Human Rights and Reproductive Healthcare in Rural, Remote, and Northern Manitoba

by

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Table of Contents

List of Figures

Abstract

This study aims to analyze if there are human rights violations regarding reproductive healthcare in rural, remote, and northern Manitoba, focusing on STBBIs, contraception, maternity care, and abortion. No similar research applies international human rights treaties to reproductive healthcare in rural Manitoba. There is minimal research on reproductive healthcare in the region. Chapter one focuses on Canada's human rights obligations based on international human rights treaties. Chapter two maps out what reproductive healthcare is available in the region. Chapter three analyses how reproductive healthcare in Manitoba meets and does not meet Canada's international human rights obligations. Chapter four makes recommendations. The respect, protect, fulfil framework, is used to analyze if there are human rights violations occurring in Manitoba in relation to reproductive healthcare. The research includes a scoping review. An analysis if the reproductive care provided in rural, remote, and northern Manitoba amounts to a human rights violation is complex. Rural, remote, and northern Manitoba is vast geographically. The research found limited or no violations in obligations related to STBBIs and contraceptives. Concerningly, there were many violations in relation to obligations surrounding care for pregnancy, including abortion and maternity care, specifically around prenatal care and the birth evacuation policy.

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Introduction

This research focuses on human rights and reproductive healthcare in rural, remote, and northern areas in the Canadian province of Manitoba. Specifically, the research aims to analyse if there are human rights violations within the current state of reproductive healthcare. Violations may be expected as living in remote or rural regions negatively impacts access to health services and exercise of the right to health.[1] Globally, poor services, discrimination, and lack of information contribute to poor reproductive health.[2] This research expects to find human rights violations in the healthcare provided in rural, remote, and northern Manitoba. Expected findings include a large southern/northern divide in regard to health service ability and quality, as well as differences in experiences and outcomes between Indigenous and non-Indigenous women. Another expected finding is significant barriers to accessing abortion. Due to impacts of remoteness, centralized health services, and lack of reproductive health services in Manitoba, reproductive healthcare is inadequate and there are violations of the right to health.

Reproductive rights include "safe pregnancy and safe delivery, with adequate antenatal and post-natal care, as well as access to family planning counselling and a range of modern contraceptive methods."[3] This research mainly focuses on four areas of reproductive health: sexually transmitted and blood-borne infections (STBBIs), contraceptives, abortion, and maternity care.

Research Questions

Three questions guide this research. The research questions are (i) What are Canada's international legally-binding human rights obligations to providing reproductive healthcare to rural women? (ii) Are Canada's international human rights obligations being fulfilled in rural, remote, and northern communities in Manitoba? (iii) If obligations are not fulfilled, what are

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[1] UN Human Rights Council and Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, "Visit to Canada : Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health" (Geneva: UN, June 19, 2019), para. II. A. 6., https://www.ohchr.org/sites/default/files/HRBodies/HRC/RegularSessions/Session41/Documents/A_HRC_41_34_Add.2.docx.

[2] UN Population Fund, "Programme of Action: Adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994" (United Nations, 2004), para. 7.3, https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf.

[3] Natalia Kanem, "Sexual and Reproductive Health and Rights: The Cornerstone of Sustainable Development," *United Nations Chronicle* 55, no. 2 (2019 2018): 34.

possible changes to reduce barriers and provide better care? These questions will be answered through doctrinal analysis, through UN treaties and jurisprudence. Discourse analysis will be conducted, using relevant literature and grey literature.

This research has four main chapters, each with specific questions:

1. Human Rights Obligations – What are Canada's legal obligations to provide reproductive healthcare to rural women? What is the standard Canada has agreed to be legally bound by based off international human rights treaties, the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)?
2. Healthcare in Practice – What is the current landscape of healthcare in Manitoba with regards to accessibility of reproductive health services? This will include grey literature.
3. Analysis of Healthcare Provision: How it Meets and Does Not Meet International Human Rights Standards – How does the reproductive healthcare Manitoba should be providing (obligations) align with what is actually being provided (practice)? Where does it align? Where does it not? Where are the violations?
4. Recommendations – If there is a discrepancy between what Canada should be providing and what is occurring in practice then recommendations will be made.

Theoretical Framework – Tripartite Typology

This paper will use the human right tripartite typology as its theoretical framework. The tripartite typology is more commonly known as the respect, protect, fulfill framework. This framework is used when analysing if there are human rights violations within complex issues. The respect means states must refrain from interfering with individuals exercise of their rights, to "avoid harming, or introducing deprivation of concern to, protected interests."[4] Protect in the framework means that a state must protect individuals from having their rights violated by third-party actors (other than the state itself).[5]

Fulfill is often where violations are found, as it involves aiding "those whose protected interests are experiencing remediable setbacks." [6] It requires that states take full and proper

[4] Zahara Nampewo, Jennifer Heaven Mike, and Jonathan Wolff, "Respecting, Protecting and Fulfilling the Human Right to Health," *International Journal for Equity in Health* 21, no. 1 (March 15, 2022): 2, https://doi.org/10.1186/s12939-022-01634-3.
[5] CESCR, "General Comment No. 14: The Right to the Highest Attainable Standard of Health" (Office of the High Comissioner for Human Rights, August 11, 2000), para. 33.
[6] Nampewo, Mike, and Wolff, "Respecting, Protecting and Fulfilling the Human Right to Health," 2.

measures to the realization of the right.[7] It is broken up into three distinct but interrelated sections, facilitate, provide, and promote. Facilitation involves states taking positive measures that support exercise of a right.[8] To provide, states must provide for individuals to exercise the right when they are unable to realize the right by themselves.[9] Promote involves actions taken by the state to endorse the actualization of a right.[10]

This paper will largely focus on the right to health, or the right to an adequate standard of health. While individuals, NGOs, corporations, and states have duties and obligations towards the right to health, the obligations to states are more vast and states "must take the lead in fulfilling the duties necessary to effectively guarantee [the right to health]."[11] The argument against states fulfilling many economic, social, and cultural rights, including the right to health, is the ask that they fulfill too many positive rights, that are too numerous, too costly, and too time consuming.[12] However, this criticism can be questioned as Nampewo, Mike, and Wolff state "we interrogate [this criticism] by focusing on the human right to health as one of the cornerstones for the enhancement and improvement of overall social, cultural, economic welfare and human development."[13] Health is an essential building block of life, without it other rights struggle to be realized.[14]

Manitoba's Rural Population

Manitoba is a prairie province in the centre of Canada where most of the population lives in its southern capital city, Winnipeg. The province is divided into 5 regional health authorities (RHAs): Winnipeg Regional Health Authority (WRHA), Southern Health-Santé Sud (SHSS), Prairie Mountain Health (PMH), Interlake-Eastern Regional Health Authority (I-ERHA), and the Northern Health Region (NHR).[15] These regions have vastly different population density,

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[7] CESCR, "Highest Attainable Standard of Health," para. 33.
[8] CESCR, para. 37.
[9] CESCR, para. 37.
[10] CESCR, para. 37.
[11] Nampewo, Mike, and Wolff, "Respecting, Protecting and Fulfilling the Human Right to Health," 2.
[12] Nampewo, Mike, and Wolff, 2.
[13] Nampewo, Mike, and Wolff, 2.
[14] Nampewo, Mike, and Wolff, 2.
[15] Southern Health-Santé Sud [SHSS], "Annual Report 2021-22:...Meeting the Moment...," Annual Report (Manitoba, 2022), https://www.southernhealth.ca/assets/AnnualReports/Annual-Report-2021-2022-website.pdf; Interlake-Eastern Regional Health Authority [I-ERHA], "Annual Report: 2021-2022" (I-ERHA, 2022), https://www.ierha.ca/files/Interlake-Eastern-RHA-Annual-Report-2021-2022-FINAL-POST.pdf; Prairie Mountain Health [PMH], "Health and Wellness for All: Annual Report 2021-2022" (PMH, 2022), https://prairiemountainhealth.ca/wp-content/uploads/Annual-Report-2021-2022.pdf; Northern Health Region [NHR], "Annual Report 2021-22," 2022, https://northernhealthregion.com/wp-content/uploads/2022/09/NHR-

geographic area, and population makeup, and what services individuals have access to is greatly impacted by which health region they reside.[16]

Figure 1: Map of Manitoba's Regional Health Authorities. [17]

With a population of 216 253, SHSS is the most populous of the rural health regions in Manitoba, and has the largest growth in the province.[18] The growth is due to international immigration and a higher birth rate.[19] The region includes over 60 Hutterite colonies and a growing Mennonite population.[20] There are many Métis and Francophone communities within

Annual-Report-2021-22.pdf; Winnipeg Regional Health Authority [WRHA], "WRHA Annual Report 2021/2022" (Winnipeg, Man, 2022), https://wrha.mb.ca/files/wrha-annual-report-2122.pdf.

[16] NHR, "Annual Report 2021-22"; SHSS, "Annual Report 2021-22"; I-ERHA, "Annual Report: 2021-2022"; PMH, "Annual Report 2021-2022."

[17] Shared Health, "Regional Map," eChart Manitoba, accessed January 31, 2024, https://echartmanitoba.ca/?da_image=510.

[18] SHSS, "Annual Report 2021-22," 6.

[19] SHSS, 6.

[20] SHSS, 6.

the region as well as seven First Nations. [21] There are lower than provincial average teen pregnancy, preterm and small births, however there is a low but growing STBBI rate.[22]

Covering 64,800 square metres in southwestern Manitoba, Prairie Mountain Health (PMH) serves 34 Hutterite communities, 14 First Nations, as well as multiple Métis and Francophone communities.[23] The most recent community health assessment shows the population at approximately 171,000 people, with significant First Nations and aging populations.[24] The region notes that low population density and geography are challenges to service delivery.[25] PMH birth rates is near the provincial average, but does vary within the region, as certain areas within the region have significantly higher and lower birth rates.[26] PMH has the highest visible minority community (non-Indigenous) in Manitoba, outside the WRHA.[27]

The Interlake-Eastern Regional Health Authority (I-ERHA) has 133,800 residents, approximately 10% of Manitoba's population, covering approximately 10% of Manitoba's geography, 61,000 square kilometres on the southeastern part of the province. The region has 17 First Nations, and an aging population. [28] Demands on the regional healthcare system increases annually in the summer, due to the large numbers of camping and cottaging in the region.[29] The 2021-2022 year saw 449 babies born in Selkirk. [30]

The Northern Health Region (NHR) covers the northern part of Manitoba. The Northern Health Region's Annual Report notes that some of the largest issues for the region is the isolation and remoteness of the population, as well as jurisdictional issues.[31] There are 26 First Nations communities and 16 Northern Affairs communities in the NHR.[32] While approximately 40% of residents of the NHR live on reserve, they often travel to access healthcare in other areas.[33] They

