requires consent from the

Governor General, the Senate and House of Commons, and the legislative assembly of each implicated province (Constitution Act, 1982, Part V). Section 35 of the act states that "representatives of the aboriginal peoples" must be consulted over any proposed amendments to any section of the act which refers to "aboriginal peoples" and their rights, or proposed amendments to the BNA Act's distribution of legislative powers as it relates to "Indians and lands reserved for Indians" (Constitution Act, 1982, Part II, section 35). It does not require that Indigenous peoples be consulted on constitutional amendments not referring to Indigenous peoples specifically. Further, it does not specify the representation of the aboriginal peoples or ensure that groups representing Indigenous women's interests are equally consulted. The Charter refers those who feel their rights have been infringed or denied to the courts for "remedy" as the court considers "appropriate and just" (Constitution Act, 1982, Part I, section 24). This provision set the foundation for the decriminalization of abortion in 1988 through R. v Morgentaler, and the removal of sexist status stipulations in the 1985 Indian Act.

Following the implementation of the 1982 Constitution Act, Prime Minister Brian Mulroney attempted to pass two constitutional amendment accords in 1987 and 1992 (the Meech Lake Accord and the Charlottetown Accord, respectively), involving premiers from all of Canada's provinces and territories. Indigenous peoples were entirely excluded from negotiations surrounding the former accord (Peach, 2011). Their resistance to this resulted in its ultimate failure and in the inclusion of Indigenous perspectives in subsequent negotiations surrounding the Charlottetown Accord (Peach, 2011). Specifically, four Indigenous organizations, including the AFN, were provided funding to participate in consultations on behalf of Indigenous peoples in Canada and prepare constitutional amendments to be presented to the government in a consensus package (Native Women's Assn. of Canada *v.* Canada, 1994). NWAC was not included in this selection of organizations or the disbursement and were concerned that their exclusion threatened the equality of Aboriginal women[32]. NWAC proceeded to the federal court, claiming their exclusion violated their freedom of expression and right to equality as per the Charter (Native Women's Assn. of Canada *v.* Canada, 1994). The case was ultimately struck down by the federal court on the basis that "the right of the Aboriginal people of Canada to participate in constitutional discussions does not derive from any existing Aboriginal or treaty right protected under s. 35 of the Constitution Act, 1982", and that "the freedom of governments to choose and

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[32] In 1990, the AFN's member composition was 91 percent male (Desmarais, 1998).

fund their advisors on matters of policy is not constrained by the Charter" (Native Women's Assn. of Canada *v.* Canada, 1994, para. 9 & 11).

1984 Canada Health Act.

Context.

The Canada Health Act ("CHA") was passed in 1984 as a means of securing universal health care in Canada within the parameters of the BNA Act's distribution of powers. This followed on an evolution of the State's role in public health administration, as well as the evolution of publicly funded health insurance. The 1966 Medical Care Act preceded the CHA as the first example of public health care. It set national standards for health care pricing, providing coverage for 50 percent of provincial health costs tied to distinct conditions (Canadian Health Coalition, n.d.). This reflected an evolution in the federal/provincial fiscal relationship: as provincial health programs became more established throughout this time period, the federal government moved away from cost-sharing tied to rigorous reporting and auditing, and towards transfer payments tied to broad principles, allowing greater flexibility in program design and administration (Government of Canada, 2014). Namely, in 1977, the former system of cost coverage was replaced with transfer payments, and in 1984, with the implementation of the CHA, these transfer payments were made conditional to five criteria (Government of Canada, 2014).

Beyond its funding structure, the CHA was implemented in the context of the newly enshrined Charter of Rights and Freedoms and recommendations made by the 1980 Health Services Review to mitigate discrepancies in physician billing. The act was instituted by Health Minister Monique Bégin, whose human rights and gender equality-based values – having formerly acted as Chair of the Royal Commission of the Status of Women – underpinned her desire to secure equal and fair access to comparable health services for all Canadians (The Governor General of Canada, n.d.; Clark, 2018). Notably, no Indigenous peoples or organizations were consulted in the act's development despite the 1979 Indian Health Policy's recognition of Indigenous peoples' unique position in the health care framework (Kirkup, 2020).

Text. The Canada Health Act states that the primary objective of Canadian health care policy is to "protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (Canada Health Act, 1985, Canadian Health Care Policy section). The act is described as coming into force in recognition that “continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians”. It does not however, define quality or tie requirements to quality of health service (Canada Health Act, 1985, Preamble, section). Later, the act requires that provinces and territories provide reasonable access to medically necessary hospital and doctor services as a requirement for the receipt of funding under the act. It defines something as medically necessary if it is “for the purpose of maintaining health, preventing disease, or diagnosing or treating an injury, illness or disability” (Canada Health Act, 1985, p. 3). A definition of “health” is not provided; it is unclear whether emotional or mental health are encapsulated by this definition. Further, the act lists required hospital services such as nursing and physiotherapy, but does not name reproductive health services, inclusive of abortion (Canada Health Act, 1985, p. 3). In 1985, the incoming Health Minister Jake Epp, who replaced Begin in 1984, issued a letter to the provinces and territories, clarifying the government’s position on the implementation of the Canada Health Act, writing, “within these broad parameters, provinces, along with medical professionals, have the prerogative and responsibility for interpreting what physician services are medically necessary” (Government of Canada, 2015, Annex B – Policy Interpretation Letters section). Notably, Minister Epp was a key advocate for the cabinet’s 1989 passing of a bill to criminalize abortion (The Canadian Press, 2013, para. 14).

Overall, the CHA makes no mention of Indigenous people and their specific social locations or the governance structure shaping their access to health care. It defines “insured person” as resident of the province, and “resident” as “in relation to a province, a person lawfully entitled to be or remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province” (Canada Health Act, 1985, p. 4). This definition is confusing in the context of Indigenous peoples in its reference to provincial belonging. Further still, this definition of resident uses patriarchal language, referring to a resident as “he”; this despite the release of the Charter of Rights of Freedoms and its equal treatment of Canadians under law two years prior, combined with Minister Begin’s equality-based values.

Altogether, the CHA lacks a focus on the specific interpersonal treatment of individuals within the health care system, including ensuring equal or quality treatment. Of the five criteria that provinces are required to adhere to in delivering insured health services, “universality” requires provinces/territories to "entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions" (Canada Health Act, 1985, p. 6). Separately, the principle of "accessibility" calls for provinces and territories to provide reasonable access to insured health services to all insured persons, without providing a definition of "reasonable" (Canada Health Act, 1985, p. 8). Overall, the language of the CHA, including its criteria for jurisdictional service delivery, is vague and open to interpretation. As written in my above contextual analysis, this was a product of the federal-provincial fiscal relationship at the time of the act's inception.

Consequences. The CHA includes provisions for the federal government's withholding of block funding to a province or territory if out of compliance with its criteria. Reports are submitted to Health Canada annually by provinces and territories on their use of funds. The federal minister is then responsible for submitting an annual report to Parliament on each province and territories' compliance with the act. The Compliance and Interpretation Unit of the Canada Health Act Division within Health Canada is responsible for the initial identification of issues of non-compliance (Government of Canada, 2015). The act writes that "where the Governor in Council considers it appropriate", they may "direct that the whole of any cash contribution to that province for a fiscal year be withheld" (Canada Health Act, 1985, p. 10). This said, these accountability mechanisms are inconsistent with the purpose of the act (being to promote the health of Canadians) and thus ineffective. Specifically, withholding health care funding from a province lessens its ability to provide quality health care to its population. As a result, the federal government has infrequently and insignificantly withheld funding from a province/territory since the act's inception. Beginning in 2014, the Government of Canada noted "concerns" regarding New Brunswick and PEI's compliance with the act as it relates to the provision of accessible abortion services. This said, no action was taken to withhold funding until 2020 (Government of Canada, 2015). In 2020, the government withheld $140,216 from its transfer to New Brunswick, and $64,850 the following year; this is compared to the total transfer of roughly 9 million dollars (Quon, 2021; Walsh, 2022).

The act itself includes no provisions for its own review of effectiveness. It places power over its amendments to the Governor in Council[33]. Three bills have been introduced by Members

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[33] Per Canada's legislative process, this includes the act's (or amendment's) passing via majority vote in all three readings of the Chambers (Government of Canada, 2021-b).

of Parliament in aim of amending the act, including in the early 2000s and in 2019, but no bill has passed, and consequently no amendments have been made to the CHA to date (Tiedemann, 2019). Many have proposed that the CHA be amended to clarify its criteria, including wording regarding medical necessity (Tiedemann, 2019). Suggestions have included improving its structure for enforcement of provincial/territorial compliance and improving its patient focus (Tiedemann, 2019). Indigenous peoples, along with academics, professionals, and public sector representatives have recently called on the government to revise the act in recognition of Indigenous-specific racism in Canada's health care system (Kirkup, 2020). Notably, Prime Minister Trudeau's mandate letter to the Minister of Health in 2019 suggested that the Minister "consider amendments to the Canada Health Act … including new accountability standards" (Prime Minister of Canada, 2019, para. 15). Further, during Trudeau's 2021 re-election campaign, he committed to introducing regulations under the CHA to define abortion as a medically necessary and publicly funded procedure (The Canadian Press, 2022).

1985 Indian Act.

Context. This amendment to the Indian Act came as a result of significant advocacy efforts by Indigenous women in Canada for the removal and reversal of sexist status stipulations throughout the 1970s and early 1908s. In 1971 and 1973, two Indigenous women challenged the Indian Act in the Supreme Court on the basis of the 1960 Bill of Rights but ultimately lost their cases in appeal (Indigenous Foundations, 2009). This invoked significant frustration and advocacy by Indigenous women in Canada and led to the formation of the Native Women's Association of Canada in 1974. Indigenous women felt that national Indigenous organizations at the time were male-dominated and not representative of their views (Barker, 2020). In 1974, a third Indigenous woman challenged the Indian Act in the Supreme Court, and upon being denied, proceeded to the UN Human Rights Committee (Indigenous Foundations, 2009). In 1981, the United Nations Human Rights Committee ruled that the Indian Act violated multiple articles of the International Convention on Civil and Political Rights (Indigenous Foundations, 2009). The following year, the 1982 Charter of Rights and Freedoms was implemented, setting the legal precedent in Canada for amendment to the Indian Act through its guarantee of equality rights under law. Bill C-31 was passed three years later in 1985, removing enfranchisement stipulations and all other provisions specific to the loss of status for Indigenous women (The Canadian

Encyclopedia, 2020-a). This amendment resulted in the restoration of status to all women from whom it had previously been taken.

Text. The 1985 Indian Act remains the most current piece of federal Indian Act legislation today[34]. This said, the act is still largely problematic in its continuation of systems of control by the federal government over Indigenous people's freedoms and identities. In the current iteration of the act, "lands" remain defined as "for the use and benefit" of Indians, where the legal title remains vested in Her Majesty (Indian Act, 1985, p. 2). A 1951 amendment to the act established the Indian Register, which remains today as a list of every individual whom the government declares to have Indian status. According to the act, the "Registrar may at any time add to or delete from the Indian Register the name of any person who, in accordance with this Act, is entitled or not entitled, as the case may be, to have his name included in the Indian Register" (Indian Act, 1985, p. 5). Similarly, under the act, the Minister is provided the power to, "amalgamate bands that … request to be amalgamated" and "constitute new bands and establish Band Lists with respect thereto from existing Band Lists if requested to do so" (Indian Act, 1985, p.19).

The 1985 iteration of the act references health three times, where "the Minister may authorize the use of lands in a reserve for Indian health projects" (Indian Act, 1985, p. 20); where the Governor in Council may make regulations under the act "to provide medical treatment and health services for Indians" (Indian Act, 1985, p. 48); and where the council of a band may make by-laws "to provide for the health of residents on the reserve and to prevent the spreading of contagious and infectious diseases" (Indian Act, 1985, p. 53). None are framed as obligations. The language of the 1985 remains patriarchally gendered, framing the male sex as the standard, where individuals to which the act applies to are referred to with the pronouns "his" or "him". The act continues to refer to Indigenous peoples as subordinate, framing them as subjects needing governing. It remains in the Minister's power to deem whether an "Indian" was lawfully in possession of "his" land at the time of his death. Amongst the provisions of the act, only one reference is made to its equal application to men and women, reading specifically, "this section applies in respect of an intestate woman as it applies in respect of an intestate man" (Indian Act,

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[34] Note that the title of the act is legislatively time-stamped with the year 1985 while having been amended several times since, including as recently as 2019.

1985, p. 33) reflecting a male dominance through the majority of the act. Finally, the act includes references to the Minister's control over Indian children, such as in the following statement:

> The Minister may, regardless of whether a payment is made under section 52.1, pay all or part of any money administered by the Minister under section 52 that belongs to an infant child of an Indian to a parent or person who is responsible for the care and custody of the child or otherwise apply all or part of that money if (a) the Minister is requested in writing to do so by the parent or the person responsible; and (b) in the opinion of the Minister, the payment or application is necessary or proper for the maintenance, advancement or other benefit of the child. (Indian Act, 1985, p. 36)

The Minister is given authority to determine whether something is "necessary or proper for the maintenance, advancement, or other benefit of the child", challenging Indigenous women's caregiving roles as mothers (Indian Act, 1985, p. 36).

Consequences. In the 1985 Act, provisions are included related to its review. It writes, "The Minister shall cause to be laid before each House of Parliament, no later than two years after this Act is assented to, a report on the implementation of the amendments to the Act … which shall include detailed information on (a) the number of persons who have been registered…" (Indian Act, 1985, p. 66). Similarly, the act writes that a committee of Parliament is to be tasked with reviewing the report and may subsequently undertake a review of any specific provision (Indian Act, 1985).

Since patriation of the constitution in 1982, the Indian Act has been amended through parliamentary bills in line with the Canadian parliamentary process based on either advocacy by Indigenous populations or legal impetus (Native Women's Association of Canada, n.d.). Bill S-3 was tabled in the Senate in 2017 to "address outstanding sex-based inequities in registration" (Native Women's Association of Canada, n.d., para. 1). The Bill provides status to (a) any descendant of someone who lost status and had their name omitted from a band list due to their marriage to a non-status man prior to 1985 or the descendant of any individual who lost status due to their mother's loss of status from marrying a non-status man; and (b) any descendant of someone who lost status due to being born out of marriage to a status man and non-status woman (Government of Canada, n.d.-a). It also lessens the severity of provisions related to ancestral evidence in demonstrating entitlement as stated in the 1985 Act (Government of Canada, n.d.-a).

Level 3: Operational Documents

Non-Insured Health Benefits Program[35].

