“They couldn’t talk to anybody because there’s so much stigma”:

A qualitative study exploring Indigenous Peoples’ experience of abortion-related stigma in Canada

by Arie Ross

B.A., University of British Columbia, 2013

A thesis submitted in partial fulfillment of the requirements for the degree of

MASTER OF PUBLIC HEALTH

in the School of Public Health and Social Policy

University of Victoria

We acknowledge and respect the lək̓ʷəŋən peoples on whose traditional territory the university stands and the Songhees, Esquimalt and W̱SÁNEĆ peoples whose historical relationships with the land continue to this day.

Supervisory Committee

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Abstract

Although there are no laws restricting abortion access in Canada, stigmatizing views of abortion still exist. Abortion-related stigma contributes to feelings of isolation and shame among those who have abortions, often leading to secrecy and hesitancy to seek support. However, experiences of abortion-related stigma among Indigenous Peoples in Canada have not been explored. This thesis research was nested within the exploratory study *Global Goal, Local Impact: Access to Abortion Services for Indigenous Peoples in Canada* (GGLI). Interview data were collected using a conversational method and analyzed following the DEPICT model. An intersectional feminist approach woven with a Two-Eyed Seeing methodology guided this work. Abortion-related stigma was experienced by all participants (N=15) and included internalized, service provider, social, and community stigma. Commonly, multiple aspects of stigma were experienced, revealing the interwoven and layered nature of abortion-related stigma. Abortion-related stigma was heightened further in the presence of intersecting identity factors, geographic barriers, lack of support, stereotypes, and perceived lack of credible information. Service provider stigma was most prevalent and manifested as poor communication, coercion, poor treatment, and potentially health care avoidance. Family and community, particularly those influenced by faith-based values and beliefs, impacted the experience of stigma and influenced feelings of shame, abortion access decisions, and contributed to a perceived lack of choice among some participants. Participants embodied resilience in the face of systemic barriers and proposed multiple solutions to reduce abortion-related stigma, including sharing stories as a means of resilience, reclamation, and support.

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A note on gendered language: It is important to note that abortion is not exclusively a gendered health service. Though most of the literature on abortion is explicitly gendered, not all who have abortions identify as female, as abortion impacts Two-Spirit, trans, non-binary, and other gender-diverse individuals (Moseson et al., 2021). Any gendered language in this thesis is because of direct quotes from the existing literature. However, we must move beyond the gender binary in discussions of abortion and sexual and reproductive health and rights overall. This may help to improve health outcomes and to realize reproductive justice.

Dedication

I would like to thank the participants of the GGLI project for sharing your stories. In the process, you demonstrated great strength and resilience, and will help to support others who may be grappling with their abortion decisions.

I especially would like to thank Dr. Renée Monchalin for guiding, encouraging, and supporting me throughout every aspect of this thesis. So many amazing opportunities to grow and develop my skills were made possible because of you. I am so honoured and grateful to have had this opportunity to contribute to this ground-breaking project and to learn from such an amazing person. As well, to Dr. Astrid Perez Piñan, Madison Wells, and Willow Paul who warmly welcomed me onto the research team, and the Indigenous Advisory Committee who supported my participation in this work. I would also like to thank Dr. Natalie Frandsen for supporting me with your compassion and empathy through a very trying time and for stepping in so fully when Renée went on maternity leave. I am in awe of your amazing eye for detail which helped me to enhance the clarity of my work. I am very grateful for our chats and check ins, and your valuable feedback throughout this process. I have truly learned so much from each of these amazing women and am so grateful to have worked with each of them.

I also want to express gratitude to my little family, Kieran and Eclipse, who have supported me and stuck by my side throughout writing this thesis and in life in general. I truly could not have done this without all the support you gave me. Kieran, from making food for me when you knew I would not stop working to eat, to bringing me tea (both the bubble and non-bubble varieties) and making me laugh when I could not stop crying from stress. To Eclipse, thank you for interrupting my meetings and writing with your barks to remind me that life exists outside of research and that it was about time to take a walk, and all the cuddles you provided throughout this process. I would like to express my gratitude to my parents, Bruce and Brenda, who supported me throughout my degree and particularly during my thesis development (and fed me during my frequent writer's retreats at their house). Thank you also to my grandma Gloria who supported my graduate work and made sure I knew that when I finished, it would be time to get a proper job.

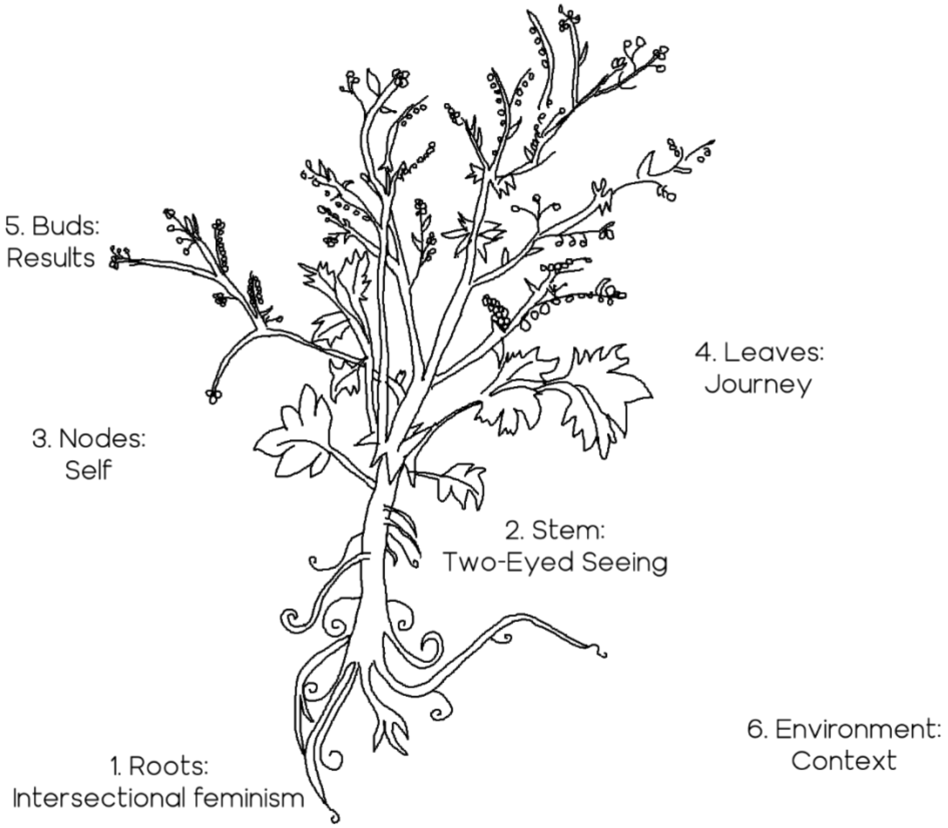
I also wish to thank Christina and the amazing acupunks at Heart & Hands Health Collective, who grounded me back in my body at least once a week (but if I'm being honest, more like 2-4x a week) with acupuncture throughout writing this thesis.

I would also like to thank the BC Support Unit for supporting me during the research aspect of my thesis through the Graduate Fellowship and the University of Victoria School of Public Health and Social Policy for honouring me with the James and Phillippa Kerr scholarship to support my completion of this thesis.

Self-location and positionality

Wormwood Diagram

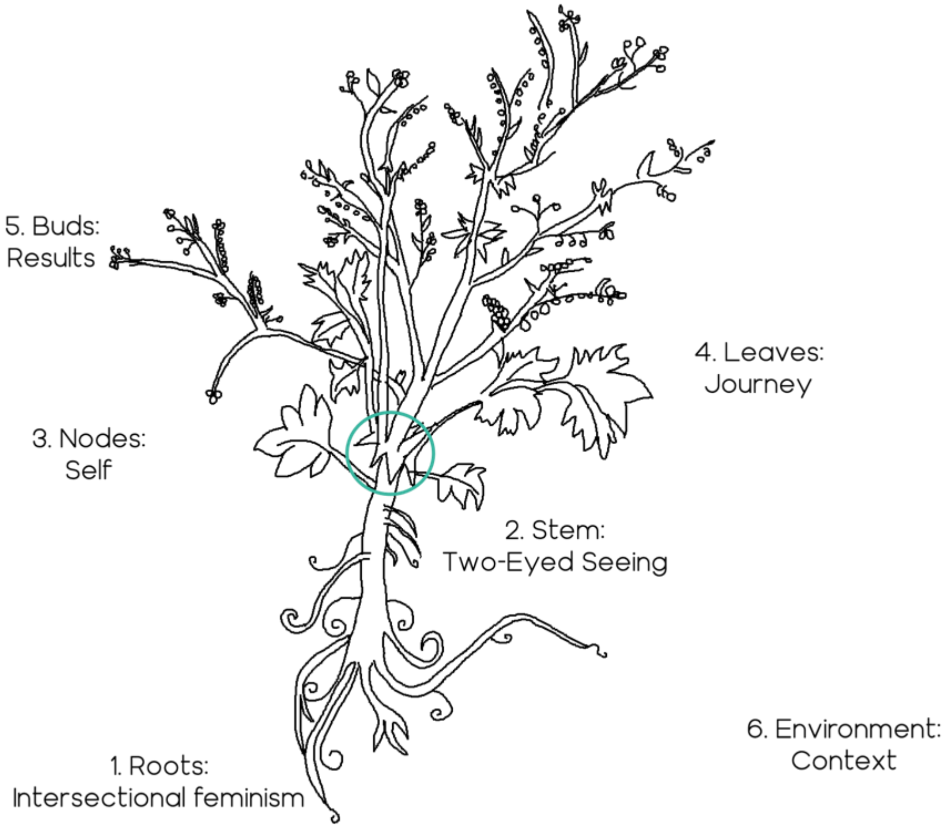
Figure 1
Wormwood diagram representing the elements of my thesis research.



As part of my thesis journey, I created a diagram demonstrating the interplay of my methodology, approach, methods, and results about the types of abortion-related stigma. This was inspired by Kathy Absolon's (2011) petal flower diagram. I wanted to incorporate aspects of my identity and to follow the knowledge gardening (Hall et al., 2015) analogy described in my methods section, which led me to research the herbal medicines of Eastern European Jews. Wormwood leaves and flowers were taken in a tincture and drunk to induce abortion by Eastern European Jews in the 19th Century (Cohen & Siegel, 2021). Wormwood is also considered a protective herb by contemporary witches. Throughout my thesis, the sections of the plant will be highlighted to demonstrate which aspect is being discussed.

The elements of my wormwood diagram include: (1) the roots, representing intersectional feminism which grounds this work; (2) the stem, representing the Two-Eyed Seeing methodology which supports and connects all parts of the whole; (3) the nodes, representing my social location which informs this work; (4) the leaves, representing the journey, including my personal journey and the application of the DEPICT method; (5) the buds, representing the results of my research about internalized, service provider, social, and community stigma; and (6) the environment in which the research takes place.

Figure 2
The nodes: my self-location and social identity as central to my research.



Locating ourselves in research is integral to qualitative research, as well as intersectional feminist and Two-Eyed Seeing practices specifically. Métis scholar Natalie Clark (2016) reminds us that Indigenous research paradigms require us to "*situate ourselves in our writing, to start from our intentions, to answer the questions: Who are you and why do you care?*" (p. 148; see also Kovach, 2009; McGregor et al. 2018; Snooks et al., 2021; Wilson 2008).

In the spirit of my intersectional feminist approach and Two-Eyed Seeing methodology, I must self-locate. I am a fourth-generation settler of mixed Central and Eastern European Jewish descent on my father's side, and Central, Western, and

Northern European descent on my mother’s side. I hold unearned privilege and power due to my identities as a cisgender, heterosexual, white woman with an invisible disability. I have experienced sexual violence and was able to access resources relatively easily due to my privilege, but I know this is not the case for many. This experience ignited my passion to work on reproductive justice issues, ultimately leading me to the Global Goal, Local Impact: Access to abortion services for Indigenous women and Two-Spirit people in Canada (GGLI) project.

Intersectional feminism requires us to identify and consider the intersecting lived experiences that shape our identities and realities. Self-sufficiency in Jewish and Mennonite communities was necessary due to historic oppression of these cultures. There is a history of forced sterilization among Jewish people at the hands of Nazi scientists surrounding the Holocaust. My lineage has endured genocide and assaults to our reproductive rights. Though experiences are unique and not interchangeable, Jewish and Indigenous Peoples have historically endured systematic attacks on our very existence, and there is now an urgency to reproduce to rebuild our populations. Kim Anderson states “*it’s simple: when a people are under siege, it becomes imperative to reproduce*” (Anderson, 2003, p. 175). Though I personally have chosen not to reproduce, I will fight for the reproductive autonomy of everyone, whatever that looks like.

Rabbi Lori Koffman notes that in Judaism, protecting the life of the pregnant parent is paramount and a fetus does not have independent rights (Koffman, n.d.). This means abortion is not only permitted but may be required if pregnancy threatens the wellbeing of the parent (Koffman, n.d.). This is in contrast with prevalent anti-abortion sentiments of other mainstream religions (Action Canada for Sexual Health and Rights, 2019; Koffman, n.d.). I am called to this work to help realize equitable access to reproductive health services in Canada and to build a just future that honours our experiences, traditional knowledges, and respects self-determination.

I bring this cultural context to my work while partnering with the Indigenous-led research team and the Indigenous Advisory Committee (IAC), which embodies a Two-Eyed Seeing approach to research, seeing with the strengths of Western knowledges with one eye, and Indigenous knowledges with the other. We each bring our own cultural assumptions and backgrounds to the work, bridging Western with traditional knowledges and meeting in the middle to receive the wisdom of both worldviews to benefit community.

I seek to approach my work as a humble and helpful ally. I am a scholar, advocate, witch, partner, and dog mother. I come to know through my community organizing experience, work, and education experience in environmental advocacy, philosophy, and public health. My journey towards intentional allyship with Indigenous communities began in organizing against the Enbridge Northern Gateway Pipeline, Kinder Morgan pipeline, as well as the proposed Fraser Surrey Docks and Cherry Point coal terminals. My allyship continues now through my thesis work and two research assistant positions working with Indigenous professors exploring: (1) decolonizing nursing practice and addressing anti-Indigenous racism in nursing education; and (2) expanding knowledge and sharing stories around abortion access experiences for

Indigenous Peoples in Canada.

My academic training has centred around social policy, Indigenous health, intersectional feminism, and environmental and health advocacy. I have turned my attention to helping to rectify the gross health inequities experienced by Indigenous Peoples within Canadian health systems. The goal of my research is to contribute to literature that will help to advance knowledge of experiences of abortion-related stigma among Indigenous Peoples. My hope is this knowledge contributes to policy change to reduce barriers and improve access to abortion services for Indigenous Peoples in Canada. I aim to approach this work with humility, always centring the priorities and voices of Indigenous Peoples with lived experience.

Chapter 1: Introduction

Abortion is a safe and common medical procedure which terminates pregnancy. There are two types of abortion accessible in Canada. Medication abortion involves taking two medications, Mifepristone and Misoprostol, and is approved for use up to nine weeks' gestation (BC Women's Hospital and Health Centre, n.d.). These medications were approved for use by Health Canada in 2015 and became available to the Canadian public in 2017 (Action Canada for Sexual Health and Rights (Action Canada), 2019a). Aspiration or therapeutic abortions are performed by doctors in clinics or hospital and vary in their availability and accessibility across Canada. Aspiration abortions are available from between 12 weeks to 24 weeks and 6 days in Canada. This depends on which province/territory the abortion is accessed in (National Abortion Federation Canada, 2023). Several studies show that abortion-related stigma is common among many abortion seekers (Astbury-Ward et al., 2012; Belfrage et al., 2020; Cockrill et al., 2013; Hanschmidt et al., 2016; Shellenberg & Tsui, 2012; Sorhaindo & Lavelanet, 2022).

Stigma has been shown to create and exacerbate barriers to accessing health services (Major et al., 2018). Stigma is a public health issue because it creates barriers to health-seeking and engaging with health services, and adhering to treatment plans (Corrigan, 2004; Mahajan et al., 2008; Stangl et al., 2019). Stigma may also negatively influence stress, emotional and physical wellbeing, and the availability of resources

(Stangl et al., 2019). This may exacerbate poor health outcomes for individuals with a stigmatized condition or experience (Stangl et al., 2019).

The effects of abortion-related stigma on Indigenous Peoples[1] in Canada has not been sufficiently examined. This is worrisome, as Indigenous women and Two-Spirit peoples experience severe disparities in health determinants and outcomes (Allan & Smylie, 2015; Monchalin et al., 2020; Native Women Association of Canada (NWAC), 2020; Reading & Wien, 2009). Abortion-related stigma may increase disparities in health outcomes among Indigenous women, Two-Spirit, non-binary, and other gender diverse people.

Indigenous women and Two-Spirit people in Canada experience sexual violence at a rate three times higher than non-Indigenous women (Cohen, 2020; Monchalin, 2021; National Inquiry into Missing and Murdered Indigenous Women and Girls (NIMMIWG), 2019; NWAC, 2020). Higher rates of sexual violence and documented health service access barriers may contribute to a potentially greater need for abortion access among Indigenous Peoples in Canada (Cohen, 2020; Monchalin, 2021; NIMMIWG, 2019; Rumack, 2020; Shaw, 2013; Smith, 2010).

Research is required to gain an understanding of how abortion-related stigma is experienced by Indigenous Peoples in Canada to help reduce health disparities. Nested

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[1] Indigenous cultures in Canada are unique and diverse. In this thesis, Indigenous Peoples includes First Nations, Inuit, and Metis Peoples. It is not the intention of this work to imply homogeneity among Indigenous cultures in Canada. As no research has specifically examined abortion experiences among any Indigenous nations in Canada, this broad application is meant to begin to acknowledge and address the health inequities and inequitable access to health care that Indigenous Peoples generally experience in Canada. I hope this work can provide a starting place from which further research that honours nuances in individual people, nations, and cultures can expand.

in a Canada-wide exploratory study titled *Global Goal, Local Impact: Access to Abortion Services for Indigenous Peoples in Canada* (GGLI), this research explores how, and in what ways, abortion-related stigma is experienced among Indigenous women and Two-Spirit people in Canada.

Research question

How, and in what ways, is abortion-related stigma experienced among Indigenous women and Two-Spirit peoples in Canada?

Research objectives

1. Examine the literature to determine what is known about the experience of abortion-related stigma among Indigenous Peoples in Canada.
2. Conduct a thematic analysis of GGLI results to better understand abortion-related stigma among Indigenous Peoples in Canada.
3. Develop knowledge translation materials that will reach both academic and community audiences. These will aim to advance knowledge around abortion-related stigma and contribute to efforts towards destigmatizing abortion.

Chapter 2: Literature Review

The literature review was conducted using the University of Victoria library and EBSCOhost database. I began with searching “abortion-related stigma Canada” and then “abortion-related stigma Indigenous Canada”. I broadened my search criteria geographically when I felt I needed to gain a clearer understanding of abortion-related stigma and the literature in Canada was inadequate. Literature published from January 1, 2016, to January 1, 2022, were included, as were works cited in the relevant abortion-related stigma literature that predate 2016. I chose this period given the rate of change in health research, where the best practice is to use sources published within the past five years. Further, after receiving requested revisions from my supervisors (Dr. Renée Monchalin and Dr. Natalie Frandsen) additional peer-reviewed articles were added to improve clarity.

This literature review will explore the following topics: (1) History of access to abortions in Canada; (2) Abortion-related stigma; (3) Religion and abortion-related stigma; and (4) Indigenous perspectives on abortion. The abortion-related stigma literature cited throughout this section does not examine abortion-related stigma as experienced by Indigenous Peoples in Canada specifically, as this is a gap in the literature.

History of access to abortions in Canada

Abortion was illegal in Canada prior to 1969 (Shaw & Norman, 2020). Canada decriminalized abortion in certain circumstances by amending the criminal code in 1969 (Ackerman & Stettner, 2019; Kirby, 2017; Sethna & Doull, 2013; Shaw & Norman, 2020). Providing abortion was only allowed if: (1) the pregnant person's life was threatened by the pregnancy; (2) the abortion was performed by a physician in hospital; and (3) the abortion was approved by a therapeutic abortion committee (Kirby, 2017; Shaw & Norman, 2020). These requirements kept safe abortions inaccessible for many people, particularly for marginalized communities (Kirby, 2017; Shaw & Norman, 2020). In response, a caravan of protestors stormed Canadian parliament in 1970 and chained themselves inside, calling for decriminalization and safe abortion access (Shaw & Norman, 2020).

The Supreme Court of Canada struck down the restrictive abortion law through the historic Morgentaler decision in 1988 (Kirby, 2017; Shaw & Norman, 2020). The Morgentaler decision made abortions induced by a medical doctor safer, and more accessible and affordable for some (Kirby, 2017). Henry Morgentaler, Holocaust survivor, physician, and abortion rights advocate, states that just because something is the law, does not make it right (Musée de l'Holocauste Montréal, 2019):

> *The fact that I am a survivor of the Holocaust played a tremendous part in my decision to break the [anti-abortion] law … because while I was in a concentration camp, I was there lawfully … laws should be rational, in the interest of people. A law which is unfair and cruel like the abortion law, which condemns women to die*

> *horrible deaths and to seek illegal abortion and to abort themselves, is not a law which I can respect* (Musée de l'Holocauste Montréal, 2019, 0:05).

Canada is now one of only four countries globally to have no restriction against abortion in law (Ackerman & Stettner, 2019; Kirby, 2017; Monchalin, 2021; Myran & Bardsley, 2018; Shaw & Norman, 2020). Unfortunately, legal abortion does not mean safe and accessible abortion for all (Monchalin, 2021; Monchalin et al., 2023a, 2023b). Lack of knowledge about abortions and how to access them, and geographic and financial barriers block safe access to abortion services for many (Kirby, 2017; Monchalin, 2021; Monchalin et al., 2023a, 2023b; Myran & Bardsley, 2018; Shaw & Norman, 2020).

Access to abortion services varies by community. Aspiration abortion services in Canada are generally only accessible in major cities, exacerbating existing barriers to accessing this essential health service for many communities (Mehta, 2019; Shaw, 2013). Remote, rural, and northern communities experience greater barriers to accessing health services including abortion services, because of factors such as distance, cost, and time associated with traveling to urban centres (Mehta, 2019; Shaw, 2013). Individuals in these communities may also have less access to contraception, which may increase the need to access abortion care (Monchalin, 2021; Shaw, 2013; Smith, 2010). Five provinces and territories in Canada have no rural access to aspiration abortion services (Action Canada for Sexual Health and Rights, n.d.). In Prince Edward Island, the Yukon, and the Northwest Territories, there is one provider of aspiration abortions for each jurisdiction (Action Canada for Sexual Health and Rights, n.d.; Loreto, 2020). Abortion access is restricted after 12 weeks and six days' gestation in Prince Edward Island (Government of Prince Edward Island, 2021), and after 15 to 16 weeks' gestation in Newfoundland and Labrador (Planned Parenthood, 2020), the Yukon (Opal Clinic, 2022), Nova Scotia (Halifax Sexual Health Centre, n.d.), and New Brunswick (Horizon Health Network, 2022).

There are several benefits to having locally accessible care, such as avoiding travel and costs associated with leaving home communities to access care. However, accessing care in local communities where abortion seekers may know the service providers may result in a loss of anonymity for abortion seekers. This loss of anonymity may pose privacy, confidentiality, and safety risks. For example, there may be a risk of intimate partner violence if the abortion seeker had not disclosed their pregnancy/abortion to their partner. This may prompt someone to consider an unsafe abortion rather than be seen to have an abortion by their community (Cohen, 2020; Sethna & Doull, 2013; Shaw & Norman, 2020; Smith, 2010).

The COVID-19 pandemic brought some improvements to accessing medication abortion with less in-person testing (i.e., ultrasound) required and more remote service delivery (Vogel & Basky, 2022), although there were significant shortages of medication abortion medications (BC Women's Hospital and Health Centre, n.d.; Gilmore, 2020; Monchalin, 2021). These improvements may help reduce abortion access barriers for remote, northern, and rural people, though access to aspiration abortion is still a barrier (Violet & Spillet, 2017).

Some groups, including Indigenous Peoples, face increased challenges to accessing abortion. Importantly, barriers to accessing health services are disproportionately experienced by racialized communities with intersecting identities such as Indigenous women and Two-Spirit peoples, who also experience severe disparities in social determinants of health and outcomes (Allan & Smylie, 2015; Monchalin, 2021; Reading & Wien, 2009; Shaw, 2013). For example, Indigenous Peoples experience disparities including homelessness, unemployment, and violence at a rate higher than non-Indigenous Peoples in Canada (Allan & Smylie, 2015; Monchalin, 2021; Reading & Wien, 2009). These factors may overlap and intersect to increase barriers and experiences of oppression for Indigenous communities (Anderson, 2003, 2011; Burnett, 2018; Redvers, 2019).

Abortion-related stigma

Abortion-related stigma has been defined in several ways in the literature (Cockrill et al., 2013; Hanschmidt et al., 2016; Ipas, 2018; Kumar et al., 2009; Millar, 2020). Most of these definitions are based on Goffman's (1963) definition of stigma as the devaluing of a person with a stigmatized attribute which marks that person as being somehow spoiled or tainted.

Abortion may be seen as socially deviant, going against traditional gender roles and social norms (Belfrage et al., 2020; Erdman, 2016; Kumar et al., 2009). Joanna Erdman (2016) writes:

> *Abortion, the decision and act to terminate a pregnancy, has long been linked to undesirable moral qualities in the individual—sins of lust and gluttony, the sins of desire. … A woman who wishes to or does terminate a pregnancy challenges gender and moral codes, and so unsettles, if not threatens, communal norms. She is, for this reason, a 'public enemy.' The criminalization of abortion in the nineteenth century traded on this idea, reflecting general anxieties of modernity and its effects on the moral fabric of society* (para. 5).

This quote demonstrates the ways in which abortion and those who have and provide them have become demonized which contributes to abortion-related stigma.

Abortion-related stigma may be seen as a social process which devalues and discriminates against people associated with abortion, including seekers and providers (Belfrage et al., 2020; Cockrill et al., 2013; Erdman, 2016; Ipas, 2018; Kumar et al., 2009). Millar (2020) writes that abortion-related stigma should be framed as a social process to avoid an individualistic understanding of stigma.

