Contraception 124 (2023) 110056

Contents lists available at ScienceDirect

Contraception

journal homepage: www.elsevier.com/locate/contraception

Original Research Article

A qualitative study exploring access barriers to abortion services among Indigenous Peoples in Canada☆,☆☆

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ARTICLE INFO

Article history:
Received 12 June 2022
Received in revised form 19 April 2023
Accepted 20 April 2023

Keywords:
Abortion
Canada
Indigenous
Access
Colonialism
Qualitative

ABSTRACT

Objective: This paper reports on findings from our exploratory qualitative study that aims to advance knowledge around access to and experiences with abortion services among Indigenous Peoples in Canada.
Study design: We applied an Indigenous methodology to engage with 15 Indigenous Peoples across Canada utilizing a conversational interview method. Our study was informed by an Indigenous Advisory Committee consisting of front-line service providers working in the area of abortion service access and/ or support across Canada.
Results: We conducted conversations from September and November 2021. Participants identified with Métis, Cree, Dene, Inuit, Haudenosaunee, Anishinaabe, and Mi'kmaq nations, across nine provinces and territories. Participants spoke to six themes encompassing challenges and potential solutions around abortion access experiences among Indigenous Peoples in Canada. These included (1) logistical barriers, (2) poor treatment, (3) stigma, (4) impacts of colonialism on attitudes towards abortion, (5) traditional knowledge, and (6) follow-up care and support.
Conclusions: Our study demonstrates that Indigenous Peoples experience abortion access barriers that are different than non-Indigenous Canadians, and that these barriers are closely linked to colonialism.
Implications: Indigenous knowledges and practices that honor reproductive choice that pre-dates settler colonialism, must be brought forward into today to enhance the quality of abortion care.

1. Introduction

On a global scale, Canada is often praised for having no federal law restricting abortion. Yet abortion access barriers persist, contributing to negative outcomes, and impacting populations differentially [5]. For example, the 2016 United Nations Human Rights Commissioner's report indicated a lack of access to abortion for Canadians due to cost, knowledge, and geography [5–7].

Although Indigenous (First Nations, Inuit, and Métis) Peoples in Canada experience unique and persistent barriers when accessing health services as a result of colonialism, Indigenous experiences accessing abortion are largely unknown [8]. This is concerning, as available data show that one in three Canadians who are able to get pregnant will experience an abortion in their reproductive lifetime [9]. For Indigenous Peoples in Canada, reproductive health services are not free from violence and harm. This includes experiences with forced sterilization, forced abortion, violence from health care providers, and coercion of contraceptives [10–13].

☆ Conflicts of interest: The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this article.
☆☆ Funding: We want to thank the University of Victoria for funding this study through the Collaborative Health Grants program that the first two authors received.
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https://doi.org/10.1016/j.contraception.2023.110056
0010-7824/

These experiences are rooted in colonial policies and processes that disrupt the intergenerational transfer of knowledge related to traditional family planning and reproductive health, such as residential schools and the outlawing of Indigenous midwifery [14,15]. Yet oral histories and archives reveal that contraceptives and abortifacients were used within Indigenous communities and administered by caregivers who were also kin, especially grandmothers, aunties, and two-spirit community members [8,16]. While reproductive knowledge was often overlooked by early settlers as 'unscientific' [17], Nēhiyaw scholars Erica Violet Lee and Tasha Spillett [6] remind us: "Before and through colonization, Nêhiyawak held teachings of what medicines to use to induce abortion and control birth (you surely didn't think all science and medicine were imported from Europe, did you?)." (para. 2).

This paper reports on our preliminary findings from an Indigenous-led exploratory qualitative pilot study that aims to advance knowledge around access to and experiences with abortion services among Indigenous Peoples in Canada through exploring the question, "*What shapes Indigenous experiences of accessing abortion care in Canada?*".

1.1. Decolonizing approach

We utilized an Indigenous-led, community-partnered approach informed by Indigenous feminism. 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 settler state [18]. For this study, we drew on Indigenous feminist scholars theorizing reproductive justice and the impact of colonialism on Indigenous Peoples' reproductive lives for contextualizing and interpreting our results [6,13,19].