Context. The Non-Insured Health Benefits ("NIHB") program was instituted in line with an evolution in public medical insurance in Canada between the 1960s and 1980s, and commitments made by the federal government on a renewed role in health care delivery in the 1979 IHP. Through the 1966 Medical Care Act, and in line with the federal government's ongoing abdication of responsibility for Indigenous health, all Indigenous peoples were expected to access health care services through provincial/territorial plans. Only if Indigenous peoples were denied health care insurance by provinces would the federal government provide assistance (National Collaborating Centre for Indigenous Health, 2019). Three years later, the 1969 White Paper was proposed in further attempt by the federal government to transfer authority of Indigenous populations to the provinces and territories. As noted earlier in this chapter, this was met with fierce opposition by Indigenous peoples, with this time period seeing heightened activism from Canada's Indigenous populations surrounding the role of the federal government, ultimately resulting in the IHP. Surrounding health insurance, the IHP committed to establishing uninsured health benefits guided by "professional medical or dental judgment, or by other fair and comparable Canadian standards" (Government of Canada, 1979, p. 4). National program directives were completed in 1989 that set out the terms and conditions for the NIHB program, including available benefits (Moeller, 2013). At no point were Indigenous populations consulted on the form of the program. A "Medical Transportation Policy Framework" was added to the NIHB in 2005 for the purpose of providing medical transportation benefits to status Indigenous people in reserve communities. The framework was updated in 2019 in the form of an "interim" framework amidst a 2014 (and ongoing) AFN-ISC-led review of the NIHB and recommendations made through a 2015 internal government audit of the program.

Text. The language of the NIHB program is vague and difficult for both Indigenous populations and pharmacists to navigate. Given its complexity, pharmacists can be reluctant to dispense through the program and negative in their perception and treatment of Indigenous peoples (Pharmacy Connection, 2020). This is on top of already existent Indigenous-specific racism and prejudice and stereotyping specific to Indigenous women in their experiences

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[35] Unlike the former time-stamped pieces of legislation, this program is evergreen. The AFN and ISC are currently completing a substantial review of the program and incremental modifications have been made since 2014. It remains to be updated following the completion of the review.

accessing abortion. From a patient perspective, the language of the NIHB is difficult to interpret and directed towards an educated, adult audience. It does not consider age nor the potential range in literacy rates of those using its program. Where Indigenous communities have statistically higher rates of teenage pregnancy and higher early school dropout and unemployment rates, navigating the NIHB may be particularly challenging for pregnant Indigenous teens and young adults (The College of Family Physicians of Canada, 2011).

The program reflects the bias of a literate, well-off, and urban public sector employee or politician (in reference to those responsible for its design and administration); it makes assumptions surrounding the technological literacy and capacity of its users, assuming all can navigate and have access to the internet and a printer to adhere with its program requirements. Upon the results of former reviews of the program, NIHB introduced a “client enquiries” email address to support clients in navigating the program, along with a “NIHB Navigators” program, which is hosted by AFN to provide a forum for connecting clients with NIHB staff (Government of Canada, 2022-f). This said, both of these programs require a client to have access to a computer and internet connection, discriminating against lower income individuals, older populations, and those in remote locations without internet connectivity. Further, in situations in which a pharmacist refuses to process a NIHB claim or is not registered with the program, the program requires the client to print out and mail a claim form, creating extra barriers for those without access to a printer (Government of Canada, 2022-h). The program and policy framework assumes that every individual has access to a prescribing physician or nurse practitioner, however, in many remote, rural communities, this is not the case.

The program’s formulary of medications eligible for coverage does not mention traditional medicines. While the NIHB medical transportation program includes a provision offering coverage for travel to traditional healers, funding eligibility requires that a licensed physician (or a community health professional or FNIHB representative if not available) can confirm the client has a “medical condition”. No criteria are provided to guide the health processional’s interpretation of the term “medical condition” leaving this to their discretion (Health Canada, 2005, section 8). This language is not conducive with the choice to have an abortion, which can not be framed as a medical condition but rather, a matter of bodily autonomy, with psychological, social and economic consequences (Action Canada for Sexual Health and Rights, 2020-b, citing Justice Bertha Wilson). Further, allowing for discretion in interpretation can lead to significant inconsistencies, and consequently inequities, on a population-basis.

The 2005 Medical Transportation Policy Framework requires prior approval from a FNIHB representative or one of a First Nations or Inuit health authority or organization (if the community has a health transfer arrangement with FNIHB to deliver health care services directly to its residents). This means that a woman in need of medical transportation to visit a physician or nurse practitioner to discuss or procure an abortion must seek out advance approval from either their community health administration or a FNIHB representative. Either option presents barriers to access, where the latter may result in a significantly long administrative process, and the former may compromise the woman's privacy within her community and expose her to stigma. The policy states that in emergency situations where prior approval has not been obtained, "expenses may be reimbursed by FNIHB or a First Nations or Inuit health authority or organization when appropriate medical justification is provided to support the medical emergency and approved after the fact" (Health Canada, 2005, section 1.2). Use of the language "medical emergency" is problematic as it is not conducive with a woman's choice to have an abortion. This terminology allows for those in positions of power to determine whether a woman's choice to have an abortion is, in their opinion, a medical emergency, and thus eligible for coverage. This contributes to financial barriers to access.

While the interim 2019 Medical Transportation Policy Framework provides more detail than the 2005 edition, the major provisions of the program are fundamentally the same. Per the framework, approval for medical transportation coverage not only includes approval at the outset, but throughout the entirety of the process. A patient must seek approval on the mode of transportation they will take, the accommodation they will stay at if necessary, and for eligible escorts[36]. Upon an individual's access of medical transportation coverage through the program, a FNIHB or First Nations or Inuit health authority or organization must ultimately provide confirmation that the health service was obtained through the NIHB medical transportation program.

The framework details eligibility criteria for medical and non-medical escorts, where a medical escort is eligible for funding in cases that involve "a client with a health condition where

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[36] The framework provides coverage for individuals escorting a patient to their medical destination if they meet eligibility criteria as either a "medical" or "non-medical" escort.

monitoring or stabilization are required during travel" (Government of Canada, 2019, section 5.4). A non-medical escort is in only eligible for funding when there is a "legal or medical requirement that results in the client being unable to travel alone" (Government of Canada, 2019, section 5.5). Amongst these legal or medical non-medical escort requirements, the 2019 framework includes a new provision offering escort eligibility to clients that are "pregnant [women] whose trip is for the purpose of childbirth, including being closer to care while awaiting childbirth" (Government of Canada, 2019, section 5.5). On the 2017 addition of this provision, the framework writes that this was added "so all pregnant women who require transportation outside their community to deliver their babies are eligible for an escort" (Government of Canada, 2022-f, section '2017'). It makes no mention of eligibility for an escort for pregnant women who are travelling to have an abortion. Through this language, the framework reflects pro-life versus pro-choice sentiments, favouring women planning to birth a child versus those who may choose or need to abort. This is despite the emotionally and mentally stressful decision and experience associated with abortion. Rural Indigenous women are then disadvantaged compared to an urban-situated woman who may more easily bring a family member, friend, or partner to an appointment for support.

The program and policy framework makes no mention of the historical context through which Indigenous peoples, and Indigenous women specifically, access health care. Aside from the policy framework's provision of an escort for pregnant women accessing appointments related to childbirth, the program treats women and men the same. This is despite the fact that women carry additional societal caregiving responsibilities. Namely, the program does not provide coverage for a woman to bring her children with her in travel to her medical appointment. This may prevent a woman from travelling to access an abortion in the case that she cannot leave her children alone or afford or find sufficient childcare, forcing women to choose between the needs of themselves and the needs of their children. It is worth adding that Health Canada's approval of Mifegymiso in 2017 presents the opportunity for many to access an abortion in their own community without having to travel, especially early in pregnancy and if access to the medication is on the table.

Consequences. The First Nations and Inuit Health Branch (FNIHB) of Indigenous Services Canada is responsible for delivering the NIHB program. FNIHB operates regional offices across Canada to liaise with First Nations communities and health service providers regarding the program's administration. According to FNIHB's 2018-2019 annual report, the branch maintains diversity targets for its employee composition, setting targets for the number of Indigenous peoples and number of women employed; in the 2018-19 year, 25 percent of the branch's workforce identified as Indigenous, and 76 percent identified as female (Indigenous Services Canada, 2019). It contains no employee composition targets for those identifying as both Indigenous and female specifically, nor does it collect this statistical information. Since 2014 (coinciding with the start of the AFN review), the branch has maintained an "Aboriginal Peoples Employment Program", with the aim of increasing Indigenous representation within the organization to at least 30 percent of the workforce (Indigenous Services Canada, 2019). The goal is to "ensure better distribution across functional categories and classification levels in areas that will have the most positive impact on program delivery and health outcomes of the disadvantaged target client population" (Indigenous Services Canada, 2019).

As noted above, the AFN[37] has been working in partnership with ISC on a joint review of the NIHB since 2014. The purpose is to "identify and implement actions that enhance client access to benefits, identify gaps in benefits, [and] streamline service delivery to be more responsive to client needs" (Assembly of First Nations, 2018-b, p. 4). The review is being overseen by a steering committee comprised "equally of First Nations and Indigenous Services Canada representatives and guided by an elder" (Assembly of First Nations, 2018-b, p. 3). According to the Government of Canada (2022-d), the 2019 interim Medical Transportation Policy Framework will undergo further revisions once the AFN-ISC review is complete.

The NIHB program is subject to evaluation every five years in accordance with the frequency of the federal government's program evaluation requirements (Statistics Canada, 2016). Separately, it may be subject to an internal audit by the Office of the Auditor General per the request of citizens, members of Parliament, senators, and parliamentary committees (Office of the Auditor General of Canada, n.d.). An internal audit of the program was conducted in 2015, leading to program revisions.

The NIHB Medical Transportation Policy Framework specifically includes an audit program which is designed to audit "NIHB medical transportation benefit providers to make sure

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[37] Today the AFN includes both female and male representation; representatives are nominated through an electrical process; the National Executive is made up of a National Chief, 10 Regional Chiefs, and the chairs of the Elders', Women's, Youth and Veteran's Councils (Assembly of First Nations, 2022).

they are accountable, meeting program requirements and complying with terms and conditions or applicable contribution agreements" (Government of Canada, 2022-e). Its objectives are to "detect billing and claim irregularities, ensure that the NIHB client received the services for which they paid, and ensure that the provider retained the appropriate documentation in support of each claim". The 2019 iteration of the policy framework includes the same definition as the 2005 policy framework; however, in 2015, the Auditor General of Canada identified that the framework did not have proper checks in place to evaluate health care providers/FNIHB/a First Nation or Inuit health authority or organization's approval of medical transportation coverage (Office of the Auditor General, 2015). It found that regional FNIHB offices were not keeping track of denied requests, nor the reason for denials (Office of the Auditor General, 2015).

1988 Health Transfer Policy.

Context. As above, the 1988 Health Transfer Policy ("HTP") followed on the government's commitments and affirmations under the 1979 Indian Health Policy. This included affirmation of the fact that Indigenous governments were best placed to provide tailored health services to their populations. The 1988 Health Transfer Policy also followed the coming into force of the 1982 Constitution Act and its recognition of aboriginal treaty rights. Three months after the launch of the IHP, the government released an "Indian Health Discussion Paper" which presented the results of a study of Indian health services conducted by the Medical Services Branch (Health Canada, 2006). The paper acknowledged the branch's failures and the necessity for a change in structure of health administration:

> It has become apparent that government's efforts to improve the health of Indian people are no longer having the desired effect. Our standard medical tools do not seem to address (the) accelerating crisis of health and social breakdown. (This) situation is incompatible with both the aspirations of the Indian people and the tenets of self-determination and human rights. It has contributed to a deep-rooted passivity I the health services which has almost destroyed the interest of the Indian people in providing for their own health needs. (Kue Young, 1984, p. 263)

The following actions were recommended:

1. The achievement of effective communication between Indian people and National Health and Welfare through the development of mutually acceptable communication strategies;

2. Sharply increased efforts to reduce environmentally related diseases and to promote a healthy social environment on Indian reserves;
3. The achievement of self-determination in the health field by Indian communities; and
4. The encouragement of community development through the creation of a National Institute of Indian Health and Social Development. (Health Canada, 2006, p. 38).

Also following the 1979 Indian Health Policy, and as above, a system of health liaisons was established by provincial Indigenous organizations to liaise with the federal government on a new structure for health care delivery (Kue Young, 1984). Three years later in 1981, Health Minister Monique Bégin tabled a document exploring the possibility and complexities of transferring existing services to First Nations (Health Canada, 2006). The "Community Health Demonstration Program" was established to trial the delivery of different models of community-based health care delivery by Indigenous governments to their populations with government funding. Health Canada next established subcommittees with "representation from First Nations with experience in health care" to prepare recommendations for a "developmental and consultative approach to health transfer", incorporating experiences from the demonstration projects (Health Canada, 2004, p. 40). In 1985, the Sub-Committee on Community Health recommended that the Medical Services Branch shift its role from service provider to a funding and development branch that "supports Indian Bands in their operation of their own services" in the "context of progressive control of Indian Health Services by the Indian people" (Health Canada, 2006, p. 39). It also recommended delegating central authority to regions; the establishment of multi-year agreements; and the use of aggregated First Nation and Inuit community health plans as the basis for regional and national planning (Health Canada, 2006, p. 39). A parallel Sub-Committee on the Transfer of Health Programs to Indian Control recommended the transfer of existing services based on existing funds flowing through the Branch. It also recommended that "annual adjustments for price and other relevant cost factors be included in the transfer agreement" (Health Canada, 2006, p. 39). The vision of the committee was a "balance between flexibility in the community allocation of resources to locally defined priority areas, and the respect of nationally defined minimum program requirements in mandatory key areas" (Health Canada, 2006, p. 39).

The pilot projects were showing success in communities and Indigenous organizations wanted assurance that funding would continue into the future. In this context, and based on the sub-committees' recommendations, the Health Transfer Policy was proposed in 1986 and a Health Program Transfer Handbook was shared with AFN in November 1987 at a consultative conference for their feedback (Health Canada, 2006). The AFN made 94 recommendations on the revision of this handbook, including on matters such as treaty rights and issues specific to communities north of the 60th parallel (Health Canada, 2006). The National Indian and Inuit Community Health Representatives Organization and the Indian and Inuit Nurses of Canada were also given the opportunity to provide comment. A middle ground was found on the transfer program's form, and in 1988, Treasury Board provided approval to the Health Transfer Policy and handbook. In 1999, the Health Program Transfer Handbook was updated and retitled, "Transfer of Health Programs to First Nations and Inuit Communities – an Introduction to Three Approaches"[38], which introduced two additional options for transfer, each offering different levels of responsibility to the community (Health Canada, 2004). This handbook was revised to its current state in 2004 and now includes three separate volumes outlining the specifics of the transfer process. According to a 2006 evaluation of the effectiveness of the Health Transfer Policy, implementing the IHP became equated with the transfer of on-reserve services to First Nations, resulting in the "broader context of the Indian Health Policy, including off-reserve services, virtually [disappearing] from the national agenda" (Lavoie et al., 2005, p. 38).

Text. The three original objectives of the 1988 HTP were to (a) enable Indian Bands to design health programs, establish services and allocate funds according to community health priorities, (b) strengthen and enhance the accountability of Indian Bands to Band members, and (c) ensure public health and safety is maintained through adherence to mandatory programs (Health Canada, 2004). It applies to First Nations communities south of the 60th parallel only and excludes Métis and Aboriginals living off a land base or reserve (Health Canada, 2004-a). It must be noted that neither the policy itself, including information relating to its 1988 Cabinet approval, nor the 1989 Treasury Board approval are publicly available.[39] This textual analysis applies to the 1999 program transfer handbook, comprised of three parts, titled "Transfer of Health Programs to First Nations and Inuit Communities", which provides details on the program

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[38] I refer to this document as the "Health Transfer Program Handbook" or "the handbook" throughout this thesis for the sake of brevity.