Conceptualizing abortion-related stigma as an individual trait may serve to ignore structural inequities in reproductive health choices and outcomes (Millar, 2020). Link and Phelan (2001) also conceptualize stigma as a social process in which people are marked as others with negative attributes and discriminated against. Conceptualizing abortion-related stigma as a social construct is a useful framing. This is because of the ongoing impacts of colonialism perpetuated through structural inequities and institutional racism against Indigenous Peoples in the health setting (Allan & Smylie, 2015; Monchalin, 2021; Reading & Wien, 2009). The structural and social underpinnings that perpetuate stigma must be addressed and rectified, rather than placing the burden of dismantling abortion-related stigma on individuals (Millar, 2020).

Abortion-related stigma has been tied to factors of difference through which power relations are reproduced (Millar, 2020). The impacts of stigma are often driven by the distribution of power (LeTourneau, 2016; Ross, 2017; Stangl et al., 2019). Literature on sexuality, race, and gender -based discrimination suggests that the marginalization of people discriminated against in general society is associated with adverse health outcomes (Allan & Smylie, 2015; LeTourneau, 2016; Monchalin et al., 2020; Reading & Wien, 2009; Shaw, 2013; Wylie & McConkey, 2019). This is concerning, as Indigenous Peoples in Canada experience marginalization in several aspects of life and already face disproportionately poor health outcomes (Allan & Smylie, 2015; Monchalin, 2021; Monchalin et al., 2020; Reading & Wien, 2009). This may mean that multiple identity factors may create further barriers to accessing abortion care for Indigenous Peoples, leading to worse health outcomes.

Scholars have categorized abortion-related stigma in several ways. Cockrill and colleagues (2013) categorize abortion-related stigma as internalized (negative feelings and self-judgment around abortion); perceived (fears or expectations of being stigmatized); and experienced stigmas (such as service provider stigma and stereotypes) (Cockrill et al., 2013; see also Belfrage et al., 2020; Cockrill & Nack, 2013, Hanschmidt et al., 2016; Kumar et al., 2009; Makleff et al., 2019). Ipas (2018) categorizes abortion-related stigma as internalized, anticipated, perceived, social, service provider, stereotyping, and experienced stigmas.

Experiences of abortion-related stigma may include anticipated judgment and discrimination by friends, family, community, and society influenced by negative beliefs around abortion (Belfrage et al., 2020; Cockrill et al., 2013; Cockrill & Nack, 2013; Hanschmidt et al., 2016; Ipas, 2018; Shellenberg & Tsui, 2012). Shellenberg and Tsui (2012) explored the prevalence of stigma among abortion patients in the United States (U.S.) and found that 66% expected to be looked down on by at least some people due to their abortion, indicating internalized stigma. Several studies found that people experienced negative emotions around their abortion, such as guilt and shame, emotions which are commonly associated with internalized stigma (Cockrill et al., 2013; Cockrill & Nack, 2013; LaRoche & Foster, 2018; Shellenberg & Tsui, 2012; Smith et al., 2016). These feelings were often rooted within perceptions of how other people might view abortion (Hanschmidt et al., 2016; Shellenberg & Tsui, 2012). For example, Shellenberg and Tsui (2012) explored internalized stigma and found that 58% of women in their study felt they needed to keep their abortion secret due to stigma and anticipated judgment.

Studies show that many who access abortion experience stigma and that internalized stigma is common among those who seek abortion (Astbury-Ward et al., 2012; Belfrage et al., 2020; Cockrill & Nack, 2013; Cockrill et al., 2013; Hanschmidt et al., 2016; Shellenberg & Tsui, 2012; Sorhaindo et al., 2014). The systematic review by Hanschmidt and colleagues (2016) revealed feelings of guilt, shame, and self-blame in experiences of abortion-related stigma. For example, scores on the Individual Level Abortion-related stigma Scale as employed by Cockrill and colleagues (2013) showed that participants in their study experienced moderate to strong negative feelings like guilt and shame after their abortion. This feeling was echoed in Shellenberg and colleagues (2012) where people frequently reported feelings of guilt, shame, and selfishness after their abortion.

Abortion-related stigma contributes to secrecy around abortion experiences (Astbury-Ward et al., 2012; Belfrage et al., 2020; Cockrill et al., 2013; Cockrill & Nack, 2013; Hanschmidt et al., 2016; Shellenberg & Tsui, 2012; Sorhaindo et al., 2014; Sorhaindo & Lavelanet, 2022), which is problematic as abortion cannot be normalized if no one talks about it (International Planned Parenthood Federation, 2016). As a result of abortion-related stigma, people who have abortions may face social and self-judgment, and a desire to keep abortions private (Belfrage et al., 2020; Hanschmidt et al., 2016; Kumar et al., 2009). This may perpetuate secrecy and reinforce the myth that abortion is abnormal, uncommon, and shameful.

Quantitative studies reveal that secrecy is used to manage stigma, but evidence points to the consequences, including social isolation (Astbury-Ward et al., 2012; Belfrage et al., 2020; Cockrill & Nack, 2013; Ipas, 2018; Sorhaindo & Lavelanet, 2022), distress (Major & Gramzow, 1999), poor mental health (Belfrage et al., 2020; Hanschmidt et al., 2016; Major & Gramzow, 1999) and diminished social support resources accessed (Belfrage et al., 2020; Cockrill et al., 2013; Hanschmidt et al., 2016; Ipas, 2018; Shellenberg & Tsui, 2012; Sorhaindo et al., 2014). Secrecy and shame also may reduce the accessibility of abortion services, contribute to healthcare avoidance, and potentially result in seeking unsafe abortions (Ipas, 2018; Monchalin, 2021). It has been noted that people who want an abortion may resort to unsafe methods to terminate their pregnancies, as those "*who want an abortion will put their lives on the line to get one*" (Gilmore, 2020, para. 8).

Service provider stigma involves stigma inflicted by service providers on people accessing services that may result in poor treatment and health outcomes (Ahmedani, 2011; Nyblade et al., 2019). Literature on reproductive decision-making indicates that stigma inflicted by providers may result in people with stigmatized conditions not receiving equal care compared with the public when service providers are aware of their condition (Ahmedani, 2011; Cuca & Rose, 2016; Desai et al., 2002; McKenzie et al., 2022; Nyblade et al., 2019).

Abortion-related stigma among providers may also contribute to further barriers for people seeking safe and prompt abortion services (LaRoche et al., 2020). For example, in a systematic review of abortion-related stigma studies by Sorhaindo and Lavelanet (2022), 31 of 50 studies discussed the poor treatment of abortion seekers by providers and how this could lead people to resort to unsafe abortion (e.g., Cárdenas et al., 2018; Freedman et al., 2010; LaRoche & Foster, 2018; LaRoche et al., 2020; Makleff et al., 2019). Abortion seekers also described feeling judged or experiencing insensitive treatment from unsupportive providers (Sorhaindo & Lavelanet, 2022; see also Cárdenas et al., 2018; Makleff et al., 2019). Sorhaindo and Lavelanet (2022) write that this led to abortion secrecy for protection (Margo et al., 2016), or refusal to see their primary care providers for fear of judgment (Påfs et al., 2020).

Karen Stote (2015) discusses negative service provider views regarding the perceived inferiority of Indigenous women that may influence reproductive coercion in the context of forced and coerced sterilization of Indigenous women in Canada (see also Burnett, 2018; Dyck & Lux, 2016; McKenzie et al., 2022; Rasmussen, 2019; Ryan et al., 2021). Stote (2019) cites supposed "*feeble-mindedness*" (para 3) as a reason service providers gave to coerce or force Indigenous Peoples to be sterilized. This notion is supported by several scholars who note that sterilization occurred against Indigenous Peoples' will, secretly, and/or without express consent (Anderson, 2011; Burnett, 2018; McKenzie et al., 2022; Monchalin, 2021; Rasmussen, 2019; Ryan et al., 2021). These racist practices and stereotypes employed in the health setting in Canada may persist to this day through service provider stigma leading to poor treatment of Indigenous Peoples. While Karen Stote's work is a historical analysis of coercive sterilization of Indigenous women from 1928 to 1973 when sterilization acts were in place in BC and Alberta, it is important to note that documented cases of forced and coerced sterilization in Canada occurred as recently as 2019, though there may be more recent examples.

Stereotypes may be influenced by social, community, internalized, and service provider stigmas and upheld by society, service providers, and communities (Burnett, 2018; Cull, 2006; Stote, 2012). Burnett (2018) writes that after the 1920s in Canada:

> *Long-held and enduring racist stereotypes that characterized the childbirth experience of Indigenous women as animal-like and painless made biomedical intervention by the state appear pointless, especially when the state did not want to become involved in health care provision for Indigenous Peoples in the first place* (p. 41; see also Jasen, 1997).

This quote suggests the racist undertones that may influence Indigenous access to health care in Canada. This reflects the findings of McKenzie and colleagues (2022) who share several instances of coercion and/or pressure around reproductive decision-making related to racist stereotypes about Indigenous identity. McKenzie et al. (2022) explored the mechanisms of reproductive coercion experienced by Indigenous women in the healthcare context, including pressuring, rushing, and/or tricking people into decisions; proceeding as if consent had already been achieved; and/or referring to racist and colonial stereotypes to justify actions and/or convince people to follow recommendations. For example, shortly after giving birth, one participant in the McKenzie and colleagues (2022) study described their gynecologist saying, "*Well, because you are Aboriginal, because you are native, you should be on birth control*" (p. 1039). This indicates how service providers may perpetuate harmful stereotypes of Indigenous Peoples, contributing to racism, poor treatment, and stigma from providers in the health setting (Cull, 2006; McKenzie et al., 2022; National Collaborating Centre for Methods and Tools (NCCMT), 2014). This is reflected in the findings of Wyley and McConkey (2019) who observed that stereotypes of Indigenous Peoples may have become commonly accepted among some service providers in Canada.

Stereotypes not only degrade the autonomy and self-determination of Indigenous Peoples (NCCMT, 2014), they also damage the sense of self of generations of people who have internalized demeaning stereotypes surrounding Indigeneity (NCCMT, 2014). McKenzie and colleagues (2022) note that there is potential for positive change to address the forced and coerced sterilization of Indigenous Peoples, yet "*Canada's colonial genocidal disposition involves controlling and denying Indigenous women's reproductive futures*" (p. 1043). Systemic racism against Indigenous Peoples in the health setting is one example of how the ongoing "*genocide proper*" (Stote, 2015, p. 30) of Indigenous Peoples continues to this day. However, it is important to note the resistance to this and the resurgence of traditional Indigenous practices surrounding controlling reproductive options (Beck & LaPier, 2022; ekw'í7tl doula collective, n.d.; Monchalin et al., 2015; Monchalin, 2021, Monchalin et al., 2023a, 2023b).

Community stigma has not been specifically described in the abortion-related stigma literature. There is a need for a definition to understand the abortion-related stigma perpetuated within community based on shared cultural beliefs in the abortion context. Community stigma has been defined generally as community members' stigmatizing beliefs and attitudes around a given condition by Gonzales and colleagues (2017). Community stigma in the mental health literature includes microaggressions, subtle discriminatory behaviours, and discrimination resulting in restricted opportunities for participating in community (Cechnicki et al., 2011; Gonzales et al., 2018; Prince & Prince, 2002). Bracke and colleagues (2019) note that there is a demonstrated link between stigma and the utilization of mental health services, where stigma may create barriers to accessing services. Similarly, stigma has been shown to increase barriers to accessing abortion services (Major et al., 2018), indicating that there is a structural component to stigma.

Hatzenbuehler and Link (2014) define structural stigma as the social conditions, cultural norms, and institutional policies that limit the opportunities, resources, and well-being of stigmatized people. One component of this structural stigma consists of negative attitudes, beliefs, and stereotypes shared by community members regarding a stigmatized condition (Bracke et al., 2019), such as abortion experience. Bracke and colleagues (2019) refer to this type of stigma as "*dominant cultural stigma*" (para 2). This dominant cultural stigma is reflective of community stigma which may be applied in the unique contexts of beliefs around abortion in some Indigenous communities in Canada. The influence of intergenerational beliefs should be highlighted when considering community stigma in this context.

Though parental stigma has not been specifically examined in the abortion context, several studies in the mental health literature discuss shame and stigma experienced by parents due to their child's stigmatized condition (Chan et al., 2017; Corrigan & Miller, 2004; Corrigan & Watson, 2002; Eaton et al., 2016; Titlestad et al., 2020; Villatoro et al., 2018; Zhang et al., 2022). Family/parental stigma may become internalized and lead to self-stigma, self-blame, negative views of the self, shame, secrecy, and isolation for parents (Eaton et al., 2016; Villatoro et al., 2018; Zhang et al., 2022). Parents' perceptions of stigma in the mental health literature often contributed to secrecy and shame experienced by the parent, including blaming themselves for their child’s condition and feelings of failure as a parent (Eaton et al., 2016; HereToHelp, n.d.; Hlungwani et al., 2020; Liahaugen Flensburg et al., 2022; Zhang et al., 2022). This suggests that in communities that have internalized negative beliefs around abortion, parents may experience increased internalized stigma which may influence their reaction to their child’s abortion.

Parents may begin to see themselves as bad parents because of their child’s abortion as described in the mental health literature (Eaton et al., 2016). Eaton and colleagues (2016) write:

> *A key finding of this study is that mothers’ self-stigma (characterised by self-blame, self-shame, and/or bad-parent self-view) develops as a result of mothers becoming aware of or experiencing external stigma, which creates or exacerbates self-doubt regarding one’s ability to be a good parent, and (should mothers be unable to refute external stigma and their own self-doubt), culminates in self-stigma* (p. 3119).

This may apply to abortion-related stigma experienced by parents due to their awareness of social, community, and service provider stigma surrounding abortion. Stigma inflicted by parents and family members may be particularly impactful. Parents have been shown to both experience and inflict stigma related to their child’s stigmatized condition (Eaton et al., 2016; Gonzales et al., 2018; Liahaugen Flensburg et al., 2022; Titlestad et al., 2020; Zhang et al., 2022).

Abortion-related stigma has been shown to be associated with race, religion, and levels of social support (Carter et al., 2009; Hanschmidt et al., 2016; Kumar et al., 2009). For example, Black women were found to be less likely to describe perceived abortion-related stigma than the general U.S. population in a study by Carter and colleagues (2009). This may be due to pro-choice attitudes being more prevalent in the Black community (Carter et al., 2009; Hanschmidt et al., 2016). Loretta Ross (2017) references a 1991 study that revealed 58% of Black women over the age of 18 never used birth control, with only one percent saying they wanted to get pregnant and two percent not knowing how to use contraceptives, indicating the disproportionately high unintended pregnancy and abortion rates in the Black community in the U.S. at that time (Ross, 2017). Further, as of 2017, Black women obtain one third of abortions in the U.S. and 80% of Black women believe a woman should have autonomy over abortion decisions (Ross, 2017). It has been argued that Canada needs to prioritize collecting high quality race-based health data to improve health equity and to better understand the unique experience of racialized people accessing health services in Canada (Canadian Institute for Health Information, n.d.). There is limited literature on Indigenous Peoples' views of autonomy over abortion decisions to compare with these results.

The consequences of abortion-related stigma are far reaching. Internalized, self-directed shame and stigma may impact emotional, mental, and social wellbeing (Ipas, 2018; Shellenberg et al., 2011). Shout Your Abortion is an online space to talk about abortion experiences, aiming to normalize and destigmatize abortion (Shout Your Abortion, n.d.). A contributor shared that "*getting an abortion did not traumatize me. Abortion-related stigma traumatized me*" (Shout Your Abortion, n.d.). This demonstrates the harmful impacts of abortion-related stigma on a person's wellbeing.

Abortion-related stigma impacts abortion experiences and access to abortion (Belfrage et al., 2020; Kumar et al., 2009; LeTourneau, 2016). Recommendations have been made by groups such as Action Canada for Sexual Health and Rights to reduce abortion-related stigma and its harms, like loneliness, depression, and trauma, associated with abortion (Action Canada for Sexual Health and Rights, 2019; Ipas, 2018; Stangl et al., 2019).

Abortion-related stigma includes categories such as internalized, service provider, social, and community stigmas. Internalized stigma contributes to feelings of guilt and shame around abortion and may contribute to abortion secrecy leading to isolation for abortion seekers. Stereotypes may be used by service providers to justify poor treatment of Indigenous Peoples in the health setting. The influence of parents and family members may be particularly impactful on abortion seekers. Community stigma has not been discussed in the abortion-related stigma literature, yet this may be an important element to consider in the context of the influence of cultural beliefs about abortion among some Indigenous Peoples in Canada. There is a need to better understand the unique experience of abortion-related stigma among Indigenous Peoples in Canada.

Religion and abortion-related stigma

Stigmatizing views on abortion are socially constructed and may be influenced by religious values within community (Belfrage et al., 2020; Hanschmidt et al., 2016;

Kumar et al., 2009). However, this has not been adequately explored in the Canadian context, nor in the Indigenous context within Canada.

Catholicism is the predominant religion in Canada. The Catholic Church currently advocates against abortion to prevent taking a life that has received "*its soul*" (Abortion Rights Coalition of Canada, 2017, p. 1). It should be noted that not all Catholics are against abortion (Abortion Rights Coalition of Canada, 2017). Christian and/or Catholic identities and influences were associated with increased internalized and perceived abortion-related stigma in several studies (Belfrage et al., 2020; Cockrill et al., 2013; Hanschmidt et al., 2016; Shellenberg et al., 2011; Shellenberg & Tsui, 2012; Sorhaindo et al., 2014). Being highly religious was also associated with increased risk of internalized stigma including negative feelings, guilt, shame, and self-judgment (Cockrill et al., 2013; Shellenberg & Tsui, 2012). Religious contexts may contribute to fears of judgment and feelings of guilt and shame among people with abortion experience (Belfrage et al., 2020; Hanschmidt et al., 2016; LeTourneau, 2016; Shellenberg et al., 2011; Sorhaindo et al., 2014; Sorhaindo & Lavelanet, 2022).

Religious condemnation of abortion influences abortion-related stigma among people who grew up with strong anti-abortion attitudes in their family or community, such as communities influenced by Catholic values (Astbury-Ward et al., 2012; Cockrill et al., 2013; Hanschmidt et al., 2016; Shellenberg & Tsui, 2012). In quantitative studies examining abortion-related stigma in U.S. populations, people who perceive abortion-related stigma may be more likely to keep their abortion secret and/or not disclose their abortion to their loved ones (Cockrill et al., 2013; Shellenberg & Tsui, 2012; see also

Hanschmidt et al., 2016). This may mean that people with religious backgrounds are more likely to keep their abortion a secret due to abortion-related stigma. It should be noted that none of these studies were conducted in Canada, nor focused on Indigenous Peoples specifically.

Abortion-related stigma may have a greater impact when a person accesses abortion in communities vocally against abortion (Hanschmidt et al., 2016; Kumar et al., 2009). Communities influenced by colonial religions are often vocally against abortion, which may mean that abortion-related stigma will have a greater impact on these communities. Roughly 40% of Indigenous Peoples listed a form of Christianity as their religion in the 2021 census in Canada (Statistics Canada, 2022). Abortion-related stigma often persists in communities where abortion is not seen as 'traditional' (Anderson, 2003, 2011; Monchalin, 2021). Colonial Christian ideas that stigmatize reproductive autonomy may now be seen as 'traditional' in some Indigenous communities (Anderson, 2003). Christian and Catholic anti-abortion ideas may have displaced traditional Indigenous practices that historically honoured reproductive autonomy, including birth control and abortion practices (Anderson, 2003, 2011; Burnett, 2018; Monchalin, 2021; Monchalin et al., 2015) among some community members.

Indigenous perspectives on abortion

Literature suggests that many Indigenous community's perspectives were not always against abortion and exercising reproductive autonomy (Anderson, 2003, 2011; Burnett, 2018; Redvers, 2019). Rather, stigmatizing views of abortion were introduced through colonization and reinforced through colonial violence (Anderson, 2003, 2011; Burnett, 2018; Redvers, 2019) and colonial religion (Abortion Rights Coalition of Canada, 2017; Anderson, 2003, 2011; Monchalin, 2021; Monchalin et al., 2015; Redvers, 2019). Today, colonial religious ideologies and beliefs are prominent in Indigenous communities in Canada, at least in part due to the ongoing effects of colonialism, such as residential schools, the sixties scoop, and other acts of violence from the Canadian settler state (Anderson, 2003, 2011; Burnett, 2018; Monchalin, 2021; Redvers, 2019).

Before settler arrival, traditional contraceptives and abortifacients were used in many Indigenous communities, often given by grandmothers and aunties (Anderson, 2003, 2011; Monchalin, 2021). This knowledge was intergenerational and passed down through generations (Anderson, 2011; Monchalin, 2021; Monchalin et al., 2015).

A toolkit created by the Native Youth Sexual Health Network quotes Elder Joanne describing how Indigenous medicines and knowledges existed to control reproductive options before contact (Monchalin et al., 2015). Elder Joanne describes that judgment and stigma around contraceptives was not always a traditional Indigenous practice:

> *In our traditional way, we knew how to stop pregnancies. There were medicines. So, we knew, when women found out they were pregnant, they would know how to get un- pregnant. It is not our traditional way to pass judgment on that, the Creator always gives us choice* (as quoted in Monchalin et al., 2015, p. 18).

Similarly, Kim Anderson (2003) quotes Elder Edna Manitowabi about how traditional reproductive medicines to control birthing options must have been commonly practiced by Indigenous communities because of the low numbers of children among the Ojibwee when compared with white settlers. Elder Edna Manitowabi describes how Indigenous families were intentionally small:

> *When you talk to the elder women about what it was like a long time ago – before we became shackled by the church – [they say that] in order to survive, and because people travelled to follow the game, it wasn't their way to have a large family. Children were spaced out … So maybe two or three was the size of their families* (as quoted in Anderson, 2003, p. 178*).*

Describing a different perspective on the possible roots of opposition to abortion in Indigenous communities, Kim Anderson (2011) notes young Indigenous Peoples stating, "*I'm traditional, so I don't use birth control*" (p. 177). Anderson (2011) partially attributes the idea that birth control and controlling birthing options is not traditional to the eighteenth-century Code of Handsome Lake. The Code was outlined by a Seneca prophet with followers among the Haudenosaunee today. The Code recognizes that Indigenous women had abortive and contraceptive practices in Indigenous communities but prohibits their use (Anderson, 2011). Anderson (2011) quotes Mohawk midwife Katsi Cook and writes:

> *Domestic abuse, drunken brawling, abandonment of families, rape, suicide and wretched poverty were the legacy of whiskey and the powerlessness of a people deprived of their fertile lands and political autonomy. So prevalent was the use of abortifacients (which can also cause permanent sterility) among their down-hearted women, that Seneca Chief and Prophet Handsome Lake preached*

> *against their use so the People could continue to live.* ***Today, followers of the Handsome Lake Code teach their daughters that abortion is a great evil*** [emphasis added]*"* (as quoted in Anderson, 2011, p. 180).

This quote provides insight into some of the possible roots of stigma around abortion experienced in certain Indigenous communities.

However, with the growing influence of the church, large families became more common due to the church's opposition to birth control and the pressure on women to reproduce (Anderson, 2003). Even as the settler-colonial state systematically condemned and denigrated Indigenous reproductive knowledges, settler women sought out Indigenous knowledges for reproductive and sexual health early contact as Christian and Catholic morality forbade birth control and restricted reproductive autonomy (Anderson, 2003; Burnett, 2010, 2018; Monchalin, 2021; Rasmussen, 2019).

Although the settler-colonial state attempted to suppress traditional reproductive medicines (Anderson, 2003, 2011; Burnett, 2018; Monchalin, 2021; Redvers, 2019), Kim Anderson (2003) describes how traditional reproductive knowledges are still held by knowledge keepers to this day:

> *A number of Elders have told me of medicines that brought on menstruation if a woman missed her cycle, and of teas that were used on a daily basis, likely as a contraceptive measure. There are older women who still have the knowledge of these medicines, but much of this information has gone underground or has died out as a result of repression from the church and fear of exploitation* (p. 180).

These medicines still exist to this day and there is a movement towards resurgence of these practices (Beck & LaPier, 2022; ekw’í7tl doula collective, n.d.; Monchalin et al., 2015; Monchalin, 2021). For example, the ekw’í7tl Indigenous doula collective have developed reproductive educational models specifically by and for Indigenous Peoples that are grounded in Indigenous ways of knowing, decolonizing, and reclaiming bodily autonomy and reproductive choice.

Beck and LaPier (2022) shared that abortion is a religious right for Indigenous Peoples in response to the overturning of Roe v. Wade in the U.S.:

> *Our grandmother taught us that Blackfeet women used both medicinal plants and ritual practices for reproductive health. The Blackfeet used over a dozen plants to regulate menstruation, for abortion, for the birth process, and to address symptoms of menopause. Blackfeet women also held a religious ceremony during which a sanctified belt decorated with religious symbols was worn to regulate fertility and prevent pregnancy. Whether using medicinal plants or religious rituals, Blackfeet people viewed reproductive health and bodily autonomy as part of our relationship with the sacred realm.* (para. 4).

This quote demonstrates that traditional reproductive medicines and knowledges are still held by Indigenous communities across Turtle Island. Researchers advocate that to improve access to abortion services, there is a need to bridge Indigenous and Western medical knowledges and honour a variety of ways of knowing and doing around controlling birthing options and reproductive autonomy (Monchalin, 2021; Redvers, 2019). Current reproductive rights discussions may dismiss Indigenous reproductive knowledges, "*ignoring our long-standing and well documented history of self-control over reproductive choices … their indoctrination/colonization has manipulated things so that we weren't allowed to follow the way we always did things*" (Lightfoot as quoted in Burnett, 2017, p. 35).