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[21] SHSS, 6, 7.
[22] SHSS, "Our Call to Action: Healthier People. Healthier Communities. Thriving Together.," 2023-2028 Strategic Plan, 2022, 25-26, https://www.southernhealth.ca/assets/AnnualReports/2023-28-Strategic-Health-Plan.pdf.
[23] PMH, "Annual Report 2021-2022," 11.
[24] N McPherson et al., "Prairie Mountain Health Community Health Assessment 2019" (PMH, 2019), 1, https://prairiemountainhealth.ca/files/2019CHAFeb102020.pdf.
[25] McPherson et al., 1.
[26] McPherson et al., 6.
[27] McPherson et al., 13.
[28] I-ERHA, "Annual Report: 2021-2022" (I-ERHA, 2022), 12, https://www.ierha.ca/files/Interlake-Eastern-RHA-Annual-Report-2021-2022-FINAL-POST.pdf.
[29] I-ERHA, 14.
[30] I-ERHA, 66.
[31] NHR, "Annual Report 2021-22," 5.
[32] NHR, 4.
[33] NHR, 5.

also have some on-reserve care, provided by First Nations Inuit Health (FNIH).[34] Accessing care through different providers on and off reserve results in jurisdictional issues and confusion for patients.[35] Many individuals do not have homes with telephones, strong WIFI, or even running water. [36] Some communities are only accessible by winter ice roads or by air, and weather can impact access to healthcare if flights are delayed or cancelled. [37] The NHR has a significantly higher birth rate than the Manitoban average.[38] Within the region there are issues with high rates of STBBIs, inadequate prenatal care, and preterm births.[39]

So, when we are discussing those living in rural, remote, and northern communities in Manitoba, we must be mindful that these health regions are vastly different culturally, linguistically, geographically. The challenges faced by the regions are not uniform and reflect their own unique makeup. The ability for one to access care, and what that care looks like would be impacted by which health region they reside in.

Language – Why Focus on Women?

While reproductive justice substantially impacts women and girls, all people are impacted by access to sexual and reproductive healthcare.[40] To summarize Erin Nelson, all people have reproductive healthcare needs, but the repercussions of impaired access are more extreme for women.[41] As Nelson states:

> Women's autonomy and equality – their ability to chart their own lives and have opportunities to participate fully in civic and economic life – depend on their ability to obtain sexual and reproductive health care in ways that men's do not. Women's social and political circumstances are intimately connected to their ability to access sexual and reproductive health services and thereby exert some degree of control over their sexual and reproductive lives. In my view, the interrelationship between reproductive autonomy, equality, and access to sexual and reproductive health care is obvious and critically important.[42]

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[34] NHR, 5.
[35] NHR, 5.
[36] NHR, 5.
[37] NHR, 5.
[38] NHR, "Community Health Assessment 2019" (NHR, 2020), 35, https://northernhealthregion.com/wp-content/uploads/2020/01/2019-NHR-CHA-Rev-Jan-27-2020.pdf.
[39] NHR, "Annual Report 2021-22," 6, 88, 89.
[40] Kanem, "Sexual and Reproductive Health and Rights," 34.
[41] Erin Nelson, "Autonomy, Equality, and Access to Sexual and Reproductive Health Care," *Alberta Law Review*, Special Issue: Health Law, 54, no. 3 (2017 2016): 708.
[42] Nelson, 708.

In many lesser developed countries, those with the least decision-making power over their reproductive health is the poorest women and girls.[43] These women often do not have access to quality pre- and post-natal care, or care during childbirth, and as a result have higher rates in maternal morbidity and mortality.[44] This is unfortunately similar to what is experienced by those living rurally and remotely in Manitoba, especially access to prenatal care, teen pregnancy, low birth weights, and preterm births.[45]

The language used in ICESCR and CEDAW is men and women. These terms, while still relevant categories for this discussion, are not defined and many people fall into both or neither categories. The author is mindful of the experiences of intersex individuals, trans, fluid, and other identities. Not all women will have a need for contraception or pregnancy care, while some men and others will. While the experiences of men, intersex, trans, or fluid identities will not be explicitly excluded from analysis, the focus of this research will be on women generally.

Scoping Review

Search Strategy

A scoping review was conducted using PubMed, JSTOR, HeinOnline, as well as google searches in order to include government research as well as other relevant grey literature. Combinations of the following keywords were used: reproductive health, sexual health, rural, remote, northern, Manitoba, Canada. Citation mining for other relevant articles was also undertaken. Articles that did not have a focus on rural, remote, or northern healthcare were excluded, as were those that did not include Canadian populations.

The scoping review search was conducted in three stages, with an initial search, a second search, and a reference list search. The initial search used title/abstract screening, then the second search was examined and then screened out, then those included, the reference list was examined. The initial search provided 33 articles, that were then narrowed down to 14 in the second search. Multiple studies were excluded as they did not have a large or explicit focus on rural, remote, or Northern populations. Some studies were excluded as they did not focus on Canadian populations. Other studies were excluded because they did not focus on sexual or reproductive healthcare. Reference list searches of included articles provided an additional three

[43] Kanem, "Sexual and Reproductive Health and Rights," 34.
[44] Kanem, 34.
[45] NHR, "Annual Report 2021-22," 7.

articles.[46] Grey literature was identified via Google. Annual reports from all Manitoban RHAs were searched for relevant information, as well as the annual reports from community health clinics in the province.

Scoping Review Findings

Many of the studies included focused on Indigenous populations.[47] Teens in the Northwest territories, Inuit, or teens living rurally or northern were another population group that emerged.[48] Three articles focused on northern healthcare providers.[49] Two articles had a focus on teen pregnancy.[50] Nine studies focused on STBBIs, harm reduction, or condom use in Canada.[51]

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[46] Christabelle Sethna and Marion Doull, "Spatial Disparities and Travel to Freestanding Abortion Clinics in Canada.","*Women's Studies International Forum* 38 (2013): 52–62; Carmen H. Logie et al., "Exploring Factors Associated with Condom Use Self-Efficacy and Condom Use among Northern and Indigenous Adolescent Peer Leaders in Northern Canada," *Vulnerable Children and Youth Studies* 14, no. 1 (2019): 50–62; Gregory J Corosky and Astrid Blystad, "Staying Healthy '"under the Sheets"': Inuit Youth experiences of Access to Sexual and Reproductive Health and Rights in Arviat, Nunavut, Canada," *International Journal of Circumpolar Health* 75, no. 1 (2016), https://doi.org/10.3402/ijch.v75.31812.

[47] Zehbe et al., "Engaging Canadian First Nations Women in Cervical Screening through Education"; Lys, Logie, and Okumu, "Pilot Testing Fostering Open eXpression among Youth (FOXY), an Arts-Based HIV/STI Prevention Approach for Adolescent Women in the Northwest Territories, Canada.""; Cidro, Dolin, and Queskekapow, "Bored, Broke, and Alone: Experiences of Pregnant and Expectant First Nations Mothers Birthing in and out of the Community from Indigenous Experiences of Pregnancy and Birth"; Olson, "Bearing Witness: Rural Indigenous women's experiences of childbirth in an urban hospital"; Corosky and Blystad, "Inuit Youth Experiences of Access to SRH and Rights"; Logie et al., "Condom Use among Northern and Indigenous Adolescents"; Sethna and Doull, "Travel to Abortion Clinics."

[48] Lys et al., "Exploring Uptake of HIV/STI Knowledge and Safer Sex-Efficacy in an Arts-Based Sexual Health Workshop among Northern and Indigenous Adolescents in the Northwest Territories, Canada"; Mikhail, Kelly, and Davison, "Reproductive Health Interventions for Inuit Youth in the North"; Healey, "Youth Perspectives on Sexually Transmitted Infections and Sexual Health in Northern Canada and Implications for Public Health Practice"; Moisan et al., "Teen Pregnancy in Inuit Communities - Gaps Still Needed to Be Filled"; Logie et al., "Syndemic Factors Associated with Safer Sex Efficacy Among Northern and Indigenous Adolescents in Arctic Canada"; Logie et al., "Examining Pathways from Food Insecurity to Safer Sex Efficacy Among Northern and Indigenous Adolescents in the Northwest Territories, Canada"; Lys, Logie, and Okumu, "Pilot Testing FOXY in the NWT"; Corosky and Blystad, "Inuit Youth Experiences of Access to SRH and Rights"; Logie et al., "Condom Use among Northern and Indigenous Adolescents."

[49] Machalek et al., "Chlamydia Screening Practices among Physicians and Community Nurses in Yukon, Canada"; Cidro, Dolin, and Queskekapow, "Experiences of Pregnant and Expectant First Nations Mothers"; Olson, "Bearing Witness."

[50] Moisan et al., "Teen Pregnancy in Inuit Communities - Gaps Still Needed to Be Filled"; Paulina Ezer et al., "Heterosexual Female Adolescents' Decision-Making about Sexual Intercourse and Pregnancy in Rural Ontario, Canada," *Rural and Remote Health* 16, no. 1 (January 30, 2016), https://doi.org/10.22605/RRH3664.

[51] Coast et al., "The Microeconomics of Abortion"; Healey, "Youth Perspectives on Sexually Transmitted Infections and Sexual Health in Northern Canada and Implications for Public Health Practice"; Jaworsky et al., "Geographic Differences in the Experiences of HIV-Related Stigma for Women Living with HIV in Northern and Rural Communities of Ontario, Canada"; Logie et al., "Examining Pathways from Food Insecurity to Safer Sex Efficacy Among Northern and Indigenous Adolescents in the Northwest Territories, Canada"; Machalek et al., "Chlamydia Screening Practices among Physicians and Community Nurses in Yukon, Canada"; Fetner et al., "Condom Use in Penile-Vaginal Intercourse among Canadian Adults"; Lys, Logie, and Okumu, "Pilot Testing FOXY in the NWT"; Corosky and Blystad, "Inuit Youth Experiences of Access to SRH and Rights"; Logie et al., "Condom Use among Northern and Indigenous Adolescents."

Knowledge and education about STBBIs or sexual and reproductive health was focused on in nine studies.[52] Abortion was a focus of five articles.[53]

Multiple articles found that confidentiality and privacy were concerns when trying to access reproductive healthcare.[54] Major themes included lack of trust in the sexual and reproductive health supports, especially around confidentiality.[55] One noted confidentiality as barrier to accessing, particularly in small communities.[56] Another noted that "scarcity of discreet services" was a barrier to accessing care.[57] Privacy also seemed to be extra important for teens and youth, with one study finding that privacy was one of the factors in teens' decision-making around sexual activity.[58] A study also found that a reason women bypass abortion clinic close to them is privacy and confidentiality.[59]

A common finding was long travel times for reproductive healthcare.[60] This was noted by the NHR as a challenge in the region, as residents sometimes have to travel long distances and

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[52] Lys et al., "Exploring Uptake of HIV/STI Knowledge and Safer Sex-Efficacy in an Arts-Based Sexual Health Workshop among Northern and Indigenous Adolescents in the Northwest Territories, Canada"; Mikhail, Kelly, and Davison, "Reproductive Health Interventions for Inuit Youth in the North"; Healey, "Youth Perspectives on Sexually Transmitted Infections and Sexual Health in Northern Canada and Implications for Public Health Practice"; Jaworsky et al., "Geographic Differences in the Experiences of HIV-Related Stigma for Women Living with HIV in Northern and Rural Communities of Ontario, Canada"; Logie et al., "Syndemic Factors Associated with Safer Sex Efficacy Among Northern and Indigenous Adolescents in Arctic Canada"; Logie et al., "Examining Pathways from Food Insecurity to Safer Sex Efficacy Among Northern and Indigenous Adolescents in the Northwest Territories, Canada"; Lys, Logie, and Okumu, "Pilot Testing Fostering FOXY in the NWT"; Corosky and Blystad, "Inuit Youth Experiences of Access to SRH and Rights"; Logie et al., "Condom Use among Northern and Indigenous Adolescents."