[39] I emailed multiple government representatives including representatives from Indigenous Services Canada, Health Canada, and the Library archives, along with submitting an Access to Information request; however, no person could locate the document.

to First Nations communities but lacks details specific to policy commitments. According to the handbook, it “updates earlier documents on transferring health programs to First Nations and Inuit Organizations” (Health Canada, 2004-a, p. 1). It writes, “if there are any other handbooks or documents providing policy statements that conflict with the contents of these National Handbooks, the policies in this Handbook are the ones to follow” (Health Canada, 2004-a, p. 1). It states that the relationship between the federal government and Aboriginal people across Canada “is evolving” and that “FNIHB regularly reviews its policies on transfer of control of health programs to make sure they support this renewed relationship” (Health Canada, 2004-a, p. 1). This said, the handbook has not been updated since 2004 (Health Canada, 2004-a). The handbook acknowledges the government’s new nation-to-nation relationship with Indigenous peoples; its mission being, “a renewed relationship with First Nations and Inuit that is based on the transfer of direct health services, and a refocused federal role that seeks to improve the health status of First Nations and Inuit” (Health Canada, 2004-a, p. 2).

The handbook acknowledges the history and contexts of Canada’s Indigenous people and their access to health services, albeit from a colonial perspective. Similar to the IHP, it does not accept accountability for its historic actions: “To put Health Transfer in context, it is useful to understand from a historical perspective how First Nations and the Federal Government have worked together to respond to First Nations’ expressed desire to manage and control their own health programs” (Health Canada, 2004-a, p. 39). It writes, “the White and Red Papers served as an impetus for the collaborative effort of the Federal Government and First Nations to begin serious planning for the future” (Health Canada, 2004-a, p. 39). Further, it does not acknowledge the historic context of Indigenous health care dating prior to the 1969 White Paper, such as the impacts of the Indian Act.

The handbook makes the following three services mandatory for communities in any of the three forms of transfer, while the rest can be determined by the community based on its needs and in accordance with program guidelines: communicable disease control, environmental health, and treatment services (Health Canada, 2004-b). As it pertains to treatment services, in each community’s mandatory “Community Health Plan”, they must indicate where community members will receive “primary care treatment, specialist referrals, hospitalization, rehabilitation services, institutional services, and home care” (Health Canada, 2004-b, p. 12). Primary care treatment is not defined. The program makes no reference to reproductive or sexual health services or abortion. There is no reference of gender or the specific health needs and contexts of women. The handbook does not specify whether communities funded through the transfer are required to abide by the criteria set by the CHA. It makes no requirement for communities to ensure universal access to health services, nor does it specify any provisions related to equal treatment or quality of care. Despite the fact that most communities are small and tightknit, the program makes no provisions relating to patient privacy. Altogether, the handbook lacks a patient focus and instead is concerned with financial and reporting arrangements, of which it is highly prescriptive. As an example, in a key word search for "access" (searching specifically for provisions related to equitable access to health services), provisions related only to the FNIHB's access to the funded community's financial and reporting information, and to access to professional supervision for health employees working in the communities: "Access to professional supervision for all health professional employees is an essential requirement of Health Services Transfer. The Community Health Plan must include detailed information on how professional supervision will be provided for employees including nurses, environmental health officers and dental therapists" (Health Canada, 2004-b, p. 25). The handbook emphasizes the management and control of Indigenous communities' health operations without considering the health outcomes of the populations, such as through requiring adequate access to services.

Consequences. According to the handbook, community leaders are to be held to account regarding the success of their health program "in meeting community needs and for ensuring fair and equal access to service for all community members" through a complaints and appeal process (Health Canada, 2004-a, p. 18). Again, the handbook states no requirement for community leaders to ensure fair and equal access to begin with. Aside from this, community leaders are to be held to account through stringent financial and performance reporting requirements associated with the program's transfer payments. Communities must provide annual reports to provincial and federal authorities and conduct evaluations of their health service delivery effectiveness every five years. There are no provisions related to the election, appointment, or term period of community health leaders who are the key contacts for FNIHB and responsible for program administration.

Unlike with the CHA, and like with the NIHB, there is a lack of a statutory funding base for the delivery of services under the HTP (Fryer & Leblanc-Laurendeau, 2019). This translates to significant uncertainty and variation of funding levels year-over-year impeding community health planning (Fryer, & Leblanc-Laurendeau, 2019). Further, many communities have reported challenges in meeting the stringent program reporting requirements, including reporting on performance indicators through data collection and management. Doing so severely limits their capacity to deliver health service programming. Finally, it has been observed by First Nations communities that their lack of control over funding combined with prescriptive reporting requirements maintains the historic power structure of Indigenous peoples being reliant or dependent on the federal government (Fryer, & Leblanc-Laurendeau, 2019). This is contrary to the intention of the program in enabling self-government and a nation-to-nation relationship (Fryer & Leblanc-Laurendeau, 2019; Greenblatt, 2009). The handbook includes no information regarding its future amendment.

5.3 Findings: Provincial Analysis

In studying the province of Manitoba as a case study of the policy landscape of abortion access at the provincial level, I identified three core policy documents shaping the policy framework. These include (a) The Health System Governance and Accountability Act, (b) its preceding Regional Health Authorities Act; and (c) the College of Pharmacists of Manitoba's Code of Ethics and Obligations. These policy documents were identified as relevant to Indigenous women's access to both surgical and medical abortion service in Manitoba. Their selection was informed through a preliminary understanding of barriers to abortion service access faced by Indigenous women in Manitoba, as identified in my preliminary background research. Such barriers and their basis in each policy document are as follows:

- Vast discrepancies in the quality of, and access to, care across the province resulting from a long history of decentralized, regional health care delivery (Regional Health Authorities Act)
- Inequitable dispersion of surgical abortion service, with services focused largely in Winnipeg (Regional Health Authorities Act)
- Difficulties in navigating siloed interregional health systems such as when travelling from the Northern region to the Winnipeg health region (Regional Health Authorities Act)

- Issues accessing Mifegymiso in regions outside of Winnipeg, including being dispensed this medication by a pharmacist (Regional Health Authorities Act; College of Pharmacists Code of Ethics and Obligations)
- A lack of information on abortion service policy and options for reform, with the responsibility for abortion care being allocated to the Department of Families, but without associated funding (Health System Governance and Accountability Act)

The results of my policy analysis of these documents are detailed below.

1996 Regional Health Authorities Act.

Context. The Regional Health Authorities Act came into force in 1996 in the context of a broader health system reform implemented by Manitoba's Progressive Conservative party. This broader health system reform followed on a highly decentralized system of hospital management, including significant nurse shortages, hospital bed closures, and physician and nurse strikes. The Regional Health Authorities Act was created to establish regional health authorities across the province of Manitoba to distribute health services to their distinct populations. The act structured health care delivery, and consequently access to abortion service, until its amendment in 2021.[40]

Text. The act places all regulatory power in the hands of the [politically appointed] Health Minister, beholden to the Lieutenant Governor in Council, including for determining health regions and regional health authorities. The act establishes a Board of Directors for the management and direction of each RHA, responsible for "establishing by-laws and policies … regarding its internal organization and proceedings for the general conduct and management of the affairs of the regional health authority" (The Regional Health Authorities Act, 1996, Part 4, By-laws and policies). The Minister is responsible for appointing the first directors of the Board and a Chairperson, and the Board is responsible for appointing a Chief Executive Officer of the RHA. The CEO is responsible for "the general management and conduct of the affairs of the regional health authority in accordance with the by-laws, rules, policies and directions of the board" (The Regional Health Authorities Act, 1996, Part 4, Responsibilities of Chief Executive

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[40] This act is analyzed in addition to the newer Health System Governance and Accountability Act (HSGA) given that most reported barriers align with the structures set through this act, having been reported prior to the HSGA's 2021 implementation. Given the recent implementation of the HSGA, not all impacts have yet been identified or reported. The HSGA was implemented within a broader health service transformation, which remains ongoing.

Officer). Both the Board and CEO operate within the regulatory environment established by the Minister. This is problematic given that the Minister is appointed by the Premier and designated to act in accordance with the political priorities and values of the Premier and associated party. While the Minister is required to work with medical professionals to identify "medically necessary" health care (Government of Canada, 2015, Annex B – Policy Interpretation Letters section), health care service delivery, and relatedly, abortion service delivery, is consequently influenced by the political ideology of the party and Premier in power. In this case, this Act was put into force by Manitoba's Progressive Conservative party, which has historically discriminated against Indigenous peoples and maintained pro-life values (AMMSA.Com, n.d.; Abortion Rights Coalition, 2022).

According to the act, RHAs are required to provide "community health services; emergency medical response services; home care services; hospital services; medical services; medical laboratory services; mental health services; nursing services; personal care services; the provision of drugs; medical supplies and surgical supplies; public health services; and diagnostic imaging services" (The Regional Health Authorities Act, 1996, Part 1, Interpretation). "Reproductive health services" is not explicitly listed amongst these services. Relating to abortion service provision access and effectiveness, the RHAs are assigned to:

- "Promote and protect the health of the population of the health region"
- "Ensure that the prescribed health services are provided or made available" and that there is "reasonable access to health services"
- "Develop objectives and priorities for the provision of health services which meet the health needs in the health region and which are consistent with provincial objectives and priorities"
- "Manage and allocate resources, including, but not limited to, funds provided by the government for health services, in accordance with this Act, the regulations, and the regional health plan"
- "Assess health needs in the health region on an ongoing basis, and publish reports about the assessments on the authority's website as required by the Minister";
- "Manage and evaluate the delivery of health services and compliance with prescribed standards and provincial objectives and priorities, in accordance with guidelines provided or prescribed by the Minister";

- “When carrying out its duties … consult with the residents of its health region (The Regional Health Authorities Act, 1996, Division 2, Duties And Powers Of Regional Health Authorities)”

The RHAs have high autonomy in determining all other components of the delivery of these services beyond these requirements. Like the CHA, the act directs RHAs to ensure “reasonable” access without specifying the parameters for reasonable access. The RHA Act identifies no central organization for overseeing the provision of health services across regions, including the consistency and integration of service provision.

Separate from this act, the Regulated Health Professionals Act makes the Health Minister, beholden to the Lieutenant Governor in Council, responsible for designating regulated health professions and establishing colleges for regulated health professions. Per the act, colleges are mandated to regulate the practice of health professions and govern its members; to establish standards of practice; and to work “in consultation with the Minister towards achieving access for the people of Manitoba to adequate numbers of qualified and competent members of the regulated health profession” (Regulated Health Professions Act, 2019, Part 3, College). Accordingly, colleges and the Minister are equally responsible for ensuring residents of Manitoba can access adequate numbers of qualified and competent abortion service providers. Here, no definition of “adequate” is provided.

The Regional Health Authorities Act (“RHA Act”) establishes RHAs across all regions of Manitoba, including where First Nations reserves reside. It mandates RHAs to provide health services to all residents of its region, including First Nations. This said, the act makes only two references to Indigenous peoples or organizations, both out of the context of health care delivery. Regarding consultations, it specifies that the regional health authority consult with “any agency it deems appropriate” in its preparation of its health plan, including Indian Bands (The Regional Health Authorities Act, 1996, Duties And Powers Of Regional Health Authorities). Secondly, it states that the RHA may enter into an agreement with the government, a municipality, or another RHA, but must obtain consent from the Minister to enter into an agreement with an Indian Band, the Government of Canada, or the government of another province (The Regional Health Authorities Act).

The policy does not acknowledge intersectional barriers faced by certain segments of the population or the context of which certain populations (including Indigenous populations) access health care. The policy makes no mention of equity or equality aside from mandating reasonable access to service for all residents.

Consequences. The act stipulates that the Minister may withhold funding from RHAs who do not adhere to the regulations prescribed in the act, in line with the CHA. This said, as above, the regulations regarding service delivery are broad and undefined, including a lack of definition on what consists of "reasonable access". The act requires RHAs to "review and revise its regional health plan at least once a year" and "review and revise its strategic plan at least once every five years" (The Regional Health Authorities Act, 1996, Division 2, Duties And Powers Of Regional Health Authorities). It also requires RHAs to submit annual reports to the Minister on their: "health services provided and funds associated; the health status of the population and the effectiveness of the health services provided and funded; financial information, and any other information as may be required by the Minister" (The Regional Health Authorities Act, 1996, Division 3, Financial Matters). It does not declare how the effectiveness of the health services provided is to be determined, establishing no consistent way to measure effectiveness in service delivery across the province. It states that RHAs are to assess health needs in the health region on an ongoing basis, and "publish reports about the assessments on the authority's website, as required by the Minister" (The Regional Health Authorities Act, 1996, Division 3, Financial Matters). Similarly, it writes that "a regional health authority, health corporation or health care organization must, as specified by the regulations, make periodic public reports about matters relating to the quality of health services provided and patient safety, at the time and in the form specified by the regulations" (The Regional Health Authorities Act, 1996, Division 3, Financial Matters). Further, it states that "a regional health authority shall provide to the Minister any reports, returns, and statistical information that the Minister may require from time to time for the purposes of this Act and the regulations" (The Regional Health Authorities Act, 1996, Division 3, Financial Matters). In summary, it does not define how service effectiveness nor health needs should be assessed, nor prescribe any commitment to assessing and reporting on these, leaving these decisions within the hands of the Minister.

The act makes no provisions surrounding its own review for effectiveness; amendments are to be made by the Lieutenant in Council as they see fit. The act writes that "prior to the establishment of a health region and a regional health authority … the Minister may, if he or she considers it advisable, carry out consultations in the manner and to the extent that the minister considers appropriate" (The Regional Health Authorities Act, 1996, Part 3, Proposal and Consultations).

2021 Health System Governance and Accountability Act.

Context. The Health Governance System and Accountability Act ("HGSA Act) came into force in 2021 in place of the Regional Health Authorities Act; its implementation rooted in an ongoing system-wide "transformation" of the provincial health care system. This followed on reports from several health system reviews identifying major discrepancies in the provision of health care across the province and an overall ineffective and inefficient delivery of health care services (Allec, 2005). The reviews identified duplication of efforts between RHAs and the associated mismanagement and inefficient use of provincial resources; a lack of transferability and information sharing between regions; and specifically, inequities for Indigenous peoples in accessing services (Allec, 2005).

The act's core purpose is to "consolidate administrative services related to health care and centralize the delivery of certain health services across Manitoba" (The Regional Health Authorities Amendment Act, 2021, section 130). The act was implemented by Manitoba's Progressive Conservative government and Manitoba's Health Minister. Notably, MLAs of the Progressive Conservative party – led by Manitoba's Premier, Brian Pallister – have unanimously and consistently voted against a series of bills proposed by the NDP party to implement safe access zones surrounding abortion clinics (CTVNewsWinnipeg, n.d.). According to the Abortion Rights Coalition of Canada (2021), "Pallister's cabinet consists almost entirely of MLAs … with "pro-life" views" (para. 3). Regarding perspectives towards Indigenous peoples, he has been widely criticized by Indigenous leaders for publicly dismissing the impact of colonizers and residential schools in the context of the discovery of mass graves, stating that colonizers did not come to Canada "to destroy, but to build communities" (The Canadian Press, 2021, para. 7).

Regional health authorities were consulted on the implementation of this new bill (Manitoba Health, n.d.-a). It is unclear whether Indigenous organizations were consulted.