There is limited research in Canada around access to abortion for Indigenous Peoples (Anderson, 2003; Burnett, 2018; Kirby, 2017; Monchalin, 2021), though this is beginning to shift (see McKenzie et al., 2022; Monchalin et al., 2023a, 2023b). Due to racism in health services, pressure to reproduce due to genocide, and early feminist notions that abortion is a 'white woman's issue', access to abortion for Indigenous Peoples has not been prioritized (Kirby, 2017). Racism against Indigenous Peoples in the Canadian health setting is well documented (Allan & Smylie, 2015; Monchalin et al., 2020; Reading & Wien, 2009; Wyley & McConkey, 2019). This may influence this lack of research because Indigenous Peoples may not receive equitable care in health settings due to racism. The National Collaborating Centre for Indigenous Health (NCCIH) (2014) discuss how racism in health settings contributes to several harms experienced by Indigenous communities. These include emotional and social harm, distrust in the health system resulting in diminished use of preventative health services and reduced access to essential medication interventions. Ultimately, these factors contribute to poor health outcomes such as a disproportionately high burden of disease and diminished life expectancy (NCCIH, 2014). Inequitable and unsafe access to health services may influence the lack of literature on abortion access for Indigenous Peoples.

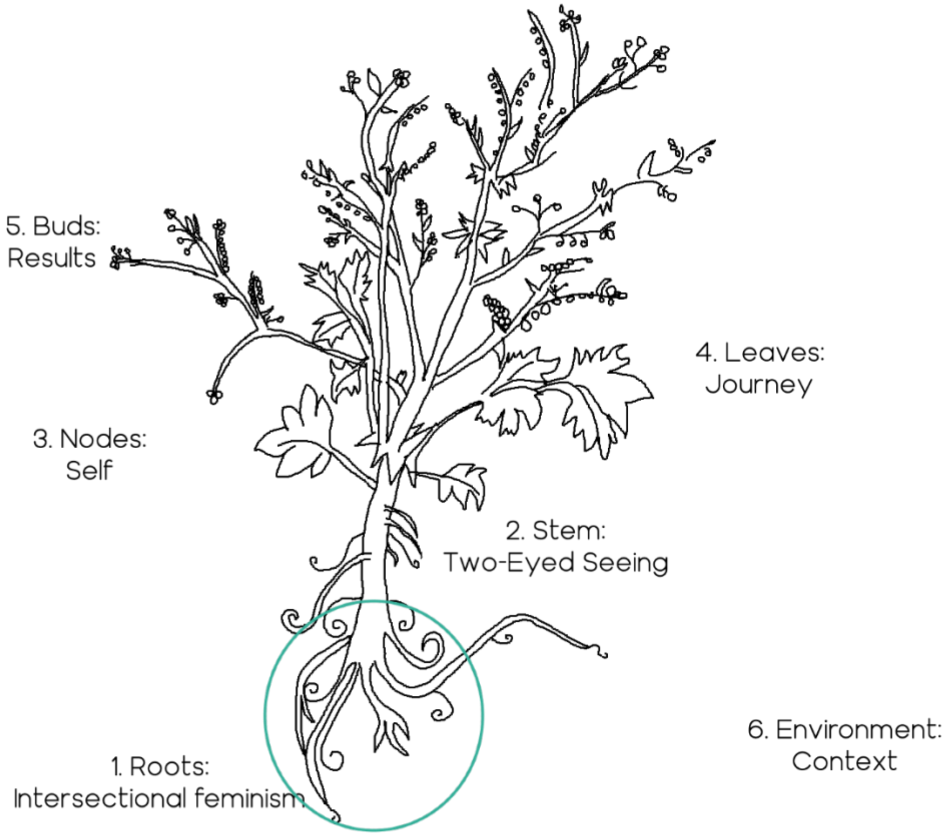
Barriers to abortion access, coupled with colonialism, stigmatizing views of and interference with traditional reproductive autonomy practices have contributed to lost and fractured intergenerational knowledge systems and feelings of shame around abortion among Indigenous Peoples in Canada (Anderson, 2003, 2011; Burnett, 2018; Cattapan et al., 2021; Kirby, 2017; Lawford & Giles, 2012; Rasmussen, 2019; Redvers, 2019), though there is evidence of a resurgence and reclamation of traditional reproductive practices.

Chapter 3: Framework

Intersectional Feminist Framework

An ***intersectional feminist framework*** adapted from Snooks et al. (2021) guided my exploration of abortion-related stigma experienced by Indigenous Peoples' accessing abortion services in Canada. I chose Snooks and colleagues (2021) as I valued the way they wove in concepts of Indigenous feminism into their intersectional feminist approach. In this chapter, I will define and contextualize the concepts of intersectionality, feminism, intersectional feminism, and reproductive justice. I will then describe how an intersectional feminist approach is useful to explore the complex factors influencing abortion-related stigma among Indigenous Peoples in Canada.

Figure 3
This section of the Wormwood diagram highlights the roots: ***Intersectional feminism.***



Intersectionality

Intersectionality was coined by Kimberlé Crenshaw in 1989 and is a lens to understand how systems of power and oppression overlap to create distinct experiences for people with multiple intersecting identity factors (Miller, 2020). Crenshaw explains intersectionality as "*a prism for seeing the way in which various forms of inequality often operate together and exacerbate each other*" (Crenshaw as cited in UN Women, 2020, para. 2). Intersectionality shows the way that social identities can overlap, creating intersecting experiences of discrimination (UN Women, 2020). Crenshaw observes that:

> *We tend to talk about race inequality as separate from inequality based on gender, class, sexuality or immigrant status. What's often missing is how some people are subject to all of these, and the experience is not just the sum of its parts (Crenshaw as cited in UN Women, 2020, para. 4).*

Intersectionality emerged from Black feminists in the U.S. as a way of thinking about identity and its relationship to power (Heard, 2021) and has grown beyond its roots related to the specific, interlocking experiences of the unique injustices faced by Black women (UN Women, 2020). Intersectionality is a lens to analyze the interlocking oppressive forces that shape people's lived experiences and health outcomes. These interlocking oppressive forces contribute to the adverse outcomes Indigenous, Black, and/or People of Colour (IBPOC) experience. It posits that all identities must be honoured simultaneously to address specific experiences of privilege and oppression (Ross, 2017; UN Women, 2020). Intersectionality allows us to look at the big picture and the ways that power operates and seek to dismantle oppressive power structures (Hankivsky, 2014; Ross, 2017; Snooks et al., 2021). An intersectional approach also considers how structural violence in the form of colonialism, racism, poverty, transphobia, homophobia, and sexism informs lived experiences of injustice (Snooks et al., 2021).

Importantly, the concept of intersectionality can be found in the work of IBPOC prior to Kimberlé Crenshaw coining the term in 1989 (Clark, 2016; Snooks et al., 2021). For instance, Natalie Clark (2016) describes that Sioux activist Zitkala-Sa and other Indigenous scholars wrote about how "*violence has always been gendered, aged, and* *linked to access to land*" (p. 49) in the early 1900s. It is important to acknowledge and honour the ways in which intersectionality has been engaged by Indigenous scholars and Knowledge Keepers for over a century prior to it being coined in the academic literature (Snooks et al., 2021), if not always labeled as such. Intersectionality seen through this historical context helps shine light on the social and identity factors that influence health outcomes for IBPOC. This will be useful in exploring Indigenous Peoples' experiences of abortion-related stigma in Canada.

Intersectionality requires us to understand lived experiences to inform health promotion and interventions (Heard, 2021). Intersectionality involves honouring and understanding an individual's social location and examining how health system structures, and Canada more broadly, may create specific experiences of oppression within a health context. For example, intersectionality can help us to understand how experiences of abortion-related stigma among Indigenous Peoples are rooted in and influenced by colonialism and structural racism (Anderson, 2003; Monchalin, 2021).

The NIMMIWG (2019) executive summary report reflects an intersectional approach:

> *Understanding the many shapes violence against Inuit, Métis, and First Nations women, girls, and 2SLGBTQQIA people can take requires an intersectional approach. Intersectionality recognizes that a person's experience will be different than another's based on their particular interplay of race, ethnicity, Indigeneity, gender, class, sexuality, geography, age, and ability, as well as how these intersections encourage systems of oppression and, ultimately, target Indigenous*

> *women, girls, and 2SLGBTQQIA people. For Indigenous Peoples in particular, using an intersectional approach requires understanding how a history of colonization has shaped their experiences today* (p. 11).

Further, racism was seen to be a core cause of colonial violence faced by Indigenous Peoples, but the NIMMIWG (2019) revealed that there are intersecting experiences of discrimination based on other identity factors:

> *Overwhelmingly, participants identified racism as being at the heart of the colonial structure, representing a core cause for the violence faced by Métis, First Nations, and Inuit communities. At the same time, participants highlighted intersecting experiences of discrimination based on gender and sexual orientation, discrimination against marginalized populations such as sex workers, people engaged in substance use, people who are homeless, or based on their intersectional identities as First Nations, Métis and Inuit groups with many distinctive experiences and perspectives* (p. 49).

This quote highlights that there are intersecting factors that contribute to discrimination against Indigenous Peoples in Canada.

When conducting research led by and for Indigenous Peoples, it is important to consider my social location as a white- cis- privileged woman ally and collaborator. Intersectionality is a lens that allows me to honour my own background while understanding experiences of abortion-related stigma within the Canadian health system as the result of privileging certain identities (white, cis-, het-) over others (Indigenous, non-binary, queer, etc.) within the Canadian health system and society more broadly. This privileging of identities is apparent where racialized communities may not receive equal care in the health setting (El-Mowafi, 2021; NCCIH, 2014). This may lead to decreased or delayed utilization of health services, decreased access to treatment and interventions, ultimately leading to disproportionate burden of disease and diminished life expectancy as described by the NCCIH (2014). The intersectionality lens helps to recognize that systemic racism exists in the Canadian health system and relates to abortion-related stigma among Indigenous Peoples in Canada. IBPOC are subject to institutional racism and there is a history of harms perpetuated within the Canadian health system against IBPOC (El-Mowafi, 2021). This is expanded upon in the literature review and discussion sections of my thesis.

Colonization, racism, social exclusion, and a lack of self-determination play a key role in the disparities between Indigenous and non-Indigenous Peoples' health (Allan & Smylie, n.d.; Coen-Sanchez et al., 2022). Coen-Sanchez and colleagues (2022) describe how Canada must acknowledge that the structural roots of power and socioeconomic differences between races are founded by a history of oppression which perpetuates injustice and leads to health inequities among IBPOC. This assessment may be applied to Indigenous access to abortion services, as Indigenous Peoples experience multiple systemic inequities and hold intersecting identities which interlock to create unique experiences of oppression within the settler-colonial system of Canada. This knowledge can inform policies, programs, and interventions that dismantle institutionalized racism and create better health outcomes for IBPOC in Canada (Coen-Sanchez et al., 2022). Acknowledging the structural barriers experienced by Indigenous Peoples accessing abortion services in Canada may help to inform better public policies that create better health outcomes for Indigenous Peoples in Canada.

Structural racism in the healthcare system must be addressed to rectify the myriad health inequities experienced by IBPOC in the health setting (Coen-Sanchez et al., 2022; El-Mowafi et al., 2021). Structures rooted in colonialism and oppression include policies that allow and perpetuate racism against IBPOC peoples in health settings, leading to worse sexual and reproductive health and rights (SRHR) outcomes as compared to their white counterparts (Coen-Sanchez et al., 2022). This calls for dismantling systemically oppressive structures and rebuilding with systems that acknowledge and respond to lived SRHR experiences of IBPOC communities (Coen-Sanchez et al., 2022).

Feminism

Feminism is a social justice movement seeking to transform gender-based oppressions and injustices (hooks, 2015). However, feminism historically excluded racialized, poor, and other marginalized groups (Loreto, 2020). Feminism generally focused attention on affluent, educated, white women and their issues while often further oppressing all who did not fall into this category (Loreto, 2020).

Indigenous feminism is an intersectional theory and practice of feminism with a focus on decolonization, Indigenous autonomy and sovereignty, and human rights for Indigenous Peoples (Gearon, 2021). Indigenous feminism seeks to support movements for decolonization and Indigenous self-determination by exploring how the intersections of gender, race, and sexuality shape Indigenous Peoples' realities in the Canadian settler state (Green, 2017). This largely aligns with intersectional feminism yet differentiates itself by the focus on the unique intersecting experiences of Indigenous Peoples specifically. For this study, we drew on Indigenous feminist scholars theorizing reproductive justice (RJ) and the impact of colonialism on Indigenous Peoples' reproductive lives (Anderson, 2003, 2011; Violet & Spillet, 2017) to contextualize and interpret our results.

Intersectional Feminism

Adding feminism to intersectionality highlights the importance of including all genders within the fight for equity (Sharkey & Hawk, 2016). Intersectional feminism takes the feminist concept beyond gender to address several other identity factors such as class, sexuality, and race. Intersectional feminism centres the voices of people experiencing overlapping, concurrent forms of oppression to understand the depths of the inequalities and the relationships among them within unique contexts (UN Women, 2020). Intersectional feminism is not only for females. It is a framework for increasing justice and equity for all people.

Intersectional feminism is required to encompass experiences and issues of all non-men, racialized women, and equity seeking groups due to historic exclusion within feminist and women's movements and to rectify the historic injustices perpetuated by white feminists (Kirby, 2017; Loreto, 2020). Indigenous feminism is an intersectional theory and practice of feminism with a focus on decolonization, Indigenous autonomy and sovereignty, and human rights for Indigenous Peoples (Gearon, 2021). An intersectional approach is useful in exploring the reproductive health experiences of Indigenous Peoples in Canada. For example, Indigenous women have been particularly harmed through forced, coerced sterilization, abortion, and/or contraceptives (Burnett, 2018; McKenzie et al., 2022; Monchalin et al., 2020; Rasmussen, 2019; Stote, 2012, 2015). This may be viewed in the context of colonialism and the attempted erasure of Indigenous knowledge systems, acknowledging the layered factors that impact Indigenous Peoples' reproductive autonomy (McKenzie et al., 2022; Monchalin, 2021; Rasmussen, 2019). For the purposes of my research, I will refer to intersectional feminism with the understanding that in my application this incorporates aspects of Indigenous feminism.

An intersectional feminist approach is well-suited for this research as it considers the multiple social locations and the structures of power that influence inequitable access to abortion services for Indigenous Peoples. For example, intersecting factors such as income, geographic location, gender, as well as structural factors such as colonization and its associated discriminatory policies and practices contribute to the marginalization of Indigenous Peoples (McKenzie et al., 2022). Consideration of these factors helps us to identify the roots of inequities within the Canadian health system so we can address them. Indigenous and intersectional feminist perspectives prioritize relationships and lived experiences while remaining conscious about power dynamics of privilege and oppression and their implications (Cupchik & Schnarr, 2021). Focusing on lived experience reflects the methods of the GGLI project which prioritized honouring individual stories while understanding the broader context of abortion experiences.

My intersectional feminist approach seeks to honour Indigenous feminist thinkers such as Kim Anderson, Kathy Absolon, Joyce Green, Natalie Clark, Cheryl Suzack, among others, who centre their work around resistance, sovereignty, and anti-colonialism and whose work is "*inherently activist*" (Clark, 2016, p. 50). Due to my self-location as a white, cisgendered, heterosexual settler allied researcher, I use an intersectional feminist approach more broadly to guide this work. I aim to honour individual stories and relationships throughout this work and to amplify Indigenous voices around abortion-related stigma while critiquing colonialism and its harms (Absolon, 2011; Arvin et al., 2013; Clark, 2016; Green, 2017; Snooks et al., 2021; Suzack, 2010).

Reproductive justice

The term reproductive justice (RJ) was coined by Black women at the Black Women's caucus in Chicago in 1994 (Cattapan et al., 2021; Kirby, 2017; SisterSong, n.d.). RJ emerged from Black women's experiences and subjugated knowledge which were excluded by the mainstream pro-choice movement based on the perceived lower social location of Black women (Ross, 2017).

This section will focus on RJ because focusing on abortion alone cannot adequately address the intersectional oppressions in reproductive health born of white supremacy, colonialism, and misogyny– therefore, we need RJ (Ross, 2017; SisterSong, n.d.). SisterSong (n.d.) defines RJ as "*the human right to maintain personal bodily autonomy, have children, not have children, and to parent the children we have in safe and sustainable communities*" (para 1). RJ allows us to examine the nuanced ways oppressions impact self-determined reproductive decisions (SisterSong, n.d.).

Abortion has been characterized as a white woman's issue, pointing to needs that privileged white women are often able to take for granted (Kirby, 2017; Ross, 2017; SisterSong, n.d.; Solis, 2020) such as the right to have and raise children and access to basic health services. In contrast, inequitable access to reproductive health services for racialized communities is commonly ignored (Burnett, 2018; El-Mowafi et al., 2021; Garcia & Sharif, 2015; Kirby, 2017; SisterSong, n.d.). The inaccessibility of basic reproductive healthcare is seen in mandatory birth evacuations from remote and Northern Indigenous communities (Cattapan et al., 2021; Kirby, 2017; Lawford & Giles, 2012), and the widespread forced and coerced sterilization of Indigenous Peoples across Canada (Agecoutay, 2022; Rasmussen, 2019; Stote, 2012, 2015). Systemic racism, discrimination, and ongoing attempts to control Indigenous Peoples' birthing through forced sterilization, violence from healthcare providers, child apprehension, and coerced abortion contribute to complex intersectional barriers to accessing abortion services faced by Indigenous Peoples (Burnett, 2018; Cattapan et al., 2021; Dyck & Lux, 2016; Monchalin, 2021; Rasmussen, 2019). We need RJ and intersectionality to reduce systemic barriers to accessing abortion services and address the structural factors that exacerbate abortion-related stigma among Indigenous Peoples in Canada.

RJ aligns with intersectionality as it accounts for diversity and examines multiple experiences of injustice and oppression as they relate to reproductive autonomy (Ross, 2017). RJ is a framework within which all people's reproductive concerns may be mediated to redistribute social benefits and uplift knowledges of de-privileged voices (Ross, 2017; SisterSong, n.d.). As SisterSong (n.d.) notes, "*the intersectionality of RJ is both an opportunity and a call to come together as one movement with the power to win freedom for all oppressed people*" (para. 10). RJ is needed to achieve equitable health outcomes for all people as advocated for within intersectional feminism and intersectionality.

McKenzie et al. (2022) provide an example of how an intersectional feminist approach can be used to analyze the material context of Indigenous Peoples—building on the literature that demonstrates how intersecting policies continue to undermine Indigenous Peoples' rights to RJ in Canada (see de Leeuw et al., 2010; Hunting & Browne, 2012; McKenzie et al., 2022).

It is important to note that abortion is not exclusively a gendered health service. Not all who have abortions identify as female, and abortion impacts trans, non-binary, Two-Spirit, and other gender diverse individuals (Moseson et al., 2021). This is an aspect of intersectionality and RJ which acknowledges nuanced lived experiences and diverse identities.

People experiencing injustices are experts in their own lives and experiences. Intersectional feminism incorporating RJ provides a framework for analysis that honours histories, recognizes ongoing colonialism, and understands how these intersect to create barriers to reproductive autonomy for Indigenous Peoples. An intersectional feminist approach striving towards RJ is required to help address abortion-related stigma experienced by Indigenous communities and people.

I seek to work towards a broader, self-determined vision of bodily and reproductive autonomy for all. Intersectionality, intersectional feminism, and RJ guide my analysis. My intention is that this work will advance RJ by helping to improve abortion access and reduce abortion-related stigma for Indigenous Peoples across Canada.

Chapter 4: Methodology

Qualitative inquiry and Indigenous methodology

Margaret Kovach (2021) writes that qualitative inquiry is an approach to research that "*tells a story through words, not numbers*" (p. 24). Indigenous methodologies adopt a relational approach which aligns with many qualitative approaches such as feminist methodologies and participatory action research (Kovach, 2021). One difference between qualitative methodologies and Indigenous methodologies is that Indigenous methodologies are based on Indigenous epistemology (ways of knowing), rather than a Western intellectual and historical tradition (Kovach, 2021). These two types of methodologies coexist and may be merged using Two-Eyed Seeing.

Kovach (2021) describes how the interpretive nature of qualitative research means that stories from both the researcher and research participants are reflected in analysis. According to Kovach (2021), this is where qualitative research differs from traditional positivist approaches:

> *One approach [positivist] is a seeker of a singular, static objective truth. The other [qualitative] seeks contextualized experience and acknowledges that the truth heard depends upon the voice heard. However, be it reflexive qualitative research or traditional positivist methodologies, both are historically embedded within and arise from Western thought and thus cannot help but formulate interpretations through a Western gaze or construct.* (p. 26)

This quote demonstrates that using Western methodologies when conducting research with Indigenous Peoples is not appropriate as these methodologies inherently support Western understandings of the world. It is important to note the historic and ongoing harms done by Western research and researchers conducting research on, rather than with, Indigenous Peoples (Kovach, 2021).

Indigenous culture and methodology prioritizes process, holism, and collectivism, whereas Western culture often prioritizes individualism and outputs (Kovach, 2021). Key principles of Indigenous research include an awareness that there are multiple ways of seeing and knowing the world that are experienced through cultural contexts (Pidgeon & Riley, 2021). Margaret Kovach (2005) has advocated for an approach to Indigenous methodologies that honours that: (a) experience is a legitimate way of knowing; (b) Indigenous methods like storytelling are a legitimate way of sharing knowledge; c) relationship between research and participants is a natural part of the research methodology; and d) collectivity is a way of knowing that assumes reciprocity to the community (see also Pidgeon & Riley, 2021). A limitation of Indigenous methodologies is that despite progress towards acceptance of Indigenous methodologies in academic circles, there are still some who may question whether it constitutes legitimate knowledge and struggle to take stories at face value.

Broadly speaking, Indigenous research "*flows from an Indigenous belief system that has at its core a relational understanding and accountability to the world*," including the nonhuman world (Kovach 2010, p. 3). Western qualitative methodologies such as critical theory also align with this philosophy, yet Indigenous methodologies may consider additional factors that Western qualitative methods may not. Peltier (2018) notes when discussing Indigenous research methodologies that embracing research in a way that uplifts Indigenous voices and ways of knowing will change the way research is conducted and quotes Smith (2013): "*When Indigenous people become the researchers and not merely the researched, the activity of research is transformed. Questions are framed differently, priorities are ranked differently, problems are defined differently, and people participate on different terms*" (p. 193). Our interview questions were co-developed by our principal investigators (PI), a Métis researcher with Métis, Anishinaabe, Scottish and French ancestries and the Indigenous-led research team in consultation with the IAC, focusing on questions and methods that aligned with preidentified and co-developed research priorities.

Research with, by, and for Indigenous Peoples runs deeper than consultation with Indigenous communities (Peltier, 2018). In Anishinaabe ontology (ways of being), "*relationships tie us to everything and everyone in both physical and spiritual realms*" (Peltier 2018, p. 3). Indigenous ways of knowing and being are holistic and include the physical, mental, emotional, and spiritual realms (Snooks et al., 2021). Indigenous ways of knowing are based on a worldview and values that are place-based, relational, and composed of knowledge, beliefs, and practice (Held, 2019). It should be noted that this aligns with some Western qualitative research methods, such as Place-Based methodology (Crosby & Vanni, 2022). The focus on the spiritual realm may be stronger in Indigenous research methodology. Indigenous knowledge cannot be separated into factual knowledge, ecological knowledge, spirituality, or other components; it is holistic

(Held, 2019). A relational understanding of the world is key for understanding personal stories of abortion-related stigma among Indigenous Peoples in Canada. This is because these abortion experiences take place in relation to and within multiple oppressive systems that impact the lived experience of Indigenous Peoples, such as racism in the health system.

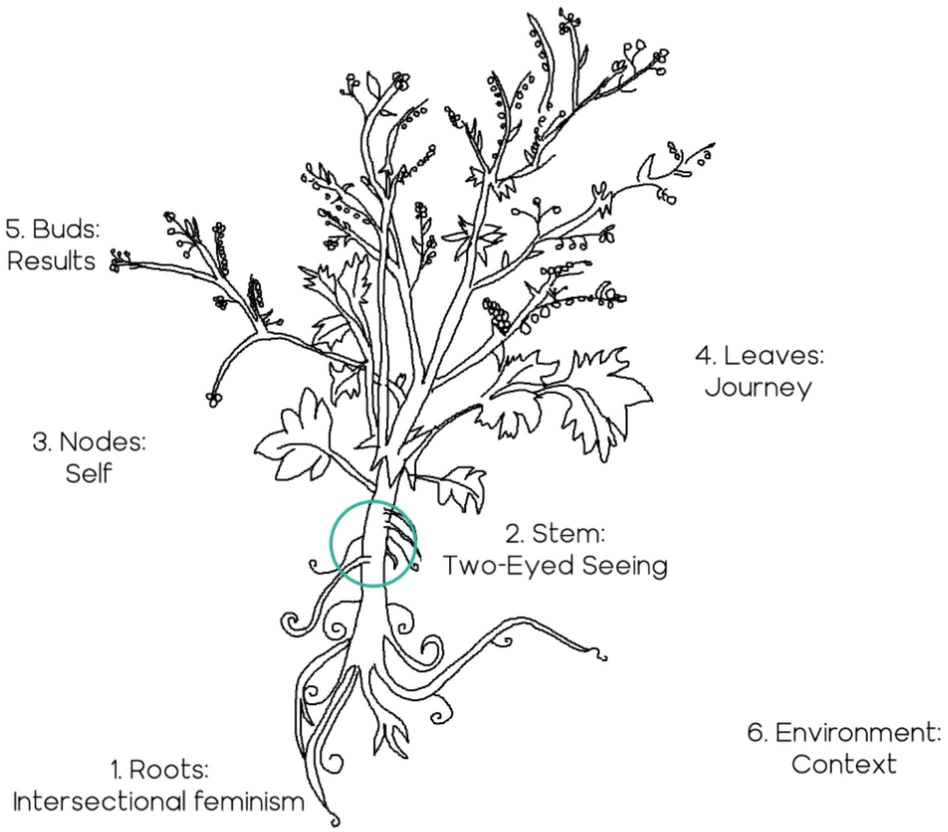
Drawson and colleagues (2017) note a distinction between Western and Indigenous research methods, describing how collaborative research with Indigenous Peoples not only reveals knowledge, but can also decolonize, rebalance power, and promote healing. Drawson and colleagues (2017) further note that Indigenous methodology should be culturally relevant and help to create relationships and support autonomy and self-determination.