[53] Cano and Foster, "They Made Me Go through like Weeks of Appointments and Everything"; Sethna and Doull, "Travel to Abortion Clinics"; Canadian Institute for Health Information., "Induced Abortions Reported in Canada in 2021: Update."; Women's Health Clinic, "Access: Annual Report 2022/23"; Action Canada for Sexual Health and Rights [Action Canada] and National Abortion Federation Canada, "Trends in Barriers to Abortion Care."

[54] Ezer et al., "Heterosexual Female Adolescents' Decision-Making about Sexual Intercourse and Pregnancy in Rural Ontario, Canada," sec. Introduction; Corosky and Blystad, "Inuit Youth Experiences of Access to SRH and Rights," sec. Results; Sethna and Doull, "Travel to Abortion Clinics.","sec. Discussion.

[55] Corosky and Blystad, "Inuit Youth Experiences of Access to SRH and Rights," sec. Results.

[56] Sethna and Doull, sec. Discussion.

[57] Ezer et al., "Heterosexual Female Adolescents' Decision-Making about Sexual Intercourse and Pregnancy in Rural Ontario, Canada," sec. Discussion.

[58] Ezer et al., sec. Results.

[59] Sethna and Doull, "Travel to Abortion Clinics.","sec. Results.

[60] Ezer et al., "Heterosexual Female Adolescents' Decision-Making about Sexual Intercourse and Pregnancy in Rural Ontario, Canada"; Jaworsky et al., "Geographic Differences in the Experiences of HIV-Related Stigma for Women Living with HIV in Northern and Rural Communities of Ontario, Canada"; Cidro, Dolin, and Queskekapow, "Experiences of Pregnant and Expectant First Nations Mothers"; Sethna and Doull, "Travel to Abortion Clinics."; Women's Health Clinic, "Access: Annual Report 2022/23"; NHR, "Northern Health Region Annual Report 2022-23"; Action Canada and National Abortion Federation Canada, "Trends in Barriers to Abortion Care."

pay out-of-pocket to travel costs to access care.[61]A study found that those living with HIV in northern areas had unique challenges, including long travel. [62] One study found that the living in a secluded or isolated area was a factors in teens' decision-making around sexual activity.[63] Another study notes that when women travel to give birth, they have financial stress when paying for transportation.[64]Additionally, the limited local sexual health resources and education was also a factor. [65] Women's Health Clinic in Winnipeg notes that timely access to abortion is difficult for those living rurally and remotely, and recommends local, community-based services.[66] Action Canada also echoed this, stating travelling for abortion care is very common for those living rurally and remotely.[67] The authors of one study stated that "mapping the data on women's journeys to freestanding abortion" raised the concern of the scarcity of services outside of urban areas and the need to travel to access, particularly in northern communities.[68] Most participants lived within 100km of clinic, but 18% lived over 100km, from 1km to 3,558km.[69] The research found just under 50% of participants traveled an hour or more for abortion services, however many bypassed the closest clinic to their homes, for a variety of reasons (too booked up, did not receive call back, etc.).[70] They also noted that in the research women who were First Nations or Métis "were almost three times more likely to report travelling over 100kms to access a clinic as compared with white women." [71]

Overall long wait times, or delay of services was common across studies.[72] Especially when pertaining to how far individuals must travel for services, or due to jurisdictional barriers when moving between practitioners. One study found that "fragmented services" left women

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[61] NHR, "Annual Report 2021-22," 5.
[62] Jaworsky et al., "Geographic Differences in the Experiences of HIV-Related Stigma for Women Living with HIV in Northern and Rural Communities of Ontario, Canada," sec. Discussion.
[63] Ezer et al., "Heterosexual Female Adolescents' Decision-Making about Sexual Intercourse and Pregnancy in Rural Ontario, Canada," sec. Results.
[64] Cidro, Dolin, and Queskekapow, "Experiences of Pregnant and Expectant First Nations Mothers," 77.
[65] Ezer et al., "Heterosexual Female Adolescents' Decision-Making about Sexual Intercourse and Pregnancy in Rural Ontario, Canada," sec. Results.
[66] Women's Health Clinic, "Access: Annual Report 2022/23," 6.
[67] Action Canada, "Policy Brief: Increasing Abortion Access in Canada through Midwife-Led Care" (Action Canada, 2023), 2, https://www.actioncanadashr.org/resources/policy-briefs-submissions/2023-03-07-increasing-abortion-access-canada-through-midwife-led-care.
[68] Sethna and Doull, "Travel to Abortion Clinics," sec. Discussion.
[69] Sethna and Doull, sec. Results.
[70] Sethna and Doull, sec. Results.
[71] Sethna and Doull, sec. Results.
[72] Cano and Foster, "They Made Me Go through like Weeks of Appointments and Everything"; Sethna and Doull, "Travel to Abortion Clinics."

feeling "unsatisfied, stressed and/or upset with the lack of information, multiple appointments and lengthy wait times."[73] The study noted that "rural, remote and northern regions of Canada face challenges with both limited healthcare facilities and providers, creating fragmented care and increased wait time for many healthcare services. However, the hoops that women have to jump through to access abortion care in the Yukon create additional barriers." [74]

Financial barriers were also found to be major obstacles for those trying to access care in multiple studies.[75] Healthcare access in rural areas is influenced by "limited financial means to cover driving expenses to health appointments or for birth control and other resources."[76] A study noted when women travel for birth, they experience financial stress when spending money on plane or bus tickets, gas, accommodation, food, or childcare, which can be especially onerous if women are staying in urban areas for weeks.[77] Disturbingly, the study states how due to lack of childcare, some parents place their children in the care of Child and Family Services when travelling to give birth.[78] In another study, the authors stated that through mapping women's journeys to abortion clinics, one of the important concerns raised was "the burdensome costs of travel and, in some cases to costs of the abortion procedure itself, especially for younger women who travel the farthest." [79] When travelling for abortion, costs ranged from paying nothing to over $100, and women reported paying for "plane tickets, bus tickets, gas for vehicles, ferries and taxis, often for themselves and a travel companion". [80] Additionally, some women incurred other expenses such as child care while they were having the abortion, food, parking, car repairs, and loss of income. [81] Around a quarter of women reported paying for their abortion, even though abortion should be fully funded. [82] Action Canada also found that great costs are incurred when travelling for abortion care.[83]

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[73] Cano and Foster, 494.
[74] Cano and Foster, 494.
[75] Ezer et al., "Heterosexual Female Adolescents' Decision-Making about Sexual Intercourse and Pregnancy in Rural Ontario, Canada"; Cidro, Dolin, and Queskekapow, "Experiences of Pregnant and Expectant First Nations Mothers"; Action Canada and National Abortion Federation Canada, "Trends in Barriers to Abortion Care."
[76] Ezer et al., "Heterosexual Female Adolescents' Decision-Making about Sexual Intercourse and Pregnancy in Rural Ontario, Canada," sec. Introduction.
[77] Cidro, Dolin, and Queskekapow, "Experiences of Pregnant and Expectant First Nations Mothers," 77.
[78] Cidro, Dolin, and Queskekapow, 84.
[79] Sethna and Doull, "Travel to Abortion Clinics.", sec. Discussion.
[80] Sethna and Doull, sec. Results.
[81] Sethna and Doull, sec. Results.
[82] Sethna and Doull, sec. Results.
[83] Action Canada, "Midwife-Led Abortion Care," 2.

Finding links between reproductive healthcare or sexual health knowledge and food insecurity, poverty, and low socioeconomic status was found in numerous studies.[84] A study found that food insecurity, poverty, and violence, were associated with lower safe sex efficacy.[85] They noted that addressing systemic poverty is "urgently required" in the northern context where STI rates are high.[86] Associations between low socioeconomic status, intimate partner violence, food insecurity, and low safe sex efficacy underscore "the need to address poverty and violence to advance adolescent sexual health in NWT."[87] Another study evaluated youth food insecurity with how often youth went to bed hungry without food, and safer sex efficacy with condom use.[88] The study found almost half of respondents reported food insecurity, and found that "food insecurity was indirectly associated with condom use self-efficacy through resilience and depression and associated with situational safer sex self-efficacy through resilience."[89]A third study found around one third of participants reported vaginal sex, being in a relationship, and food insecurity. [90] The findings suggest that strength and resilience based sexual health strategies to increase condom use, and also an urgent need for poverty reduction strategies.[91] Costs related to purchasing food was a stressor for those travelling for abortion.[92]

One finding was that more sexual and reproductive health education and information was needed.[93] A study on cervical cancer screening in First Nations women found that health education was needed, particularly in a way that was culturally relevant, rather than fearing death, promoted screening as a way to keep holistic wellness.[94] The study found that interactive programs like FOXY were promising in engaging Indigenous and northern women, but noted that to be effective interventions must be "interactive, age specific, and geographically and

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[84] Logie et al., "Syndemic Factors Associated with Safer Sex Efficacy Among Northern and Indigenous Adolescents in Arctic Canada"; Logie et al., "Examining Pathways from Food Insecurity to Safer Sex Efficacy Among Northern and Indigenous Adolescents in the Northwest Territories, Canada"; Logie et al., "Condom Use among Northern and Indigenous Adolescents"; Sethna and Doull, "Travel to Abortion Clinics."
[85] Logie et al., "Syndemic Factors Associated with Safer Sex Efficacy Among Northern and Indigenous Adolescents in Arctic Canada," 451.
[86] Logie et al., 452.
[87] Logie et al., 449.
[88] Logie et al., "Examining Pathways from Food Insecurity to Safer Sex Efficacy Among Northern and Indigenous Adolescents in the Northwest Territories, Canada," sec. Methods.
[89] Logie et al., sec. Discussion.
[90] Logie et al., "Condom Use among Northern and Indigenous Adolescents," sec. Results.
[91] Logie et al., sec. Discussion.
[92] Sethna and Doull, "Travel to Abortion Clinics.","sec. Results.
[93] Zehbe et al., "Engaging First Nations Women in Cervical Screening"; Cano and Foster, "They Made Me Go through like Weeks of Appointments and Everything"; Lys, Logie, and Okumu, "Pilot Testing FOXY in the NWT."
[94] Zehbe et al., "Engaging First Nations Women in Cervical Screening," 261–62.