Text. Despite the act coming into force in the context of findings from a mass review of Manitoba's health care system which specifically identified significant inequities for Indigenous people, the act does not make any reference to Manitoba's Indigenous peoples. Where the RHA Act previously included a provision relating to RHAs' consultation with Indian Bands, the HGSA act removes this reference in stipulating consultations. The act establishes a provincial health authority ("PHA") to provide central oversight to RHAs' health service delivery. As it relates to abortion service, the PHA is responsible for:

- The establishment of standards committees and clinical standards for the delivery of health services delivered or funded by the government or an RHA;
- Managing and allocating provincial resources to RHAs;
- Monitoring and evaluating RHAs and their compliance with clinical standards and provincial priorities;
- Ensuring reasonable access to health services across the province;
- Preparing an annual provincial health capital plan; and
- Reviewing proposals for capital projects submitted by RHAs and making recommendations to the Minister. (The Health Governance System and Accountability Act, 2021).

The act requires the PHA to prepare a "clinical and preventative services plan" complete with a provincial health human resources plan every five years (The Health Governance System and Accountability Act, 2021).

The PHA is accountable to the Minister in the same format as RHAs. While previously RHAs had significant autonomy in the provision of health services in their region, the act places greater responsibility for health service delivery in the hands of the PHA, which is more directly beholden to the Minister. Under the new act, RHAs are required to participate in: the preparation and review of provincial clinical plans and preventative services plans; managing and allocating regional resources; ensuring that there is reasonable access to health services; and ensuring that health services are made available in accordance with directions given by the minister (The Health Governance System and Accountability Act, 2021).

The amended Act broadens the scope of the Minister's powers in regard to health service delivery. It offers the Minister the power to prescribe provincial objectives and priorities and to determine the suite of health and administrative services to be provided by the PHA and RHAs based factors it considers relevant.

Consequences. In addition to annual reporting, RHAs and the PHAs are required to enter into an accountability agreement with the Minister and prepare an annual strategic and operational plan for the Minister's approval, including a financial plan which outlines how the authority will allocate its financial and human resources. As with the RHA Act, the government may withhold funding if it deems one of them to be out of compliance (The Health Governance System and Accountability Act, 2021). While the policy includes greater checks and balances for the actions of RHAs, including more regimented systems of accountability, the RHAs remain accountable to the Minister and their political priorities. Like in the RHA Act, the Minister is responsible for appointing the first directors and chairperson of the PHA's Board. The Board has the same responsibilities as RHA boards, including managing the affairs of the authority. No diversity targets are tied to the PHA or RHA board's composition. Board members can serve for a total of three years, but the Minister can extend these appointments beyond six years (The Health Governance System and Accountability Act, 2021).

Notably, according to the Abortion Rights Coalition of Canada (2021), following the implementation of the HSGA Act, the Progressive Conservative party transferred the portfolio for all matters relating to women's reproductive health – including abortion – to the Manitoba Status of Women Secretariat, which is housed under the Department of Families Health. This said, the Department of Health is still responsible for all health care funding, including for reproductive health services (Von Stackelberg, 2019). This transfer of reproductive health services to outside of the Department of Health's portfolio disadvantages women and their health needs specifically. This change has also lessened the power of civil society and the public to influence meaningful reform as it pertains to abortion service provision in the province. The Director of Manitoba's Women's Health Clinic – one of the province's few abortion clinics – for example, indicated that they are directed to the Status of Women Secretariat in their outreach to the Minister of Health, and associated advocacy efforts (Von Stackelberg, 2019). While they receive funding from the Department of Families, the clinic is required to report abortion numbers to the Status of Women Secretariat (Von Stackelberg, 2019).

2014 College of Pharmacists Code of Ethics & Obligations.

Context. The Manitoba College of Pharmacists' Code of Ethics ("the Code") defines the "values of ideal practice and the norms of professional practice" for all licensed pharmacists in Manitoba (College of Pharmacists of Manitoba, 2014a, p. 2). It sets standards around pharmacists' conduct, including in dispensing drugs and interacting with customers, and guides the conduct of licensed pharmacists, students, interns, and pharmacy owners (College of Pharmacists of Manitoba, 2014a). An accompanying guide titled, "Explanatory Document: Applying the Code of Ethics in Pharmacy Practice" outlines detailed obligations per each of the

Code's ten statements. The explanatory document is expected to be used in conjunction with the code, stating that, "the statements have been grounded in some more concrete obligations … since the concepts [of the Code] are in some respects abstract" (College of Pharmacists of Manitoba, 2014a, p. 2). The Code is based on "universally acknowledged bio-medical ethics", including autonomy (respect for persons and personal liberty to determine their own actions), non-maleficence (the need to avoid harm), beneficence (the need to do what benefits patients), and justice (the need to treat people fairly) (College of Pharmacists of Manitoba, 2014a). Other values that underpin the Code include veracity (honesty to patients); privacy and confidentiality, and fidelity (a promise of care) (College of Pharmacists of Manitoba, 2014a).

The College itself is the regulatory body responsible for the licensing and regulation of the pharmacy practice in the province. Along with establishing technical and academic standards and licensing pharmacists, it sets standards of practice, establishes the code of ethics, and manages compliance with both (College of Pharmacists of Manitoba, n.d.). The College's Code of Ethics was substantially revised in 2012 amidst broader changes to the Pharmaceutical Act, and came into force in 2014 (College of Pharmacists of Manitoba, 2014a). Regarding power structures, the council of members responsible for developing this new Code of Ethics consisted of 75 percent men and 25 percent women (Manitoba Society of Pharmacists, 2013).

Text. Relevant to the dispensing of Mifegymiso to Indigenous women, pharmacists are obliged through the code and its accompanying set of obligations, to:

- Place "the welfare of patients above all other factors" and "act in the best interest of the patient" (College of Pharmacists of Manitoba, 2014a, p. 8). This leaves decisions on what consists of a patient's welfare, and what is in the patient's best interest, in the hands of the pharmacist and their values and perspectives. One may, for example, believe abortion is not in the patient's best interest.
- "Contribute to societal health needs and promote justice in the distribution of health resources" and "ensure treatment, care, and professional services do not discriminate against any patient" (College of Pharmacists of Manitoba, 2014a, p. 5). Here, "justice" is not defined. A pro-life pharmacist may interpret justice as saving the life of an unborn child.
- "Take special care to maintain boundaries and safeguard the wellbeing of patients who are vulnerable" (College of Pharmacists of Manitoba, 2014a, p. 8). The code makes

mention of “vulnerable” patients but does not define parameters for this term, again leaving this to the pharmacist’s interpretation.

- “Provide patients with information they need and want to make informed decisions about their health care”, “recognize the right of informed patients to make choices about their care” and “respect the autonomy, values, and dignity of each patient” (College of Pharmacists of Manitoba, 2014a, p. 7). Like the above obligation to “[act] in the best interest of the patient”, a pro-life pharmacist may feel that a patient is not informed if they are not knowledgeable of all other options besides the abortion pill. They may seek to push this information on the patient, contributing to feelings of guilt or shame.
- “Pharmacists shall cooperate with other pharmacists and other health professionals to assist a patient to achieve their health care goals” and “work with pharmacists and other health care professionals to promote safe and effective pharmacy care” (College of Pharmacists of Manitoba, 2014a, p. 4).

The Code states the following regarding conscientious objection and self-assessed areas of competence, respectively:

- Pharmacists shall “recognize personal limitations and refer patients to other health care professionals as needed” (College of Pharmacists of Manitoba, 2014a, p. 11). Tied to this, a pharmacist must “arrange practice to ensure that patients are able to obtain services from another pharmacist or pharmacy in a reasonable timeframe if unable to provide the pharmacy service or unwilling to provide the service due to conscientious objection” (College of Pharmacists of Manitoba, 2014a, p. 11). Similarly, the pharmacist is required to “ensure continuity of care by providing pharmacy care for a patient until it is no longer required or wanted or until another suitable health care professional has assumed responsibility for their care” (College of Pharmacists of Manitoba, 2014a, p. 11).
- Pharmacists shall “continually self-assess practice and assume responsibility for continuous improvement of knowledge and skill” as well as “keep informed about new pharmaceutical knowledge, clinical literature, and guidelines through a commitment to lifelong learning” (College of Pharmacists of Manitoba, 2014a, p. 3). According to this, all pharmacists should be trained in dispensing Mifegymiso. This said, the Code also writes that pharmacists shall, “restrict practice to areas within the limitations of personal competence and practice only when fit and competent to do so” (College of Pharmacists

of Manitoba, 2014a, p. 3). According to this, a pro-life pharmacist may decide that they are not personally competent to dispense Mifegymiso.

The College's 2018 Practice Direction surrounding conscientious objection[41], which pharmacists are similarly required to abide by, provides the following additional details regarding conscientious objection:

- "2.1 A pharmacist is permitted to object to the provision of a certain pharmacy product or service if it appears to conflict with the pharmacist's view of morality or religious beliefs and if the pharmacist believes that his or her conscience will be harmed by providing the product or service". (College of Pharmacists of Manitoba, 2018, p. 1)
- "2.2 A pharmacist who knows they will object, as a matter of conscience, to providing a particular pharmacy product or service must:
    - 2.2.1 Immediately provide a written declaration stating the basis of their objection to their current pharmacy manager, or any subsequent pharmacy manager, and the declaration must be well in advance of a possibility of receiving a request for the pharmacy product or service in question.
    - 2.2.2 Not describe the reason or basis of the objection to the patient and guide the patient or prescriber to a pharmacist or pharmacy that can provide the desired service or product.
    - 2.2.3 Not influence or attempt to influence the patient's opinion when conveying the required guidance in 2.2.2 to the patient.
    - 2.2.4 Not impede or block access to information, care or services.
    - 2.2.5 Fulfill their duty to care to the patient in a manner that is non-judgmental, continuous and non-discriminatory.
    - 2.2.6 Take steps to ensure continuity of care for the patient which includes:
        - 2.2.6.1 Expediting the provision of all relevant drug records to the prescriber and/or other pharmacist; and
        - 2.2.6.2 Continue to provide pharmacy services unrelated to the objectionable product or service unless the patient requests otherwise or

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[41] Of note, this practice direction was not released until 2018, four years after the establishment of the Code, and likely following the certification of Mifegymiso one year prior.

> until an effective transfer of care is completed". (College of Pharmacists of Manitoba, 2018, p. 1)

Regarding its consideration of intersectionality, the Code does not make any specific reference to Indigenous populations, traditional Indigenous ways of healing, or the contexts of prejudice and stereotyping specific to Indigenous women and abortion. Beyond the Code, the College maintains no by-law or practice direction recommending that pharmacists in Manitoba understand the historic context of Indigenous health in Canada and Manitoba, including inequitable health outcomes, the context of oppression, different health needs, and traditional medicines. The code does not make any reference to women, men, or gender diverse people, but rather treats clients of pharmacists as one homogenous population.

Consequences. The College's one mechanism for evaluating pharmacists' compliance with the Code of Ethics and other standards of practice and by-laws is a complaint and disciplinary process carried out by the Council. According to the Regulated Health Professionals Act (2019), any person may make a complaint about a pharmacist in writing to the Registrar of the College, to be investigated by an investigation committee. The Registrar may also file a complaint against a pharmacist to the investigation committee (Pharmaceutical Act, 2014). According to the Explanatory Guide, pharmacists are also obliged to "challenge the judgment of colleagues or other health care professionals if there is reason to believe their decisions could compromise the safety or quality of care" and "not tolerate unethical or unprofessional conduct by colleagues or other health care professionals and report any unethical or unprofessional conduct to the appropriate regulatory body" (College of Pharmacists of Manitoba, 2018, p. 4).

Per the Pharmaceutical Act (2014), pharmacists who do not comply with the Code or any other regulation or standard of practice, or else display a "lack of judgment" (section 54), may be investigated and reviewed by a panel. They may consequently have their license suspended, revoked, or limited by the College. Aside from this process, there is no regulation mandating the College's assessment of pharmacists' compliance with the above-mentioned policies aside from the complaints process, nor any practice or mechanism for doing so as established by the College. The Code itself may be amended or repealed by a majority of council members of the college entitled to vote.

The College maintains no diversity targets for the composition of its council. Currently, it is managed by a council comprised of males and females in equal count[42], however there is no Indigenous representation and no geographic diversity amongst the council; its composition includes four elected pharmacists from the City of Winnipeg and four from outside of Winnipeg (College of Pharmacists of Manitoba, 2022). Five of the Council's 15 members are appointed by the Minister, and one is selected to represent the general population (selected from outside the pharmacy and health care practice) (College of Pharmacists of Manitoba, 2022).

5.4 Summary

The policy documents forming "Level 1" of the policy framework are steeped in patriarchal, colonial bias and imbued with sexist and racist language. These documents were implemented by white, all-male cohorts who maintained derogatory views towards women and Indigenous peoples. They were implemented in an authoritarian-like manner, involving no engagement with citizens or Indigenous peoples or governments specifically. The broader sociopolitical context at this time in history, including outdated norms, was significant in shaping these documents and the prevailing health system. This includes involvement by the Church in political affairs and perspectives of health as a private matter. Separately, Canada's federalist structure, which greatly impacts health service provision today, was pioneered as opposed to informed through past experience and best practice. Neither policy included processes for evaluation to ensure its continued effectiveness over time, while placing power over future amendments at the discretion of a select group of powerful people.

While these Level 1 documents set the structural foundations for the framework of abortion service access by Indigenous women, the systems which define access today are deeply rooted in the "transformational-level" policies of the 1980s. Despite the inception of these policies being influenced by advocacy from women's organizations, consultations informing the design of these policies were largely male-dominated. Similarly, while Indigenous voices helped to influence these policies' design, no policy legislatively enshrined governmental accountability for the provision of equitable, quality health care for Indigenous peoples. The Constitution Act, for example, enshrined treaty rights, the Canada Health Act mandated equal access to health services, and the Charter guaranteed the right to equal treatment under the law, but none secured

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[42] It is not clear whether the council includes representatives from the 2SLGBTQQIA+ community.

equitable health outcomes for Indigenous people. Separately, while the Indian Health Policy acknowledged federal responsibility, this two-page policy statement lacked any legislative basis.

As noted above, values within this time period were significant in shaping the text of these policy documents. This includes heteronormative values surrounding equal treatment in comparison to today's emphasis on equity, or equal outcomes. Accordingly, these policies treat all sexes and all races (with the exception of the IHP) as equal, without regard for intersectionality and the need for some to be treated differently to experience equal outcomes based on their social locations. Finally, like the BNA Act, these acts came into force in a specific political context that no longer holds today. An example is the political motive underpinning the CHA's broad criteria for provincial health care administration.

Based on the policy documents forming Level 2 of the framework, the third level of documents forming the "operational level" lack a legislative basis. This results in such operational programs being provided by the federal government on "a matter of policy" or "benevolence". This results in insecure funding and maintains structures of federal control and Indigenous reliance – contrary to the aims of self-determination which these documents (the IHP and HTP) sought to further. These programs reflect the privileged biases of the literate and financially secure public servants and policymakers responsible for their design. They do not consider the literacy levels or technological and financial capacity, amongst broader locational factors, of their audience. The language of the programs, and the administrative processes associated, are complex and difficult to navigate, resulting in a lack of information and time delays for users. The program language reflects a relationship of authority, management, and control by federal administrators, altogether lacking a focus on patient outcomes. The programs do not consider the specific societal and biological contexts of women, nor make any reference to abortion in their discussion of medical service.