Cupchik and Schnarr (2021) state that in Indigenous research, dissenting opinions foster collaborative ideas and outcomes through bridging understandings across diverse locations. Collective knowledge production can move in agreement across balanced dynamics of dissensus and resistance (Cupchik & Schnarr, 2021). Cupchik and Schnarr (2021) also acknowledge that to perceive across worlds does not restrict knowledge but offers an intersectional engagement for translation of that knowledge. It is prudent to use a methodology that honours, incorporates, and makes space for honouring all experiences and worldviews to foster a rich and inclusive research environment. This can be achieved through engaging Indigenous research methodologies such as Two-Eyed Seeing.

Two-Eyed Seeing

Figure 4

This section of the Wormwood diagram highlights the stem: ***Two-Eyed Seeing***



Guided by an ***intersectional feminist approach***, this research follows a ***Two-Eyed Seeing*** ***research methodology*** as employed by Anishinaabe scholar Cindy Peltier (2018) to explore abortion-related stigma experienced by Indigenous Peoples in Canada. Two-Eyed Seeing was coined by Mi'kmaw Elder Albert Marshall of the Eskasoni First Nation in collaboration with Elder Murdena Marshall and Dr. Cheryl Bartlett (Bartlett et al., 2012). Two-Eyed Seeing or *Etuaptmumk* involves seeing the strengths of Indigenous knowledges and ways of knowing with one eye and using the strength of Western ways of knowing with the other (Bartlett et al., 2012). The concept of Two-Eyed Seeing is helpful as it describes ways of weaving together Indigenous and Western knowledges, drawing on the strengths of each "*for the benefit of all*" (Bartlett et al., 2012, p. 335). Two-Eyed Seeing is represented by the stem of the Wormwood diagram to signify that Two-Eyed Seeing is the backbone of this research. Two-Eyes Seeing uplifts and connects every aspect of this research.

Two-Eyed Seeing presents a way to bring together different ways of knowing, skills, and understandings to guide Indigenous and allied researchers (Hovey et al., 2017). It allows for the exploration of lessons learned and working together to enhance the health of Indigenous Peoples through a practical sharing of knowledge to improve outcomes (Bartlett et al., 2012; Hovey et al., 2017). According to Mi'kmaq elder Albert Marshall, achieving Two-Eyed Seeing involves a dynamic, interactive, and relational process which generates new ideas, understandings, and information (Bartlett et al., 2012; Hovey et al., 2017).

Hovey et al. (2017) share that Two-Eyed Seeing is not reducible to simply a method or best practice. Rather, it is a complex and ongoing set of relational and personal sharing of ideas, ways of knowing, and understandings that affect our co-learning journey (Hovey et al., 2017). Ideally, individual perspectives do not compete in Two-Eyed Seeing, but rather collaborate towards fostering a shared understanding

(Hovey et al., 2017). Two-Eyed Seeing becomes part of each researcher's way of seeing the world, and contributing perspectives become interwoven into a new common understanding and interpretation of a shared experience (Hovey et al., 2017).

Two-Eyed Seeing honours individual social location and worldview and fosters collaboration to bridge Indigenous and Western knowledges (Peltier, 2018). Following the concept of Two-Eyed Seeing requires researchers to locate themselves within their research (Cupchik & Schnarr, 2021; Peltier, 2018). This practice is also common in other Indigenous methodologies and some qualitative methodologies such as participatory action research (Kovach, 2021). Two-Eyed Seeing, the "*gift of multiple perspectives*" (Bartlett et al. 2012, p. 335), is appropriate for my research given my social location as an allied white settler researcher working on a research project led by and for Indigenous Peoples. I sought to take a holistic approach to research around coming to know and making meaning in my exploration of abortion-related stigma experienced by Indigenous Peoples.

Two-Eyed Seeing involves weaving themes back and forth among the research team and engaging each of our ways of knowing and understanding (Hovey et al., 2017) to honour and make-meaning from the stories shared in the GGLI interviews. The research team wove our diverse worldviews, educations, and lived experiences together to create a dynamic understanding of abortion access experiences among Indigenous Peoples in Canada. The GGLI research team is made up of women from diverse backgrounds, including Indigenous women and settler allies/accomplices, all of whom have lived experiences of abortion and/or adverse reproductive health experiences. I joined the GGLI project to help conduct thematic analysis of the interview transcripts alongside four other researchers.

Snooks et al. (2021) note that the process of researching and writing as an alliance requires a non-hierarchical approach to knowledge sharing, ensuring that each team member has an opportunity to contribute. This is especially important regarding academic and community-based partnerships with those who may have different backgrounds or priorities (Snooks et al., 2021). This principle in Two-Eyed Seeing was honoured as we conducted this research. For example, some members of the research team had other ongoing projects, so we supported each other to take on only what we had capacity for.

The Indigenous-led research team brought together an IAC consisting of four front-line service providers across Canada working in abortion service access and/or support who were identified through relational networks. The IAC provided guidance and support on all components of the study, including data collection, recruitment, data analysis, and knowledge translation (KT). Collaboration with an IAC is one of the key facets of conducting Two-Eyed Seeing research in a good way as discussed by Bartlett et al. (2012). The IAC members are also consulted with and invited to coauthor all publications.

According to Cindy Peltier (2018), Two-Eyed Seeing involves drawing on decolonizing research and honouring the four principles of *relevant*, *reciprocal*, *respectful*, and *responsible* research (the four Rs) in collaborative research with Indigenous Peoples. The Four Rs are necessary for building good relationships and socially just practices (Kirkness & Barnhardt, 1991; Kovach, 2010; Peltier, 2018; Strega & Brown, 2015), both of which are imperative in my research.

My research is *relevant* in that it addresses an unmet need identified by Indigenous communities, researchers, and peoples with abortion access experience and is not simply a topic forced upon the community. It is *reciprocal* in that the conversations provided benefits to the researchers and participants, with potential to affect social and policy change that will help to create better abortion access experiences for Indigenous Peoples. Further, the research provides a safe space to share personal stories relating to abortion experience which was said to be healing for some participants. Some participants had never shared their experiences and were excited that their stories might help others. The research is *respectful* in that it builds relationships and bridges between cultures and honours ethical story sharing by keeping all stories anonymous and ensuring ongoing consent. Responsibility in Indigenous research speaks to the importance of making meaning together, of listening carefully and engaging in critical self-reflection with respect to power dynamics between researcher and participants (Peltier, 2018). The research is *responsible* in the ways in which it invited written and verbal feedback from participants and provided opportunities for collaboration with the participants and IAC. For example, participants were given copies of their transcripts to redact or change anything, or to withdraw from the study with no penalties. There is a responsibility for researchers to honour Indigenous intellectual property rights and not to share cultural knowledge without permission (Peltier, 2018; Snooks et al., 2021). Ongoing methods of ensuring consent such as confirming consent verbally before, during, and after the interviews were employed throughout the interview, analysis, and manuscript development processes. See Appendix A for the interview guide which includes examples of how ongoing consent was confirmed throughout the interviews. Alongside formal procedures of gaining and confirming informed consent, the passing and acceptance of gifts can serve as what Peltier (2018) calls a "*traditional consent process*" (p. 8), further signaling *respect* for the participants, their time, and their stories. In the GGLI project, participants were given gifts of $100 honorariums, a blanket, and a thank you card from the research team, where the gift the participants brought us was their generous sharing of stories.

GGLI utilized a trauma-informed approach (TIA) in which participants were provided the questions in advance and invited to skip altogether any questions they were uncomfortable with. TIA started as a framework for recognizing and addressing the effects of trauma in healthcare settings (Cahill & Doyle, 2021). In the context of abortion, trauma-informed abortion and reproductive care includes practices that emphasize safety, empowerment, and healing (Cahill & Doyle, 2021). Trauma-informed approaches also involve recognizing the legacy of systemic racism and the exploitative roots of obstetrics and gynecology, recognizing that fear and distrust of sexual and reproductive healthcare systems are a symptom revealing a need for services that may heal and prevent further re-traumatization (Cahill & Doyle, 2021). Trauma and adversity are pervasive among individuals, groups, and communities who experience discrimination and exclusion in social, political, and economic domains (Voith et al., 2020; Isobel, 2021). This research met people where they were at with curiosity and empathy, rather than by forcing a certain pre-determined narrative onto the participants.

Martin (2012) describes how Two-Eyed Seeing attempts to account for the partiality of researchers to certain perspectives used to understand different ways of knowing, ideally without prioritizing one over the other. Rather, Two-Eyed Seeing may be seen as an attempt to consider health topics through bridging Western and Indigenous perspectives. One critique of Two-Eyed Seeing is that it is idealistic, as practically speaking the two opposing worldviews that inform Indigenous and qualitative methodologies may not seamlessly merge to transcend barriers (Broadhead & Howard, 2021). Still, I felt Two-Eyed Seeing was a meaningful methodology for my work given my self-location and my participation on the Indigenous-led research team.

Two-Eyed Seeing has been applied in the health context through research on diabetes (Hovey et al., 2017), cancer (Peltier, 2018), and human trafficking (Snooks et al., 2021), among others. As noted by Hovey and colleagues (2017), Two-Eyed Seeing in health promotion research helps us to recognize that there are multiple worldviews with different meanings and understandings of how we see and hear information on the same topic (Battiste & Henderson, 2000; Hovey et al., 2017; Smith, 2005).

The emphasis on relationship in Two-Eyed Seeing has not always been prioritized in some research conducted on Indigenous Peoples, which has historically opted for a more extractive approach (Held, 2019; Hovey, 2017). As Held (2019) describes, historically research involving Indigenous Peoples has often been exploitative, not done for or by Indigenous communities. In some cases, research among Indigenous Peoples was aimed at assimilation and/or was invasive and unethical (Held, 2019). For example, skin grafting experiments were conducted on Inuit peoples from Iglulik in the early 1970s without their individual and continuous consent (Dossetor, 2005; Held, 2019; Wachowich et al., 1999).

Many Western researchers are now actively working to involve and support Indigenous Peoples and their own priorities in research. Qualitative research methods such as ethnography and participatory action research also centre relationships and prioritize the voices of participants. However, extractive and exploitative research practices continue in some areas, sometimes perpetuated through educational and institutional bodies (e.g., funding tied to short and arbitrary timelines).

Snooks and colleagues (2021) describe how research needs to move beyond signaling change and provide real resources to support Indigenous-led research. Snooks et al. (2021) aptly state that:

> *Decolonizing practices must move beyond superficial gestures of reconciliation and redress that reiterate colonial power through top-down practices. This means … providing the practical resources to support Indigenous-led initiatives that are grounded in Indigenous knowledges, including in anti-violence work addressing issues of violence against Indigenous women and girls* (p. 165).

My research is a humble attempt to support and provide such practical resources to Indigenous-led initiatives and to help reduce the harms perpetuated against Indigenous Peoples in the Canadian health system. I hope to contribute to efforts to destigmatize abortion and improve access to abortion services. Specifically, I aim to advance knowledge on how abortion-related stigma may be experienced through sharing the stories of GGLI participants.

Kovach (2010) posits that meaning making can incorporate both Indigenous and Western approaches to data organization. Following Peltier's (2018) application of Two-Eyed Seeing, when looking through the metaphorical Western knowledge eye, the conversational interview component of the research aimed to advance knowledge around Indigenous experiences with abortion access in Canada and produce literature aimed at improving health outcomes (i.e., improving access to abortion services for Indigenous Peoples in Canada). Looking through the Indigenous knowledge eye, the abortion access stories shared during the GGLI interviews were presented in a meaningful context for Indigenous Peoples and shared in a research process that was culturally safe.

I applied Two-Eyed Seeing in my analysis by prioritizing stories and letting the participants speak for themselves, while learning from and uplifting Indigenous voices. In the thematic analysis, we always honoured the context of the quotes, resulting in lengthier quotations, which may also be found in qualitative research approaches such as ethnography. Prioritizing individual stories follows Indigenous oral traditions and research methodologies. Further, this approach helps to embrace a holistic conceptualization of health, as encouraged in Indigenous research methodology.

Marshall (2012) suggests Westernized academic perspectives tend to categorize or colonize knowledge and ways of knowing to fit knowing, co-learning, and collaboration into a discipline or subject area (Hovey et al., 2017). The categorization of the stories required for our thematic analysis seemed to follow more of a Western qualitative research paradigm. This was discussed among the research team and honoured throughout the thematic analysis, as we understood that we need the strengths of both Indigenous and Western knowledges to gain a full understanding of Indigenous abortion access experiences. This is spoken to in more detail below within the methods section. Categorization of stories is realistically required within health research due to the way that funding systems are structured. In contemporary research, it is almost impossible not to work within a discipline when conducting research beholden to funding structures.

I refer to my analysis as knowledge gardening as it is useful to understand the analysis process. The concept of knowledge gardening was coined by Dr. Cheryl Bartlett, and is described as a dynamic interplay of seeding, nurturing, and growing information, like land based gardening (Bartlett et al., 2012, p. 336). Knowledge gardening recognizes a consciousness in environments, and the advantages of recognizing and bringing such knowledge together in timely, patient, and respectful ways (Bartlett et al., 2012; Hall et al., 2015). Knowledge gardening provides a holistic Indigenous health-inspired metaphor for data analysis which I will use to describe my findings. Honouring individual stories and experiences was embraced throughout the knowledge gardening process and this work was informed by an intersectional feminist approach. Through co-creation of stories and knowledge with and for Indigenous communities, knowledge transfer and community-driven priorities can be developed and shared in a good way (Peltier, 2018) to provide benefit to the community the research aims to serve.

The concept of knowledge gardening resonates with me as we applied a holistic, Indigenous lens when exploring the stories shared in the GGLI interviews. We prioritized stories as key information regarding the lived experiences of participants, taken at face value, as is appropriate in Two-Eyed Seeing methodology.

There is a diversity of worldviews within the research team, and Two-Eyed Seeing shines through in the ways we collaboratively found meaning within the transcripts. A Two-Eyed Seeing approach allowed for meaningful collaboration between the research team and the IAC. The research team encouraged co-authorship with all members of the IAC on all published works. The IAC was invited to collaborate and suggest changes on all manuscripts and KT products.

Chapter 5: Methods

An overview of the GGLI project

Co-led by Drs. Renee Monchalin and Astrid Perez Piñan and funded by the University of Victoria, GGLI is an exploratory study that aims to advance knowledge around access to and experiences with abortion services among Indigenous women and Two-Spirit people in Canada. GGLI was fully guided by an IAC consisting of four members of Indigenous abortion support workers from Abortion Support Services Atlantic, ekw'í7tl Indigenous doula collective, and Northern Reproductive Justice Network.

GGLI drew on Indigenous feminist scholars theorizing reproductive justice and the impact of colonialism on Indigenous Peoples' reproductive lives (Anderson, 2003; Violet & Spillet, 2017) for all elements of the study. Indigenous feminism aims to support movements for decolonization and Indigenous self-determination by exploring how the intersections of gender, race, and sexuality shape Indigenous Peoples' realities in the Canadian settler state (Green, 2017). Through an Indigenous feminist lens, GGLI engaged with 15 self-identifying Indigenous Peoples across Canada on the following topics: (1) abortion access experience; (2) abortion-related stigma; (3) abortion-related supports, such as post-abortion support and support from family; (4) racism and discrimination; (5) Indigenous service providers; (6) traditional medicines or teachings; and (7) recommendations for improving abortion access. My thesis research project drew upon and is nested within the stigma-related results of the GGLI project.

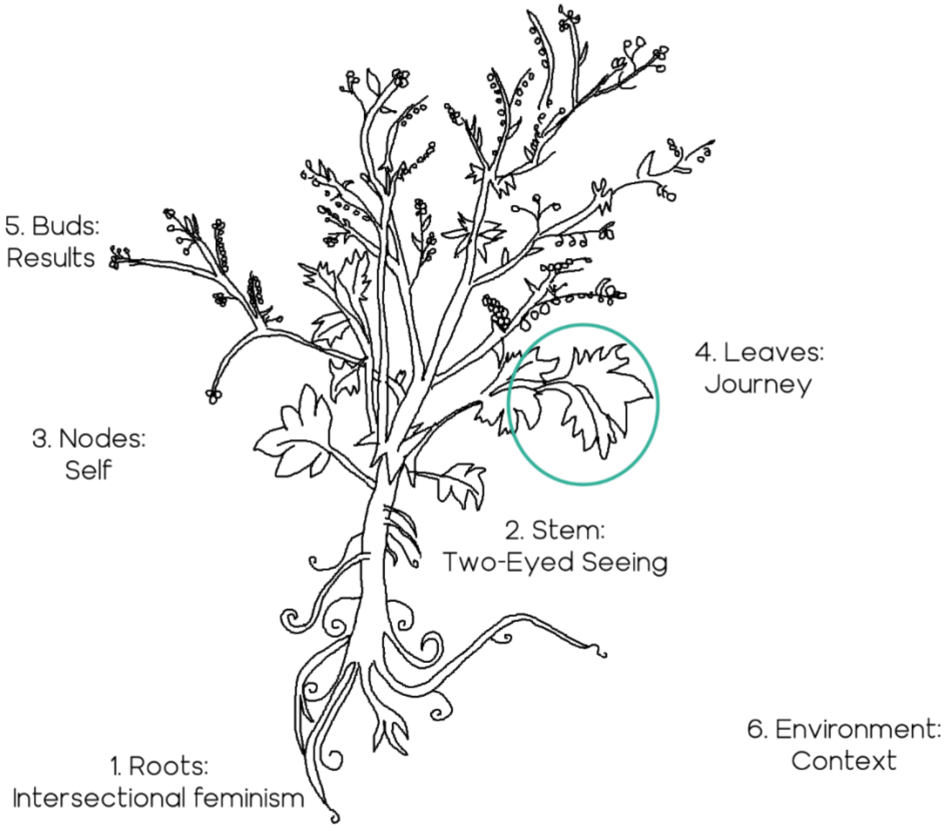
Prior to my arrival on the project, recruitment for the GGLI project began in September 2021 with the research team and the IAC sharing the recruitment poster via social media. Selection criteria included participants who self-identified as First Nations, Inuit, and/or Métis; were 19 years old or older; and accessed or tried to access an abortion in Canada. This project focuses on aspiration abortions as every participant in the GGLI project accessed aspiration abortion. This was not intentional as people who had accessed any kind of abortion were eligible to participate. The research team chose to use a ***<u>conversational method</u>*** to gather data in GGLI. Margaret Kovach (2010) describes this method:

> *The conversational method is a means of gathering knowledge found within Indigenous research. The conversational method is of significance to Indigenous methodologies because it is a method of gathering knowledge based on oral story telling tradition congruent with an Indigenous paradigm. It involves a dialogic participation that holds a deep purpose of sharing story as a means to assist others. It is relational at its core* (p. 40).

This research followed an Indigenous methodological framework as defined by Ojibway scholar Kathy Absolon (2011). This method allows researchers to acknowledge and honour "*how healing is woven throughout the re-search process*" (Absolon, 2011, p. 93). Indigenous research methodology recognizes the importance of stories, and the conversational method allowed each participant's story to emerge, reflecting their lived experiences and knowledges. A conversational method is also employed in Western qualitative approaches such as ethnography. The conversational method aligns with traditional ways of sharing knowledge in Indigenous communities using oral storytelling practices (Absolon, 2011; Kovach, 2010). The interviews were semi-structured following an interview guide with 12 questions (see Appendix A). Semi-structured interviews allow researchers to explore participant thoughts and experiences and to dive deep into potentially sensitive and personal experiences (DeJonckheere & Vaughn, 2019), making this a rational choice for this research. Following data collection, I joined the GGLI project in November 2021 to support data analysis.

Data Analysis

Figure 5
Wormwood diagram: the leaves represent the journey, including the processes and transformation within this research. The DEPICT model is central to this journey.



The analysis of the GGLI interviews follows the DEPICT (Dynamic reading, Engaged codebook development, Participatory coding, Inclusive reviewing and summarizing of categories, Collaborative analyzing, Translating) model for qualitative analysis by Drs. Sarah Flicker and Stephanie Nixon (Flicker & Nixon, 2014). The DEPICT model involves collaborative and democratic data analysis among diverse stakeholders and may help to bring more nuance to the analysis of complex health issues (Flicker & Nixon, 2014).

Prior to applying the DEPICT model, we conducted a brief preliminary analysis in which each team member read the same transcript and took notes of key ideas. Then, the team met to discuss the findings to ensure the team was identifying concepts in a similar way. Once this was confirmed, we began data analysis following the DEPICT model.

The DEPICT model (Flicker & Nixon, 2014) follows six steps for collaborative data analysis. I will delineate each of these and describe how they applied to the GGLI analysis:

1. **Dynamic reading:** In this step, each team member read a subset of interview transcripts. The research assistant who conducted the interviews assigned three transcripts to each team member. We engaged with the transcripts by asking questions, identifying common concepts, taking notes, and linking ideas. Findings were then discussed to ensure the team approached the work in a congruent and good way.
2. **Engaged codebook development:** Next, we developed a rough list of categories that would be used to organize the data. Transcripts were accessed online using NVIVO 12 software and a secure shared drive via UVic. Team members wrote down specific ideas that emerged during transcript review, and these were then clustered collaboratively into categories and sub-categories. Each of these was then named and defined. Next, one research assistant compiled the categories and subcategories into a preliminary codebook and shared this with the team. After taking time to reflect, the research team gathered to refine the codebook. Next, the categories and subcategories were finalized in the codebook.
3. **Participatory coding.** The codebook was circulated, and each team member was given responsibility for coding a new subset of transcripts (three each). One team

member coded four transcripts while another coded two due to capacity constraints. The IAC was invited to participate in analysis, yet ultimately did not participate in this step. We conducted holistic coding of all transcripts as outlined by Saldaña (2013). Holistic coding is described as analyzing the data as a whole to identify basic ideas and concepts (Onwuegbuzie et al., 2016; Saldaña, 2013). This involved highlighting full passages to identify key quotes and honour the context of what each person was describing through their story (Absolon, 2011). This sometimes meant that large chunks of texts were included, to be parsed out during the collaborative analyzing (i.e., descriptive) coding process (step 5).

To improve rigour, at least two team members coded every transcript. As noted by Flicker and Nixon (2014), sharing coding among several people can help to build deeper understanding, a sense of ownership, and foster meaningful engagement among the research team (Flicker & Nixon, 2014). Sharing coding among several people is also useful for time management and workload distribution (Flicker & Nixon, 2014).

4. **Inclusive reviewing and summarizing of categories.** In this step, the coded data in each category were re-reviewed side-by-side. We worked in pairs to look for convergence and divergence and choose key, representative quotes. I was paired with Dr. Monchalin as this was my first time participating in thematic analysis. This allowed me to explore the quotes and concepts, ask questions, and provide input in an empowering and supported way. Succinct summaries were developed for each

category in pairs, though we did not adhere to the two-page summary recommendation from Flicker and Nixon (2014). We found the codes were too layered, and the context too important, to cut the content so significantly.

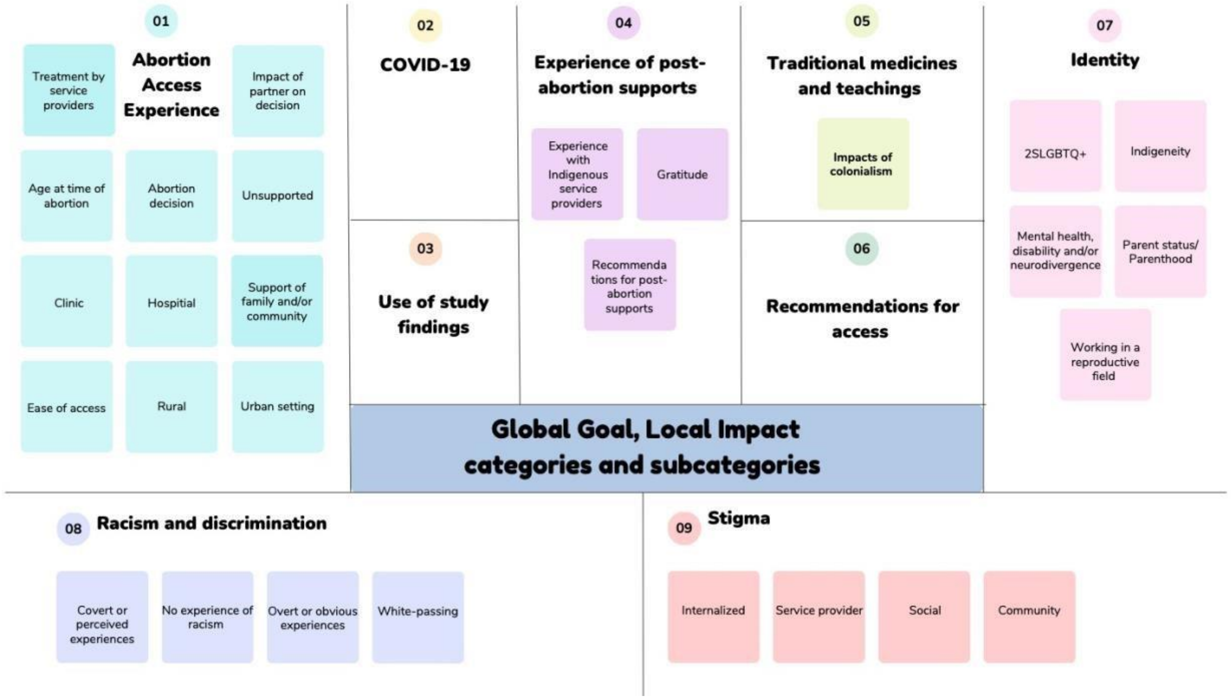
5. **Collaborative analyzing.** In this step, the summaries of each category were amalgamated into a draft descriptive report. Then, the larger team came together to discuss the report and collaborate on edits. Specific categories were assigned to individual team members based on their areas of interest. I analyzed the stigma categories. Descriptive coding was conducted in which data were organized into more specific sub-categories (Onwuegbuzie et al., 2016; Saldaña, 2013). For example, stigma was organized to include internalized, service provider, social (including stereotypes), and community stigma. In total, there were nine main categories and six of these included subcategories in the analysis (see Figure 6).

The results of the descriptive coding were reviewed by at least two team members to ensure all categories were well represented. Once each transcript received its second review, themes were identified and summarized by the responsible research team member. It was important to make room for competing interpretations (Flicker & Nixon, 2014), though this is not something we encountered. As stated by Flicker and Nixon (2014), "*surfacing and exploring diverse viewpoints can lead to richer dialogue*" (p. 621). Then, the research team gathered to discuss the themes and arrived at consensus on each of these. Next, the research team presented the revised theme summaries to the IAC for review to confirm themes and revisit the original project objectives.