culturally relevant."[95] When surveying women accessing abortion, a study found that the disjointed services left women feeling unsatisfied with the lack of information.[96]

Stigma and reluctance to discuss sexual and reproductive health was found in some studies.[97] Experiencing higher HIV stigma was associated with living in a northern or rural area.[98] HIV positive women in rural areas had more concerns about public perception of HIV and disclosing.[99] As study on the STBBI screening patterns in Yukon territory found nurses did less sexual health assessments and less STBBI testing, and patient reluctance to discuss sexual health a common barrier.[100] In a study on Inuit youth, major themes included lack of trust in the sexual and reproductive health supports, especially around confidentiality, stigma, and feeling powerless.[101] A study on condom use noted participants lacked confidence in discussing condom use. [102]

The lack of specialist or even staff trained to provide sexual and reproductive healthcare was noted in multiple studies.[103] A study found that those living with HIV in northern areas had unique challenges, including service delivery and lack of specialist medical staff. [104] There are limited providers in general in rural remote, and northern Canada, let alone specialist providers.[105] Another study noted that, over time, midwifery's been restricted in various ways in different provinces, reducing the breadth of care they can provide.[106] Due to lack of specialists,

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[95] Lys, Logie, and Okumu, "Pilot Testing FOXY in the NWT," sec. Discussion.
[96] Cano and Foster, 494.
[97] Machalek et al., "Chlamydia Screening Practices among Physicians and Community Nurses in Yukon, Canada"; Corosky and Blystad, "Inuit Youth Experiences of Access to SRH and Rights"; Logie et al., "Condom Use among Northern and Indigenous Adolescents"; Jaworsky et al., "Geographic Differences in the Experiences of HIV-Related Stigma for Women Living with HIV in Northern and Rural Communities of Ontario, Canada."
[98] Jaworsky et al., "Geographic Differences in the Experiences of HIV-Related Stigma for Women Living with HIV in Northern and Rural Communities of Ontario, Canada," sec. Discussion.
[99] Jaworsky et al., sec. Discussion.
[100] Machalek et al., "Chlamydia Screening Practices among Physicians and Community Nurses in Yukon, Canada," sec. Results.
[101] Corosky and Blystad, "Inuit Youth Experiences of Access to SRH and Rights," sec. Results.
[102] Logie et al., "Condom Use among Northern and Indigenous Adolescents," sec. Results.
[103] Jaworsky et al., "Geographic Differences in the Experiences of HIV-Related Stigma for Women Living with HIV in Northern and Rural Communities of Ontario, Canada"; Cano and Foster, "They Made Me Go through like Weeks of Appointments and Everything"; Cidro, Dolin, and Queskekapow, "Experiences of Pregnant and Expectant First Nations Mothers."
[104] Jaworsky et al., "Geographic Differences in the Experiences of HIV-Related Stigma for Women Living with HIV in Northern and Rural Communities of Ontario, Canada," sec. Discussion.
[105] Cano and Foster, 494.
[106] Cidro, Dolin, and Queskekapow, "Experiences of Pregnant and Expectant First Nations Mothers," 74.

those in rural and remote areas have given birth in hospital more frequently as time has passed.[107]

Fragmented services posing a barrier was found.[108] A large issue in the NHR is the jurisdictional issues for those living on-reserve who access health services both on- and off-reserve, which results in fragmented care.[109] One study found that "fragmented services" left women feeling "unsatisfied, stressed and/or upset with the lack of information, multiple appointments and lengthy wait times" when accessing abortion.[110] A study on the birth evacuation policy noted that there was not an agreement on what a safe location for birth is, the study found that everyone could agree that the current disjointed "system of evacuating women was broken and, indeed needed fixing."[111]

Chapter I: Human Rights Obligations

Highest Attainable Standard of Health

Firstly, in international human rights law, there is no 'right to be healthy,' but the right to health is conceptualized as the *right to the highest attainable standard of health*.[112] Joseph Raz suggests that the concept of highest attainable standard of health does not identify if it is the precise highest attainable possible globally or, if it is the "highest attainable, given proper weight to all other considerations".[113] Onora O'Neil questions this as well, "if we meant the globally highest stainable standard, then we are setting a utopian standard. If we mean the locally highest attainable standard are we not setting our target far too low?"[114] This is a good and important point, and worthwhile considering in the Canadian context. Is the highest attainable health for rural and remote Canadians different than the highest attainable health for urban Canadians? The answer is complex. While there are certainly aspects of healthcare, such as tertiary care clinics or surgical specialists, that will likely forever be more accessible to urban Canadians, by virtue of the conveniences of urban living. However, the author questions how much of reproductive

[107] Cidro, Dolin, and Queskekapow, "Experiences of Pregnant and Expectant First Nations Mothers," 75.
[108] Cano and Foster, "They Made Me Go through like Weeks of Appointments and Everything"; Olson, "Bearing Witness"; NHR, "Northern Health Region Annual Report 2022-23."
[109] NHR, 4.
[110] Cano and Foster, 494.
[111] Olson, "Bearing Witness," 92.
[112] CESCR, "Highest Attainable Standard of Health," paras. 8–9.
[113] Nampewo, Mike, and Wolff, "Respecting, Protecting and Fulfilling the Human Right to Health," 3.
[114] Nampewo, Mike, and Wolff, 3; Onora O'Neill, "The Dark Side of Human Rights," *International Affairs (Royal Institute of International Affairs 1944-)* 81, no. 2 (2005): 429.

healthcare can be provided without a large urban/rural divide. To say that all Canadians will have equal access to the best medical teams and equipment at all times is not a realistic possibility. One of Canada's greatest strengths, its size, is also one of its greatest weaknesses. There will always be at least some issues accessing healthcare due to geography.

Duties and Obligations of the State

Economic, social, and cultural rights create many duties.[115] While duties for various rights may fall to individuals, communities, states, the international community, or corporations, most agree that the "duties of the right to health sit squarely on the shoulders of the state who should ensure the fair provision of the facilities, services and products necessary to promote and safeguard the right to health, through minimum core obligations."[116] In *Indian Supreme Court Samity v State of Bengal*, the court decided on the basis of right to life, that that inclusion of "obligation to provide access to medical treatments to preserve human life as a 'constitutional obligation of the state to provide adequate medical services to people'".[117] The case confirmed that access to timely healthcare is needed to preserve life.[118] The creation of too many duties is a common criticism of economic, social and cultural rights.[119] However, this critique is too simplistic and does not differentiate the types of duties required by duty holders.[120]

Canadian Legislation

Canadian human rights legislation is weak, with few inherent rights enshrined at provincial or federal levels. Health is not conceived as a right within relevant Canadian legislation. Canada's main human rights legislation, the *Canadian Charter of Rights and Freedoms*, may implicate a right to health in s. 7 or s.15.[121] As s. 7 articulates everyone's right to life, liberty and security of person, and s. 15 focuses on "equality rights," both are relevant to the discussion of health in Canada, but do not explicitly outline health as a right.[122] The *Canadian*

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[115] Nampewo, Mike, and Wolff, "Respecting, Protecting and Fulfilling the Human Right to Health," 4.
[116] Nampewo, Mike, and Wolff, 7.
[117] Nampewo, Mike, and Wolff, 7; (1996) AIR SC 2426/ (1996) 4 SCC 37, para. 9, 15-16.
[118] Nampewo, Mike, and Wolff, 7; (1996) AIR SC 2426/ (1996) 4 SCC 37.
[119] Nampewo, Mike, and Wolff, 4.
[120] Nampewo, Mike, and Wolff, 4.
[121] Martha Jackman, "The Application of the Canadian Charter in the Health Care Context," SSRN Scholarly Paper (Rochester, NY, 2001), 22, https://papers.ssrn.com/abstract=2578206; "Canadian Charter of Rights and Freedoms, Part 1 of the Constitution Act, Being Schedule B to the Canada Act," c 11 § (1982), s. 7, 15, https://canlii.ca/t/ldsx.
[122] Canadian Charter of Rights and Freedoms, Part 1 of the Constitution Act, being Schedule B to the Canada Act, secs. 7, 15.

Human Rights Act enacted in 1985 is similar in its focus on equality and discrimination, rather than a right *to* something.[123] The *Act* states that "where the ground of discrimination is pregnancy or child-birth, the discrimination shall be deemed to be on the ground of sex."[124] Access to healthcare facilities could be implicated in s. 5, to deny access to facilities or "differentiate adversely in relation to any individual, on a prohibited ground."[125] However, discrimination must be found on the basis of one of the prohibited grounds, and women living in rural and remote areas have the same (lack of) access to healthcare services that men do. So, while healthcare can be implicated in federal legislation, it is not enshrined in any or conceptualized as a right to health.

The *Human Rights Code* of Manitoba is in many ways similar to the federal C*harter* and *Act.* The *Code* focuses on discrimination as well, on the basis of gender identity, marital status, sexual orientation, social disadvantage, or sex "including sex-determined characteristics or circumstances, such as pregnancy, the possibility of pregnancy, or circumstances related to pregnancy," among others.[126] There is no mention of a right to health in the *Code*.

Health is governed by the *Canada Health Act* (CHA). The CHA, again, does not provide much relevant to right to health. The CHA states that its primary objective is to "protect, promote and restore" health and "facilitate reasonable access to health services."[127] However, the rest of the CHA focuses on cash transfer between the federal to provincial governments, administration of health programs, comprehensiveness and universality in terms of insurance of all in the province (i.e. All provincial residents must have 100% coverage for insurable services).[128] One section is relevant for this discussion, as the CHA outlines accessibility and states that the province "must provide for insured health services on uniform terms […] on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services."[129]

Within Health Canada's 2023-24 departmental plan, they acknowledge that their core responsibilities involve Canada's healthcare systems and the promotion and protection of

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[123] "Canadian Human Rights Act," c H-6 RSC § (1985), sec. 2, 3(1), https://canlii.ca/t/7vh5.
[124] Canadian Human Rights Act, sec. 3(2).
[125] Canadian Human Rights Act, sec. 5.
[126] "The Human Rights Code," c H175 CCSM § (1987), sec. 9(2), https://canlii.ca/t/55q5f.
[127] "RSC 1985, c C-6 | Canada Health Act" (CanLII), sec. 3, accessed February 6, 2023, https://www.canlii.org/en/ca/laws/stat/rsc-1985-c-c-6/latest/rsc-1985-c-c-6.html.
[128] "RSC 1985, c C-6 | Canada Health Act," secs. 5, 8, 9, 10.
[129] "RSC 1985, c C-6 | Canada Health Act," sec. 12(1)(a).

health.[130] The plan includes "improving Canadian's access to family health services, regardless of where they live" and bolstering digital technology for healthcare.[131] So while the department acknowledges their responsibility for health in Canada, it is not legislated within the CHA. Due to the lack of legal mechanisms or even recognition of a *right* to health in Canada, we must look to international treaties for information of what directs the right to health in Canada.