At the Manitoba-provincial level, I determined an overall absence of available information surrounding the publicly-funded provision of abortion care (including in the Government of Manitoba's consolidated acts and regulations; the Manitoba Health Department webpage; the webpage for the Status of Women Secretariat; its College of Physicians and Surgeons webpage; and its College of Pharmacists Manitoba webpage). There is a lack of publicly available information on where one can access a surgical abortion in the province, including which hospitals provide this service. The two hospitals which supposedly provide surgical abortion service – as determined through external sources – contain no information on their website about abortion service provision.

Manitoba is in the middle of a health system transformation. The HGSA Act has been designed to improve inefficiencies and discrepancies in health care administration as found through recent reviews. While such reviews highlighted a need to improve care for Indigenous peoples, the act makes no mention of Indigenous peoples or governments. The new act places greater power in the hands of the Minister of Health, who is accountable to the province's Conservative Party. This party – responsible for the act and the broader transformation – is comprised of politicians with pro-life values (Abortion Rights Coalition of Canada, 2022-c). Early implications include the party's transfer of responsibility for reproductive health and abortion from the outside the Department of Health, which maintains funding for the service (Abortion Rights Coalition of Canada, 2022-c).

The language of the Code of Ethics is vague and open to interpretation by pharmacists, allowing for pharmacists' own values (e.g., pro-life) to dictate the service they provide (or choose not to provide). Further, limited accountability mechanisms are in place to ensure pharmacists' compliance with the code, such as ensuring a patient receives the help they need if the pharmacist cites conscientious objection, and committing to continuous training (including with respect to dispensing Mifegymiso) (Froese, 2018; Von Stackelberg, 2019).

In the following chapter, I will discuss these findings in the context of my research questions, literature review, and conceptual framework, and draw conclusions on opportunities for reform.

Chapter 6: Discussion and Analysis

6.1 Answering the Research Questions

In my research, I conducted a dual-phased critical analysis of a policy framework I determined through background research to form the policy landscape shaping Indigenous women's access to abortion services.[43] This analysis extended to the design, text, and implementation of the policy documents forming this framework. My policy framework of study included pertinent documents from the province of Manitoba given, that (a) provinces and territories have jurisdiction over public health per Canada's Constitution Act, and (b) given Manitoba's high proportion of Indigenous peoples and evidenced issues of access for Indigenous women in the province.

The goal of this research was to determine the ways in which the policy framework, including its design, text, and implementation creates barriers to accessing abortion services for Indigenous women in Canada. The purpose was to identify the most salient policies to inform reform and improve reproductive justice for this population.[44]

Through my research, I determined the following federal-level policy documents across all three levels of the policy framework to be most salient in perpetrating barriers in access:

- **Level 1: The 1867 British North America Act and the 1876 Indian Act.** Both historic documents established the structures and norms shaping access to abortion service for Indigenous women today, regardless of their eventual amendment. Both have resulted in a convolution in health care authority and a lack of authority over health care for Indigenous peoples. This has resulted in vast discrepancies in care and neglect, and consequently, severe inequities in access to abortion service. The lack of legislated jurisdiction surrounding Indigenous health has resulted in federal-level health programs (including those through which status Indigenous women may access abortion service through) being offered on a matter of "policy" or "benevolence". Accordingly, complete power is vested in the hands of the federal government, maintaining a federal-Indigenous

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[43] As earlier acknowledged, this analysis and my associated findings and recommendations pertain to the colonial Western policy framework.

[44] As I note in my Introduction, all reform must be led by Indigenous women. My research findings are provided for information purposes to help illuminate the areas of the Western policy landscape that create the most significant barriers.

relationship of control and reliance, contrary to self-determination. The Indian Act instituted the systemic oppression of Indigenous women resulting in centuries worth of neglect and mistreatment, and resultant poor social determinants of health; both of which impact access. It established power structures that enabled colonizers to outlaw traditional contraception and abortion practices in place of Eurocentric beliefs, resulting in entrenched abortion-specific stigma in many Indigenous communities. It also generated norms surrounding the subjugation of Indigenous women, which continue to impact Indigenous women's interpersonal experiences with Western health care providers (Monchalin, 2021-a; Nelson, 2017; Shaw, 2013).

- **Level 2: The 1984 Canada Health Act.** The Canada Health Act is not fulfilling its mandate of ensuring equitable health care for Canada's collective population. It is not effectively holding provinces to account for their use of funding in line with its core criteria, including accessibility and universality. Further, the act is vague and open to interpretation. Its broad criteria allow for decentralization at the provincial level, where clinics and hospitals set their own gestation limits on surgical abortion (Abortion Rights Coalition of Canada, 2022-a; Flood & Thomas, 2016). Revisions, such as specifically defining reproductive health care, including abortion, as a medically necessary service; setting parameters around reasonable access; and instituting better controls to reprimand provinces out of compliance with its funding criteria, would improve the current state of access. This would theoretically resolve a number of barriers as identified in the literature, including service provider scarcity, geographic access, and discrepancies between provinces/territories.
- **Level 2: The 1982 Constitution Act and the 1985 Indian Act.** Neither the right to health care, the right to access an abortion, nor Indigenous rights to access health care specifically, are enshrined in the Charter of Rights and Freedoms. Enshrining the right to access an abortion and the right to equitable health care for Indigenous populations could help to better encourage equitable provision at both the federal and provincial level. Revisions to the Constitution Act's distribution of legislative powers to specifically attribute responsibility for the health of Indigenous peoples, along with revisions to the language used in the Indian Act regarding health service provision ("shall provide" health

services versus “may provide” services) could be significant in helping to alleviate the barrier of a lack of accountability for Indigenous peoples’ health care.[45]

- **Level 3: The Health Transfer Policy in the form of the 2004 Health Transfer Program Handbook.** The Health Transfer Program Handbook (“the handbook”) lacks a patient focus and rather focuses on the management and control of Indigenous populations. It has not been updated since its inception in 2004. Revisions to the document to lessen its prescriptiveness could better enable communities to provide health care services, improving access for women based on reserves. On the other hand, the program handbook’s prescriptiveness could be increased surrounding patient outcomes, including through providing guidance to communities on ensuring equitable access to health service, patient privacy, access to adequate information on options for sexual health. This could help with resolving the barriers of a lack of privacy and a lack of abortion literacy on reserves, as identified in my literature review (Monchalin & Paul, 2021-b; Minacci-Morrey, 2020; Bollinger, n.d.).
- **Level 3: The Non-Insured Health Benefits Program and its Medical Transportation Policy Framework[46].** The Non-Insured Health Benefits Program is administratively complex for both patients and pharmacists (Kirlew, 2016; Office of Audit and Evaluation; 2017). This results in significant time delays in the context of the time-bound nature of abortion and can result in negative treatment by pharmacists (Pharmacy Connection, 2020). Further, the program does not consider literacy, age, or socioeconomic status, including access to and proficiency with the internet or a printer. It reflects the privileged bias of literate, able-bodied, public servants of high socioeconomic class responsible for its design. There are no adequate mechanisms in place to ensure that it is being applied effectively and consistently across Canada (Office of the Auditor General, 2015). Its medical transportation policy framework program favours life over choice through providing special treatment to pregnant women choosing to birth a child as opposed to those choosing to abort. Improving the efficiency, consistency, and

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[45] As identified in my literature review and background research (Palmer et al., 2017; Katz et al., 2021; Halseth, 2013; Lavoie, 2013; Nelson, 2017).

[46] This analysis refers to the most current versions of the NIHB and its Medical Transportation Policy Framework, which have both been updated as a result of the AFN & ISC’s ongoing review; this suggests the need for further reform as it refers to abortion access for Indigenous women.

usability of the program, in addition to its recognition of the specific social locations of Indigenous women, and of abortion as medically necessary, would be significant in alleviating barriers to abortion service for users of the program.

At the Manitoba-provincial level, I identified the following policies as most salient in perpetrating barriers in access:

- **The Health System Governance and Accountability Act.** The HSGA Act fails to acknowledge any responsibility for the health of Manitoba's Indigenous population – including those on and off reserve – and their specific health contexts. It includes no parameters around reasonable access to health services and fails to provide a definition of medically necessary service, nor acknowledge reproductive health service as medically necessary. The HSGA Act places greater control over health service delivery, including the decisions related to abortion service delivery, in the hands of the Health Minister, who is accountable to the Premier and their political values and priorities. In Manitoba, the Conservative government's Health Minister has referred all issues regarding abortion and reproductive health to the Department of Families as opposed to treating it as a matter of health (Abortion Rights Coalition of Canada, 2021; Von Stackelberg, 2019). As well, there is an overall lack of information on any provincial webpage regarding access to abortion services. Revisions to better acknowledge responsibility for Indigenous peoples and of abortion as a necessary health service, plus greater checks on the Minister's regulating powers, would help to alleviate barriers associated with geographic access, service provider scarcity, and Indigenous-specific neglect.
- **The College of Pharmacists Code of Ethics & Obligations**. The Code is significant in in its attempt to ensure pharmacists provide just quality service, however, its terms are broad and open to interpretation by pharmacists. On one hand, this makes the Code more difficult to enforce. Separately, based on my research, the complaints process in place to ensure pharmacists' compliance with the Code is not adequately doing so; pharmacists are not appropriately being held to the Code's obligations, such as a commitment to continuous education (e.g., in dispensing Mifegymiso) and patient referral in the event of cited conscientious objection (Froese, 2018; Von Stackelberg, 2019). Clarification to language, along with revisions to accountability mechanisms, such as an improved complaints system and greater pharmacy oversight, would be significant. These would

help to alleviate barriers related to interpersonal racism, conscientious objection, and a lack of trained pharmacists, altogether improving access to Mifegymiso.

6.2 Unexpected Findings, New Themes, and Recommendations

The above section references the policies which most significantly impede access to abortion service, in other words, those of which the reform of which would most positively impact access. This said, in my analysis of “consequences”, I determined that reform for some, while impactful, may not be feasible. Accordingly, I analyzed the identified policies based on both impact (in terms of the number and significance of barriers alleviated) and feasibility (in terms of likeliness of reform given factors such as their process for amendment, political will to do so, the implementation of the policies in practice, potential consequences). My options analysis of impact and feasibility is depicted in Table 2 below.

As I note above, the 1867 BNA Act and the 1876 Indian Act continue to structure Indigenous women’s access to abortion service today (such as through instituted systemic racism) despite being no longer in effect. Amendments to the current version of the Indian Act are unlikely to be impactful in alleviating interpersonal Indigenous-specific racism given the extent to which it is now entrenched. Similarly, while the 1979 IHP was significant in establishing today’s structures of federal health care delivery, such structures have now become institutionalized; given its lack of a legislative basis, reform of the two-page policy statement today would likely have low consequence on the now status quo. Lavoie et al. (2005), for example, describe how the IHP in practice has become equated with the Health Transfer Policy, its reference to off-reserve service “virtually [disappearing] from the national agenda” (p. 38). Further still, many policies were designed to be difficult to reform. Reform to the 1982 Constitution Act, for example, requires a constitutional conference and agreement by at least two-thirds of the provinces and territories that have at least fifty percent of the population of Canada (Constitution Act, 1982, Part V). Finally, there are the factors of political appetite and alignment with current policy agendas. Without instituted requirements by the CHA, for example, Conservative politicians in Manitoba would have no political appetite to implement any reform to improve abortion access in the province. Finally, I determined that some revisions might also come with consequences: enshrining the right to abortion in the Constitution Act for example, could further politicize the issue, setting the grounds for, and making it more vulnerable to, fiercer opposition (Abortion Rights Coalition of Canada, 2022-b).

Factoring in both impact and feasibility, I identified the following opportunities for policy reform that remain impactful with respect to improving abortion access, while also being relatively feasible to undertake. The following have also been identified in aim of resolving barriers at all levels in a complimentary way to improve ease of access across the entire policy landscape. Table 3 below outlines the summative barriers resolved through the proposed reform of each policy. As I note above, these suggestions are for the purpose of informing how access might be improved within the colonial landscape. They have been designed to evidence the need for reform, as well as to inform the efforts of those with policymaking power and those advocating for change, including Indigenous women's organizations. Any ultimate reform must be both desired by Indigenous women and achieved in partnership with Indigenous women's organizations or collectives. Future reform must also be culturally responsive, context-specific, and respectful of characteristics of place. I note that options for reform to the above-mentioned Manitoba-specific documents are not included in the suite of below opportunities given their specificity to Manitoba and inapplicability to the whole of Canada. This said, the above Manitoba-specific findings can inform those pursuing reform in the province but also the identification of policy-level barriers in other Canadian provinces and territories.

1. **Revising the Canada Health Act.** Three opportunities for reform of the Canada Health Act that could significantly help to alleviate key barriers are as follows:
    a. Implementing stronger accountability (compliance and enforcement) mechanisms to better ensure provincial/territorial compliance with criteria.
    b. Greater clarity in the definition of "reasonable access", such as through specific parameters on what reasonable access consists of (e.g., distance in kilometres to population centres).
    c. Clarity on the definition of "medically necessary" and "medically required" services that provinces and territories must provide. This could include the incorporation of the terms "mental and emotional health" in the definition of medically necessary's reference to "maintaining health", or listing "reproductive health services, including abortion" in its list of medically necessary hospital services (Canada Health Act, p. 3).

This option would be highly impactful in improving access at the provincial/territorial level, including through ensuring the necessary provision of abortion service despite a lack of political will within the province. From my research, I have determined this option to have medium feasibility within the federal context. Most significantly, there is an understanding of the need for reform at the federal level, including political will to do so by the Prime Minister. In his 2021 Mandate Letter, Justin Trudeau tasked the federal Minister of Health with amending the Canada Health Act to "[ensure] that all Canadians have access to the sexual and reproductive health services they need, no matter where they live". This included through enhancing compliance by provinces and territories with the act (Prime Minister of Canada, 2021, para. 12). This builds on the statements of his 2019 Mandate Letter, in which he tasked the Minister with "[considering] amendments to the Canada Health Act … including new accountability standards" (Prime Minister of Canada, 2019, para. 14). This said, as identified in my literature review, the polarizing subject of abortion service has caused the federal government to refrain from implementing any significant action since its decriminalization in 1988 (Long, 2022).

A fourth, impactful reform opportunity includes the act's clarification of responsibilities for the provision of equitable, quality health care for Indigenous peoples. This option is less feasible, however, given the government's long history of abdication on this matter and an associated lack of federal political will.

2. **Revising the Non-Insured Health Benefits Program (inclusive of the NIHB Medical Transportation Policy Framework).** Below I cite five opportunities for reform to the NIHB and its Medical Transportation Policy Framework that would improve ease of access to abortion for status Indigenous women. Opportunities include:
    a. Streamlining and reducing the complexity of the administrative process to improve timely access for patients and ease of use by pharmacists.
    b. Updating program language for easier interpretation and use; ensuring the language considers the needs, abilities and social locations of its target population, including all age groups, literacy levels, socioeconomic levels, and technological capacities.
    c. Rephrasing the terms "medical condition", "medically required service", and "medical emergency", or else their definitions, in acknowledgment of the choice

    to have an abortion. This could, for example, include reference to mental and emotional health.
    d. Expanding escort eligibility to provide cost coverage for escorts for pregnant women seeking abortion (beyond pregnant women planning to birth a child), and coverage options for a woman's dependents.
    e. Revising the approval process to better protect women's privacy when seeking approval for either Mifegymiso or medical transportation.