6. **Translating.** In the DEPICT method, the final step is to plan knowledge translation activities (Flicker & Nixon, 2014). Therefore, our last step was to create a dissemination plan. Each team member was assigned a manuscript to develop. Manuscript topics include an overview of the project, recommendations, methods, and stigma. I will be writing the manuscript on stigma. An infographic and podcast to summarize and disseminate accessible findings will also be developed. The GGLI project received funding to expand on this work and interview more people to build on the initial study's findings.

Figure 6

A diagram of each of the categories and subcategories from the GGLI project.

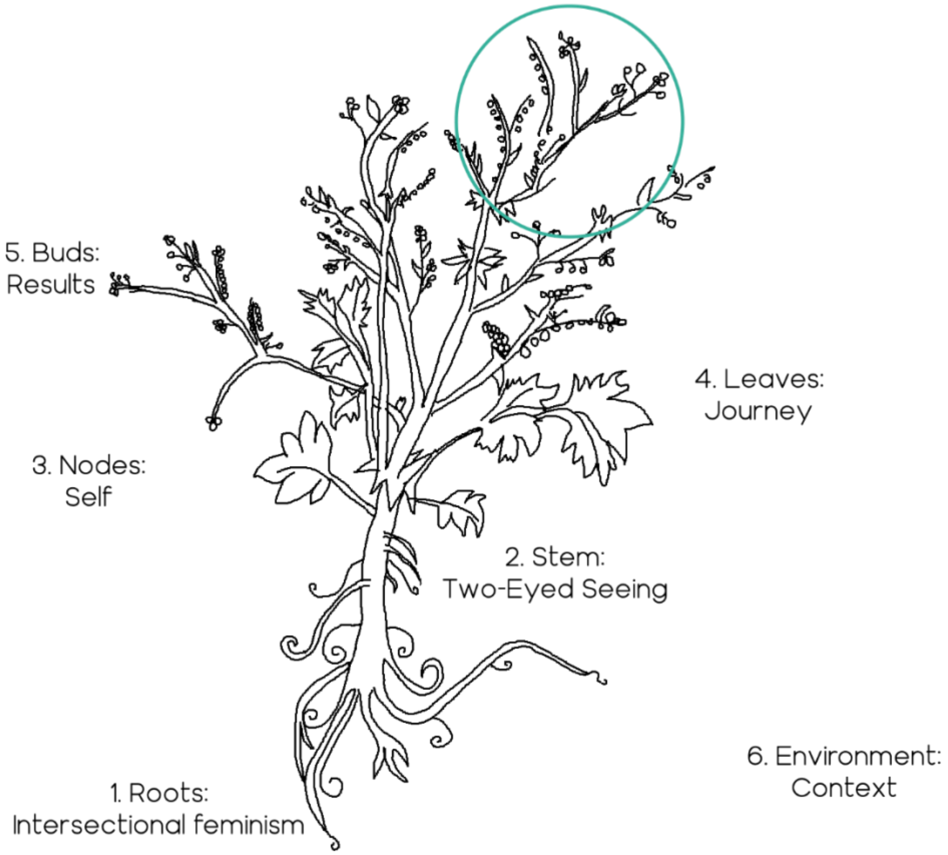


Note: *The colourful boxes include each of the subcategories, whereas the bolded text shows the broader categories.*

Chapter 6: Results

Figure 7

The Wormwood diagram buds, representing the results of this research.



Context for Analysis

Fifteen participants between the ages of 16 to 29 at the time of their abortion, who identified with the Métis, Cree, Dene, Inuit, Haudenosaunee, Anishinaabe, and/or Mi'kmaq Nations, from nine provinces and territories across Canada participated in the GGLI study. All participants accessed an aspiration abortion, with one participant having two failed attempts with a medical abortion. This was coincidental as the study was open to people who had accessed either a medical or an aspiration abortion. Study participants were given plant medicine names that were used for traditional reproductive medicines by Indigenous communities in Canada.

In the GGLI thematic analysis, we found that experiences of abortion-related stigma were interwoven and layered throughout all abortion access experiences, with all 15 participants speaking to at least one element of abortion-related stigma in their stories. Participants spoke to challenges and potential solutions around access to abortion that related to geographic barriers, poor treatment, stigma, impacts of colonialism on attitudes towards abortion, traditional knowledge, and follow-up care and support.

Experiences of abortion-related stigma as described in the GGLI interviews were complex, layered, and interwoven with intersecting identity factors and oppressive experiences. For example, several quotes represented experiences of service provider stigma, internalized stigma, social stigma, and anti-Indigenous racism all at once. In these quotes, participants described feeling judged and/or experienced fear of judgment by service providers due to their Indigeneity. This made it very difficult to categorize each quote into just one type of stigma. While many quotes may fit into several themes and sub-themes, for the purposes of my thesis organization I have placed quotes within their *most* relevant sub-theme. This speaks to the difficulty of attempting to categorize knowledges while seeking to honour individual stories and to allow these to speak for themselves.

The concept of intersecting stigmas described in Ipas (2018) is applicable to this research, as the experiences of Indigenous Peoples within the Canadian health system often intersect with other factors and oppressions (Allan & Smylie, 2015; Reading & Wien, 2009). For example, experiences of abortion-related stigma may intersect with racism, colonialism, classism, and other forms of discrimination (Ipas, 2018; LeTourneau, 2016).

Rationale for abortion-related stigma categories

It is important to acknowledge the differences in abortion-related stigma categories used for the analysis from the abortion-related stigma literature. Cockrill and Nack (2013) categorize abortion-related stigma into internalized, felt, and perceived stigmas. Hanschmidt and colleagues (2016) describe internalized, felt, and enacted stigmas in their systematic review. Ipas (2018) included a broader number of categories, including internalized or self-, experienced, anticipated, social, health professional, discrimination, intersecting stigma, and stereotyping. The stigma related themes described in our study were most aligned with the categories put forward by Ipas (2018). Anticipated stigma was treated as a part of internalized stigma because in my opinion, anticipated stigma often stems from stigma that has been internalized. While this may be a theoretical leap, it felt out of alignment with the intersectional feminist lens to downplay the systemic ways that abortion-related stigma becomes internalized, contributing to anticipated stigma and discomfort in the health setting. Stereotypes were treated as an aspect of social stigma as per the definition of social stigma from the

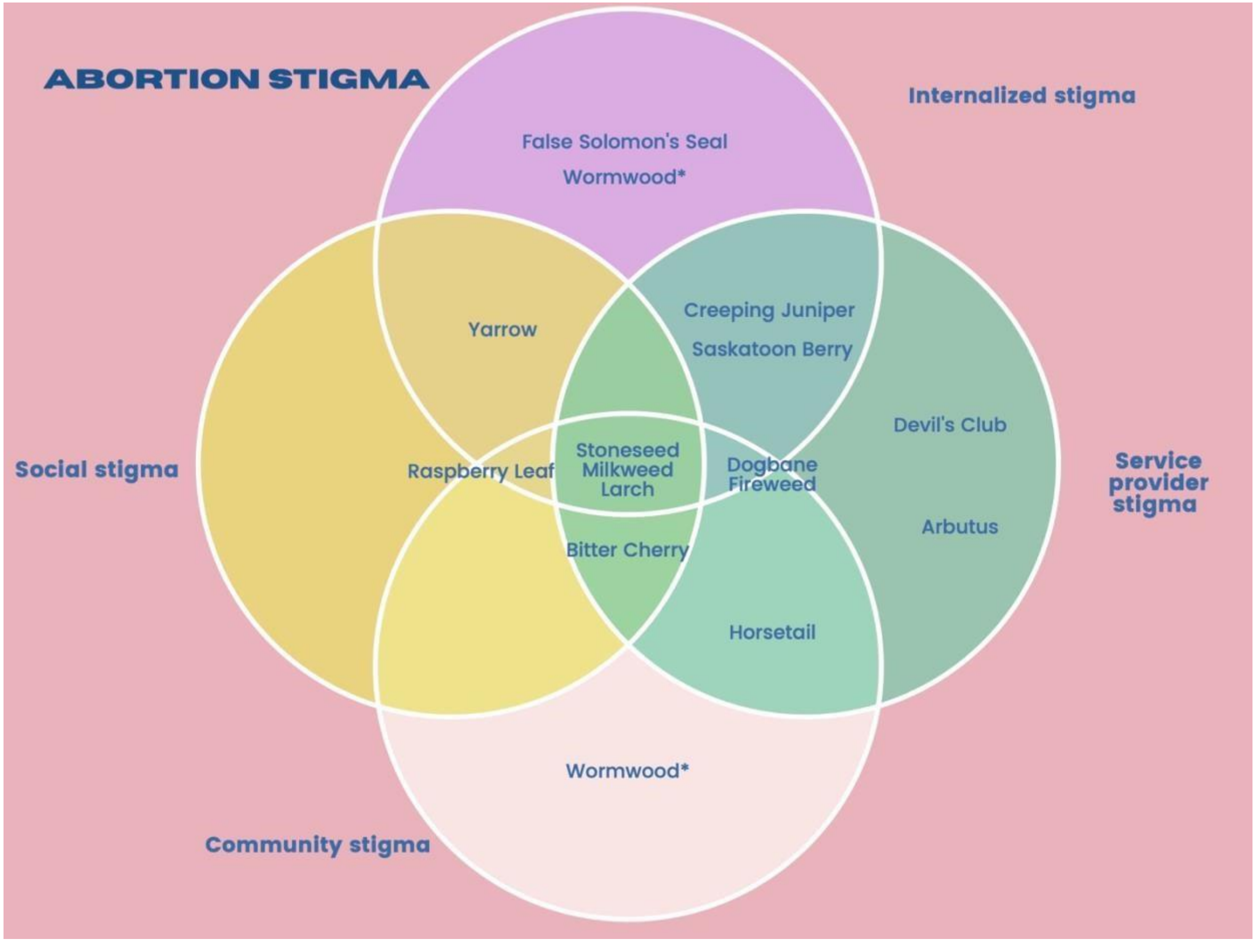
World Health Organization (2020). While there was some congruence between my work and the known literature, there was an apparent gap around stigma specifically experienced in Indigenous communities. This led to the inclusion of the community stigma category.

Themes of stigma were organized into the following categories: (1) Internalized stigma, including internalized shame and stigma; (2) Service provider stigma, including pressure and coercion from service providers, judgment from service providers, and poor treatment by service providers due to Indigeneity; (3) Social stigma, including stereotypes; (4) Community stigma, including religious/colonial influence; and (5) Strategies for dismantling abortion-related stigma suggested by participants.

Chapter 7: Results of Abortion-related stigma Thematic Analysis

Figure 8

The interwoven nature of abortion-related stigma



Note: Figure 8 is a four aspect Venn diagram. It demonstrates the overlapping nature of the types of stigmas as experienced by participants in the GGLI interviews.

Experiences of stigma were overlapping and layered, as shown in Figure 8. Three participants described experiencing one type of stigma each, whereas the remaining 12 participants experienced 2 to 4 types of stigmas. For example, Stoneseed, Milkweed, and Larch all noted experiencing each type of stigma, including internalized, service provider, social, and community stigmas. Wormwood experienced internalized and community stigmas. Yarrow experienced social and internalized stigmas, whereas Dogbane and Fireweed experienced internalized, service provider, and community stigmas.

Internalized stigma

Internalized stigma refers to an individual's inner experiences with perceived and anticipated judgment, stigmatizing views of the self, and includes shame contributing to secrecy regarding stigmatizing experiences such as abortion (Ipas, 2018). Eight participants spoke to internalized stigma. Participants who described internalized stigma experienced shame, anticipated judgment, and often decided to keep their abortion a secret.

Internalized shame and stigma

Internalized shame was experienced by eight participants and stemmed from internalized stigmatizing views of abortion. For example, one participant expected to be judged by other people at the abortion clinic. They worried that people may view them as 'another' young, pregnant Indigenous person. These quotes revealed anticipated and internalized stigmas which frequently led to feelings of shame. They also hint at the participant's perception of the harms of racism and stereotyping present in the healthcare setting.

> *I did feel shame, sitting in that room because it was just like, this visibly Indigenous person in an abortion clinic and young and what was running*

> *through my head was like what are these people thinking of, or they're just like, 'oh my god another one'. (Dogbane)*

Another participant shared they would only disclose their abortion when talking to someone who had also had an abortion. This was because the participant believed some people think abortion is wrong.

> *I told other people who, say they were talking about it or whatever and they confide "oh I had [an abortion]" and I'd be like "okay well I had one too" but I wouldn't tell anyone because I feel like people think it's the wrong thing to do, a lot of people look at you like you did something wrong. (False Solomon's Seal)*

A third participant echoed these feelings of shame and fear of judgment for having more than one abortion.

> *Then the second [abortion] a year later I didn't tell anyone because I was ashamed that it had happened again. (Stoneseed)*

A fourth participant also described feelings of shame about their abortion when they were put in a room with several other people who had also just had an abortion. The lack of privacy caused them to worry about confidentiality and left them feeling dehumanized.

> *It would have really been nice to have my own private space after the surgery was done, just because at the time I really was dealing with those feelings of shame. I didn't want anyone to know, and I was really scared that this random stranger had seen my face and I'm sure that they might have felt the same. And*

> *it was also just really dehumanizing to just be thrown into a room with a bunch of strangers. (Milkweed)*

Another participant described internalized stigma that is hard to escape because of negative community views surrounding abortion such as the idea that abortion is not normal or acceptable in Indigenous communities. Wormwood spoke to this in the context of high teenage pregnancy rates that they believed were influenced by youth feeling forced and/or pressured to have children by older generations. This may also be because community members may value having children in all situations. Further, individuals may not want to go against communal norms and/or to face judgment and disapproval from others based on their reproductive decision-making. The potential impacts of not being able to move away from stigma include a perceived lack of reproductive autonomy for young Indigenous Peoples which may contribute to the inaccessibility and unacceptability of abortion services in Indigenous communities. The values and beliefs of people in community and support networks influence decision-making around abortion, though not necessarily due to stigma.

> *We're stuck with all these views that have been forced upon us and that we hold on to dearly. It's kind of internalized and then it's hard to move away from it. (Wormwood)*

These findings suggest that internalized stigma and shame around abortion was present among participants. Participants spoke to how other people, including family members and those in their community influenced this internalized stigma, contributing to shame and sometimes leading them to keep their abortion a secret. For example, Dogbane described anti-Indigenous racism and stereotyping that may have become internalized, impacting their abortion experience and emotional wellbeing. Another participant noted that being put in a room with several other people after having an abortion was harmful. They suggested that being in their own private space may have helped them to deal with their feelings of shame in a safer and more private way. Internalized stigma and shame contribute to the ongoing stigmatization of abortion. These findings point to the need to normalize abortion to reduce the impacts of shame and internalized stigma on abortion seekers.

Anticipated judgment. Anticipated judgment may be seen as a facet of internalized stigma where individuals expect to be judged negatively for their abortion decision. Eight participants discussed anticipated judgment from parents and community, which ultimately influenced their decision to keep their abortion secret. Five participants anticipated judgment if they shared their abortion with a parent figure. Mothers and mothers-in-law were most frequently discussed, with fathers being mentioned by two participants.

A participant described feeling very scared to disclose their abortion to their mother and ended up keeping their abortion a secret.

> *I was way too terrified to tell my mom about it. My mom and I have always been best friends and we didn't really keep any secrets but that was one thing I just yeah, I didn't feel comfortable telling her about. (Yarrow)*

Another participant did not have a close relationship with their mother and felt their abortion was not something to discuss with their father. Though they might have been able to talk to a friend’s mother about their abortion, they decided not to disclose their abortion to anyone.

> *I was kind of cut off from my mom when I was younger, I started working right away so I mean that’s just not something you would talk to your dad about or pick up the phone and have that sterile phone conversation to your mom that you don’t see every day, not really something that I felt comfortable doing. I maybe could have talked to my friends’ moms, but I didn’t really tell anybody. (Creeping Juniper)*

Another participant stated that they did not feel ashamed about disclosing their abortion decision to their mother who had anti-abortionist relatives in the U.S. They expressed discomfort around disclosing their abortion to their husband’s religious family out of concern that it would change relationships.

> *I finally just told my mom. … I think probably about four years ago now I might have finally mentioned something to her. And it was because, she lives here in Canada, and she has two sisters in the states and they’re very religious. And they were posting a lot of, you know, anti-choice material on Facebook and stuff like that and so me and my mom had gotten into a conversation about that and so I finally told her, and she was glad I told her. She was surprised, she’s like ‘I never would have thought’ … It’s not something that I’m ashamed of but it’s not something that I go around and talk a lot about. Especially my husband’s family, they’re religious and his mom is very, very child oriented so I know any*

> *conversation like that would not fly, it would totally change relationships and stuff and for me, it's not worth it. (Larch)*

This quote suggests that religious affiliation may influence the ways abortion is perceived and whether a person will disclose their abortion or keep it secret for fear of stigma. Abortion-related stigma may be experienced in different ways depending on a range of factors, including the ideologies, spiritual and/or religious beliefs and cultural norms of a person's family and support network. This may influence how abortion-related stigma must be addressed as social constructs and affiliations may contribute to complexities that make discussion of abortion complicated and socially risky.

Another participant worried that if their community found out, they might judge them or their mother about the abortion. While literature suggests that historically Indigenous views around controlling birthing options centred around personal choice and that abortion was not necessarily wrong, what is considered 'traditional' in Indigenous communities has shifted due to the influence of colonial religions and faith-based beliefs (Anderson 2003, 2011; Monchalin, 2021; Redvers, 2019). As with all cultures, there are a diversity of worldviews that exist within Indigenous communities. What is considered traditional may not be the same for all community members. For example, one participant described a perspective that reflects traditional values as meaning those that are aligned with Catholic/Christian worldviews (i.e., that abortion is wrong). They noted how their mother's traditional ways may be called into question if community found out about their abortion.

> *It’s not that I couldn’t tell my mom, I just chose not to. It’s just something I didn’t want her kind of brewing in the back of her head on top of anything else she worries about … It’s not like I was hiding it. I don’t think she could be bothered with it, she has enough going on. … She would be this traditional clan mother type who goes to Longhouse and follows all these traditional rules and values and ‘Oh no, she has the daughter who had the abortion’. (Raspberry Leaf)*

The same participant described how their mother’s values contributed to their decision not to disclose their abortion to family members. They spoke of fear of being perceived negatively by community.

> *It’s this old way of thinking that if you get an abortion, you’re a baby killer, it’s a sin, and you’re going someplace bad, so I never actually told my mom. (Raspberry Leaf)*

Ultimately, Raspberry Leaf stated they were fine with keeping their abortion secret from their mom and noted that they could rely on support from their partner. They noted that their mother was very ‘traditional’ which contributed to them keeping the abortion a secret. This quote suggests that worldviews and belief systems are shaped by a multitude of factors and belief systems are not homogenous. This signals the complexity of belief systems and the variability in what is seen as traditional by some people.

Another participant felt lucky to have support from family during their abortion experience. They felt they needed to tell their parents about their abortion because they did not have a car or the financial resources to get an abortion without support.

They were 19, living on their own for the first time and lived about eight hours away from the nearest abortion clinic. They required financial support for transportation, hotels, as well as someone to take them to the appointment, which their parents were able to provide. However, they echoed concerns presented by another participant and felt that their dad knowing about the abortion changed their relationship. Although he was supportive, Horsetail felt that their father knowing about the abortion changed the way he perceived them, perhaps prompting him to realize that they had grown into an adult woman. If they had had another option at the time, they likely would not have told their parents about the abortion.

> *I was really lucky that I did have support from my family. There's still people in my life that I haven't told and wouldn't tell just because I know their views and I see what they say and I'm like, you don't need to know, right? And while my dad was supportive it did change our relationship. … I don't know if it was just that or in a way that was just like holy s---, that was a lot, but I did feel that that relationship changed, which sucks. And I wish that I didn't have to tell him, that if I didn't have any conversation that I had with my parents, I would have gone and done that with the support of some other people that I had in my life that it wouldn't have made me feel as awkward to have those conversations with my parents. (Horsetail)*

Horsetail's abortion was dependent on involvement from their parents because they lived in an area where abortion was not accessible. While Horsetail was privileged to have family support to enable and finance travel, this may not be the case for all. For example, if Horsetail did not have support from their parents, they may have had to resort to other means to seek the care they needed, which may have led to seeking unsafe abortion services. Horsetail's story points to the need to improve accessibility of abortion services and to reduce the financial burden of accessing abortion, as they rightly note, many people may not be able to afford the travel costs and the loss of confidentiality by revealing their need for an abortion to family members. It is key that abortion services are holistic, accessible, and come with counselling services.

Another participant discussed the isolation that may be associated with having an abortion but not being able to talk about it to loved ones.

> *The women I've encountered who had not so great [abortion] experiences, they just said they felt like they couldn't talk to anybody because there's so much stigma around it. (Raspberry Leaf)*

This quote demonstrates how stigma may contribute to abortion secrecy and isolation for people who have abortions.

Another participant would like to see abortion-related stigma eliminated overall and described some potential dangers of not destigmatizing abortion.

> *My biggest hope is that Indigenous or not, that this stigma around [abortion] is just wiped out more like it. To me, I find it frustrating how still, even though it's a legal and acceptable thing to do, it's still very much swept under the rug. I think by doing that too, it allows it to be open to political attack, which is very dangerous. That scares me a lot. (Larch)*

This quote suggests that the stigma that keeps discussions of abortion in the shadows may have political implications and consequences for individual reproductive choice.

The quotes in this section may indicate that people experience fear of judgment and repercussions when deciding whether to disclose their abortion to other people, particularly their parents. This section also speaks to the potential influence of faith-based and cultural norms which may impact how abortion is perceived in certain communities and/or by certain community members, contributing to abortion secrecy and fear of disclosure. This section also suggests that there is a need for support to improve the accessibility of abortion by reducing barriers and financials costs to access, particularly for young people in rural areas across Canada so that people do not have to disclose their abortion to family members in order to access abortion. Participants also discussed the potential isolation associated with having an abortion and not being able to talk about it with loved ones. The final quote points to the importance of reducing stigma around abortion overall.

Service provider stigma

Service provider stigma is the stigmatization of people accessing services that results in poor treatment of these people in the health setting (Ahmedani, 2011; Desai, 2002). Service provider stigma may result in individuals with stigmatized conditions not receiving equivalent care when compared to the public if health professionals are aware of their condition (Ahmedani, 2011; Desai et al., 2002). LaRoche and Foster (2018) described the abortion-related stigma that is present among some health care providers in Canada.

Service provider stigma was the most frequently cited form of stigma within the GGLI interviews. Ten participants indicated service provider stigma and felt pressured, coerced, and/or judged by service providers during their abortion-related experiences. In every case, service provider stigma contributed to feelings of shame and/or anticipated judgment from others in their lives, which generally led to secrecy surrounding abortion. Secrecy around abortion is impactful because there can be negative impacts associated with it, such as isolation (Astbury-Ward et al., 2012; Belfrage et al., 2020; Cockrill & Nack, 2013; Ipas, 2018), poor mental health outcomes (Belfrage et al., 2020; Major & Gramzow, 1999), and diminished social support accessed (Belfrage et al., 2020; Cockrill et al., 2013; Hanschmidt et al., 2016; Ipas, 2018; Shellenberg & Tsui, 2012; Sorhaindo et al., 2014). For some people, keeping their abortion a secret is supportive, whereas for others there may be adverse impacts on their mental and social wellbeing.

Pressure and coercion from service providers

Reproductive coercion occurs when someone pressures another person about their reproductive choice and/or takes action that makes exercising reproductive choice harder (Canadian Women's Foundation, n.d.). Several participants experienced coercion and significant pressure from doctors and other service providers who wanted them to carry out their pregnancy, despite their clear indication that they wanted an abortion.

For example, one participant was pressured by a doctor to have a baby, despite clearly stating they wanted an abortion and strong rationale for not wanting a child while in their first year of university. Saskatoon Berry wondered whether trying to access abortion in a "*really religious community in small town Alberta*" (Saskatoon Berry) influenced this doctor's insistence that they stay pregnant. This suggests the potential influence of service providers' religions and cultural beliefs when providing abortion care. Saskatoon Berry described feeling ashamed after talking to the doctor which contributed to their decision not to tell their parents.

> *The doctor was like, you should seriously consider having this baby. …I just remember thinking I cannot have this baby … I was drinking, and I was just like there's no way, I was not ready to be a mom. … I just remember feeling like why on earth would this doctor who doesn't know me, doesn't know my circumstances, doesn't know anything. Why would they say I shouldn't have an abortion? I was like I need to have an abortion and he was like, I think you should reconsider. … I don't really know how my parents would have acted at the time I guess I didn't talk to them. So even though we were really close or whatever. I guess I felt too ashamed to talk to them about it. (Saskatoon Berry)*

Another participant echoed this experience and similarly felt pressured by a doctor who also encouraged them to remain pregnant. In this case, the doctor questioned their decision and seemed to attempt to coerce them into having a baby, indicating that having an abortion could be a big mistake.

> *The doctor came back and told me that I was pregnant, and I immediately was like, okay, well I want an abortion how do I do that? He was a old white haired old man. And he was like why do you want an abortion and I was just trying to explain, I've literally never wanted to be pregnant, in my life. I'm only 18 and that's not what I want. And he literally said, I don't want you to feel like you're going to make the biggest mistake of your life. (Milkweed)*

This startling quote suggests that health care providers may attempt to coerce individuals surrounding their reproductive decisions.

Another participant reflected on how a given doctor's beliefs should not factor into how abortion care is provided. The participant also described the importance of accurate and readily available resources on abortion to counter abortion-related stigma.

> *Even if the specific doctor was not supportive, I think it's their [job] to ensure that we have those resources, it's our right and it's their job. And I think that that would also help with the stigma a little bit, just making it more readily available whether someone wanted it or not. (Milkweed)*

This participant noted that a doctor's personal beliefs should not factor into care and reiterated the need for easily accessible information on abortion to help reduce stigma. The GGLI interviews demonstrate that people's reproductive decisions may not be trusted and respected by all service providers. People accessing care need to know that there are avenues to raise complaints against health care providers who inappropriately attempt to pressure/coerce them regarding their health decisions. However, this solution places the impetus on individuals rather than addressing the root cause of reproductive coercion and potentially a misuse of power by health care providers.