The Indigenous-led research team convened an Indigenous Advisory Committee consisting of four front-line Indigenous service providers working in the area of abortion service access and/ or support across Canada who were identified through relational networks. The Indigenous Advisory Committee provided guidance and support on all components of the study, including data collection, recruitment, and knowledge translation. Prior to recruitment, the Indigenous Advisory Committee instructed the research team to participate in a trauma-informed abortion support workshop offered by Abortion Support Services Atlantic to ensure the research was carried out in a good way. This 2-day workshop covered topics including definitions of trauma and trauma-informed care; the impact of trauma across the lifespan, signs and symptoms of trauma, techniques for creating safety for people exposed to trauma; use of trauma-informed language; and recognizing our own trauma reactions and supporting self-management. The Indigenous Advisory Committee and the research team participated in the workshop together and then collaborated to apply the principles of trauma-informed abortion care to data collection.

2. Methods

Using a conversational interview method informed by an Indigenous methodology, our research team and the Indigenous Advisory Committee co-developed an open-ended interview guide to support participant comfort and consent in sharing their story [20]. Gathering stories through a conversational method fosters relational connection and flexibility and is aligned with Indigenous ways of gathering and sharing knowledge through storytelling [20]. The conversational interview guide encompassed 10 open-ended questions centered around the following themes: abortion access experience; abortion stigma; supports; racism and discrimination; Indigenous service providers; traditional medicines or teachings; and recommendations for improving abortion access.

Recruitment commenced September 2021 with our research team and the Indigenous Advisory Committee sharing the recruitment poster through our personal and organizational Facebook accounts. Seventy people responded to our recruitment poster in total; however, due to funding constraints, only the first 15 eligible people were invited to participate. Once each potential participant was screened for eligibility, we arranged a date and time to meet over Zoom. As part of our trauma-informed approach, participants were emailed the consent form and interview questions in advance with their consent. Selection criteria included individuals 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. Participants were provided a $100 CAD honorarium via e-transfer. Ethics approval (21-0131) was received from the University of Victoria's Research Ethics Board.

Data analysis followed Flicker and Nixon's [21] six-stage DEPICT model, which included the following six steps: (1) a dynamic reading of the transcripts to identify major themes; (2) engaged codebook development; (3) participatory coding; (4) inclusive reviewing and summarizing of categories stage; (5) collaborative analyzing; and (6) translation. These steps required each research team member to read each transcript to identify major themes to support codebook development. All research team members were responsible for coding transcripts using the codebook within NVivo software [22]. To improve rigor, two research team members coded each transcript. Following this, research team members were tasked with providing a summary and supporting quotes for each theme. All team members reviewed each theme summary and collaboratively agreed on edits. Next, the research team and Indigenous Advisory Committee came together to review the themes and revisit the original project objectives. At the time of writing, the project was in the final stage of codeveloping the knowledge translation strategy.

3. Results

We conducted interviews with 15 participants that averaged 1 hour in length in English, between September and November 2021. There was representation from nine provinces and territories across Canada. Participants identified with Métis, Cree, Dene, Inuit, Haudenosaunee, Anishinaabe, and/ or Mi'kmaq Nations, and were between the ages of 16–29 at the time of their abortion. All participants accessed a procedural abortion between 5 and 15 years prior to their interview, with one participant having two failed attempts with a medication abortion, resulting in a procedural abortion. Participants spoke to six themes, encompassing challenges and potential solutions around abortion access: logistical barriers, poor treatment, stigma, impacts of colonialism on attitudes towards abortion, traditional knowledge, and follow-up care and support.

3.1. Logistical barriers

Seven participants shared that abortion access information was inconsistent when contacting service providers, and that services were often located hours away by car or plane. In Canada, roughly 60% of Indigenous Peoples live in predominantly rural areas [3]. This resulted in financial hardship, having to pay out of pocket for travel, and delayed access to services. For example, one participant living in Eastern Canada shared:

> *I called and I made the appointment, and it was a couple weeks later … I didn't have a car, so I didn't know how I was getting there. I didn't have money to get there. It's about a seven- or eight-hour drive from where I was living, and that's the only place that anyone in Newfoundland can go. (006)*