As mentioned in my findings section, the AFN is currently reviewing the program (inclusive of its medical transportation policy framework) in partnership with Indigenous Services Canada to enhance client access to benefits, identify gaps, and ensure service delivery is more responsive to client needs (Assembly of First Nations, 2018-b). The impetus for this program review came about through advocacy by the AFN, demonstrating the effectiveness of advocacy and its potential for future program reform. While it is unclear whether this AFN-ISC-led reform will lead to improvements in access to abortion service specifically, it sets the precedent for future reform and reflects the government's willingness to do so in line with Indigenous desires and perspectives.

3. **Updating the Health Transfer Program Handbook.** The HTP in theory supports self-government, allowing First Nations communities to provide health care services to meet the unique needs of their populations. This said, the reporting requirements tied to the receipt of government funding are stringent and its lack of a legislative basis results in funding insecurity (Lavoie et al., 2005); both take away capacity from communities to effectively provide quality service. In reserve communities, the literature describes a lack of privacy and a lack of awareness surrounding abortion service access as significant barriers to access (Monchalin & Paul, 2021-b, Monchalin, 2021-a, Wyton, 2022). Where 89 percent of First Nations communities now provide health services to their residents through health transfer agreements in line with the handbook (Lavoie, 2018), access could be improved for women in reserve communities through the following revisions:
    a. A shift away from management and control-based language and stipulations, including a decrease in the stringency and administrative complexity of reporting requirements (the extent to which has been deemed unnecessary in an external review of the program [Lavoie et al., 2005]).

   b. A shift towards a focus on patient outcomes, including guidance to promote equitable access to services amongst all members of the community, to protect patient privacy, and to improve awareness of reproductive health options, including abortion options and availability.
   c. Consideration of equity and the need to treat individuals differently to achieve equal outcomes. This includes consideration of the specific biological and societal needs of women and gender diverse individuals with female anatomies.

ISC is responsible for managing the transfer agreement process, with final approval vested in the Minister of Indigenous Services. Like with the ongoing ISC-AFN review of the NIHB, current efforts between ISC and Indigenous organizations are ongoing to co-develop distinctions-based health legislation (detailed further in Appendix E); both of which demonstrate political will for reform of the Indigenous framework for health care amongst federal-level entities. Regarding the latter-described efforts, the federal government has committed funding for, and is currently undergoing a consultation process to, "co-develop distinctions-based legislation" with Indigenous partners in line with UNDRIP. The purpose of such legislation is to foster health systems that will "respect and ensure the safety and well-being of Indigenous Peoples", and "address the social determinants of health and advance self-determination in alignment with UNDRIP" (Indigenous Services Canada, 2021, para. 5). The process includes the joint evaluation and improvement of ISC's "programs and practices to ensure more culturally responsive and safe services" (Indigenous Services Canada, 2021, para. 8). The process has also acknowledged a need to attribute specific actions for Indigenous women and 2SLGBTQQIA+ people, who they acknowledge as being disproportionately impacted by anti-Indigenous racism in Canada's health systems (para. 7). There are opportunities to improve the program handbook in line with the above suggestions given this context.

4. **New legislation**. While reform to the above two programs would be significant in improving access at the operational level for status Indigenous women, the above two programs at current remain delivered "as a matter of policy" and are not enshrined in legislation. This results in "poorly defined essential services and confusion about what is considered adequate funding" as the Parliament of Canada (2019, Delegation and Devolution section) writes. As above, revisions to the Constitution Act and BNA Act to

enshrine health care responsibility for Indigenous populations are improbable. This said, the above-mentioned ongoing process to co-develop distinctions-based health legislation in line with UNDRIP presents significant potential for the achievement of such reform. According to Indigenous Services Canada (2022), this health legislation will reflect current views of Indigenous organizations and Indigenous peoples, including: Indigenous women's organizations; subject matter experts; health professionals; national and regional Indigenous organizations; First Nations, Inuit and Metis leadership; self-governing Indigenous governments and Treaty nations; and provinces and territories (Indigenous Services Canada, 2023). At a minimum, this legislation will enshrine the federal government's responsibility for health care, providing a constitutional basis for the above-mentioned health programs, while reforming such programs to reflect the views and perspectives of Indigenous peoples, including Indigenous women specifically.

Table 2: Policy Reform Options Analysis

Policy Reform Options	**Impact**	**Feasibility**
Federal		
1867 BNA Act, 1876 Indian Act	Null	Null
1982 Constitution Act	High	Low
1985 Indian Act	High	Low
Canada Health Act	High	Medium
Indian Health Policy	Medium	Null
Health Transfer Program Handbook	High	High
Non-Insured Health Benefits Program	High	High
Manitoba-Provincial		
RHA Act	Null	Null
HGSA Act	High	Low
Code of Ethics	High	Medium

Table 3: Policy Document Reform & Barriers Resolved (Impact)

Policy Documents	**Barriers Resolved**[47]
Canada Health Act	✓ Provincial/territorial discrepancies ✓ Geographic access ✓ Service provider scarcity
Non-Insured Health Benefits Program	✓ Complexity of navigating the program/ease of access ✓ Geographic access
Health Transfer Program Handbook	✓ Scarcity of information on reserve ✓ Lack of privacy
New legislation	✓ Lack of accountability for health care/neglect

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[47] The below barriers align with those identified in my literature review, as outlined in Appendix C.

6.3 Summary

The above reform options have been developed based on findings from my policy analysis, cross-referenced with barriers identified in my background research and literature review. In line with my feminist and intersectionality-based policy analysis paradigm, and critical policy studies-based methodology, they seek to "[ameliorate] inequitable relations of power that maintain inequity" (Ferlatte & Oliffe, 2019, p. 265), "shift dominant or racialized discourses in policy" (Hankivsky et al. (2019), and achieve policy justice (Wiebe & Levac, 2020). Of note, the first three suggested reform options aim to achieve reproductive justice for Indigenous women within the bounds of the colonial health care system. New legislation, such as that being co-developed in consultation with Indigenous peoples and in alignment with UNDRIP, will be significant in dismantling the existent structures of control-reliance and neglect. There is also specific opportunity for improvements to be made regarding access to abortion service for Indigenous women, along with a more cohesive policy agenda surrounding sexual and reproductive service provision altogether, which the literature points to as fragmented and lacking (Nelson, 2017). Notably, NWAC, a partner in the co-development process, recently put forward engagement-based recommendations to ISC calling for the new legislation's consideration of intersectionality and the unique social locations of Indigenous women, girls, and 2SLGBTQQIA+ in Canada (Native Women's Association of Canada, 2022). NWAC conducts "community-based research" to advocate for sexual and reproductive policies and programs, including those that "intersect colonialism" (Native Women's Association of Canada, 2023, para. 1). While such new legislation may not achieve the above-suggested, language-specific program-level improvements, it establishes a sound foundation for such program-level changes to be made if desired by Indigenous women. Finally, while this new legislation will be significant in reshaping status Indigenous women's experiences with federal health care administration, revisions to the CHA will likely still be necessary for improving access at the provincial/territorial level. There is potential that such legislation will help to activate system-wide reform, including to the Canada Health Act and legislation at the provincial/territorial level.

The above options outline opportunities to resolve structural and operational barriers within the policy framework but will likely be ineffective in resolving barriers generated by entrenched racism and sexism towards Indigenous women, as experienced in interpersonal treatment. As I point to in my analysis of Manitoba-level policy, such barriers may be better alleviated at the provincial/territorial level through codes of conduct for physicians and pharmacists, adequate compliance and enforcement mechanisms, and culturally-responsive and anti-racism training. Below, I discuss the need for further research in this area, including a need for greater engagement with Indigenous women on their interpersonal experiences and perspectives for improvement.

Chapter 7: Conclusion

In this thesis, I have detailed the ways in which the colonial policy landscape structures Indigenous women's access to abortion services in Canada, as well as key opportunities for reform within this system. As evidenced in my literature review, research of this kind has not been conducted before. I examined policy at both the federal and provincial/territorial level given that Indigenous women access abortion service in Canada within a framework comprised of policy at both levels. The province of Manitoba was selected as a case study of the barriers created by provincial-level policy given findings pointing to distinct issues in access faced by Indigenous women in the province. Findings from this provincial analysis can inform further research within other provinces and territories of the barriers created by comparable legislation.

My outlined options for reform align with barriers identified and recommendations made in comparable literature. This includes findings on the structural barriers applicable to all women in Canada (noted by Palley [2006], Long [2022], Schummers & Norman [2019], Action Canada [2019] and Johnstone [2017]), along with barriers specific to the historic contexts of Indigenous women and their reproductive systems, including ongoing abortion-specific stigma, and mistreatment in health care settings (noted by Monchalin [2021-a], Monchalin & Paul [2021-b], Action Canada [2020-a], Browne & Fiske [2001], Bourassa et al. [2004]; Denny [2020] and others). This also includes recommendations made by the UN Committee on the Elimination of Discrimination Against Women (2016) to eradicate discrepancies in access to abortion service throughout Canada, by the National Inquiry into Missing and Murdered Indigenous Women and Girls (2019) to improve access to health services for Indigenous women, and by Action Canada (2020-a) and Monchalin (2021-a), to improve access to abortion service in Canada for Indigenous women specifically.

My analysis of each policy's context, text, and consequences illuminated barriers rooted in their design, content, and implementation. My analysis of context highlighted the forces underpinning each policy document's form, including broader sociopolitical sentiments and the values of the powerful people responsible for their creation. This include the extent to which policies were shaped by the perspectives of Indigenous peoples and women through engagement. From this analysis, I determined a number of the documents that structure the current system as being founded on outdated sociopolitical contexts and norms, including health as a private matter, the importance of equality (over equity), and the evolving state of the federal-provincial fiscal relationship. Further, women, including Indigenous women, were not meaningfully consulted, nor were shared perspectives valued, in the formation of the bulk of these documents.

My analysis of text was significant in highlighting the power of language, with findings highlighting the impact of small revisions in language can have on the alleviation of barriers. An example is the use of the word “may” versus “shall” regarding the Indian Act’s reference of the federal government’s power versus obligation to provide health services to Indigenous communities. My analysis revealed that a number of barriers are generated through language that is either too broad or vague; this allows for those interpreting the policies to form their own interpretations on its implementation – an issue in the case of the politically controversial subject of abortion. Finally, this textual analysis illuminated the significance of unconscious bias in generating barriers. An example is the NIHB and the assumptions those responsible for its design make about the literacy levels and technological capacity of its users.

Lastly, my analysis of policy consequences helped to illuminate the significance of accountability systems for ensuring implementation in line with intended results – particularly in the context of broad stipulations open to interpretation. The Code of Ethics is an example, where, despite its textual emphasis on fair service provision, its tenets are not effectively carried out due to a lack of an adequate compliance and enforcement system. Finally, as indicated my preceding Discussion chapter, my analysis of consequences helped to illuminate the feasibility of meaningful reform to each policy document in the context of improved abortion access.

As I write in my Introduction, this thesis is both significant and timely given the political environment in Canada at this time. In my Results chapter, I refer to the set of transformational documents forming the policy framework, including those which arose out of an environment of significant advocacy by historically marginalized voices. Today, similar organizing and activism is having a comparable effect in disrupting the status quo policy frameworks for Indigenous health care and for access to abortion service in Canada. The federal government’s collaboration with Indigenous organizations to co-develop distinctions-based health legislation, along with the AFN-ISC joint review of the NIHB, will likely result in policy better reflecting Indigenous perspectives, and create precedent for future Indigenous-led reform. Separately, significant political attention is being paid to the issue of abortion access in Canada at this time, including for Indigenous women. As I note in my Introduction, the federal government in May 2022 committed $3.5 million in funding for projects to improve access to abortion services in Canada, while acknowledging unique barriers for minority and marginalized populations, including Indigenous people (Government of Canada, 2022). Accordingly, this thesis represents a novel contribution to the literature on abortion access for Indigenous women in Canada at a timely moment in history. It is my hope that this thesis can provide helpful information to ongoing efforts to develop distinctions-based legislation and improve the state of abortion access in Canada.

Here, I note that the purpose of this research is to both evidence the need for reform to policymakers, but also provide useful information to those seeking to achieve reform of the current system, including those with lived experiences. Preliminary engagement is required with Indigenous women to firstly determine perceptions on the need for reform before work is progressed on options development. As I note earlier in this paper, Monchalin et al. are currently conducting primary research with Indigenous women to understand their experiences with accessing abortion services in Canada, including barriers faced. This work will be significant in elevating the voices and perspectives of historically marginalized individuals and guiding meaningful change. This said, more extensive qualitative research on Indigenous women's experiences is required to develop options for reform that not only alleviate structural barriers but improve interpersonal experiences. Further, as I note in my Discussion chapter, any reform must not only be informed, but guided by Indigenous women. NWAC and other organizations are currently leading important work regarding sexual and reproductive health outcomes for Indigenous women.[48]

In addition to the above, there are a number of areas in which further research would benefit this thesis's aims. Firstly, further research is needed on the specific form that the options identified in my Discussion chapter might take, such as specific policy mechanisms for ensuring provincial/territorial compliance under the CHA. As well, further research is needed on options to improve social determinants of health for Indigenous women (e.g., poverty and domestic violence) and how this might then improve barriers in access. Tied to this is the need for greater research on how inequities in public social service provision impact access to abortion service

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[48] The following Indigenous-led organizations are leading important work to secure reproductive justice, including access to abortion service, for Indigenous peoples in Canada: "Native Youth Sexual Health Network" https://www.nativeyouthsexualhealth.com/, "Indigenous Women Rising" https://www.iwrising.org/abortion-fund and the "Native Women's Association of Canada" https://nwac.ca/policy/sexual-and-reproductive-health.

for Indigenous women[49]. Further research is also needed on options to best eradicate racism, stereotyping, mistreatment and neglect by health care workers towards Indigenous women accessing Western abortion services. In my Discussion chapter, I note how at the provincial/territorial level, codes of conduct tied to compliance and enforcement structures can help to reduce interpersonal racism by health care providers. I also suggest that the incorporation of obligations in such codes requiring practitioner education on Indigenous women's historic contexts and social locations would help to change behaviours. NWAC, for example, has developed a resource to educate sexual and reproductive heath care providers on providing trauma-informed care that takes into account the impact of colonialism on Indigenous women, girls and gender diverse people.[50] Further research on the implementation of these options, and other opportunities for reducing mistreatment in health care settings is needed.

In my Discussion chapter, I suggest revisions to the NIHB and HTP to better protect women's privacy on reserves in the context of entrenched abortion-related stigma, as introduced by colonial powers. Further research on the how to best reduce the prevalence of, and exposure to, abortion-specific stigma in Indigenous communities is needed. Awareness-building on abortion and reproductive health may help to change perceptions; however, this can only be done in a way that does not repeat the imposition of Western values towards Indigenous peoples. Finally, research on options for culturally safe abortion, including access to traditional abortion practices, needs to be further explored.[51]

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[49] Jubinville et al. (2022) posit that disparities in Indigenous reproductive health in Canada are a result of inequities in both public health and social services.