United Nations Declaration on the Rights of Indigenous Peoples and the UNDRIP Act

The *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP) is a recent UN declaration.[132] Declarations are different than treaties or acts, as they are not legally binding. Declarations serve as the intent and commitment of signatories to enforce and protect the rights in the declaration, and although not legally binding, can be persuasive as "soft law".[133] In 2007 Canada voted against UNDRIP, along with the United States, Australia, and New Zealand.

The *United Nations Declaration on the Rights of Indigenous Peoples Act* (*UNDRIP Act*) is a recent Canadian legislation that brought UNDRIP into Canadian law in 2016. The *Act* is a response to the Truth and Reconciliation Commission of Canada, the National Inquiry into Missing and Murdered Indigenous Women and Girls, and UNDRIP.[134] Due to UNDRIP not being legally binding, and the *UNDRIP Act* not an international treaty, they are not used extensively in the analysis of this research.

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[130] Health Canada, "2023–24 Departmental Plan: Health Canada" (Government of Canada, February 2023), 5, https://www.canada.ca/en/health-canada/corporate/transparency/corporate-management-reporting/report-plans-priorities/2023-2024-departmental-plan.html.
[131] Health Canada, 5–6.
[132] General Assembly, "United Nations Declaration on the Rights of Indigenous Peoples," 2007, https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf.
[133] Welkins, "So You Want to Implement UNDRIP," *University of British Columbia Law Review* 53, no. 4 (September 2021): 1238.
[134] "United Nations Declaration on the Rights of Indigenous Peoples Act," c 14 SC § (2021), sec. Preamble, https://canlii.ca/t/554bd.

International Covenant of Economic, Social and Cultural Rights

The *International Covenant on Economic, Social and Cultural Rights* (ICESCR) was created in 1966.[135] Canada ratified the ICESCR on May 19, 1976.[136] The ICESCR is the treaty we look to for information on the right to health.[137] Particularly, we look to Article 12:

> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
> (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; […]
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
> (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.[138]

As mentioned prior, the right to health is conceptualized as *the right to enjoy the highest attainable standard of health* rather than the right to be healthy.[139] General Comment 14 is clear that many aspects of health cannot be a part of a states' duty to individuals, noting that "good health cannot be ensured by a state" and states cannot protect individuals from all causes of illness.[140] Unhealthy lifestyles, genetics, and individual vulnerability to illness are important factors for personal health, therefore "the right to health must be understood as a right to the enjoyment of a variety of the highest attainable standard of health."[141] However, while good health is not a right of individuals nor an obligation of states, an adequate *standard* of health is both a right and an obligation.

Article 12.1 right extends to both proper and timely care, yes, but also to the "underlying determinants of health" including sanitation, food, water, housing, and "access to health-related education and information, *including on sexual and reproductive health*."[142] Article 12.2(a) of the ICESCR has been interpreted in General Comment 14 as necessitating measures that develop

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[135] UN General Assembly, "ICESCR".
[136] UN Human Rights Treaty Bodies, "Ratification Status for Canada," Office of the High Commissioner of Human Rights, accessed September 3, 2023, https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=31&Lang=EN.
[137] UN General Assembly, "ICESCR," art. 12.
[138] UN General Assembly, "ICESCR", art. 12.
[139] UN General Assembly, "ICESCR", art. 12.
[140] CESCR, "Highest Attainable Standard of Health," para. 9.
[141] CESCR, para. 9.
[142] CESCR, para. 11, emphasis added.

reproductive and maternal healthcare, that include a broad range of services like pre- and post-natal care, family planning, and obstetric care.[143] Article 12.2(c) of the ICESR was interpreted to require the creation of both "prevention and education programs" for diseases, including ones that negatively impact reproductive health like STBBIs.[144] The scope of health has broadened as new diseases and health technologies have been discovered, which must be considered in the interpretation of the obligations and duties of article 12.[145] So, over time, Article 12 has been interpreted quite broadly, to not only include healthcare services, and hospitals, but also prevention and education around health, including reproductive healthcare and treatment. General Comment 14 is explicit in including sexual and reproductive freedoms as an important part of the right to health.[146]

General Comment 14 discusses the availability, accessibility, acceptability, and quality as essential elements in the right to health.[147] Availability includes programs, goods, services, and functioning public health systems and facilities.[148] While exact types of facilities and services can vary, they must involve "underlying determinants of health" which include "professional personnel receiving domestically competitive salaries, and essential drugs" on the WHO's essential medicines list.[149] Included on the list are contraceptive pills, IUDs, condoms, mifepristone and misoprostol (the medications in the abortion pill).[150] Accessibility entails that people can access facilities, good and services without discrimination.[151] There are four interrelated dimensions of accessibility, which include non-discrimination, physical accessibility, economic accessibility, and information accessibility.[152]

Non-discrimination outlines that all people must have accessible health services and facilities available, particularly vulnerable populations both "in law and in fact."[153] General Comment 14 describes physical accessibility as: "health facilities, goods and services must be

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[143] CESCR, "Highest Attainable Standard of Health," para. 14.
[144] CESCR, para. 14.
[145] CESCR, para. 10.
[146] CESCR, para. 8.
[147] CESCR, para. 12.
[148] CESCR, para. 12.a.
[149] CESCR, para. 12.a; World Health Organization [WHO], "WHO Model List of Essential Medicines - 23rd List, 2023" (Geneva: WHO, 2023), https://www.who.int/publications-detail-redirect/WHO-MHP-HPS-EML-2023.02.
[150] WHO, "WHO List of Essential Medicines," 52.
[151] CESCR, "Highest Attainable Standard of Health," para. 12.b.
[152] CESCR, para. 12.b.
[153] CESCR, para. 12.b.

within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS."[154] Economic accessibility, or the affordability of health goods and services is also important in the proper provision of healthcare.[155] Acceptability of health facilities includes both medically ethical and culturally appropriate.[156] They note that in relation to the right to health, "equality of access to healthcare and health services has to be emphasized."[157]

General Comment 14 makes special mention of the right to health for Indigenous people, which was not discussed in the original ICESCR.[158] General Comment 14 states that:

> **Indigenous peoples have the right to specific measures to improve their access to health services and care**. These health services should be **culturally appropriate**, taking into account traditional preventive care, healing practices and medicines. States should provide resources for indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health. […] The Committee notes that, in indigenous communities, the **health of the individual is often linked to the health of the society**.[159]

The ICESCR allows for progressive realization of the right to health.[160] It also recognizes that there are legitimate constraints upon states due to limitations on resources.[161] However, there are some immediate obligations.[162] States must "guarantee that the [right to health] will be exercised without discrimination" and have the obligation to "take steps towards the full realization of article 12."[163] Steps should be "deliberate, concrete and targeted towards the full realization of the right to health."[164] Progressive realization is not understood as a way for states to wash their hands of obligations to the right to health, but is interpreted as having "a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12."[165]

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[154] CESCR, "Highest Attainable Standard of Health," para. 12.b.
[155] CESCR, para. 12.b.
[156] CESCR, para. 12.c.
[157] CESCR, para. 19.
[158] UN General Assembly, "ICESCR"; CESCR, para. 27.
[159] CESCR, para. 27, emphasis added.
[160] UN General Assembly, "ICESCR", art. 2.1; CESCR, para. 30.
[161] UN General Assembly, "ICESCR", art. 2.1; CESCR, para. 30.
[162] CESCR, para. 30.
[163] UN General Assembly, "ICESCR", art. 2.1, 2.2; CESCR, para. 30.
[164] UN General Assembly, "ICESCR", art. 2.1, 2.2; CESCR, para. 30.
[165] CESCR, "Highest Attainable Standard of Health," para. 31.

The Committee stresses in General Comment 14 that states have a core obligation to ensure that minimum essential levels of the right to health are met, and include equitable distribution and non-discriminatory access to healthcare facilities and provide drugs that are listed as Essential Drugs by the WHO.[166] General Comment 14 also verifies that the obligation "to ensure reproductive, maternal (prenatal as well as post-natal)" health.[167] Violations to article 12 include acts of omission by failing to take proper steps to the full realization of the right to the highest attainable standard of health.[168]

Reproductive healthcare is also implicated in children's rights, as the need for the child and their family to have healthcare, including care for pregnant mothers.[169] General Comment 14 also is clear that confidentiality and privacy are important in providing care to youth, and include "appropriate sexual and reproductive health services."[170] General Comment 14 makes mention of the need for development of a national strategy for women's health, that should include "policies to provide access to a full range of high quality and affordable healthcare, including sexual and reproductive services." [171] Reducing health risks of women should be a primary objective of the plan, including protection from intimate partner violence and reducing maternal mortality.[172] In order for women to have the right to an adequate standard of health realized, a broad scope of policies, education, information, policies, and practices must be undertaken by the state.[173] This view of the UN shows that reproductive health does not exist in silo, and has multiple implications on women's physical and emotional health, economic freedom, physical safety, and lives.

[166] CESCR, para. 44.
[167] CESCR, para. 44.
[168] CESCR, para. 49.
[169] CESCR, para. 22.
[170] CESCR, para. 23.
[171] CESCR, para. 21.
[172] CESCR, para. 21.
[173] CESCR, para. 21, emphasis added.

Convention on the Elimination of Discrimination Against Women

The *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW) was created in 1979.[174] Canada ratified CEDAW on December 10, 1981.[175] Article 1 states that discrimination against women means that any:

> Distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women […] on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.[176]

Per article 2, states should take all appropriate measures to eliminate discrimination, and must ensure that "through law and other appropriate means" that non-discrimination is practically realized.[177] CEDAW stresses the essential nature of maternity and the need for states to ensure that the need for both men and women to be involved in the "upbringing and development" of children.[178] Also explicitly mentioned is the need for equality between men and women in education, and in particular "access to specific educational information to help ensure the health and well-being of families, including information and advice on family planning."[179] Article 12 is explicit of the need for non-discrimination in the right to health, that all appropriate measures must be taken "to eliminate discrimination against women in the field of healthcare in order to ensure […] access to healthcare services, including those related to family planning."[180] It affirms that states must ensure proper services in relation to pregnancy and post-natal care, including nutrition throughout pregnancy and during lactation, with free services when needed.[181]

General recommendation No. 24 focuses and elaborates on article 12 of CEDAW, women and the right to health.[182] The recommendation says that states parties must "ensure removal of all barriers to women's access to health services [including] sexual and reproductive health."[183] It

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[174] General Assembly, "Convention on the Elimination of All Forms of Discrimination Against Women" (United Nations, Treaty Series, December 18, 1979), https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/cedaw.pdf.
[175] UN Human Rights Treaty Bodies, "Ratification Status for Canada."
[176] General Assembly, "CEDAW," art. 1.
[177] General Assembly, CEDAW, art. 2(a), 2(e).
[178] General Assembly, CEDAW, art. 5(b).
[179] General Assembly, CEDAW, art. 10(h).
[180] General Assembly, CEDAW, art. 12.1.
[181] General Assembly, CEDAW, art. 12.2.
[182] CEDAW, "General Recommendation No. 24: Article 12 of the Convention (Women and Health)" (Geneva, Switzerland: United Nations, 1999), 24.
[183] CEDAW, para. 31(b).