3.2. Poor treatment

Twelve participants spoke to receiving negative service provider treatment. This involved experiencing judgment, mistreatment, being questioned about their decisions, and/ or experiencing poor treatment in comparison to 'white' patients. For example, one participant shared:

> *Felt very like nobody cared that I was cold, super cold, nobody cared if I was even there … nobody cared to put a blanket on me when the white lady beside me got the blanket, or they offered her something to drink where I wasn't offered. (008)*

One participant described being forced contraceptives by a service provider without their consent following their procedural abortion:

> *They forced me on to birth control. And without my consent, they put an IUD in me during my abortion. And later found out that I actually shouldn't be on hormonal birth control because of my heart condition. (009)*

3.3. Stigma

Abortion stigma was experienced by all participants from a societal level and/or from their Indigenous community. This resulted in internalized shame amongst participants surrounding their abortion decision. For example, nine participants shared how their Indigenous communities and/or families do not agree with abortion. One participant who accessed a Native-specific health clinic, experienced stigma from the nurse after disclosing they wanted an abortion, as this participant shared, "where I'm from, Anishnaabe families … it's all about having kids and grandkids." (005). When speaking about both abortion and contraception, another participant similarly shared:

> *Being Haudenosaunee … I call it an 'old value' … as a woman, one of your jobs is to have children… raise children, bear children, and there's that old world stigma that's like… if you don't have children and have a family and raise a family, what are you doing? … 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. If they're going to happen, they're going to happen, so why are you trying to stop it? (013)*

3.4. Impacts of colonialism on attitudes towards abortion

All 15 participants spoke to the relationship between religion, colonialism, and the fracturing of intergenerational reproductive health knowledge. Describing the influence of religion, one participant shared, "we're so indoctrinated in my family with Catholicism … being Catholic is the main determinant for women's health and my family's health." (007). At the same time, participants spoke to Indigenous communities practicing bodily self-determination prior to settler arrival. As one participant shared, "We've been managing our own bodies without Western medicines and Western policies and rules way prior to 1492." (009). This same participant continued and shared:

> *There's one plant called fire weed … I know that we traditionally used that as birth control, but also as a medicine to implement abortion… I kind of have a philosophy that … with the knowledge of herbal methods ending a pregnancy, Indigenous culture suggests a tradition of honoring pregnant people's self-determination of their own bodies. … Unfortunately, in my culture you hear a lot of "abortions never happened, we didn't do abortions, abortions are a sin" and … I think that really came from colonial Christian Catholic, settler ideologies. (009)*

3.5. Traditional knowledge

Five participants recommended for local Indigenous teachings and/or practices be woven into the abortion care experience, including the incorporation of plant medicines or teas. As one participant shared, *"If I ever needed to have an abortion again or wanted one, I would definitely be much more comfortable with doing it a traditional and natural way." (011).* While recognizing the diversity among and within Indigenous communities, one participant shared around the potential of incorporating birth rituals, traditional healers, and plant medicines into the care experience:

> *The way I was raised in our teachings, when a woman gives birth, the afterbirth, we're supposed to bury it, right?. Right away that was the first thing that popped in my head. if I was given that I would have, if they had asked like, 'okay as an Indigenous person did you want us to save this so that you can properly bury it or whatever', I probably would have taken that if I had that option. (005)*

3.6. Follow-up care and support

Eight participants described having no support or follow-up care post-abortion, often being sent home with only a pamphlet. As one participant shared, "There's no aftercare, there's no recognition of it being what could be a pretty monumental procedure for some people. Nope, nothing. You could call them if you wanted, but it was you who had to reach out." (011).