[50] Found here: https://www.nwac.ca/assets-knowledge-centre/Transforming-our-response-to-sexual-and-reproductive-health.pdf

[51] Dr. Sarah Munro's The STORY Project (ongoing) is one source to be reviewed in connection with the findings of this thesis. This program of research is investigating "culturally-safe, gender-affirming, trauma-informed contraception and abortion care" for Indigenous peoples "in partnership with youth and Indigenous communities" (The University of British Columbia, n.d.).

Appendix A: Research Framework

The research framework below encapsulates the two frameworks I applied to my analysis of identified policy documents across my two phases of research. The policy document analysis framework applied in Phase 1 is based on that conceptualized by Taylor (1997) and informed by critical policy studies theory. The framework applied in phase 2 is based on feminist and intersectionality-based policy analysis theory, per Kanenberg et al.'s (2019) Feminist Intersectional Policy Analysis framework.

Phase 1 – Policy Document Analysis	Phase 2 – Feminist Intersectional Policy Analysis
Context	Context
• By whom and in what/whose interests (stakeholders?) • Underpinning values towards Indigenous people and women; Indigenous women? • Sociopolitical environment (regarding Indigenous people and women; Indigenous women) • Preceding policy documents of relevance	• Are women representing diversity along race/ethnicity, sexual identity, gender identity/expression, class, religion, national origin, documentation status, migration status, carceral status, ability/disability identities involved in making, shaping the policy? Public consulted? Specific organizations/committees?
Text	Text
• What are the key elements of the policy? What problem is it addressing? • Phrasing/use of language o re: Power structures o Mention of "Indian" at all; mention of Indian in a negative light? As "different"? o What values/sentiments underpin the language used? • What is inferred but not said? What is left out?	Intersectionality • Is there acknowledgement of multiple identities (race/ethnicity, sexual identity, gender identity/expression, class, religion, national origin, documentation status, migration status, carceral status, ability/disability) present in the language of the policy? • Does the policy consider the historical, legal, social, cultural and political contexts of women's lives and lived experiences both now and in the past? • Does the policy address the multiple identities of women? The multiple oppressions an individual woman may face? Gender/Patriarchy

	• Are women clearly visible in the policy? • Does the policy blame, stigmatize, regulate, or punish women? Or does it specifically blame, stigmatize, regulate or punish, marginalized groups of women such as poor, queer, trans, undocumented, incarcerated, and/or abused women of color? • Does the policy impact women's economic autonomy as a step toward equality? Does it pay special attention to the differences of women along their race/ethnicity, sexual identity, gender identity/expression, class, religion, national origin, documentation status, migration status, carceral status, and ability/disability identities? • Does the policy pit the needs of women against the needs of their fetus or child(ren)? Does the policy address the needs of certain women but not others? Are certain fetuses/children valorized while others are deemed punishable? • Is women's biology treated as normal rather than as an exception to a male-defined norm? Is womanhood not defined in biology? • Does the language infer white, cisgender, heterosexual, able-bodied male dominance or female invisibility? • Is the white, cisgender, heterosexual, able-bodied male experience used as a standard? Are results extrapolated from male experience and then applied to women? How are the specifics of a variety of women's experiences centered to inform the policy (i.e., how are the intersections of a woman's identity brought to light in the policy?)? Neutrality/Special Treatment • Does the policy treat people differently in order to treat them equally well?

Does the policy consider gender differences and resultant discrimination based upon race, ethnicity, sexual identity, gender identity/expression, class, religion, national origin, documentation status, migration status, carceral status, ability/disability in order to create more equality?

- Does the presumed gender / *racial* neutrality hide the reality of the gendered nature of the problem or solution?
- Does the special treatment of women and those who occupy different social locations (race, ethnicity, class, sexuality, etc.) cause unintended or restrictive consequences?
- Is there an implicit or explicit double standard regulating the lives of women who represent varied race, ethnicity, sexual identity, gender identity/expression, class, religion, national origin, documentation status, migration status, carceral status, ability/disability identities?

Essential Woman

- Does the policy make an “essential woman” visible (white, able-bodied, cisgender, and privileged) while leaving others in shadow? Coming out of theories of essentialism where ‘essence’ forms ideas around entire categories and becomes a way of making problematic blanket statements. Does it fail to consider the discrepancies faced by Indigenous women compared to an essential (white, privileged) women?

Problem Definition/Policy Silences

- Is the social construction of the problem recognized? What are alternate representations of the problem?

	• Where are the policy silences? What are the problems for women of color, women with disabilities, immigrant women, formerly incarcerated women, queer women, trans women, and more that are denied the status of problem by others? What policy is not being proposed, discussed, and implemented?
Consequences	Consequences
• Powerful people: who is interpreting the text/who is implementing it? • Accountability/checks and balances on power: o How is policy implementation intended to be monitored? o How and when is the policy to be reviewed? o How may the policy be amended? • How is the policy taken up and to what end?	• Are women representing diversity along race/ethnicity, sexual identity, gender identity/expression, class, religion, national origin, documentation status, migration status, carceral status, ability/disability identities involved in implementing the policy? Specific organizations/committees? • Is the policy merely symbolic or does it come with provisions for funding, enforcement, and evaluation? • Are special interest groups involved in overseeing the policy implementation? • How do those in power over the policy implementation get to their position (hired, government appointment, etc.)? Do those with power represent a diversity of perspectives and identities?

Appendix B: Policy Landscape Overview

The following section details the policy documents forming the policy framework analyzed in my research, including my rationale for their inclusion in this framework. This context is provided to supplement the reader's interpretation of my findings in Chapter 5, including how each document directly structures Indigenous women in Canada's access to abortion services today. Such context is a consolidation of findings from both my policy analysis, my background research, and my literature review.

Federal Landscape

Level 1: Foundational Documents

The 1867 British North America Act.

The BNA Act established the structure through which Indigenous peoples experience health care in Canada today, uniting Canada's provinces into one dominion and declaring Indigenous peoples and their lands to be within the control of the newly established government. It dismissed any territorial borders established by Indigenous peoples and imposed its own colonial system of provincial and territorial borders. It reframed the prior "nation-to-nation relationship" to one of paternalism and authoritarianism by the federal government, and subversion of Indigenous peoples. This new power structure set the stage for centuries of condescension, belittlement, and neglect; all of which continue to impact Indigenous women's experiences in the health care system and abortion access specifically. The act established Canada's federal system, vesting power over the "the establishment, maintenance, and management of hospitals" into the hands of the provincial governments. As a result, health care, including abortion service provision, is provided divergently across the country. The act did not attribute responsibility to either power for the health of Indigenous peoples specifically, which itself has resulted in an abdication of responsibility by both levels of government and resultant severe health inequities compared to the general population. The federal government has consistently throughout history upheld the position that they have no constitutional or legal obligation to provide health services to Indigenous peoples.

The 1876 Indian Act.

The 1876 Indian Act impacts Indigenous women in Canada's access to abortion service in Canada in multiple, interconnected ways. At its core, the purpose of the 1876 Indian Act was to assimilate Canada’s Indigenous population into British North American culture – this involved ceasing all cultural traditions specific to Indigenous populations, including traditional ways of healing. The act sought to remove rights originally guaranteed to Indigenous peoples in the Royal Proclamation through enfranchisement, which replaced one’s Indian rights or “status” with rights to property under the colonial administration. Sexist provisions were implemented with the aim of eradicating status for future generations of Indigenous peoples; women who married a non-Indian man or were abandoned by their husband were to lose their status, as were her children. In addition to this patrilineality-based criterion for status, the act implemented male-only band and council governance structures; all of which resulted in fewer rights for Indigenous women than their male counterparts. Women became subjugated within an already oppressed population group under the colonial administration. From these sexist, assimilation-based stipulations, women have been subject to centuries worth of marginalization, prejudice, mistreatment, violence, and neglect. Such factors equate to significantly lower social determinants of health for Indigenous women than Indigenous men and significant health inequities. Further still, such stipulations have resulted in entrenched norms of stereotyping and racist treatment towards Indigenous women. Finally, the introduction of patriarchal systems into Indigenous communities has resulted in systems of subjugation and violence towards women by male community members (Monchalin, 2021-a). Today, rates of female-specific domestic violence and rape are significantly high in Indigenous communities; this in the context of a specific lack of access to abortion service for this population group (Monchalin, 2021-a). Additionally, such colonial stipulations surrounding status have divided the population in terms of governmental accountability, resulting in significant discrepancies in care between status and non-status women and Indigenous women as a whole. Some Indigenous women access abortion services within health frameworks established by the provincial/territorial governments and others the federal government.

The Indian Act’s creation of the reserve system also has direct consequences for access to abortion service. This allocated plots of land to First Nations that were generally far from urban centres and on less valuable terrain from an agricultural and natural resources perspective. Where provincial governments have power over establishing health care facilities, and where there is no constitutional obligation for them to provide health services to Indigenous peoples, the majority of health services and facilities – including for abortion service – are generally offered near or in populous urban centres. Consequently, those living on reserve have to travel significant distances to access such services. Plots of land were also significantly smaller than traditional territories, resulting in cramped living conditions and a lack of privacy (as it relates to abortion service) (Wilson, 2018). Further, the Indian Act restricted Indigenous peoples from resource extraction on their reserves, hampering traditional Indigenous means of survival and economic activity (Wilson, 2018), along with traditional means of healing (including in relation to contraception and abortion), which were historically deeply tied to the land and its resources (Jubinville et al., 2022). Reserves have consequently historically been food and water-insecure, all of this contributing significantly to determinants of health (Wilson, 2018).

Lastly, an 1884 amendment to the Indian Act introduced the residential school system, through which the church and state took Indigenous children from their homes and indoctrinated them with European values in church-run education systems. This has resulted in significant generational trauma, contributing to lower social determinants of health. It has also resulted in a long legacy of stigma towards abortion service that preserves in Indigenous communities today, where such systems sought to prevent all forms of abortion and birth control through negative connotations and the framing of these as “devil’s work” (Monchalin & Paul, 2021-b).

Level 2: Transformational Documents

The 1979 Indian Health Policy.

The 1979 Indian Health Policy represented a significant shift in the framework for Indigenous health; it affirmed the federal government’s responsibility for the health of Indigenous people while also recognizing Indigenous peoples’ right to self-determination. It also clarified roles between federal and provincial/territorial powers. Through such commitments, the IHP set the precedent for numerous governmental health programs available to status Indigenous peoples today, including the NIHB. The policy clarifies that “registered Indians residing off-reserve” should receive health services from their province or municipality of residence, but if such services are denied, the federal government will attempt to ensure their provision (Government of Canada, 1979, p. 2). Regarding self-determination, the policy emphasizes “increased participation of Indian bands in health care delivery, where sought by chief and council” and provides for “close consultation at band, provincial and national levels on health programs, finances, and the allocation of resources” (Government of Canada, 1979, p. 3). This led to the 1988 Health Transfer Policy, where roughly 89 percent of all First Nations communities in Canada now provide health services to its residents through these arrangements (Lavoie, 2018). Status Indigenous women living on reserves today may access Mifegymiso through the NIHB or receive coverage for transportation to access abortion service through the policy framework. As well, the HTP enables First Nation communities to provide tailored health care services to its community members, including reproductive options. As above, the IHP set the foundation for health care service delivery for those with status only; this disadvantages any remaining Indigenous person not granted status, or those who have not elected to receive status through the ISC Registrar.

The 1982 Constitution Act.

The amended Constitution Act and its associated Charter of Rights and Freedoms came into force in 1982. It subsumed the BNA Act while upholding its constitutional division of powers, including provinces' jurisdiction over health services. In relation to Canada's Indigenous peoples, the act affirmed the existing Aboriginal and treaty rights of aboriginal peoples in Canada, defining Aboriginal peoples as inclusive of Indian, Inuit, and Metis peoples, and guaranteeing such rights equally to both sexes (Constitution Act, 1982). This was monumental in the federal government's recognition of the traditional nation-to-nation relationship and Indigenous peoples' right to self-determination. The Constitution Act's Charter of Rights and Freedoms set the foundation for the decriminalization of abortion in Canada through *R v. Morgentaler* by enshrining the right to "life, liberty, and security of the person" (Constitution Act, 1982, Part I). Related to Indigenous women's access to abortion services, the Charter constitutionalized the right to equality under the law without discrimination, including on the conditions of "race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability" while also declaring that Canadians have the right not to be "subjected to any cruel and unusual treatment or punishment" (Constitution Act, 1982, Part I). All of its rights and freedoms are guaranteed "equally to male and female persons". This set the foundation for the removal of sex-based provisions relating to status from Indian Act in 1985 version, entitling women and their descendants to status where it was previously lost.

The 1984 Canada Health Act.

The Canada Health Act prescribes criteria for provinces and territories to adhere to in their delivery of health services so as to ensure consistency in service delivery across the country. Amongst these criteria, it mandates that all "medically necessary" health services be universally provided and covered under provincial/territorial health plans, and that provinces must ensure all residents have “reasonable access” to these services. The act should in theory ensure that abortion services are provided universally and within reasonable access to all of Canada’s residents (including Indigenous peoples) given that abortion has been treated as a medically necessary service since 1988. This said, neither term is defined in the act, leaving its interpretation to provincial/territorial discretion. Further, the act’s broad terms have resulted in a significant decentralization of medical service regulation; leaving decisions over what is considered medically necessary in the hands of provincial/territorial medical institutions, including professional associations, hospital institutions, and practitioners themselves (Flood & Thomas, 2016). Such institutions can form their own regulations surrounding medical (and abortion) services provided that they are in accordance with the broad criteria of the act. In Manitoba for example, clinics and hospitals set their own gestation limits for surgical abortion service.

In aim of ensuring compliance, the act frames the above criteria as conditions for the receipt of federal transfer funding. According to the act, the federal government may withhold funding if it deems a province to be incompliant with these conditions. This said, this mechanism is contrary to the goal of the act in ensuring quality health care for all; the withholding of funds equates to a province’s diminished capacity to provide health services to its population, and thus, has infrequently been used by government, and if so, in small sums (Government of Canada, 2015). Where abortion is a politically controversial issue, these broad definitions and lack of adequate compliance and enforcement mechanism have resulted in a continued lack of adequate, equitable, and universal abortion service provision at the provincial/territorial level.

The 1985 Indian Act.

The Indian Act was amended in 1985 with the intent of removing sexist stipulations relating to enfranchisement. From this amendment, more than 114,000 people regained status and accordingly became eligible for the NIHB and other federal assistance (The Canadian Encyclopedia, 2020-a). This was significant as many Indigenous peoples who lost status have historically continued to reside on Indigenous reserves or in rural Indigenous communities while lacking the privileges associated with status, including use of the NIHB. Accordingly, this amendment improved access to federal health services, including abortion services, for many Indigenous women and their descendants.

The 1985 Indian Act is the most current version of the legislation and continues to structure the lives of Indigenous people today. The act has consequently been analyzed in addition to the original 1876 version.

Level 3: Operational Documents

The 1988 Health Transfer Policy.

The Health Transfer Policy followed on the 1979 Indian Health Policy, which affirmed (in the form of a policy statement as opposed to legislation) self-determination for Indigenous peoples in Canada. The HTP, through its handbook, established a framework to allow for the transfer of health care delivery from the federal government to Indigenous bands in three tiers. As a result, and as of 2018, roughly 89 percent of all First Nations communities in Canada provide health services to its residents through these arrangements (Lavoie, 2018). According to Health Canada (2004, p. 36), through such agreements,

> The community is fully responsible for administering health programs and services under the agreement – they employ or contract the service providers, deliver mandatory programs and services, plan and develop new programs, manage finances and are solely accountable to the community for how money is spent and how programs are run. They are responsible for making sure that mandated programs that protect public health and safety are run effectively, e.g., immunization and environmental health services. They are required to prepare annual financial and program reports. Communities conduct ongoing evaluation of how successful they are in managing their own health services to remain accountable to community members.