stresses the need for services to be "consistent with the human rights of women including, including the rights to autonomy, privacy, confidentiality, informed consent and choice".[184]

While women all have rights regardless of their location, CEDAW mentions rural women specifically, and in article 14 states that:

> States Parties shall take into account the particular problems faced by rural women and the significant roles which rural women play in the economic survival of their families, including their work in the non-monetized sectors of the economy, and shall take all appropriate measures to ensure the application of the provisions of the present Convention to women in rural areas.[185]

Noting specifically that there are *particular problems* that rural women face, but that all appropriate measures should be taken to ensure the application of CEDAW in rural areas. States must also ensure that rural women can "participate in and benefit from" development in rural areas, and that they have "access to adequate healthcare facilities, including information, counselling and services in family planning."[186] CEDAW outlines that men and women must have "the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."[187]

CEDAW's General Recommendation No. 34 focuses and expands on article 14 and rural women.[188] Globally, rural women experience higher levels of poverty, discrimination, and inequality than rural men, urban women, and urban men, and are "particularly disadvantaged with respect to access to healthcare."[189] The recommendation notes that sexual and reproductive healthcare for rural women is frequently inadequate, due to many factors including remoteness, lack of infrastructure, and insufficient funding of rural clinics.[190] Lack of birth workers, medical practitioners, access to family planning, and higher rates of adolescent pregnancies are common and result in disproportionately high rates of maternal morbidity and mortality in rural areas.[191]

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[184] CEDAW, para. 31(e).
[185] General Assembly, CEDAW, art. 14.1.
[186] General Assembly, CEDAW, art. 14.2(b).
[187] General Assembly, CEDAW, art. 16.1(e).
[188] CEDAW, "General Recommendation No. 34 on the Rights of Rural Women" (Geneva, Switzerland: United Nations), accessed September 5, 2023, https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW%2FC%2FGC%2F34&Lang=en.
[189] CEDAW, para. 5.
[190] CEDAW, para. 37.
[191] CEDAW, para. 38.

The recommendation notes that unsafe abortion is more common in rural areas, but that "even in countries in which abortion is legal, restrictive conditions, including unreasonable waiting periods, often impede access for rural women." [192] The recommendation states that countries must ensure culturally acceptable healthcare services should be financed and available to rural women, and include family planning, obstetric, and abortion care, and that laws and policies must not obstruct access to care.[193] They note that rural women in developed countries face some unique issues, such as Indigenous communities having higher rates of isolation and poverty.[194]

Chapter II: Healthcare in Practice

This section will map sexual and reproductive health care in Manitoba. The focus will be on rural, remote, and northern Manitoba. The WRHA provides specialized care. People living in other health regions must travel to WHRA to access this specialized care. Telehealth is a form of heath care that is provided by a practitioner over phone, video chat, or other virtual means.[195] Telehealth is used to connect those living in rural, remote, and northern locations to urban specialists for some appointments. Telehealth is provided through MBTelehealth throughout all five regional health authorities (RHA).[196]

Abortion

Abortion is covered with a Manitoba Health Card or if a person has coverage in another province. [197] According to the Abortion Rights Coalition of Canada, aspiration abortion services are available at the Brandon Regional Health Centre until 12 weeks' gestation, and in Winnipeg's Women's Hospital at the Health Science Centre until 19 weeks and 6 days.[198] Women's Health Clinic (WHC) in Winnipeg offers aspiration up to 16 weeks.[199]

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[192] CEDAW, para. 38.
[193] CEDAW, para. 39.
[194] CEDAW, para. 89.
[195] NHR, "Northern Health Region Annual Report 2022-23," 8.
[196] MBTelehealth, "About Us," MBTelehealth, accessed January 8, 2024, https://mbtelehealth.ca/about/.
[197] Women's Health Clinic, "Abortion," Women's Health Clinic, accessed May 18, 2023, https://womenshealthclinic.org/what-we-do/abortion/.
[198] Health Sciences Centre, "Pregnancy and Prenatal Care," Health Sciences Centre, sec. Pregnancy counselling, accessed August 16, 2023, https://hsc.mb.ca/adults/womens-health/our-services/pregnancy-and-prenatal-care/.; Abortion Rights Coalition of Canada, "Abortion Clinics and Services in Canada," March 2023, 10–11, https://www.arcc-cdac.ca/media/2020/08/list-abortion-clinics-canada.pdf.
[199] Women's Health Clinic, "Abortion."

Figure 2: Map of Aspiration Abortion Services in Manitoba.[200]

Medication abortion is slightly more available, up to 8 weeks at the Women's Hospital in Winnipeg, and 9 weeks throughout the NHR, in Brandon, and in Winnipeg at WHC.[201] Family physicians and nurse practitioners can also prescribe for medication abortion, however a list of providers who are willing to prescribe is not publicly available. WHC provides referrals and counselling for those needing support or information in their decision-making process.[202] Although WHC is located within the WHRA, they provide birth control and pregnancy counselling and abortion services to individuals living in other RHAs in Manitoba. In a message from Kemlin Nembhard in the WHC's 2022/23 Annual Report, Nembhard stated that:

> Timely access is especially difficult for people living in rural and remote areas. It's simply not enough for abortion services to be legally available. For real access, services need to be community-based. They need to be within reach across the many intersections

[200] Erin Gobert, "Aspiration Abortion Map Manitoba," Google My Maps, accessed February 8, 2024, https://www.google.com/maps/d/new?hl=en&cid=mp&cv=tsAQOm8_ueg.en.
[201] Abortion Rights Coalition of Canada, "Abortion Clinics and Services in Canada," 10–11.
[202] Women's Health Clinic, "Abortion."

> of people's lives – as students, workers, parents and caregivers – both geographically and financially.[203]

There is no publicly-available information on abortion services in two health regions, SHSS or I-ERHA. Aspiration abortion is only available in Winnipeg (WHRA) and Brandon (PMH), and not available in NHR, SHSS, and I-ERHA. Even in PMH, Brandon is the only location, which while the largest population centre, is not accessible for those living throughout the region. The SHSS website states that they provide counselling "related to a full range of reproductive health matters, including birth control, pregnancy and sexually transmitted infections".[204] It is unclear if abortion is included in pregnancy counselling.

Contraception

Presently, the sole country with universal healthcare without some coverage of prescriptions is Canada.[205] The birth control injection can cost up to $180 annually, whereas oral contraceptive pills can be $240.[206] Intrauterine devices (IUDs) can be up to $400.[207] These costs are huge barriers.[208] A plan to provide free contraceptives was announced by Manitoba's New Democratic Party (NDP) in 2023. [209] As well, a deal was reached between the federal NDP and Liberals in 2024 to enact the NDP's pharmacare plan which includes contraceptives.[210] Pharmacare coverage of prescriptions impacts reproductive healthcare access in many ways, by reducing unintended pregnancies and improving family planning, as well as resulting in better outcomes for those who are pregnant.[211] Currently nearly half (47%) of all pregnancies in Canada are unintended.[212] Each year, this costs Canada millions of dollars.[213]

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[203] Women's Health Clinic, "Access: Annual Report 2022/23," 6.
[204] SHSS, "Pregnancy Testing, Birth Control & Counselling," SHSS, accessed May 18, 2023, https://www.southernhealth.ca/en/finding-care/health-info-for-you/healthy-sexuality/pregnancy-testing-birth-control-and-counselling/.
[205] Action Canada, "Policy Brief: Canada's Pharmacare Plan Should Provide Access to All Forms of Contraception" (Action Canada for Sexual Health and Rights, 2022), 2.
[206] Action Canada, 3.
[207] Action Canada, 3.
[208] Action Canada, 3.
[209] "Speech from the Throne," Province of Manitoba, 2023, sec. A New Vision for Health Care, https://www.gov.mb.ca/thronespeech/thronespeech-2023.html.
[210] Aaron Wherry, "Liberals and New Democrats Reach a Deal on Pharmacare | CBC News," CBC, February 23, 2024, https://www.cbc.ca/news/politics/liberals-ndp-pharmacare-deal-1.7123952.
[211] Action Canada, "Pharmacare Should Provide Access to Contraception," 2.
[212] Action Canada, 2.
[213] Action Canada, 2.

A 2013 study of the patterns of surgical sterilization (tubal ligation and vasectomy) in Manitoba found that vasectomy rates were higher than the rates of tubal ligation across the province.[214] This study found that the rates of tubal ligation were higher in low-income areas and vasectomies were more common in high income areas.[215] The authors stated that vasectomies were higher within high-income earners, and tubal ligations more common in low-income earners which "may reflect underlying differences across income groups in male-female relationship dynamics and decision-making regarding reproductive health issues."[216] Another notable finding was that women were younger when undergoing sterilization than their male counterparts.[217] Rural and northern females also had higher rates of sterilization than urban females, with the reverse for males.[218]

Forced sterilization

Canada's eugenics movement in the 1900s resulted in legislation like the *Alberta Sexual Sterilization Act,* and British Columbia's *Act Respecting Sexual Sterilization.*[219] The Acts led to the forced sterilization of thousands of people, many of which were Indigenous.[220] In federal government-run Indian Hospitals, it was reported that thousands of women were still being sterilized until the 1970s.[221] In the mid 2010s over 100 Indigenous women from multiple provinces and territories, including Manitoba, stated they were coerced or forced into sterilization.[222] A report on forced sterilization in the Saskatoon Health Region published in 2017, exposed that forced and coerced sterilization of Indigenous women was occurring as recently the 2010s.[223]

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[214] Randall Fransoo et al., "Social Gradients in Surgical Sterilization Rates: Opposing Patterns for Males and Females," *Journal of Obstetrics and Gynaecology Canada* 35, no. 5 (2013): 457, https://doi.org/10.1016/S1701-2163(15)30936-1.
[215] Fransoo et al., 457.
[216] Fransoo et al., 457.
[217] Fransoo et al., 458.
[218] Fransoo et al., 459.
[219] 7/17/2024 4:19:00 PM
[220] Candice M. McCavitt, "Eugenics and Human Rights in Canada: The Alberta Sexual Sterilization Act of 1928.," *Peace and Conflict: Journal of Peace Psychology* 19, no. 4 (November 2013): 364, https://doi.org/10.1037/a0034604.
[221] Standing Senate Committee on Human Rights, "Forced and Coerced Sterilization of Persons in Canada," June 2021, 18, https://sencanada.ca/content/sen/committee/432/RIDR/reports/ForcedSterilization_Report_FINAL_E.pdf.
[222] Chaneesa Ryan, Abrar Ali, and Christine Shawna, "Forced or Coerced Sterilization in Canada: An Overview of Recommendations for Moving Forward," *International Journal of Indigenous Health* 16, no. 1 (2021): 278.
[223] British Columbia, "An Act Respecting Sexual Sterilization," Ch. 59 § (1933), https://www.bclaws.gov.bc.ca/civix/document/id/hstats/hstats/1887728313; Yvonne Boyer and Judith Bartlett, "External Review: Tubal Ligation in the Saskatoon Health Region: The Lived Experience of Aboriginal Women," July 22, 2017.