Nine participants recommended an increase in abortion support such as an abortion doula to help with navigating appointments, travel, post-abortion, and as often shared, "to have somebody to hold your hand" (008). When reflecting on their post-abortion experience, one participant shared:

> *Maybe have the support of a doula or a midwife or someone who is able to care for you and knows some basic post-abortion care I guess would have made such a difference because back then I didn't really know how to take care of myself afterwards. (011)*

4. Discussion

Results from our study demonstrate that Indigenous Peoples experience abortion access barriers such as distance, mistreatment, stigma, and lack of support; some of which are echoed in the broader Canadian literature [5,23,24]. Participants described experiencing reproductive violence around abortion decision making, mistreatment, including coerced contraception. These experiences reflect patterns of reproductive coercion and abuse that are documented in Indigenous feminist literature and theorized as colonial practices that facilitate the elimination of Indigenous Peoples in their own lands [13,16,19,25]. For example, forced birth control and forced sterilization have been used as a method of population control, even at the time when mainstream feminism was fighting for or celebrating increased access to reproductive health services [1]. While most Canadians would like to think of these coercive practices as something from the past, a recent publication by Clarke discussing the impact of eugenically guided policies in Canada identifies contemporary cases in Alberta, British Columbia, Northwest Territories, Ontario, and Saskatchewan where women reported being coerced into having tubal ligation procedures by their healthcare providers [2]. In Clarke's analysis, "These procedures fit the definition of *genocide* according to the United Nations, and a form of *torture* as defined by the Criminal Code of Canada" (p.144).

Participants spoke to the impacts that settler religious beliefs have had on Indigenous reproductive knowledge and practices.

Knowledge around preventing and ending pregnancies was once commonplace in Indigenous communities yet has been suppressed to the point that it is now hard to find [8,19]. Religious views imposed on Indigenous communities forced much of this knowledge 'underground' and disrupted the intergenerational transfer of reproductive practices. However, Indigenous Peoples continue to hold and express a desire to reclaim traditional knowledge and practices for enhancing reproductive health, as demonstrated in our study [8,19].

Participants spoke to the need for abortion access support, including help with appointments and travel, as over half of the Indigenous population in Canada reside in rural or remote areas [3]. Living in these areas is often coupled with high transportation costs and can be precarious navigating Canada's harsh climates. This was identified by our participants in resulting in delayed access to abortion services. Participants also spoke to the need for post-abortion support, through the form of a doula, for example. While doulas have become more prevalent across rural and remote Indigenous communities in Canada, a lack of abortion support was mirrored in other Canadian literature [4]. A lack of support is often accompanied with high costs, lack of confidentiality, judgment, and long wait times, and was exacerbated by the COVID-19 pandemic [23,26,27]. Currently, in Canada, full-spectrum doulas or birth workers, who support all elements of the birth process including abortion, remain unregulated and are not paid through the universal health care system [28,29]. This presents a missed opportunity, as abortion doulas have been found to provide validating and empowering support, can act as advocates, and help normalize the abortion experience [29]. As a result, abortion doulas play an important role in reducing stigma and shame around the abortion experience, which impacted all of our study participants [29]. Indigenous doulas take it one step further, as they have been found to identify and counter medical racism in hospital and clinical settings, while encompassing cultural teachings and spiritual connections [28,29]. This was identified by our participants to be of importance when accessing an abortion.

This paper reports on our exploratory qualitative study that had a small sample size. Given this, our results are not intended to be representative or generalizable for the entire population of Indigenous Peoples who are able to get pregnant in Canada. As this study was conducted during COVID-19, our one-on-one conversations took place over Zoom due to public health protocols. Participants without access to these technologies were unable to participate. At the same time, conducting conversations over Zoom allowed our team to reach participants in locations that we would not be able to afford to travel to. Further, all interviews were conducted in the English language, potentially limiting participation. Despite these limitations, this research contributes to the limited literature surrounding abortion access experiences among Indigenous Peoples in Canada.

Our study provides preliminary evidence that Indigenous Peoples may experience abortion access barriers that are different than non-Indigenous Canadians and that these barriers are closely linked to colonialism. Our study points to the significance of Indigenous knowledge and practices for honoring reproductive choice that predates settler colonialism, which can be brought forward into today to enhance the quality of abortion care. This study demonstrates that to enhance equity in abortion services, Indigenous knowledge must be honored through centering Indigenous voices. More research is needed to better understand Indigenous Peoples' experiences of accessing abortion care in Canada, particularly for understanding the intersections between abortion access and geography, Indigenous identity, gender, sexuality, and experiences of accessing contraception.

Acknowledgments

The author would like to acknowledge and thank the Indigenous Advisory Committee that guided this work to make sure it was done in a good way, as well as the Indigenous community who shared their stories with us to improve abortion access in Canada.

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