This in theory allows for care to be delivered by each organization to meet the specific needs of its population in a culturally appropriate way. While the program is positive in providing First Nations with self-determination to deliver health care to their populations in culturally appropriate ways, there are privacy implications for accessing abortion services on reserve. This is compounded by a legacy of abortion-specific stigma in Indigenous communities as remaining from church and state indoctrination. Further, many communities have voiced concerns with the program given its stringent reporting requirements which limit the capacity for meaningful service delivery by communities (Lavoie et al., 2005). This also upholds structures of management and control, contrary to its goal of self-determination (Greenblatt, 2009). Similarly, the language of the program handbook for communities, which is meant to structure all aspects of service delivery, maintains this language of control; it lacks a patient focus and includes no guidance related to ensuring health outcomes, including equitable access to service, such as abortion service. Finally, given the program's lack of a legislative basis, funding is not fixed and subject to fluctuation year-over-year (Lavoie et al., 2005). Communities consequently face challenges in adequately budgeting for health service provision (Lavoie et al., 2005).

The Non-Insured Health Benefits Program.

The Non-Insured Health Benefits Program was developed out of the 1979 Indian Health Policy, as outlined above. Its official Program Directives and associated terms and conditions (including for the provision of the benefits available under the program) were established in 1989. The program provides insured benefits to status Indigenous peoples living on reserves, and medical transportation coverage through its "Medical Transportation Policy Framework". In the province of Manitoba, for example, this should in theory provide financial capacity for a reserve-based Indigenous woman to travel from her reserve to the City of Winnipeg to access a surgical abortion. This said, the processes for accessing a drug through the NIHB, or approval for medical transportation, are administratively complex, creating barriers for those needing to access abortion service given the time pressures associated with the procedure (Kirlew, 2016; Office of Audit and Evaluation; 2017). Further, individuals are required to receive approval from a community health organization (if registered under the HTP), or the FNIHB if not, which can compromise their privacy and subject them to judgment and shame. The NIHB is available to status Indigenous peoples only, underserving those living on remote reserves without status. Lastly, like with the HTP, the program has no legislative basis and is similarly delivered as a matter of policy or benevolence, vesting all power into the hands of the federal government.

Provincial Landscape in Manitoba

The Regional Health Authorities Act (1996).

This act structured health care delivery in Manitoba between 1996 and 2021 and can be attributed to reported barriers in access during this time period. The act was amended in 2021, becoming the new Health Governance System Accountability Act. I have chosen to analyze both documents given that the implementation of the HGSA is too recent for its full impacts to be reported and accounted for. The Regional Health Authorities Act established a highly decentralized system of health care delivery with limited mechanisms in place to ensure consistency between regions. Regional health authorities (RHAs) were given full responsibility for the planning and delivery of health care to their populations in line with broad provincial directions; no central body was responsible for managing the coordination or oversight of these authorities. RHAs maintained responsibility over regional health plans and priorities, accompanying policies and programs, and the management and allocation of human and capital resources. The Minister of Health was provided responsibility in the allocation of funding between regions, and final approval over major expenses, such as the implementation of hospitals, and the purchasing of equipment (such as to conduct surgical abortions).

Health system reviews were conducted in and around 2015 pointing to a lack of coordination between regions regarding health care and patient information; a lack of central human resource planning to ensure adequate practitioner dispersion (such as in relation to pharmacists and surgeons providing abortion service); along with a lack of standards for the delivery of health care (Manitoba Health, n.d.-b; Shared Health, 2019). Additionally, given the lack of central authority and Winnipeg's population base, it was found that a number of provincial health programs and related resources were assigned to the Winnipeg Health Authority, treating it as a provincial health authority, but without adequate funding or resource capacity to facilitate as such (Manitoba Health, n.d.-b; Shared Health, 2019). As has been stated, there are a lack of abortion services outside of urban centres in Manitoba resulting in women having to travel long distances to access these services. Under the RHA Act, the region they travelled to would operate independently form their home region, resulting in a lack of health information and insufficient treatment.

The Health Governance System Accountability Act (2021).

Under the Health Governance System Accountability Act, a Provincial Health Authority was established to provide greater oversight and coordination amongst the RHAs. While the PHA is managed by a Board of Directors, it operates under the approval of the Minister. Accordingly, power over the provision of abortion services, and funding for such services, remains within the hands of the Minister who is accountable to the Premier and their political values and priorities. The PHA is responsible for developing human resource plans, meaning they maintain responsibility for ensuring regions have qualified health care professionals who can conduct surgical abortions and prescribe and dispense Mifegymiso. The PHA is responsible for setting guidelines for RHAs and establishing and overseeing health care facilities and professional practitioner associations, including those responsible for making decisions surrounding abortion.

The College of Pharmacists of Manitoba Code of Ethics (2014).

Despite the fact that Mifegymiso is insured by all provinces and territories, access is conditional to the receipt of a prescription written by a physician or nurse practitioner, and its dispersion by a registered pharmacist. While telemedicine services have broadened women’s capacity to access a prescription to the drug, there remains a lack of access to the drug in rural pharmacies either due to, (a) pharmacists’ refusal to dispense the drug, (b) a lack of training in its disbursement or (c) fear of harassment from pro-life community members (Froese, 2018; Von Stackelberg, 2019). Further still, Indigenous women face compounded barriers in accessing Mifegymiso given racist and sexist stereotypes framing Indigenous women as unfit mothers (Corbett, 2019). Additionally, those accessing Mifegymiso through the NIHB may be subject to prejudiced treatment by pharmacists given the perceived burden of dispensing through NIHB (Pharmacy Connection, 2020). The College of Pharmacists of Manitoba – the governing body for pharmacies and pharmacy professionals in the province of Manitoba – maintains a Code of Ethics citing several obligations for licensed pharmacists to abide by in their pharmacy practice. This includes ensuring that patients can access the medication they need, and that pharmacists dispense without discrimination and work with other authorities to ensure patients receive adequate care if they cite conscientious objection. While the code seeks to ensure fair and equitable treatment, its terms are vague and open for pharmacists to infer their own meaning. A complaints process is established by the College to enable citizens of Manitoba to hold pharmacists to account if they are out of compliance with this code. Pharmacists who do not comply with the Code of Ethics and obligations can have their license revoked or be suspended by the College. This said, given the reported barriers, it is clear that this process is not sufficiently holding pharmacists to compliance. There is no further oversight for pharmacists beyond this complaints process.

Appendix C: List of Identified Barriers Specific to Indigenous Women

The following list details the barriers Indigenous women in Canada face in accessing abortion services, as identified through my literature review and background research.

To begin, the literature pointed to the following barriers in access for women in Canada at large:

1. **Provincial/territorial discrepancies**: Provincial/territorial jurisdiction over abortion service provision resulting in varying policies based on the political ideology of the reigning government, and significant discrepancies in care between provinces;
2. A **limited supply of service providers** Canada-wide and their **urban-centric geographic distribution**;
3. A **scarcity of information** on service availability and options;
4. **Conscientious objection** by physicians and pharmacists; and
5. **Stigma and shame** from pro-life communities.

In addition to the above, Indigenous women are subject to the following additional barriers:

6. Enduring colonial policies and practices designed to assimilate and contain Indigenous populations, that:
    a.) **Disregard traditional Indigenous approaches to health**;
    b.) **Disregard the distinct needs and social locations** of Indigenous women;
    c.) Have and continue to engender **low social determinants of health**; and
    d.) Perpetrate **structural Indigenous-specific racism**
7. A convoluted and overcomplicated patchwork of governance pertaining to Indigenous Peoples' health and wellbeing causing **complexity for Indigenous people in navigating the system**, and in association, a **lack of accountability for Indigenous health and wellbeing** resulting in **systemic neglect** and inequities in access to care
8. Challenges in navigating **administratively complex management and control-based federal-level health programs**, combined with the time-bound nature of abortion
9. Widespread Indigenous-specific **interpersonal racism and bias amongst health care workers**, manifesting in mistreatment, abuse, and neglect

10. A **history of systemic violence and subjugation towards Indigenous women**, and a specific **history of controlled fertility** resulting in a well-founded **fear and mistrust of mainstream reproductive health care**
11. **Prevailing stigma amongst Indigenous communities** surrounding abortion, instigated by colonizers' indoctrination of Eurocentric beliefs and religious values
12. **A lack of privacy** (from other community members) in the context of on-reserve care

Appendix D: Feminist Intersectional Policy Analysis Framework Principles Defined (Kanenberg et al., 2019)

Below, I explain the significance of each of the sections forming Kanenberg et al.'s revised version of McPhail's Feminist Policy Analysis framework. This includes definitions originally determined by McPhail along with alterations and updates made by Kanenberg et al. These detail the theory underpinning each section of the framework, translating in turn to guiding principles for the researcher in applying the framework to policy analysis.

1. "Multiple Identities/Intersectional Identities": In her 2003 framework, McPhail cites intersectionality as a key dimension of the framework, citing the theory of intersectionality as crucial to a feminist policy analysis. Kanenberg et al. bring this to the forefront, making it central to every aspect of the analysis. Kanenberg et al. (2019) write that "understanding the many ways inequality is perpetuated through policy is at the heart of any policy analysis informed by intersectional theory" (p. 12). The authors note the importance of examining the social locations of those impacted by the policy, and "the ways in which the policy might advance or perpetuate systems of equality" (p. 12).
2. "Equality" refers to the idea that being treated equally does not equate to being treated differently in order to be treated equally (McPhail, 2003).
3. Related to the principle of "Equality", "Special Treatment/Protection" asks, if the individuals/groups are treated differently, what is the unintended or intended result of that treatment (McPhail, 2003).
4. "Context" refers to the researcher's consideration of the full suite of economic, political and social realities impacting the subject of the policy, as well as how the policy of study interconnects with other policies (McPhail, 2003).
5. "Language" refers to the language of the policy, including whether gender neutral language is used, and if so, whether its use obscures the gendered nature of the policy (McPhail, 2003).
6. "Care and Rights/Responsibility" refers to factoring in inequalities faced by women as a result of gender norms; for example, factoring in specific societal burdens to women, including norms associated with caretaking, impacts of colonialism, and unequal pay in the labour force (McPhail, 2003).

7. “Symbolic vs. Material” refers to whether the policy has sufficient enforcement and policy outputs (McPhail, 2003).
8. “Role Change and Role Equity” refers to whether policies are producing role equity or role change, where role equity equalizes opportunity to women by extending rights to women previously enjoyed by men, whereas, role change refers to creating new opportunities for women based on their social locations and assisting them to move (McPhail, 2003).
9. “Power Analysis” refers to analyzing shifts in power and their impacts, including who had the power to define the problem, propose the solution, and take action (McPhail, 2003).

Kanenberg et al. (2019) maintain the “fundamental feminist lens” used in McPhail’s original framework and the themes identified as key elements, as listed above. In addition to weaving intersectionality throughout the framework, they bring the inequitable treatment of women and men into focus. They emphasize gender equity over gender equality, the influence of patriarchy on women’s societal experiences, and the burdens that result (Kanenberg et al., 2019). Additionally, their revision of the framework acknowledges more current thinking on oppression, including that institutional systems and structures create systems of oppression and prevent individuals from moving out of their circumstances to access power or privilege (Kanenberg et al., 2019). They write of the importance of factoring in such institutional factors when conducting a policy analysis, including the forces that render women immobile (Kanenberg et al., 2019).

Appendix E: Federal UNDRIP Commitments

The following section provides additional context to the status of UNDRIP's uptake in Canada, including the current state of federal efforts to co-develop "distinctions-based" health legislation. The process and resulting legislation represent a significant shift in the federal-Indigenous health care relationship, with consequent implications for improvements in abortion access in Canada.

Co-developing Distinctions-based Health Legislation

In January 2021, in partnership with Indigenous physicians, nurses, midwives and other health professionals, the Government of Canada announced a commitment to co-developing "distinctions-based health legislation", "informed by the spirit and elements of Joyce's Principle"[52] (Indigenous Services Canada, 2021, para. 5). The purpose of such legislation is to foster health systems that will "respect and ensure the safety and well-being of Indigenous Peoples", and "address the social determinants of health and advance self-determination in alignment with UNDRIP" (Indigenous Services Canada, 2021, para. 5). The government committed $126.7 million over three years, a portion of which is dedicated to providing capacity to Indigenous partners to participate in regional roundtables and address anti-Indigenous racism in Canada's health systems (Indigenous Services Canada, 2021). Funding will also support the evaluation and improvement of ISC's "programs and practices to ensure more culturally responsive and safe services" (Indigenous Services Canada, 2021, para. 8). ISC (2021) writes that this investment aligns with the government's response to the National Inquiry into Missing and Murdered Indigenous Women and Girls Calls for Justice, "in recognition of the fact that Indigenous women and other marginalized groups, such as 2SLGBTQQIA+ people, are disproportionately impacted by anti-Indigenous racism in Canada's health systems" (para. 7). According to ISC (2023, para. 6), co-development is designed to occur in two stages, the first including engagement with Indigenous organizations and peoples, provinces and territories, and subject matter experts to "determine the co-development pathway"; followed by the second stage

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[52] "Joyce's Principle" is a call to action in the spirit and legacy of Joyce Echaquan for government to eradicate prejudiced treatment towards Indigenous peoples in Canada's health care system in line with the principles of UNDRIP, found here: https://principedejoyce.com/sn_uploads/principe/Joyce_s_Principle_brief___Eng.pdf

which consist of the “co-development of legislative options”. Specifically, it entails working with Indigenous partners to:

- “co-develop an approach to engagement;
- co-develop options for potential federal legislation; and
- ensure that the distinct cultures, needs and aspirations of First Nations, Inuit and Métis are understood and reflected in any potential legislation”

and working with provinces and territories to, “make sure potential federal legislation:

- is informed by provincial and territorial perspectives;
- is complementary to existing provincial and territorial health systems, self-government or tripartite models; and
- does not infringe on provincial jurisdiction or the territorial role in health”. (Indigenous Services Canada, 2013, para. 7)

The United Nations Declaration on the Rights of Indigenous Peoples Act

In June 2021, the Parliament of Canada passed the United Nations Declaration on the Rights of Indigenous Peoples (“UNDRIP”) Act. According to AFN (n.d.), this outlines Canada’s obligation to uphold the human rights of Indigenous peoples affirmed in UNDRIP, and to work with Indigenous peoples to “review and reform the laws of Canada” (AFN, n.d., para. 7). The act seeks to ensure federal laws reflect UNDRIP’s standards (Duncanson et al., 2021) and declares that the UN declaration can be used to interpret Canadian laws (AFN, n.d.).

In December 2021, funding was announced to support Indigenous-led consultations on the development of a National Action Plan for implementing the act (AFN, n.d.). The Action Plan is aimed for completion by December 2023.

Regarding Indigenous health, UNDRIP asserts the following:

- "Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals” (Government of BC, n.d.).
- “Indigenous individuals also have the right to access, without any discrimination, to all social and health services” (Government of BC, n.d.).

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