The UN's Committee Against Torture made recommendations regarding informed consent and the need to "prevent and criminalize forced or coerced sterilization."[224] Canada affirmed that forced sterilization is a *Criminal Code* offence, and reiterated that medical procedures require consent in all jurisdictions in Canada.[225] While there have been no recent inquests on forced sterilization in rural, remote, and northern Manitoba, it is essential to include in discussion when exploring the landscape of reproductive healthcare.

Maternity Care

There is large variation in the maternity landscape across Manitoba's RHAs. Within the I-ERHA, obstetric care is provided at Selkirk Regional Hospital.[226] There are eight beds in the unit and they can provide care for low-risk births and caesarean sections.[227] In 2019, 1,360 births occurred in the region.[228] In the 2021-2022 year, 449 babies were born at the Selkirk Regional Health Centre, up from the prior two years.[229]

In 2021-22 there were 1,618 births in SHSS, the large majority at Bethesda Regional Health Centre, Boundary Trails Health Centre, or Portage District General Hospital.[230] Boundary Trails provides obstetric care, but notes that parents may be referred to a different site if their needs or desires "exceed that which can be provided" at Boundary Trails, as services vary between sites.[231] The SHSS website notes that "for a number of reasons, including priority populations, high-risk pregnancies, staffing levels and geographic locations, not everyone can be accommodated" in having births close to home.[232] SHSS is below the provincial average for preterm births, small births, and teen pregnancy.[233] Midwives can attend hospital births at:

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[224] Standing Senate Committee on Human Rights, "The Scars That We Carry: Forced and Coerced Sterilization of Persons in Canada - Part II," July 2022, 25, https://sencanada.ca/content/sen/committee/441/RIDR/reports/2022-07-14_ForcedSterilization_E.pdf.
[225] Standing Senate Committee on Human Rights, 26.
[226] I-ERHA, "Family Birthing Unit," I-ERHA, accessed May 24, 2023, https://www.ierha.ca/programs-services/public-health/family-birthing-unit/.
[227] I-ERHA.
[228] I-ERHA, "Strategic Plan 2021-2028: Priorities for the Development of a Regional and Provincial Health-Care System," 2023, 11, https://www.ierha.ca/wp-content/uploads/FINAL-PRINT-VERSION-Interlake-Eastern-RHA-Strategic-Plan-2021-28-UPDATED-1.pdf.
[229] I-ERHA, "Annual Report: 2021-2022," 66.
[230] SHSS, "Annual Report 2021-22," 49.
[231] "Boundary Trails Health Centre," SHSS, sec. Services, Obstetrics, accessed May 18, 2023, https://www.southernhealth.ca/en/finding-care/winkler/boundary-trails-health-centre/.
[232] "Birthing Options," SHSS, accessed May 18, 2023, https://www.southernhealth.ca/en/finding-care/care-by-topic/parents-parents-to-be/birthing-options/.
[233] SHSS, "Healthier People. Healthier Communities. Thriving Together.," 25.

"Boundary Trails Health Centre, Hôpital Ste-Anne Hospital, Centre de santé Notre-Dame Health Centre and Bethesda Regional Health Centre."[234]

In PMH, births can take place in Brandon's hospital or at private residences within Brandon.[235] It appears midwives cannot assist with home births outside of Brandon. There are currently seven midwives in PMH, located in Brandon.[236] The Region's most recent Community Health Assessment showed that the birth rate was significantly higher than the Manitoban average.[237]

NHR birth rates are high and they have high rates of teen births, high birth weight babies, low birth weight babies, and preterm births.[238] Access to prenatal care is a challenge due to "the geography and remoteness of communities".[239] Gillam, Snow Lake, and Wabowden Public Health provide pre- and post-natal support.[240] There have been issues staffing in the obstetric department in The Pas, and the state of the obstetric unit in Thompson was described as "fragile."[241] Recently the NHR noted that greater attention to maternal healthcare is necessary to improve outcomes.[242] Indigenous doulas have been hired by the NHR in partnership with Keewtinohk Inniniw Minoayawin who work in Thompson General Hospital.[243] Another positive in the recent annual report was that the NHR have begun the process to start home births aided

[234] "Midwifery Services," SHSS, sec. Can I have a midwife if I'm planning a hospital birth?, accessed May 18, 2023, https://www.southernhealth.ca/en/finding-care/find-a-service/midwifery-services/.
[235] PMH, "Midwifery Services," PMH, accessed May 24, 2023, https://prairiemountainhealth.ca/programs-and-services/primary-health-care/midwifery-services/.
[236] PMH.
[237] NHR, "Community Health Assessment 2019," 35.
[238] NHR, "Northern Health Region Annual Report 2022-23," 5–6.
[239] NHR, 6.
[240] NHR, "Gillam Public Health Services," NHR, accessed May 18, 2023, https://northernhealthregion.com/programs-and-services/public-health/gillam-public-health-services/; NHR, "Snow Lake Public Health Services," NHR, accessed May 18, 2023, https://northernhealthregion.com/programs-and-services/public-health/snow-lake-public-health-services/; NHR, "Wabowden Public Health Services," accessed May 18, 2023, https://northernhealthregion.com/programs-and-services/public-health/wabowden-public-health-services/.
[241] NHR, "Northern Health Region Annual Report 2022-23," 22–23.
[242] NHR, 6.
[243] NHR, 17.

by midwives, as well as increase virtual obstetric consults and a walk-in prenatal clinic in Thompson.[244]

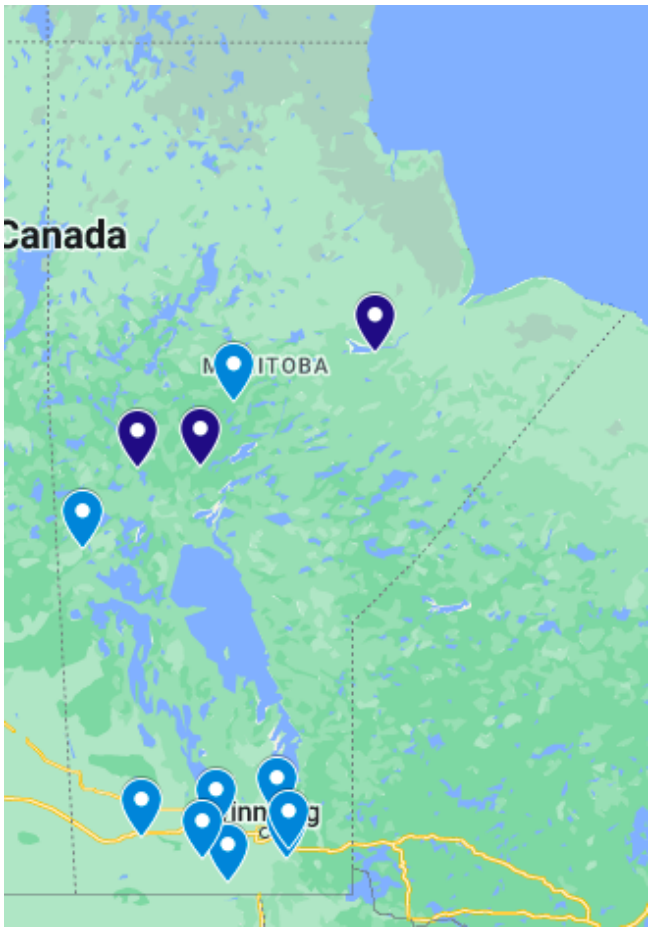

Figure 3: Map of Maternity Services in Manitoba.[245]

Strengthening Families Maternal Child Health Program run by the First Nation Health and Social Secretariat of Manitoba aims to promote health, well-being, trust and empower families and increase community capacity.[246] Located in 17 communities, the program includes health promotion, home visits, referrals and links with other services, as well as case management for families who have more complex needs.[247]

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[244] NHR, 23.
[245] Erin Gobert, "Maternity Care Map Manitoba," Google My Maps, accessed February 14, 2024, https://www.google.com/maps/d/new?hl=en&at=AAX3J7CtssNItRJhXLK5SS4_cHky_N65JA:1707922553167&hl=en, Dark blue pins reflect clinics that only provide pre- and post-natal support.
[246] "Maternal Child Care," FNHSSM, accessed June 28, 2023, https://www.fnhssm.com/copy-10-of-new-page.
[247] "Maternal Child Care."

Birth Evacuation Policy

Many pregnant First Nations women living on-reserve leave their communities between 35 to 37 weeks pregnant to give birth.[248] This is known as Health Canada's birth evacuation policy, an unwritten policy that results in First Nations women throughout Canada travelling to give birth. In Manitoba, they are sent to The Pas, Thompson, or Winnipeg.[249] Although birth evacuation policy is well known by both providers and communities, the details are "elusive and undocumented".[250]

Community health nurses can provide prenatal care to on-reserve First Nations women up to 37 weeks.[251] However, due to airline policies and the unpredictability of northern weather, most women leave around 35 weeks pregnant, meaning they spend a month or more away from home.[252] While travel costs are sometimes covered, others are paid out of pocket.[253] Travel escorts became funded in 2017, but prior to that it was standard for women to travel and birth alone, which some women described as feeling like they were "being punished for having a family".[254]

Due to lack of local providers, many First Nations women go into labour at the hospital without *ever receiving* prenatal care.[255] While there is no consensus on the amount of necessary prenatal visits, the Public Health Agency's guidelines note that women in developed countries have between 7 to 11 prenatal appointments.[256] Additionally, postnatal care is sparse, with many women waiting two weeks for an appointment once they return home.[257] The conditions of the birth evacuation policy has been described as "inhumane".[258]

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[248] Karen M. Lawford, Ivy L. Bourgeault, and Audrey R. Giles, "'This Policy Sucks and It's Stupid:' Mapping Maternity Care for First Nations Women on Reserves in Manitoba, Canada," *Health Care for Women International* 40, no. 12 (December 2, 2019): 1302, https://doi.org/10.1080/07399332.2019.1639706.
[249] Lawford, Bourgeault, and Giles, 1303.
[250] Lawford, Bourgeault, and Giles, 1306.
[251] Lawford, Bourgeault, and Giles, 1306.
[252] Hilah Silver et al., "Childbirth Evacuation among Rural and Remote Indigenous Communities in Canada: A Scoping Review," *Women and Birth* 35, no. 1 (February 1, 2022): 16, https://doi.org/10.1016/j.wombi.2021.03.003; Lawford, Bourgeault, and Giles, "This Policy Sucks and It's Stupid," 1318.
[253] Lawford, Bourgeault, and Giles, 1317.
[254] Lawford, Bourgeault, and Giles, 1307, 1317.
[255] Lawford, Bourgeault, and Giles, 1320.
[256] Public Health Agency of Canada, "Chapter 3: Care during Pregnancy: Family-Centred Maternity and Newborn Care National Guidelines," Family-Centred Maternity and Newborn Care: National Guidelines, February 8, 2021, 7, https://www.canada.ca/en/public-health/services/publications/healthy-living/maternity-newborn-care-guidelines-chapter-3.html.
[257] Lawford, Bourgeault, and Giles, "This Policy Sucks and It's Stupid," 1324.
[258] Lawford, Bourgeault, and Giles, 1321.