Study findings suggest that there is a need to have mandatory service provider training around patient-centred care and decision-making to ensure non-judgmental and supportive care in the Canadian abortion context. The Canadian Medical Association (CMA) (2018) is committed to patient-centred care and writes about their commitment to "*always treat the patient with dignity and respect the equal and intrinsic worth of all persons, always respect the autonomy of the patient*" (p. 2). Some experiences described by GGLI participants may not align with these ethical principles.

Judgment from service providers

Eight participants described judgment from service providers who were aware of their abortion decision and/or abortion history, including poor treatment such as judgmental comments and changes in service provider attitudes between abortion experiences. Stories revealed the impacts of these judgments including avoiding disclosure of abortion, leaving a medical practice, and not wanting to address their pregnancy.

One participant described inappropriate treatment from a nurse who said judgmental things to them during their abortion access experience. For example, they were told that abortion should not be used as birth control.

> *The way that [the service provider] talked to me was definitely not okay. She was telling me things like "you know this shouldn't be a form of birth control and you*

> *need to look at what you're doing". I understand two abortions, that's not great, nobody wants to make that choice twice, so for someone to put it in your face that you're doing something wrong when you're just trying to make the best decision for you. It was atrocious to me that kind of behavior, especially in a caring environment and caring profession. (Creeping Juniper)*

This experience of judgment by service providers is echoed by several other participants.

Another participant discussed a difference in treatment from service providers between an abortion they had when they were 18, and another pregnancy later in life.

> *When I was with my doctors, I could just tell there was that judgment of being 18 and Indigenous. The stigma was real, and it feels so different now [that I am pregnant intentionally]. (Dogbane)*

This quote suggests that younger age may influence the judgment experienced, with teenage pregnancies potentially being more at risk of experiencing abortion-related stigma. This is consistent with literature that discusses how stigma is frequently reported by teenage parents who describe feeling like they are being treated more negatively than older parents (Bermea et al., 2018; SmithBattle, 2020). The participant was 24 years old and pregnant at the time of their interview and so this quote may speak to both the fact that they were young and pregnant, and judgment surrounding accessing abortion versus continuing with their pregnancy.

Another participant described a perceived change in how they were treated by a service provider after stating they wanted an abortion. The participant interpreted the provider's language and non-verbal cues as indicating that the best choice for them was to have the baby.

> *I said, 'I was wanting to seek an abortion'. I could physically see a little bit of consternation after that. It was like well whatever it's my body it's not hers, that's her job she has to kind of hook me up with services after this, although it was pretty easy to see she wanted to talk about the more traditional happy options but, for me, this was the happy option. (Larch)*

Another participant expressed a similar feeling of judgment and experienced similar treatment from staff at a reproductive health clinic who did not seem very accepting of their abortion decision.

> *The people at [the reproductive health clinic] which is so strange to me because that's what the clinic is for, they didn't seem very friendly, or accepting … there was a little bit of judgey vibes there. (Devil's Club)*

This quote is significant in that if people are seeking abortion services at clinics that are tailored to reproductive health, these clinics ought to be safe, inclusive, and non-judgmental around all reproductive choices.

Another participant noticed a change in service provider attitudes from when they were struggling with addiction and seeking an abortion compared to when they were sober and seeking an abortion.

> *The first time I was using and then the second time I was getting clean, and on the road to recovering. I did feel a little bit judged at that time, more so than the first time in terms of the [abortion] decision. (Stoneseed)*

This quote reveals that many health conditions are stigmatized, including mental health and substance use issues and these may intersect with abortion-related stigma. Service providers, policy makers, and health promotion initiatives must consider and address how the intersectional impacts of stigma interlock when there is more than one type of stigma at play as this may impact quality of care.

Another participant described how shame and stigma perpetuated by service providers caused them to question their abortion decision, despite knowing their decision was right for them. Their experience with service provider stigma contributed to secrecy and fear of talking about the abortion to anyone else in their life. Judgment from service providers led to increased feelings of shame, isolation, and a lack of social support for this participant. This is consistent with the literature around the harms of abortion secrecy (Belfrage et al., 2020; Cockrill et al., 2013; Cockrill & Nack, 2013; Hanschmidt et al., 2016). This participant felt a lack of reproductive autonomy and empowerment due to fear of judgment from other people in their life.

> *Even though I was very sure what my decision was and knew that it was right for me, because of the experience with the only people I was talking to being the doctors that put a lot of shame on me in terms of questioning my own decisions and really my own values and things like that. And so, it made me really scared to talk about that with other people in my life. … I didn't want people to look down on me or make me feel bad about [the abortion]. (Milkweed)*

This same participant anticipated judgment and decided not to correct the ultrasound technician to say that they were getting an abortion rather than having the baby. As no one should feel obligated to disclose their abortion decision to an ultrasound technician, this quote suggests that technicians should use neutral language when conducting ultrasounds unless they know for sure whether the person is choosing to continue with the pregnancy. Otherwise, their comments can lead to feelings of discomfort and shame for people who choose to access abortion.

> *I just didn't want to deal with telling [the ultrasound technician] that I was getting an abortion, so I just played along. I was like yeah, it's for a baby. (Milkweed)*

Another participant decided to stop seeing a specific doctor because of how they were treated after this doctor found out about their past abortion. The doctor stopped looking at them directly and seemed to disapprove, which led to this person leaving their practice permanently.

> *I actually stopped seeing a doctor because of how she treated me after [my abortion]. … She didn't have it in my record, so I told her, and she was pregnant actually at the time and I just saw it right away and I was just like oh my god, I don't know how this is going to be. It shouldn't, but you just feel awkward. And so then, and she was a younger woman and again that shouldn't matter but I just thought maybe because she was probably not even 10 years older than me. … When I told her I had the abortion she just stopped looking at me in the face. She was like, here's your gown or whatever, I'm going to leave the room, put your stuff on, just completely night and day. It was just this very pivotal moment when I mentioned the procedure. … So, I just stopped seeing her. (Arbutus)*

In a country like Canada where there are an insufficient number of primary care providers, a person leaving a medical practice is significant as it may not be possible to find a replacement. It is critical that the care that is provided is patient-centred, non-judgmental, safe, and inclusive. This quote also brings up the notion of conscientious objection or "*belief-based care denial*" (Abortion Rights Coalition of Canada, 2022, p. 1) in abortion care, where providers can refuse to provide care if it goes against their beliefs. This may frequently be applied in the context of abortion and medical assistance in dying (Abortion Rights Coalition of Canada, 2022) where providers cause harm to patients when they should be providing care in a supportive, non-judgmental way.

This participant went on to say that another service provider continually and intentionally called their abortion a miscarriage. They described a strong desire to leave the situation, which is a sentiment echoed by several other participants who experienced service provider stigma.

> *[The doctor] refused to call it an abortion, she kept saying I had a miscarriage. I'm like, no ma'am, I had an abortion – and she's like, okay, so the miscarriage. And it's just like these are your terms, you're a doctor, these are two completely different things. … It just always seems like I have to advocate for myself which honestly in that context I don't even want to have to do that, I just want to get out. (Arbutus)*

Another participant described feeling judged by service providers for having too many abortions. This led to feelings of guilt and not wanting to deal with the pregnancy due to providers suggesting they explore adoption instead.

> *When you reach a point of having too many [abortions], you kind of start to feel guilty and you don't really want to get it dealt with because [service providers] start suggesting adoption options. (Bitter Cherry)*

A provider who does not believe in birth control for social or religious reasons may suggest adoption when a person has a history of multiple abortions. Generally, a more proactive choice may be to discuss birth control options rather than adoption as this may help reduce the need for future abortions.

Judgment from providers contributed to guilt, shame, and isolation for abortion seekers as seen in the GGLI interviews. These findings suggest there is work to be done to ensure the professional standards of care for health care disciplines are implemented in practice. Patient-centred care must be emphasized to ensure respect is shown for individual reproductive autonomy. These findings also suggest that using neutral language may help reduce perceptions of judgment. For example, the ultrasound technician should not assume the pregnant person is going to carry out the pregnancy. Care should be compassionate and nonjudgmental to improve abortion access experiences and health outcomes overall. Service providers should be aware that multiple intersecting identity factors may interlock to increase the effects of stigma, such as the example of the person who was using substances during their first abortion.

While most participants frequently highlighted largely negative abortion experiences with service providers, Bitter Cherry noted that they have had good experiences with accessing abortion with a supportive doctor.

> *I've had a few [abortions]. … I felt, it's always a good experience for myself. I always ended up with the same doctor who did the surgeries. She's very professional and she's been here for many years, so she knows the community. She made me well informed about what could happen, and it was just overall really supportive and understanding. I've never had a bad experience, or anything bad happened before it's always a good outcome, successful, and no issues or problems like during or afterwards. So, I feel like I've been lucky. … [The doctor is] really easy to get along with and she understands, and she even knows how to speak Inuktitut now because of all the years she's been here, and she wants to learn, so she speaks to you in our language. (Bitter Cherry)*

This quote demonstrates that not all abortion experiences with service providers are bad and that some people do have positive experiences during their abortions. This provides hope that abortion care may improve and may be a positive experience for some people. It is possible that given the nature of self-selection for this study, we may have missed out on more people who felt they had positive experiences because they did not feel the need to discuss the experience. Further, this quote points to the potential importance of cultural safety and the benefit of providers speaking in their native language as opposed to only offering services in English and French. In the GGLI interviews, individuals described receiving judgmental care that may have been informed by anti-abortion beliefs among providers. One participant felt they had to leave the practice of their doctor because of differences in beliefs around abortion. Work needs to be done to lessen the occurrence of conscientious objection or belief-based care denial. To improve health outcomes and reduce health care avoidance, training among providers in patient-centred, non-judgmental care is required.

Poor treatment by service providers due to Indigeneity

Two participants described feeling they were treated differently and/or poorly by service providers. They attributed this to their identity as an Indigenous person. A third participant is a birth worker who has also accessed abortion and described that they believed their Indigenous clients were often treated unfairly by service providers and ascribed this to their clients' Indigeneity.

One participant described a sense that their heart condition was used against them by service providers to coerce them into having an abortion during their first pregnancy. They wondered whether their identity as a young Indigenous person was a factor that contributed to the abortion recommendation.

> *I just remember going into the hospital and having a bunch of doctors come in and them being like, 'we think the best thing for you is to terminate the pregnancy'. And they told me to terminate the pregnancy because of my heart conditions. But now that I'm pregnant at this age with the exact same heart conditions, I've been given the green light they're just like, 'it's fine, we don't think that your heart condition will have any effect on the pregnancy we think that you'll be able to manage this pregnancy very well'. … Now that I know that information on this pregnancy it really made me question, why did they tell me that when I was 18. … Just a lot of shame and very little support, very little*

> *cultural support. And I think me being young and Indigenous was a big factor into why they thought that I should get this abortion, but they used my health … as an excuse. (Dogbane)*

Another participant is a birth worker who has personally accessed abortion. They described the inconsistent treatment their Indigenous clients receive from service providers when compared to non-Indigenous clients.

> *It only happens when I have Indigenous clients, that sometimes in the hospitals, the nurses or the OB will ask the client who is labouring and in the hospital to give birth if they've had any abortions before, or how many abortions they've had before, which is completely irrelevant information if someone is labouring in a healthy way, and I've never, ever heard that asked of any of my non-Indigenous clients. … There are these trends of really stupid questions I think that are almost, I don't know, just out of curiosity, or it's a judgment … I don't really understand where it comes from, or what it's about. (Devil's Club)*

Another participant was concerned about pain during their abortion and asked a service provider if it would be painful. The participant felt that the nurse was very rude and provided poor care. While it is not possible to say whether this was specifically abortion-related stigma, anti-Indigenous racism, bad nursing practice, or all of these, this response caused harm to the patient leading to further trauma in the health setting.

> *I don't know if it was because of my Indigeneity, but I definitely remember the first time in the hospital, as I was on the table that I was very scared and saying,*

> *is this gonna hurt, and one of the nurses saying, I guess you should have thought about that before. (Stoneseed)*

These findings suggest that there may be anti-Indigenous biases in abortion and reproductive health care overall. This is problematic for several reasons. For example, anti-Indigenous racism in the reproductive health setting may contribute to healthcare avoidance for individuals who have been harmed by the system. It may also contribute to biases in recommendations for the types of care required. The first quote around different recommendations later in life may be the result of changes overtime in cardiac care related to pregnancy. However, the fact that this person is now questioning why they were told to have an abortion when they were 18 suggests that there may be lingering harms from their abortion experience related to internalized anti-Indigenous racism.

Social stigma

Social stigma is a structural negative association between a given group or person who share certain characteristics, resulting in labeling, stereotyping, and discrimination (Ipas, 2018; Kumar et al., 2009; Shellenberg et al., 2011; World Health Organization, 2020). Six participants spoke to themes of social stigma surrounding stereotypes and difficulty finding trustworthy information about abortion and how to access it.

Stereotypes

Four participants described being stereotyped and labelled due to their abortion status, which in turn contributed to internalized shame.

One participant felt that their community believes "*you have to be careless, or stupid or foolish to accidentally get pregnant to get an abortion*" (Raspberry Leaf). This indicates a potential stereotype around the kinds of people who have abortions.

Another participant described feeling ashamed that they were fulfilling negative stereotypes around being young, Indigenous, and pregnant. They were often told they would end up a single mom or pregnant at 16 because they believed these are common stereotypes of Indigenous Peoples.

> *I think there was a lot of internalized shame of being this young Indigenous person who had been in the foster care system their whole life and already had these labels put on them. … When I was in the foster care system, I remember just constantly being told you're going to end up pregnant at 16, or you're going to end up a single mom or whatever, just because those were the labels that were put on young indigenous folks who are pregnant. So, I believed that. So, I was really ashamed with this pregnancy. …I just felt a lot of shame around the abortion. (Dogbane)*

This quote demonstrates the harms of stereotyping and shame that may become internalized for young Indigenous Peoples who are pregnant. This also points to specific stereotypes associated with being Indigenous and part of the foster care system.

Another participant echoed this and described telling their mother about their pregnancy, who reacted poorly because they did not want them to become a statistic.

> *[My mom] was very emotionally abusive I guess, where she'd yell at us, and you're supposed to do things her way. When I got pregnant at 18, she f--- hit the roof, because she didn't want me to be a statistic. (Fireweed)*

This quote suggests that there are negative stereotypes that may become internalized among some Indigenous Peoples around teenage pregnancy. It also points to social expectations and judgments about young Indigenous Peoples who are pregnant.

Stereotypes were shown to be perceived and enacted in multiple ways that impacted GGLI participants' experience of abortion-related stigma. Stereotypes influenced the stigma experienced in every category of stigma discussed in the GGLI results. Stereotypes around getting pregnant as a young Indigenous person, having an abortion, and a social belief that only a certain type of person will have an abortion were shown to contribute to shame in the GGLI interviews. Identifying as growing up in the foster care system increased the experience of stigma for one participant. Stereotypes within society and community around intersecting identity factors such as age, Indigeneity, and need for foster care, may influence feelings of shame, abortion access decisions, and contribute to a perceived lack of reproductive autonomy for some people. There is work to be done to dismantle harmful stereotypes of Indigenous Peoples in Canada.

Community Stigma

Community stigma is a stigma that persists through shared beliefs that are often passed down between generations and upheld intergenerationally. As noted previously, the abortion access themes within the GGLI interviews were overlapping, interwoven, and complex. Quotes within the community stigma category reflect this complexity and the influences of religion, tradition, racism, and colonialism on abortion experiences.

Community stigma was described by nine participants, making it the second largest category of stigma after service provider stigma. Participants discussed community not being supportive due to conflicts in 'traditional' values, isolation associated with having an abortion due to stigma, strategies to help reduce stigma, and the dangers of not destigmatizing abortion.

Religious/Colonial influence

Culture and religion influence what is and is not accepted, allowed, and stigmatized within society. Participants have a range of life experiences and grew up in diverse communities, some on-reserve, some in urban settings, and with diverse cultural influences including Christian and Indigenous worldviews. It is important to acknowledge that many Indigenous Peoples hold Christian beliefs and are active members of their churches with some practicing alongside what might be called 'traditional' Indigenous spiritual beliefs and practices. For example, some grew up as or have family members who are members of Christian churches, from families and communities that hold varied spiritual and cultural beliefs. Some of these are Christian and some of them represent Indigenous worldviews. Participants spoke to how cultural and spiritual beliefs and community norms and values influenced their experience of stigma.

Five participants discussed how religious, faith-based, and/or colonial ideals shaped community beliefs around abortion. For some, experiencing stigma was associated with being a part of families and/or communities that ascribe to Christian beliefs and values. For others, being a part of communities that hold Indigenous perspectives resulted in stigma. In contrast, some participants described how historically in their communities, they believed that abortion was not stigmatized. Beliefs and values of the support network of individuals seemed to influence experiences of stigma.

One participant emphasized that in their experience, abortion is not commonly talked about in Indigenous communities. They described shame surrounding abortion due to colonial religious values and how it is important to normalize abortion and remove shame and stigma.

> *[We need] to just normalize [abortion] in Indigenous communities because to be honest I don't hear in Indigenous communities any conversations about abortions. It's very shameful and there's that very colonial Christianity mindset that if you have an abortion you will go to hell, you're a bad person. I've been told that by people in my community. So, I think just normalizing that this happens, and we can't create even further shame because there's already so many physical and emotional and cultural barriers as is, so let's just normalize it. (Dogbane)*

This participant noted that there are already several barriers to abortion access such as stigma, the inaccessibility of aspiration abortion, and anti-abortion attitudes and beliefs of some people in their community. A perceived lack of support around accessing abortion may be influenced by family and community beliefs that having an abortion is wrong. Cultural barriers and values influence the existence and experience of all types of stigmas. In relation to abortions, the stigma may include the idea that abortion is a sin that goes against Indigenous ways of being in some communities, and that it should not be discussed openly, which contributes to further abortion-related stigma.

Another participant also described how abortion is unacceptable in their community. They discussed the influence of religious beliefs on community and family views about abortion.

> *There's no community support, [abortion] is not okay. I'm Catholic and come from a family that even if the 15-year-old is pregnant, people will say, well babies are blessings, no matter how they come. … Yeah, community mindset, family mindset. I come from a massive family [that] doesn't agree with abortion. (Wormwood)*

Another participant described the influence of the church on how abortion is perceived and how those teachings are engrained in their community. The participant did not believe that some community Elders would support their wish to have an abortion.

> *I've met a lot of older Indigenous people and Elders who have really taken the way of the church and those teachings and so I really don't think they would have supported my wish to get an abortion. Either they would have almost*

> *weaponized our indigeneity to, again, use it against me and my culture against me to say it's still not right and things like that. (Milkweed)*

This quote indicates that this participant believed that their culture and practices as an Indigenous person may be used as a method to exert control over their reproductive decision-making by others in community. This quote suggests that the religious beliefs of some community members may influence experiences of stigma because abortion is viewed as wrong in their cultural/religious beliefs. The complexity of this is that some Indigenous communities have been influenced by Christian religions because of colonization and assimilation policies (e.g., residential schools, sixties scoop, etc.). In addition, many Indigenous Peoples are now active members of Christian churches. Some of these religions have teachings that prohibit abortion. It also suggests that there may be fear around the use of Indigenous values and cultural norms as a way to pressure and dissuade potential abortion seekers.

The quotes in this section suggest that abortion is not accepted in some Indigenous communities, at least in part due to faith-based values and beliefs. All people deserve access to good, non-judgmental reproductive health care. There is a need to destigmatize abortion in Indigenous communities and society overall to help reduce barriers to access, while recognizing the cultural and faith-based influences that have contributed to the lack of support for and stigmatization of abortion.

Six participants discussed negative community views around abortion. For example, in the following quote a participant described that what is considered 'traditional' within their community contributes to stigmatizing views of people who have abortions. The quote suggests that the participant believes that ‘traditional’ values are the reason for the stigma. In contrast to some other quotes where participants discussed the influence of religious and faith-based beliefs, this participant describes traditional from an Indigenous worldview, supporting the idea that spiritual beliefs and worldviews impact what is and is not stigmatized in families and/or communities. It also suggests that these beliefs are unique to various individuals within communities. They live on a large reserve in eastern Canada and discussed how their community would likely not support abortion. They have friends who wanted abortions but did not get one because of community pressure and judgment.

> *The community, I think around here probably wouldn’t be as supportive, because it’s still very traditionally value based here. I’ve heard other people talk about other women who have had abortions, and they don’t even know these women or their situation but it’s like, ’oh, they’re a baby killer’ and they’re gonna burn in hell or whatever and I don’t want to stigmatize that anymore. I have a couple friends who wanted to get abortions, but because of the pressure of other people around them, they didn’t. And even now they’re just like I should have just did it. So, it’s very conflicted. (Raspberry Leaf)*

This quote suggests that widespread beliefs in the community impact individual reproductive decision-making and may have significant implications for the course of a person’s life. For example, Raspberry leaf described how she had friends that decided to have children because they felt like they had no choice based on community influences and beliefs.

Another participant also described how young Indigenous Peoples may feel forced or pressured into having children by community. They described the need to normalize abortion to improve personal choice around abortion in Indigenous communities.

> *It doesn't have to be a struggle and we should have the right to choose. … Maybe [young Indigenous people] want the babies. But I'm sure many of them don't, and they're just pressured or forced into having them, or there's absolutely no other option for them, and without open conversations and the normalization of accessing abortions they might not even think that that is an option. They might not even consider it. (Wormwood)*

This quote suggests some potential impacts of pressure around reproductive choice, indicating a perceived lack of reproductive autonomy in their community. This calls for open conversations to help normalize abortion to support freedom of reproductive choice. This quote supports the idea that individual and community worldviews and spiritual beliefs influence what is stigmatized. The quotes in this section provide examples of how some Christian religions stigmatize abortion and how some Indigenous perspectives do as well. This requires us to deal with stigma more broadly across society and all communities, and that we need to ensure safe and inclusive access to abortion for all.

The same participant stated that abortion is not acceptable in their community. They attribute the number of teenage parents to the fact that abortion is not socially acceptable in their community.

> *In our community [abortion is] not okay. That's why you see a bunch of teenage mums running around or did when I was growing up. All my friends had teenage pregnancies. They had children as teenagers. I absolutely did not want that. (Wormwood)*

This quote suggests that teenage pregnancies may occur in this participant's community and that some people may decide to continue their pregnancy rather than consider abortion due to stigma.

One participant discussed how they believed abortion might not have always been considered a bad thing in their community.

> *Just because of our [Anishinaabe] culture it's not something that we have to be embarrassed about, because I really don't think that. I don't know, in my heart I feel like it wasn't a horrible thing in the past, that it was made into something that's bad. (Larch)*

Four participants discussed how negative community beliefs on abortion lead to pressure on individuals around abortion decisions. This may result in people carrying out pregnancies they may not have otherwise wanted. While several participants alluded to the ways in which the Christian church has influenced stigmatizing views of abortion that may not have been present pre-contact, one participant describes a different perspective, a deeply engrained community belief around the role of women being to bear children in Haudenosaunee culture.

> *Being Haudenosaunee, I call it an old value, it's like as a woman, one of your things, one of your jobs is to have children, and to raise children, bear children,*

> *and there's that old world stigma too that's like if you don't have children and have a family and raise a family like what are you doing. I have a cousin who just had a baby. She's 17 and even her dad told her your goal or your job here on earth is to have babies, and it's like, no, it's not. Traditionally birth control, you're not supposed to do that because you're going against the Almighty Creator and trying to play God almost by controlling things that, if they're going to happen, they're going to happen so why are you trying to stop it. So, it's very pro-have babies pro-procreate. (Raspberry Leaf)*

This quote suggests that there is a prevalent community view around the supposed role of women being to have children, leading to the idea that birth control and abortion are not acceptable. This participant questions that point of view and suggests a reclamation of bodily autonomy, recognizing that there is much more to the lives of people with uteruses than just having children, which means that abortion is sometimes necessary.

The findings in this section suggest that community may not support abortion due to faith-based values that have come to be seen as 'traditional'. There is a sense that people in some communities feel they cannot talk about abortion due to abortion-related stigma. The perspectives of some participants suggest that there may be pressure from community members to reproduce based on cultural and faith-based beliefs which may mean young people feel forced into having children they may not have otherwise wanted. The GGLI interviews demonstrate that there is diversity in beliefs around reproductive health, birth control, abortion, and social roles in Indigenous communities across Canada. The findings in this section suggest that opinions differ around the acceptability of abortion within communities due to faith-based beliefs and community norms and values. In contrast, one GGLI participant believed that abortion might not have always been considered a bad thing in their culture and that it came to be viewed as wrong after contact with settlers.

Strategies to dismantle abortion-related stigma suggested by participants

Several participants noted opportunities for actions to help dismantle stigma. Three participants noted that providing easier access to informational resources may help to reduce abortion-related stigma. One GGLI participant was intimidated trying to find reliable information about how to access abortion and expressed concern about accidentally contacting a crisis pregnancy centre[2].

Participants advocated for abortion-related information to be available in print form in community and online. They expressed fear that people accessing abortion for the first time may encounter false information and resources online (i.e., crisis pregnancy centres). They described how abortion is not commonly discussed openly in their community. This participant recommended hosting information sessions for youth and making physical resources more available in community so that people have reliable resources on abortion before they need them.

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[2] Crisis pregnancy centres are clinics that provide counselling services that actively oppose abortion. These clinics often spread misinformation, hide religious affiliations, and pretend to provide abortion to delay access to abortion to the point that a person is too far along to have an abortion. https://www.ctvnews.ca/health/crisispregnancy-centres-criticized-for-deceptive-practices-1.5895702

> *It can be intimidating, I find, not knowing where to find the information, so that involves talking about it more, in terms of stigma. … Because it could be intimidating and if you don't know where, you're not sure if you want to reach out, because you don't know if it's the right people or stuff like that. So, if [the information is] just there, and it's out there then people know that [abortion is] normal and it's an okay decision to be thinking about and it's not bad. (Bitter Cherry)*

Bitter Cherry also shared the importance of anticipatory guidance around medication abortions. They shared that during a past medication abortion, they were not informed about what would physically happen during that process. They opted for aspiration abortions when terminating future pregnancies because of the discomfort and uncertainty they experienced during their medication abortion. Lack of information about what will happen may contribute to distress for a person undergoing medical procedures, including medication abortions. Providing people with information about the medications, including what to expect, may help people feel prepared and open to using that service, rather than relying on the resource intensive and generally less accessible aspiration abortion.

Findings suggest that some participants believed variable access to information may restrict access to abortion resources and information. Providing easily accessible, trustworthy information on abortion may help to combat abortion-related stigma by bringing abortion more into the open and into the public eye. This is because if information is more broadly available and accessible this will help to demystify abortion and make it clear that this is an option to consider.

Participants discussed the need to have more open conversations among society, community, and support networks about abortion to help reduce stigma and to feel supported, as well as to provide support to others. One participant described sharing their abortion story on Facebook. They received private responses from loved ones who also had abortions but felt unable to share because of stigma surrounding abortion.

> *I shared my abortion story on Facebook. … People were like 'Oh you're so brave' and then getting inboxes from family members or friends just saying, 'Oh yeah, I had one too but it's not something I'm comfortable sharing'. I feel bad for them because we're not comfortable sharing that we have had abortions. I didn't kill a baby. I got rid of a mass of cells that I didn't want to raise. (Wormwood)*

This finding suggests that for some people, stigma surrounding abortion is not enough to stop them from sharing their abortion story publicly. This quote suggests a powerful reclamation of bodily autonomy and the right to choose that is being discussed openly among some people.

Sharing abortion stories was used to help support others who may be struggling with their abortion decision. Another participant discussed their abortion with strangers anonymously online. They did this to help people who may not be able to talk about their own abortion with people in their lives.

> *A lot of people don't have the conversation with others, just because of the stigma. I've shared with strangers, kind of anonymously that I've done it to help*

> *bolster them, if it’s a decision that they’re grappling with or that they have nobody else to talk to, but like I said usually I don’t just say hey everybody I had an abortion. … I guess I’d like for the information to just somehow help people that need that, help them to know that they’re not alone. (Larch)*

This quote suggests that sharing stories online may be a powerful tool to support people grappling with abortion decisions or who are attempting to reclaim reproductive choices in their communities. This reclamation may also help to destigmatize abortion.

The idea that sharing stories may help to ease the shame and isolation caused by abortion-related stigma was also described by another participant. This became a means of healing and supporting community through open dialogue about abortion.

> *I didn't tell anyone for three years after [my abortion], at the time when I was 18 … when I matured a little bit more and made a lot more healthier friendships that's when I was able to talk to people. I think the first time was that a friend confided in me that they might be pregnant and that they're really scared and so I just shared my story with them so that they felt like they weren't alone and that they had someone to confide in and then from then on, I just was like ‘oh my god, that felt amazing finally telling someone’. So now I'm not ashamed about it, I’m able to help people. (Milkweed)*

This quote signals a potential means to reduce abortion secrecy, stigma, and shame and reclaim some power by sharing stories about abortion to help others who are struggling. This section highlights how having open conversations on abortion was used by participants as an act of resiliency, a means to reduce stigma, and to help with reclamation of bodily autonomy and choice around abortion. This is a hopeful finding that suggests bringing conversations about abortion into the open may help to reduce shame and stigma and support others who are grappling with their own reproductive choices.

Chapter 8: Discussion

This data analysis is the first of its kind in Canada to specifically explore the stigma surrounding access to abortion experienced by Indigenous Peoples. This research illustrates the challenges some Indigenous Peoples face when accessing abortion. It also brings forward their suggestions to reduce stigma and reclaim reproductive autonomy.

Participants (N=15) from nine provinces across Canada, who identified with Métis, Cree, Dene, Inuit, Haudenosaunee, Anishinaabe, and/or Mi'kmaq Nations described their experiences in semi-structured interviews. A range of factors that influenced abortion-related stigma and impacted abortion experiences were described. These contributed to feelings of shame, isolation, and perceived racism in the health setting. Participants lived in and accessed abortion in different settings (e.g., urban, reserve, rural), and at different times, with the exact year of some abortions unknown. Data analysis was conducted following the DEPICT model (Flicker & Nixon, 2014).

The themes that were identified included internalized, service provider, social, and community stigma. All the GGLI participants experienced stigma in relation to their abortion. Whether this stigma was internalized or arose from perceptions of service providers, society, and/or community views differed based on the individual and the context in which they accessed abortion (see Figure 8 for a Venn diagram of each participant's experience). An intersectional feminist analysis of the data revealed the influence of factors including racism, stereotypes, colonialism, and faith-based beliefs which affected experiences of abortion-related stigma in GGLI. An intersectionality lens helped to uncover multiple intersecting layers of abortion-related stigma experienced by Indigenous Peoples in society, their communities, and within health care settings.

In this chapter, the following will be discussed: (1) findings in relation to current literature; (2) significance, strengths, and limitations of this work; (3) implications for community services, public policy, and clinical practice; and (4) implications for future research.

Findings in Relation to Current Literature

In this section, the findings will be analyzed in relation to the literature. Findings confirm that structural racism and stereotyping in abortion care arising from the ongoing effects of colonialism contribute to harms to Indigenous Peoples in the health setting. Intersecting forms of structural violence inform people's lived experiences. This can be seen in the layers of abortion-related stigma which intersect with other forms of structural violence that contribute to the perpetuation of oppressive forces such as racism, colonialism, and patriarchy. The findings generally aligned with abortion-related stigma literature with the additional contribution of specifically exploring the unique abortion experiences of Indigenous Peoples across Canada. The contribution of a definition of community stigma as an abortion-related stigma category is a valuable addition to the literature. GGLI findings extend our understanding of coercive abortion and the potential effects of racism, poor treatment, and stigma perpetuated by service providers, particularly for people with intersecting stigmatized identities. The findings reveal some of the roots of abortion-related stigma experienced in some Indigenous communities in Canada and will ideally contribute to the realization of RJ. Finally, participants shared insights that may further our understanding of abortion-related stigma, providing a base from which further research can expand.

In the GGLI analysis, the perception of stereotypes manifested in each abortion-related stigma theme. These stereotypes may have been rooted in colonialism and anti-Indigenous racism. There was a suggestion of a stereotype that only certain types of people have abortions. This may reflect dominant heterosexist norms and ideals around who should, or should not, have children. Negative stereotypes around identity factors such as Indigeneity, age, teenage pregnancy rates, fears of being a statistic, substance use, and association with foster care may have become internalized and/or arose from participants' perceptions of family, community, and/or service provider views. Internalized stereotypes in turn impacted participants' abortion access decisions, abortion experiences, influenced feelings of shame, and emotional wellbeing. Internalized stereotypes also contributed to a perceived lack of reproductive choice in some cases. These findings confirm that discrimination is experienced by Indigenous Peoples in healthcare settings (Burnett, 2018; Cull, 2006; Monchalin, 2021; Monchalin et al., 2020; Monchalin et al., 2023a, 2023b; Rasmussen, 2019; Stote, 2012, 2015; Wylie & McConkey, 2019). This is problematic as discrimination, stereotyping, and stigma negatively influence health outcomes (Allan & Smylie, 2015; McKenzie et al., 2022; Monchalin, 2021; Monchalin et al., 2020; Reading & Wien, 2009; Wylie & McConkey, 2019). Discrimination in the health setting is informed by anti-Indigenous racism and the ongoing effects of colonialism. This contributes to intersecting experiences of stigma which interlock and exacerbate harms.

While communities are diverse, all Indigenous communities have been impacted by colonialism through fracturing of knowledges, establishing reserves, residential schools, and the imposition and adoption of colonial values, beliefs, and social norms. Reproductive autonomy has been limited because of this and is influenced by where a person lives and accesses care (e.g., mandatory birth evacuations). Indigenous access to the settler health care system has been imposed and controlled by a system peopled with providers who often uphold settler-colonial ideas. Within Indigenous communities, colonialism has set the stage for anti-Indigenous racism, contributes to anti-choice ideologies and beliefs about parenting that are held by healthcare providers and some community members. This has contributed to the experience of abortion-related stigma.

An intersectional feminist approach illustrates how structural violence via colonialism, racism, poverty, homophobia, heterosexism, and sexism may inform lived experiences of injustice (Snooks et al., 2021). In the context of Indigenous access to abortion in Canada, this may show up as racism, discrimination, stigma, and poor treatment in the health setting based on intersecting identity factors. The intersectional feminist approach shines light on the anti-Indigenous racism and discrimination experienced by most participants, informed by colonialism and stereotypes.

Abortion-related stigma may be experienced uniquely based on an individual’s social location, identity, and lived experience and may become more complex by intersections with other marginalized and stigmatized characteristics (LeTourneau, 2016). Some GGLI participants wondered if they were treated poorly due to their Indigeneity, while another wondered if their struggle with substance use may have contributed to the poor treatment they received. The intersection of being a drug user *and* having an abortion may have intensified the abortion-related stigma experienced, which was reflected in the literature (Cuca & Rose, 2016). Abortion-related stigma may be seen as a reproductive injustice resulting from structural violence in the form of anti-Indigenous racism in the health setting.

Internalized abortion-related stigma expressed included internalized shame, where participants expected to be judged by family members, community, friends, service providers, and others in abortion clinics. Participants also indicated that internalized stigma may be reinforced by negative community views surrounding abortion such as the idea that abortion is not normal or acceptable. Stigma from others led to shame and often secrecy, which is also reflected in the literature (Cockrill et al., 2013; Hanschmidt et al., 2016; Sorhaindo & Lavelanet, 2022).

Disclosure of abortion decisions in GGLI was related to the amount of support a person had and/or perceived to have, as well as fear of judgment and/or repercussions post-disclosure. Participants feared changing relationships with family and community and worried that they and their family members would be judged for their abortion. Having a supportive partner allowed some individuals to feel confident in not disclosing their abortion to other people, suggesting that trusting relationships are essential when considering disclosure of abortion-related experiences. These findings align with the work of Margo and colleagues (2016) and Påfs and colleagues (2020) where abortion seekers used abortion secrecy to protect themselves despite the potential adverse effects such as social isolation (Astbury-Ward et al., 2012; Belfrage et al., 2020; Cockrill & Nack, 2013; Ipas, 2018), adverse mental health impacts (Belfrage et al., 2020; Major & Gramzow, 1999), and diminished social support (Belfrage et al., 2020; Cockrill et al., 2013; Ipas, 2018; Shellenberg & Tsui, 2012; Sorhaindo et al., 2014; see also Hanschmidt et al., 2016; Sorhaindo & Lavelanet, 2022).

Service provider stigma was the most named stigma by participants who described feeling inappropriately judged by service providers, including being treated poorly, pressured, and/or coerced during their abortion experiences. This is consistent with the findings of Cárdenas and colleagues (2018) where abortion seekers described feeling judged and being treated insensitively by providers (see also Harden & Ogden, 1999; Margo et al., 2016; McKenzie et al., 2022). This is echoed by LaRoche and Foster (2018) who described the abortion-related stigma that may be present among some healthcare providers in Canada. This is important because stigma among providers has been shown to negatively impact care for stigmatized individuals (Cuca & Rose, 2016).

Despite feeling confident in their decisions to have abortions, some participants felt judged and pressured by service providers around their reproductive choice. This is significant because this judgment and pressure contributed to adverse experiences during abortions and commonly contributed to isolation, shame, and secrecy around abortions. This is consistent with examples described in the literature, when providers put up obstacles to accessing care and needed information even after a person clearly requested an abortion (Harden & Ogden, 1999; Hulme-Chambers et al., 2018; Påfs et al., 2020; Raifman et al., 2018; Sorhaindo & Lavelanet, 2022). Abortion-related stigma may have limited access to credible abortion resources and information and contributed to unnecessary stress for some participants. Gaps in information about what would happen during medication abortion contributed to distress for one GGLI participant and consequently led to them only using aspiration abortion in the future. Literature has suggested that there is a link between a lack of information and stigma (Nyblade et al., 2019). Lack of access to information described by GGLI participants indicates the importance of anticipatory guidance and comprehensive before and after-care information in the abortion context (Nguyen et al., 2023).

Poor treatment from providers included poor communication, rude and judgmental comments, and attempts to pressure and/or coerce participants around their abortion decisions. Poor treatment as described in the GGLI interviews indicate that service providers may not have been practicing according to their own codes of ethics and standards (CMA, 2018). This is demonstrated by perceived attempts to coerce people around their reproductive decisions, judgmental comments, and not respecting the autonomy of individuals. Experiencing poor treatment and stigma, including coercion and stigmatizing comments from health care providers, contributed to feelings of shame, isolation, fear of disclosure, abortion secrecy, and a hesitancy to reach out to loved ones for support. This is consistent with the literature which shows how stigma from providers contributes to the feelings listed above (Cárdenas et al., 2018; Cockrill & Nack, 2013; Hanschmidt et al., 2016).

The poor treatment by service providers described by GGLI participants resonates with existing literature indicating that this may lead to healthcare avoidance and/or delayed access to services (Allan & Smylie, 2015; Browne et al., 2011; Monchalin et al. 2020). Delayed access is problematic because abortion is a time sensitive procedure with significant implications for the course of a person's life (i.e., to have or not have a child). The GGLI findings extend our understanding of the possible effects of poor treatment and stigma from service providers on individuals with stigmatized identity factors such as Indigeneity when accessing healthcare.

Another effect of poor treatment due to abortion status in GGLI was an individual leaving a medical practice because of poor treatment after the doctor found out about their abortion history. This is consistent with existent literature such as the study by McKenzie and colleagues (2022) regarding refusing to engage with service providers who do not respect their decisions as a means of reclaiming reproductive autonomy. However, this act may lead to adverse health outcomes in the future because in many places in Canada, such as B.C., doctors are in short supply. Leaving a medical practice may result in losing access to many health services, contributing to adverse health outcomes.

The findings suggest that some people feared that their identity and/or health status was used as an excuse for service providers to recommend abortion, suggesting that some participants experienced and/or internalized stereotypes and racism. Participants described not feeling trusted by service providers to make their own reproductive choices, which reflects the findings of McKenzie and colleagues (2022) where people felt doctors did not trust them to make their own health-related decisions. The GGLI findings of stereotypes in the abortion care setting are consistent with research conducted by Wyley and McConkey (2019) who explored how negative stereotypes of Indigenous Peoples may have become common among service providers in Canada. This also reflects the influence of colonialism and anti-Indigenous racism that is well documented in the health literature (Turpel-Lafond, 2020). The presence of and negative impacts of stereotypes toward Indigenous Peoples in the health setting is well established in the literature (McKenzie et al., 2022; National Collaborating Centre for Indigenous Health, 2014; Stote 2012, 2015; Wyley & McConkey, 2019). For example, Wyley and McConkey (2019) discuss how service provider attitudes and actions based on stereotypes may shape practice in ways that compromise care, which seems consistent with our findings.

Interestingly, service provider pressure and coercion were not always applied in the same way. For example, some participants felt that service providers attempted to coerce them to have an abortion, while others felt pressured by providers to have a baby. Until the work of McKenzie and colleagues (2022), literature addressing reproductive coercion had limited discussion of coerced abortion and the stereotypes that enable and justify these acts. GGLI extends our understanding of coerced abortion and specifically highlights the experiences of Indigenous Peoples whose experiences are woefully under-researched.

Community stigma was the second most named stigma after service provider stigma, though as mentioned above community stigma has not been specifically discussed in abortion-related stigma literature. Community abortion-related stigma reflected in the GGLI interviews was influenced by cultural norms, faith-based values, racism, colonialism, and institutional barriers. These influences may impact how abortion is perceived and contribute to abortion secrecy and fear around abortion decision-making and disclosure. The interwoven nature of the quotes in GGLI may be attributed to the intersections of colonialism, internalized anti-Indigenous racism/stereotypes, and fracturing of knowledges[3] (Monchalin, 2021; Monchalin et al., 2023a, 2023b).

While literature suggests that historically, views in Indigenous communities around controlling pregnancies and contraception use centred around personal choice (Anderson, 2003, 2011; Burnett, 2018; Monchalin, 2021; Monchalin et al., 2023a, 2023b; Redvers, 2019), values may have shifted due to current faith-based and cultural beliefs about abortion. Some GGLI findings support the idea of this shift in values. One participant noted that:

> *Just because of our [Anishinaabe] culture [abortion is] not something that we have to be embarrassed about, because I really don't think that. I don't know, in my heart I feel like [abortion] wasn't a horrible thing in the past, that it was made into something that's bad. (Larch)*

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[3] Monchalin (2021) writes that "*the church has played a significant role in the fracture of intergenerational knowledge transfer of Indigenous reproductive health knowledge*" (p. 7). This may be seen in several acts of violence from the settler colonial state such as residential schools and the banning of potlatch from 1884-1951 due to the government of Canada viewing this ceremony as anti-Christian and wasteful (Gadacz, 2019). Ceremonies such as potlatch are important times for traditional knowledge to be passed down from Elders and aunties, but the banning of these sacred ceremonies prevented knowledge from being shared in this venue.

This participant quote indicates a belief that abortion may not have always been seen as a bad thing and that reproductive choice may have been practiced and honoured among some Indigenous Peoples across Canada. There was variability in participant opinions on this, as some indicated a belief that abortion was not generally supported in their communities 'traditionally'. For most others, it seemed clear that the church has influenced the way abortion is viewed in their communities. Many Indigenous Peoples hold Christian beliefs. As noted previously, some Christian churches have strict anti-abortion stances and up to 47% of Indigenous Peoples surveyed across Canada identify with Christian religions according to the 2022 Census (Statistics Canada, 2022).

Abortion-related stigma described in the GGLI interviews suggests that negative beliefs about abortion may exist among some Indigenous Peoples across Canada. Based on GGLI, Indigenous views about abortion appear to be mixed and this is likely due to the diversity of Indigenous communities across Canada. Participants in the study described how culture and faith-based ideals contributed to their experiences of stigma and acceptance. While some talked about how 'traditional' teachings were not supportive of abortion in some communities, others talked about how the negative view toward abortion stemmed from the influence of Christian teachings. This is consistent with literature that states that Christian anti-abortion ideologies may be present in some Indigenous communities in Canada, at least in part due to faith-based values, cultural beliefs, and the ongoing effects of colonialism (Anderson, 2003, 2011;

Burnett, 2018; Monchalin, 2021; Monchalin et al., 2023a, 2023b; Rasmussen, 2019; Redvers, 2019).

Findings support the idea that values, beliefs, and faith *do* influence the experience of stigma. Four participants specifically discussed the role of Christian beliefs on views of abortion and one participant talked about the mixed 'traditional' Indigenous views on pregnancy termination. Six participants discussed how faith-based and/or colonial ideals shaped negative community and service provider beliefs around abortion. This reflects the idea that some people have become "*shackled by the church*" (Elder Edna Manitowabi as quoted in Anderson, 2003, p. 178), which may hinder the practice of reproductive autonomy. The GGLI findings suggest that community pressure and judgment may prevent some people from accessing abortion, indicating anti-abortion values influenced by culture and faith. This is consistent with literature that describes how Christian people were more likely to internalize and perceive abortion-related stigma than non-Christian people (Shellenberg & Tsui, 2012).

Some GGLI participants felt that community members' faith-based values have contributed to a lack of support for abortion and pressure to reproduce. This may contribute to abortion secrecy and fear around the use of culture to pressure and dissuade potential abortion seekers. For example, one participant was concerned that their Indigeneity would be used against them by community members to convince them not to have an abortion.

Participants wondered if the personal values and beliefs of service providers might factor into their attempts to dissuade them from having an abortion. This finding is consistent with literature that indicates that clinical practice may be informed by the cultural and faith-based beliefs of service providers (Moyo et al., 2016). Heterosexism is dominant within colonial religions. This may contribute to anti-choice ideologies held by healthcare practitioners which have been imposed on Indigenous communities through colonial interventions such as residential schools. Further, providers are allowed to refuse care based on personal beliefs in Canada, which is referred to as conscientious objection (Abortion Rights Coalition, 2022). This may be particularly problematic in the abortion context given the strong anti-abortion sentiments found in some religions.

Some participants responded to faith-based anti-abortion sentiments with a note of reclamation, signaling that it is their right to make choices about their own bodies and that what other people think about their decision is not important. This suggests a desire for and resurgence of reproductive autonomy. These findings extend our understanding of the roots of abortion-related stigma as experienced in Indigenous communities, at the individual, community, social, and service provider level. These roots may be influenced by the cultural and faith-based beliefs of service providers and community members, as well as views of what is seen as 'traditional' and socially acceptable in community. The reclamation aspect of the findings is promising for moving towards reproductive and bodily autonomy which is reflected in the literature (Beck & LaPier, 2022).

The findings suggest that views of community members may influence individual abortion decisions. GGLI participants shared how their parents, community, friends, and Elders often held negative views surrounding abortion, stating it is not traditional, is shameful, and/or a sin, which aligns with existing literature (Anderson, 2003; Monchalin, 2021; Redvers, 2019). Participants alluded to an idea that some community members may feel pressure to reproduce due to community influence, which may remove abortion as an option for some people. One participant contemplated whether high teenage pregnancy rates were influenced by youth feeling pressured to reproduce by older generations and not believing abortion is an option.

The participants in this study described how they felt stigmatized by service providers, community members, and parents. Participants often described keeping their abortion a secret from their parents to avoid stigma. Findings suggest that involvement in community may be affected by a family members' abortion status. This is reflective of mental health literature which reveals that parents experience stigma regarding their child's condition which in turn affects community participation (Eaton et al., 2016; Gonzales et al., 2018; Liahaugen Flensburg et al., 2022; Titlestad et al., 2020; Zhang et al., 2022). Findings support the idea that community stigma around abortion may lead to social exclusion and isolation which has been described in previous research (see Astbury-Ward et al., 2012; Belfrage et al., 2020; Cockrill & Nack, 2013; Eaton et al., 2016; Gonzales et al., 2018).

Family and/or community views may also be more impactful when there are geographic barriers to accessing aspiration abortion, such as when the abortion seeker does not have the resources (e.g., money, time, access to a vehicle, etc.) to travel to access abortion without family support. Many people may not be able to afford the costs and the loss of confidentiality by revealing their need for an abortion to family members. Participants hinted at the need to reduce the financial burden of accessing abortion and improve accessibility of abortion services.

Settler-colonial ideas around who should (or should not) be a parent also contributed to the abortion-related stigma experienced by some participants. For example, the person who had struggled with addiction during one abortion and was sober in the next felt their substance use informed how they were treated by service providers. This reflects a dominant social view around who is perceived as worthy of reproducing by society, and shines light on the intersecting stigma around substance use and abortion.

Results of GGLI indicate a lack of open communication around abortion and resultant experience of shame that may be heightened due to the influence of faith-based values and beliefs. Participants pointed to the importance of normalizing abortion because there are already too many barriers, and too much shame, surrounding abortion. One participant described a prevalent community view that birth control and abortion are not acceptable. They reflected a desire to reclaim bodily autonomy and called for open conversations to help support freedom of reproductive choice. This analysis adds more evidence demonstrating how abortion-related stigma contributes to access barriers, internalized stigmatized identity, and a perceived lack of reproductive autonomy and reproductive injustice for some Indigenous Peoples in Canada. It is known that abortion-related stigma exists (e.g., Belfrage et al., 2020; Cockrill et al., 2013). GGLI findings contribute to the existing literature as this study specifically interviewed Indigenous Peoples, a population currently not represented in the literature.

Multiple participants noted a need to have open conversations to reduce shame, stigma, and barriers to access. Some people felt they could not talk to loved ones about abortion due to stigma. However, sharing stories may be a powerful tool for reclaiming reproductive choices and to help destigmatize abortion in some communities which is supported by literature (Belfrage et al., 2020). Sharing abortion stories with friends and online was used by some GGLI participants to help support others who may be struggling with their abortion decision. This may also be seen as an act of resilience and a potential opportunity to reclaim reproductive choices and bodily autonomy, and to empower others to do the same. Emotional support post-abortion has been noted as a desired and important service (Kimport et al., 2012; LaRoche & Foster, 2017) that can be therapeutic, decrease stigma and isolation, and foster community support (Belfrage et al., 2020). Therefore, it is important that abortion-related stigma is addressed to help foster open dialogue about abortion to help reduce the shame and isolation surrounding it. Belfrage and colleagues (2020) found that sharing stories with others who have had abortions in a talking circle created a safe and supportive space to discuss, develop trust, exchange experiences, and shift perceptions of abortion towards an empowering and life-affirming choice.

Implications in Relation to Abortion Services, Public Policy, and Clinical Practice

One of the original intentions of the GGLI project was to assess access barriers and uncover how cultural safety might be better incorporated into abortion care for Indigenous Peoples in Canada. However, the research team realized that the barriers to access experienced by participants were so significant that improving equity in abortion access was a more immediate priority.

As all communities and individuals are unique, there may be a need for individualized community-specific solutions to combat abortion-related stigma. Abortion-related stigma may be experienced in different ways due to factors such as religious and spiritual beliefs and cultural norms of a person's support network. This may influence the ways in which abortion-related stigma must be addressed. While social constructs such as religious beliefs contribute to stigma and complexities that make abortion difficult to discuss and access, these constructs may be hard to address from a policy perspective. However, policies are helpful tools to improve access and address stigma. Policies that are representative of diverse perspectives and worldviews and reflective of diverse access experiences, including in urban, rural, and remote settings, and made with the input of diverse stakeholders may be utilized to improve equitable access. Use of a policy creation framework based on Indigenous ways of knowing, being, and doing, such as the conceptual framework for policy development put forward by Gilroy and colleagues (2013), may be useful for this purpose. Though this was developed in the Australian context, this could be applied to the Canadian setting as it acknowledges similarities and differences between Indigenous communities, accepts colonialism as a social determinant of health, and centres self-determination for

Indigenous communities (Gilroy et al., 2013). Adopting public policy through a health equity lens may help to ensure that local and Indigenous governments create lasting positive changes for community health (Plan H., n.d.). Another applicable framework may be the Indigenous Intersectional-Based Policy Analysis framework discussed by Natalie Clark in the work of Hankivsky and colleagues (2014). This framework may be useful to inform policy and programming to reduce abortion-related stigma in the Canadian context.

It is possible that abortion-related stigma may have less of an impact when individuals are able to access services near where they live due to reduced need to seek financial and moral support to travel to access abortions. This may also be true of medication abortions which are often easier to access and can be administered in the privacy of a person's home.

Service providers, policy makers, and health promotion initiatives should consider how intersectional identity factors such as disability, gender, and stigmatized health status may exacerbate the stigma of accessing abortion. Quality of care may be reduced when there is more than one type of stigma at play. For example, experiencing substance use-related stigma at the same time as abortion-related stigma may impact quality of care. Considering intersectionality is particularly important when a person may experience multiple layers of oppression which intersect to increase barriers to safe access to necessary health services. Intersectionality is a key consideration in policy and program development, planning, and delivery in that it facilitates consideration of the ways that power operates and seeks to dismantle oppressive power structures

(Hankivsky et al., 2014; Ross, 2017; Snooks et al., 2021). It is important that intersectionality be considered when creating policy and programs, and planning care delivery in order to create better health outcomes and improve the accessibility of services (Hankivsky et al., 2014).

At the service provision level, some recommendations from participants may be applicable to improve abortion access experiences. For example, one participant recommended being in a private space following the procedure to help make the abortion process feel safer and reduce feelings of shame. This may be challenging to implement given the constraints that exist in our current health system. However, an intersectional feminist lens helps us to see that we must advocate for improved privacy and safer spaces within the constraints of the current health system to improve abortion experiences and strive towards RJ.

Participants also asked for a support person to be present during an aspiration abortion if they so desired, as was suggested in the findings of Altshuler and colleagues (2021) who explored the benefits of having a support person during abortion such as an abortion doula. Altshuler and colleagues (2021) describe how it is rare to have a support person present during any abortion-related appointment. Though these policies are in place to ensure privacy and safety, these policies also serve to reinforce the idea that abortion should be experienced alone and may further reinforce abortion-related stigma (Altshuler et al., 2021).

Abortion seekers may be reliant on finding supportive and therapeutic health care providers to ease the process. Due to the stigma that exists surrounding abortion, it is important that people seeking them have access to nonjudgmental and culturally safe care. Counselling services should be available to support this, which is evidenced by literature (Lee, 2022). People should be given information about and have access to post-abortion support. For example, post-abortion supports are available at B.C. Women’s Hospital and their website offers a list of resources a person can access (B.C. Women’s, n.d.-b).

Staff involved in abortion services need to provide culturally safe and non-judgmental care. Literature suggests that providing professional development training to health care staff may be an effective way to change service provider behaviour and reduce stigma among providers (Giliauskas & Gogolishvili, 2018; Sulzer et al., 2022). Based on the insights shared by the participants in the GGLI study, professional development training should include the following topics: trauma-informed care, cultural safety, non-judgmental and supportive abortion care, trusting patient autonomy, and counselling surrounding abortion. Service provider education needs to counter stereotypes informed by racism in the health setting. Improved interactions between service providers and Indigenous Peoples in the health setting may help to address the gaps in care and barriers to safe and accessible abortion.

Implementation of standards for training among providers in culturally safe, inclusive, and non-judgmental care centred around personal reproductive choice is required (CMA, 2018). This may involve using neutral and inclusive language during pregnancy-related testing unless their reproductive choice is known (i.e., if they are considering having an abortion or not). This may help to reduce stigma, discomfort, and shame for people who choose abortion (Sulzer et al., 2022). Service providers must examine their own practice and biases via mandatory training in patient autonomy and non-judgmental care (CMA, 2018). Conscientious objection may increase barriers to access and contribute to adverse health outcomes such as delayed access to abortion services (Abortion Rights Coalition of Canada, 2022). Education and career counselling are required to reduce the occurrence of conscientious objection so that access to necessary health services such as abortion is not unnecessarily hindered by the beliefs of service providers.

The findings from GGLI may be used to develop and evaluate educational programming within some Indigenous communities across Canada. Community education may include public awareness campaigns aimed at combating misinformation and correcting stereotypes around abortion, as this was seen to be effective in the stigma literature (Corrigan et al., 2012; National Academies of Sciences, Engineering, and Medicine (NASEM), 2016). These could take place online or through advertising in public places. In school, mental health literacy programs that are recovery focused and tailored to certain age groups may also be effective to reduce stigma (NASEM, 2016). Curriculum should be developed in multiple languages and mediums through consultation with diverse communities who have experience with and/or have accessed abortions. Native Youth Sexual Health Network, a grassroots network of Indigenous youth and intergenerational relatives that work to support reproductive health, rights, and justice for Indigenous youth has several initiatives that may be relevant for educational purposes. One example of their important work is the Sexy Health Carnival which works to break down barriers such as fear, stigma, and shame relating to issues such as consent, birth control, and sexual violence prevention by providing culturally safe sex education (Native Youth Sexual Health Network, n.d.).

People need access to objective, evidence-informed data on abortion, which may be distributed through health authorities and local primary care and public health clinics. This would help to ensure that people have the information they need to make informed choices. This may also reduce barriers to accessing abortion that seemed to be influenced by lack of information in the GGLI interviews. For example, easily accessible information could mitigate fears of accidentally encountering crisis pregnancy centres. Hosting information sessions focused on reproductive options including abortion for youth and making printed materials more available so that people have reliable resources on abortion before they need them may be beneficial. While printed materials may be preferred by some, it is also important to have reliable and safe online, social media, and phone resources that are accessible from anywhere. These may be particularly helpful in rural and remote contexts.

Significance, Strengths, and Limitations

The reduction of abortion-related stigma is required to improve access to abortion for Indigenous Peoples across Canada. This study was the first of its kind to examine Indigenous-specific experiences of abortion-related stigma where all participants experienced some form of stigma. This study points to the need to reduce anti-Indigenous racism and counter stereotypes and shame associated with abortion and Indigeneity. In this section, the significance, strengths, and limitations of this research will be discussed.

Significance

This study aimed to contribute towards the realization of RJ for people across Canada, particularly for Indigenous Peoples who have experienced disproportionate harms in the reproductive health setting (Allan & Smylie, 2020; Reading & Wien, 2009). This study is significant in that the GGLI project was the first of its kind in Canada to examine abortion-related stigma in people who self-identify as Indigenous, a community underrepresented in the abortion-related stigma literature. The participants in this study shared insights that contribute to our understanding of abortion-related stigma as experienced by Indigenous Peoples in Canada and provides a base from which further research can expand.

All 15 participants experienced some form of stigma, indicating the significance and importance of this work. Abortion-related stigma was very impactful for participants, with effects that were felt beyond the abortion itself, including secrecy, shame, fear of disclosure, healthcare avoidance, and unplanned parenthood. For example, the following quote is representative of multiple experiences of stigma and points to ways to improve access experiences by improving communication from and interactions with service providers and society:

> *When I was in the foster care system, I remember just constantly being told you're going to end up pregnant at 16, or you're going to end up a single mom*

> *or whatever, just because those were the labels that were put on young Indigenous folks who are pregnant. So, I believed that. So, I was really ashamed with this pregnancy. …I just felt a lot of shame around the abortion. (Dogbane)*

This quote points to the need to reduce and negate stereotypes and shame associated with abortion and Indigeneity.

The themes identified in the GGLI interviews may promote understanding of some Indigenous Peoples' experiences of stigma in the reproductive health setting, potentially influencing service provider and community education and interventions. The development of a potential definition of community stigma as it applies to Indigenous communities is an important contribution to the abortion-related stigma literature.

Strengths and limitations

A major strength of this study was the involvement of an IAC who supported and guided us throughout this research. The IAC consisted of four front-line Indigenous service providers working in abortion service access and/or support across Canada, including B.C., Manitoba, the territories, and the Atlantic provinces, who were identified through relational networks. The IAC provided guidance and support on all components of the study, including data collection, recruitment, and knowledge translation. This helped to ensure the team honoured community-identified priorities as determined by the IAC, assisting in the application of Two-Eyed Seeing. The GGLI research team provided a safe space to share personal stories relating to abortion experience, which some participants found therapeutic. Participants were hopeful that their stories may help others in similar circumstances and contribute to destigmatizing abortion.

This was an exploratory study with limited resources and a small sample size (N=15). Given the study design, this study did not aim to be generalizable to the entire population of Indigenous Peoples in Canada who access abortions. Rather, research methods that focused on gaining an in-depth understanding of the lived experience of some Indigenous Peoples who have accessed abortion in Canada were chosen.

In-depth conversational interviews were chosen for data collection as they honoured the ways in which participants framed their experiences through stories (Absolon, 2011). Stories were interpreted through an intersectional feminist lens that recognizes how intersecting identity factors shape lived experiences of privilege and oppression in the health setting. This allowed us to begin to honour the unique experiences of Indigenous women and gender diverse people accessing abortion. Indigenous women and gender diverse people may also embody other intersecting identities that may expose them to racism, colonialism, and other forms of oppression. For example, the intersectional feminist framework supported us to understand the unique intersecting stigmas associated with substance use *and* abortion experienced by one participant. This allowed us to identify the unique ways in which these factors intersect and create barriers in the abortion setting. Without the use of the intersectional feminist framework, the nuances that influenced abortion access experiences and how stigmatized identity factors interlock when experienced together, may not have been identified.

Although using Zoom is generally considered to improve accessibility, people who do not have internet, social media, and/or computer access were excluded. Abortion-related stigma itself may have dissuaded some people from applying to participate in this study. Therefore, the voices of those *most* affected and influenced by abortion-related stigma may not be reflected in the data. This is important because we need to hear from these voices to truly understand the influence of abortion-related stigma on Indigenous communities in Canada. Further, we may not have heard from people who had positive experiences from which we could have learned and based care models.

We do not know the exact year of each abortion. This is important because there have been changes to abortion care over the past several years, particularly with the introduction of the medication abortion in 2017. While some of the abortion access experiences took place up to fifteen years prior to their interview, the fact that participants still remembered these vividly and wanted to discuss them hints at the importance of this work, sharing stories to heal, and how impactful these experiences were for many participants.

Despite some limitations, the GGLI study contributes to the growing body of literature on abortion-related stigma in the Canadian context, specifically engaging with Indigenous Peoples. Further, this work includes a proposed definition of community stigma as applied to Indigenous Peoples in Canada. This work expands our understanding of coercion in reproductive decision-making and abortion care which is experienced by some Indigenous Peoples in Canada. This contribution broadens the base of knowledge that demonstrates how coercion around abortion takes place in the Canadian health setting, beyond the coerced sterilization that has been examined in the literature (Burnett, 2018; McKenzie et al., 2022; Rasmussen, 2019; Stote 2012, 2015, 2019).

Implications for future research

This study provides insights that can guide further research. Stigma was found to act as a barrier to abortion access both in the literature and in the GGLI interviews. Given the adverse experiences associated with abortion-related stigma discussed by all participants, this study highlights the need to allocate more resources to explore abortion-related stigma in Canada overall, and specifically within Indigenous communities. This would allow us to dig deeper into how abortion-stigma is uniquely experienced by Indigenous Peoples and identify opportunities to disrupt that stigma in a culturally safe and appropriate way. Further research is required to determine the prevalence and impacts of abortion-related stigma in Indigenous communities in Canada and to identify opportunities to destigmatize abortion. This is important because stigma has been shown to be a barrier to accessing care that contributes to adverse health outcomes and social isolation.

Continued examination of opportunities to improve abortion access experiences and reduce abortion-related stigma will help improve healthcare access and outcomes. Further research may be useful to promote better access to equitable, non-judgmental, and bias-free abortion care for all. This may help to address the disproportionately poor health outcomes experienced by Indigenous Peoples in Canada (Reading & Wien, 2009).

Hosting talking circles led by and specifically for Indigenous Peoples who have experienced abortion-related stigma may be beneficial (Belfrage et al., 2020). This is a common form of communication in many Indigenous communities and may provide a culturally safe approach (Kovach, 2021) to addressing abortion-related stigma. In these circles, each person shares their wisdom and knowledge uninterrupted by the other group members. Some people use a physical object such as a feather, wood, or medicine (S. Day, personal communication, July 25, 2020) to signal who has the floor. Belfrage and colleagues (2020) explored experiences of abortion-related stigma in Mexico and found that talking circles help~~ed~~ to reduce stigma for individuals who participated in their study. A similar study could be conducted in a willing Indigenous community in Canada to see whether feelings of stigma were reduced by participating in a talking circle conducted in a good way.

The GGLI interviews reveal a need to broaden discussions around coercion and structural racism in the health system to remove access barriers and improve health outcomes. For example, we must examine reproductive coercion and the racist stereotypes that providers may use to justify poor treatment of Indigenous Peoples in the abortion setting. There is also a need to examine how stereotypes influence stigma around abortion and make efforts to combat these. Perspectives of more Indigenous Peoples who have had abortions need to be heard to gain a more thorough understanding of how abortion-related stigma is experienced among Indigenous Peoples in Canada.

Chapter 9: Conclusion

Abortion-related stigma exacerbates barriers to abortion access, but this has not been investigated among Indigenous Peoples in Canada. This research was undertaken using a Two-Eyed Seeing methodology nested within the larger GGLI study and rooted in intersectional feminism to analyze abortion-related stigma among Indigenous Peoples in Canada.

Fifteen Indigenous Peoples from across Canada described experiencing multiple types of stigmas, including internalized, service provider, social, and/or community stigma in the GGLI study. The findings revealed layered and intersecting experiences of anti-Indigenous racism, colonialism, sexism, and other oppressive forces. These impacted their abortion experiences and created unnecessary barriers to access that made their experiences more difficult and stressful. The most prevalent was service provider stigma followed by community, then internalized, and social stigma. The results indicate that experiences of stigma are interwoven and influence each other, with most participants experiencing multiple stigmas. These interwoven and intersecting experiences should be understood in relation to oppressive power structures, stereotypes, and faith-based influences.

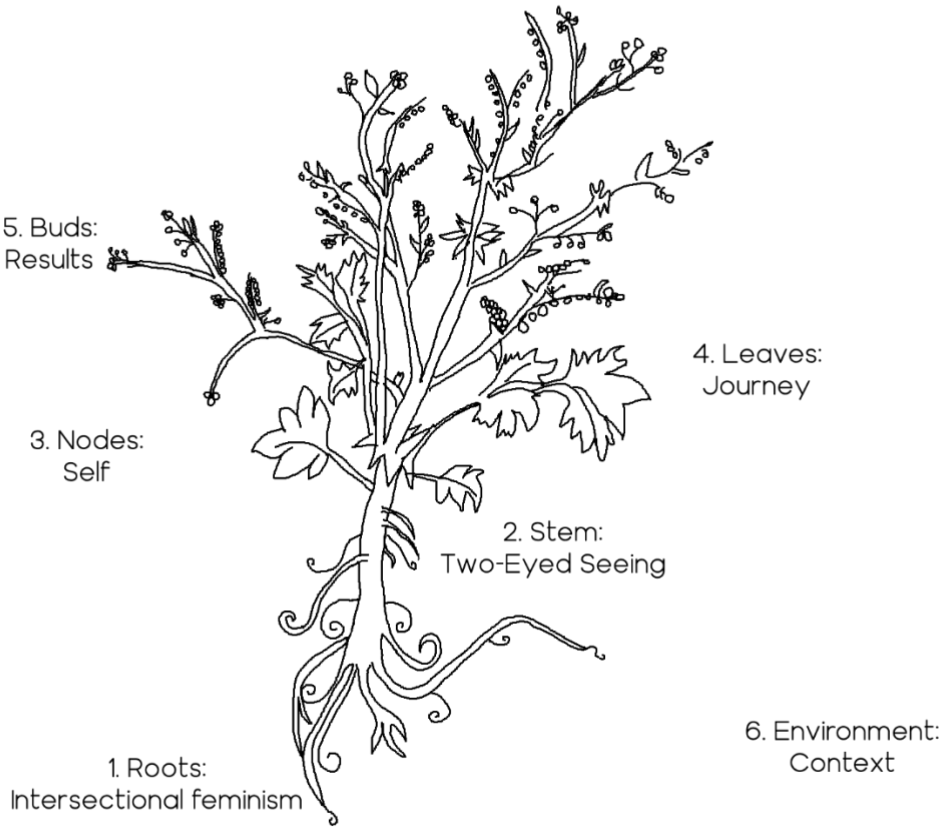
The findings are consistent with the literature in that the structural inequities and racism in abortion care arising from colonialism may be particularly harmful to Indigenous Peoples. This is because Indigenous Peoples already experience a stigmatized identity and are discriminated against in the health setting, increasing the adverse effects of abortion-related stigma. Still, participants identified several areas where abortion-related stigma may be reduced and access improved, while indicating strong resilience and a desire to reclaim reproductive decision-making and support others grappling with abortion decisions. Sharing abortion stories was seen as a mechanism of healing for some participants and many supported friends and strangers who were considering abortion.

Sharing stories around abortion is required to help destigmatize abortion, as secrecy and negative beliefs around abortion were cited as a key source of stigma by interview participants. Some important messages from participants centred around the need to destigmatize abortion to improve access. When abortion access is improved for Indigenous Peoples in Canada, it may be possible to better incorporate cultural safety and cultural practices into the abortion experience.

This analysis offers insights into how abortion-related stigma contributes to access barriers, internalized stigmatized identity, shame, a perceived lack of reproductive autonomy, and reproductive injustice for some Indigenous Peoples in Canada. The GGLI results suggest that some Indigenous Peoples may experience racism and reproductive coercion in the abortion care setting. Consequently, supporting and advocating for RJ is essential if we are to address the health inequities experienced by Indigenous Peoples in Canada. RJ is also important to improve safety and access to necessary services such as abortion. Acknowledging and addressing the structural barriers experienced by Indigenous Peoples accessing abortion services in Canada may help to inform better public policies that support improved abortion access for

Indigenous Peoples. It may take multiple complementary solutions such as policy change, mandatory service provider training, and public education to dismantle abortion-related stigma and improve health outcomes for Indigenous Peoples.

Personal reflection with Wormwood diagram



This journey led me and my research through the roots, stem, nodes, leaves, and buds of my wormwood diagram, and I cannot emphasize enough how much I've learned through this process. My intersectional feminism has grown and solidified, as well as my confidence in myself and my expertise in public health, abortion-related stigma, and RJ. I feel incredibly honoured to have had the privilege to participate in this research and to be the conduit for participant stories which will hopefully contribute to RJ and improved abortion access for Indigenous Peoples in Canada. This process has been transformational for me as a person. I have developed an understanding of the unique barriers experienced by Indigenous Peoples in the reproductive health setting while attempting to bring forward solutions as presented by participants. I am incredibly grateful to the research team and IAC for wholeheartedly welcoming me into this work and for inspiring me to continue pursuing improved access to abortion and RJ for Indigenous Peoples in Canada.

I started my MPH degree with experience in the environmental advocacy sector which I ultimately realized was motivated by concern for the health of people, perhaps partly due to my own chronic health challenges that I've lived with since birth. I am finishing this degree with renewed fire in my belly to affect change to improve access to reproductive healthcare and RJ for all people in this country. I aim to use my privilege and knowledge to challenge the status quo that allows certain populations to live with disproportionately poor access and outcomes without fighting back against these biases. I hope to work towards practical policy solutions that will improve health equity for all populations in Canada. I am proud of myself for finishing this work during one of the hardest years of my personal life and I am so grateful to all the supportive circles in my life who guided me through it.

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Appendix A

Interview Guide

(After you have reviewed the consent form)

Thank you for meeting with me today! Today I would like to have a conversation about your experiences with accessing or trying to access an abortion in Canada. The goal of this research study is to address the culturally safe abortion service gap for Indigenous Peoples in Canada. Remember that you can take breaks at any time, and that you can skip any question that you don't want to answer. If you have any questions, you can stop me at any time. I estimate that today's interview will take about 1 hour. Do you have any more questions about the consent form? Do you have any questions in general? Are you ready to get started?

1. **How would you describe yourself?**
   Based on how the question is answered above, a supplementary question is…
   a) What makes up your identity? In other words, what makes up for who you are?

2. **Can you tell me about your experience with accessing abortion(s)?**
   Based on how the question is answered above, a supplementary question is…
   a) (If able to access an abortion) Can you tell me about your experience with accessing your abortion(s)? Did you encounter any barriers?
   b) (If unable to access an abortion) Can you tell me why you were unable to access an abortion(s)? What were the barriers that you encountered?
   c) (If able to access an abortion) Did you have any helpful and/or positive experiences when accessing an abortion?

3. **When you needed to access an abortion, were you able to talk to anyone in your community about it? Such as friends, family or loved ones? Why or why not?**
   Based on how the question is answered above, a supplementary question is…
   a) Can you describe a time that you felt judged or treated differently for having an abortion? What happened?

This next question will be surrounding your experiences with racism and/or discrimination. We often hear about people being treated poorly or unfairly because they are Indigenous when accessing health services. Remember that you can take breaks at any time, and that you can skip any question that you don't want to answer. If you have any questions, you can stop me at any time.

4. **When you think back to your abortion experience, were you treated poorly or unfairly because you are Indigenous? How did this impact your overall health and wellbeing?**
   Based on how the question is answered above, a supplementary question is…

    a) How did service providers (i.e., doctors, nurses, reception staff, etc.) treat you when accessing an abortion?
    b) (If they find hard to describe) Can you share an example of how this happened?

5. **Did you encounter any Indigenous service providers when accessing abortion?**
    a) (If yes) Did having an Indigenous service provider when accessing abortion change the experience in any way?
    b) (If no) Do you wish you had access to an Indigenous service provider when accessing abortion? How do you think this would have changed your experience?

6. **If you received any post-abortion supports or services, can you describe what they were and whether these were beneficial?**

This next question is about traditional medicines and/or cultural teachings, as we have learned that many communities hold traditional medicinal knowledge around abortion or contraceptives.

7. **Are you aware of any traditional medicines or teachings in your family, community, or more broadly surrounding abortion or contraception? Can you describe them?**
    a) (If they answer yes) How does this knowledge change your perception of abortion?
    b) (If they answer no) Why do you think that is?
    c) What are your family's or community's current beliefs around abortion?

I want you to imagine the most ideal scenario when accessing an abortion, whether it be aspiration (procedure in which pregnancy is ended by removing the contents of the uterus using a gentle vacuum) or medicated (procedure that uses medication – pills taken at home – to end a pregnancy and doesn't require surgery or anesthesia), one where you feel comfortable, respected, and able to be yourself.

8. **How would it look?**
9. **Who is there?**
10. **Whether an abortion provider, or a service provider you encounter when trying to access an abortion, what are the things they can do to make you feel comfortable and respected and able to be yourself?**
11. **What about the space where the abortion is being provided? How does it look or feel?**

Based on how the question is answered above, a supplementary question is…
    a) What are the things in the space that make you feel comfortable and respected and able to be yourself?
    b) Would you prefer the abortion take place in your own home, or in a different setting? Where and why?

The last question surrounds how you would like to see the results from this conversation used. This is an opportunity for a co-developed idea between the research team and yourself to develop something that is relevant to Indigenous Peoples who have accessed an abortion, and/or to help improve access to culturally safe abortion services in Canada.

12. How would you like to see the findings from this conversation used?

Thank you for participating in this interview. Now that your interview is complete, please confirm the following questions below (Interviewer will make necessary updates on the consent form during this time if required with the participants approval).

1) *Do you want to be sent a copy of your transcript for review and approval? Yes / No;*
    a. *If yes, what is the mailing address you would like your transcript mailed to?*
    ____;
    b. *If no, are you comfortable with us using your transcript as is in its current state? Yes / No;*

2) *Do you consent to having direct quotations from your transcript used for publication? Yes / No;*
    a. *If yes, what name you would like listed beside your quotes? This can be your own name, or a name that you made up to protect your anonymity – we welcome creativity!*
    ____;

Now that the interview is complete, our team will review your transcript for themes. Once this is complete, your transcripts will be mailed to you within two weeks from the date of this interview upon your request for verification and corrections with a note of the themes the research team found. If you wish to have your transcript mailed to you, I will follow up with you by phone to discuss verification and/or corrections in your transcript.

Appendix B

Lessons learned (Reflection from September 2022)

The IAC and PI guided all aspects of this research and encouraged us to prioritize process over Western standards of productivity. To share an example, I received a research fellowship to support my work on the GGLI project. My application proposed holding a talking circle on abortion-related stigma, inviting Indigenous Peoples with lived experience to share their stories. The IAC questioned the need to have these potentially traumatizing conversations prior to building strong relationships with potential participants. I was guided to not be hasty with this work and to attempt to fill a community-identified need, rather than to force my own ideas onto community. However, I had written the fellowship application months before joining the GGLI project. This was also my first ever fellowship and I knew I had to report back on my progress to the organization, which piqued my anxiety to follow my proposal closely. My fellowship was for a four-month period, and I had created arbitrary deadlines I felt pressured to meet because of the crunched funding cycle tied to the fellowship.

The concept of knowledge gardening (seeding, nurturing, and growing information) within Two-Eyed Seeing can help to overcome the limitations and pressures of Western research-grant time frames (Hall et al., 2015; Jeffery et al., 2021). I realized that these timelines represented a colonial/Western pressure to rush things that should not be rushed: the authentic building of relationships and approaching research in a good way. Further, I needed to embody the researcher in-relation identity described by Peltier (2018). Instead of rushing to fulfill every fellowship deliverable, I took the time to ground myself in the stories shared and worked on manuscript and infographic development which aligned with the IAC and Indigenous-led research teams co-identified priorities. This ensured I participated in a good way and encouraged humility and thoughtfulness in my approach. This allowed me to work at a pace I was comfortable with, and to listen to my inner wisdom around not forcing any ideas that had not been requested by community. To me, this demonstrates great learning about working at the intersections of Indigenous and Western research paradigms and creates a strong rationale for adopting a Two-Eyed Seeing approach.

The flexibility of the DEPICT model allows individual engagement according to interest and availability. This flexibility proved useful to our research team as some members had competing priorities and were only able to review one or two transcripts. Flicker and Nixon (2014) describe that through the DEPICT model, knowledge can translate into action, which may lead to real-world impacts. For example, the GGLI results may influence health care provider practices and policy changes. For instance, one concrete change could be to shift hospital policy to allow a support person to be present during an aspiration abortion if desired. I shared this finding during the Master of Public Health Culminating Conference (2022) at UVic and service providers were excited to try to incorporate this finding into their practice.