STBBIs

STBBIs common in Manitoba include chlamydia, gonorrhea, and syphilis.[259] The most recent annual report of I-ERHA stated that 2014-2018 saw a 25% increase of chlamydia, 53% increase of gonorrhea, and a concerning 749% increase in syphilis.[260] SHSS has lowest rates in the province of childhood vaccination for HPV, and although all STBBI rates are low, they are a growing concern with a six-fold increase in the region.[261] These increases in syphilis rate are consistent with recent rapid spread across Canada.[262] PMH has not reported any STBBI rates in recent annual reports. Particularly in the north and in young women, incidents of chlamydia are high in Manitoba.[263] Overall, the NHR struggles with high rates of STBBIs, particularly chlamydia, gonorrhea, and syphilis.[264]

However, the NHR has worked on public education and harm reduction, resulting in higher prevention, testing, and contact tracing.[265] There have been increasing community demands for harm reduction supplies.[266] In the NHR, Gillam, Snow Lake, and Wabowden Public Health provide sexual health testing, treatment, and education.[267] Flin Flon has a peer group with lived experience who help with outreach and harm reduction, partnered with Public Health Agency of Canada, MB HIV and MB Harm Reduction Network.[268] A vaccine which protects against multiple strains of human papillomavirus (HPV) has been covered by Manitoba health for Grade 6 females since 2008, which was expanded to include at-risk females between 9 to 25 and Grade 6 males, in 2012 and 2016, respectively.[269] Street Connections has a webpage with an

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[259] Manitoba Health, "Sexually Transmitted and Blood-Borne Infections (STBBI) Surveillance Report" (Government of Manitoba, June 30, 2022), https://www.gov.mb.ca/health/publichealth/surveillance/stbbi/index.html.
[260] I-ERHA, "Annual Report 2022-2023," Annual Report, 2023, 8, https://www.ierha.ca/wp-content/uploads/Interlake-Eastern-RHA-Annual-Report-2022-2023-FINAL.pdf.
[261] SHSS, "Healthier People. Healthier Communities. Thriving Together.," 26.
[262] Public Health Agency of Canada, "Statement from the Chief Public Health Officer of Canada on Syphilis," Government of Canada, February 14, 2024, https://www.canada.ca/en/public-health/news/2024/02/statement-from-the-chief-public-health-officer-of-canada-on-syphilis.html.
[263] Laura H. Thompson et al., "Laboratory Detection of First and Repeat Chlamydia Cases Influenced by Testing Patterns: A Population-Based Study," *Microbiology Insights* 12 (2019): 1178636119827975–1178636119827975, https://doi.org/10.1177/1178636119827975.
[264] NHR, "Annual Report 2021-22," 6.
[265] NHR, 6.
[266] NHR, 6.
[267] NHR, "Gillam Public Health Services"; NHR, "Snow Lake Public Health Services"; NHR, "Wabowden Public Health Services."
[268] NHR, "Community Health Assessment 2019," 267.
[269] Laura H. Thompson et al., "Increasing Incidence of Anogenital Warts with an Urban-Rural Divide among Males in Manitoba, Canada, 1990-2011," *BMC Public Health* 16, no. 224 (2016): sec. Background, https://doi.org/10.1186/s12889-016-2885-4.

interactive map to find harm reduction supplies, condoms and STBBI testing.[270] When searching with the service "STI/HIV Testing," there are 4 locations in Thompson, 3 in Brandon, two in MacGregor, and Selkirk, one each in Carmen, Churchill, Dauphin, Flin Flon, Niverville, the Pas, Pine Falls, Portage la Prairie, Riverton, St. Jean Baptiste, Ste. Anne, Steinbach, Snow Lake, Sprague, Swan River, Winkler.[271]

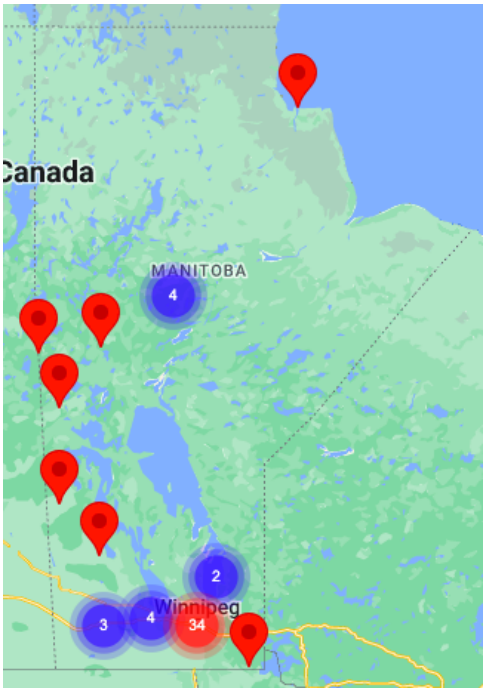

Figure 4: Street Connections Map of STI/HIV Testing Locations.[272]

The Swan Valley My Health Team consists of multiple providers, including a nurse practitioner, pharmacist, social worker, counsellor, other nurses and support staff.[273] The team's goals are to improve patient access to relevant care and improve information-sharing between care providers.[274] My Health Team also provides the Primary Care Outreach Clinic which offers harm reduction supplies and education, as well as STBBI testing and treatment.[275] The team also

[270] Street Connections, "Find a Location - Interactive Map," Street Connections, accessed May 24, 2023, https://streetconnections.ca/locations.
[271] Street Connections.
[272] Street Connections.
[273] PMH, "Annual Report 2021-2022," 31.
[274] PMH, 31.
[275] PMH, 32.

provides outreach to clients in their communities and homes, including in remote communities.[276]

Chapter III: Analysis of Healthcare Provision – How it Meets and Does Not Meet International Human Rights Standards

This section will analyze if the right to health is being actualized in Manitoba. Or, more precisely, this section will analyze where the right to health is being met, and where there are violations, using the tripartite typology of human rights: the respect, protect, fulfill framework. General Comment 33 summarizes the right to health through the respect, protect, fulfill framework:

> The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to fulfill requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.[277]

State violation of the obligation to respect the right to health are "actions, policies or laws that contravene the standards set out in article 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable mortality."[278] Violations of the obligation to protect article 12 occur from failures of the state "to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties".[279] Violations of the obligation to fulfill the right to health "occur through the failure of States parties to take all necessary steps to ensure the realization of the right to health".[280] This includes misallocation of funds, groups not being able to enjoy the highest attainable standards, and "failure to reduce infant and maternal mortality rates".[281] States must take steps necessary to ensure all are able to enjoy the right to health, through national health policies and strategies.[282]

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[276] PMH, 31–32.
[277] CESCR, "Highest Attainable Standard of Health," para. 33.
[278] CESCR, para. 50.
[279] CESCR, para. 51.
[280] CESCR, para. 52.
[281] CESCR, para. 52.
[282] CESCR, para. 53.

Respect

Respecting rights is mainly done by so-called negative obligations on the part of the state. States must refrain from interfering, either directly or indirectly, with the exercise and enjoyment of rights.[283] In order to respect the right to health, a state must not limit or deny equal access to healthcare, not enforce health practices that are discriminatory, and not "impose discriminatory practices relating to women's health status and needs."[284]

Protect

Protect is when states prevent violations of individual's or group's human rights at the hands of third-party actors.[285] To protect the right to health, states must ensure healthcare workers properly trained and follow ethics, implement policies, legislation, or other measures to ensure access to healthcare.[286] General Comment 14 is also explicit:

> States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women […] in the light of gender-based expressions of violence.[287]

There are two main avenues where states neglect to protect rights. One is within the private sphere, such as violence in the home, or any violations done by private actors to an individual, such as intimate partner violence. Another is failure to protect against violations by business or corporate actors. For instance, failure to protect Indigenous women from sexual assault and other crimes around male dominated mining and resource extraction camps.[288]

Fulfill

In order to fulfill, states must take proper measures towards full realization of rights, through administrative, legislative, budgetary, judicial and all other means.[289] While there are no

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[283] CESCR, para. 33.
[284] CESCR, para. 34.
[285] CESCR, para. 33.
[286] CESCR, para. 35.
[287] CESCR, para. 35.
[288] Justin E. Brooks, "Two Countries in Crisis: Man Camps and the Nightmare of Non-Indigenous Criminal Jurisdiction in the United States and Canada," *Vanderbilt Law Review* 56, no. 533 (2023), https://scholarship.law.vanderbilt.edu/vjtl/vol56/iss2/4; Jasmine Tordimah, "'Man Camps': Temporary Housing Facilities or Sites of Permanent Devastation? The Cases of British Columbia, Manitoba, and Nunavut"" (MA Major Research Papers, Ontario, Western University, 2021), https://ir.lib.uwo.ca/politicalscience_maresearchpapers/6.
[289] CESCR, "Highest Attainable Standard of Health," para. 33.

precise quantification of these measures, it must be to the greatest degree possible. In order to fulfill the right to health, states must put significant energy into realizing the right to health nationally, through policy and legislation.[290]

In order to fulfill their obligations, states must facilitate, provide, and promote the right. To *facilitate* the right to health, states must take positive measures to support individuals to exercise their right to health, and to *provide* "a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal".[291] States must take actions that "create, maintain and restore the health of the population" to *promote* the right to health.[292] Obligations that states have in relation to facilitation, providing, and promoting the right to health include proper dissemination of health information, supporting informed decisions around health, and culturally appropriate healthcare services.[293]

Facilitate

To *facilitate* the right to health, states must take positive measures to support individuals to exercise their right to health.[294] General Comment 14 makes specific mention that "public health infrastructure should provide for sexual and reproductive health services, including safe motherhood, *particularly in rural areas*".[295] General Comment 14 is also explicit that doctors and facilities should be equitably distributed through the country.[296] Information campaigns are also a part of the fulfillment of the right to health, and General Comment 14 makes special mention to those for STBBIs, sexual and reproductive health, as well as domestic violence.[297]

Provide

To *provide* the right to health, a state must provide access to a right "when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal".[298] Right to highest attainable standard of health also "includes obligations on

[290] CESCR, para. 36.
[291] CESCR, para. 37.
[292] CESCR, para. 37.
[293] CESCR, para. 37.
[294] CESCR, para. 37.
[295] CESCR, para. 36, emphasis added.
[296] CESCR, para. 36.
[297] CESCR, para. 36.
[298] CESCR, para. 37.

Canada to ensure that cost does not prevent people from accessing sexual and reproductive health information, services, and supplies, including contraceptive methods of their choice." [299]

Promote

States must take actions that "create, maintain and restore the health of the population" to *promote* the right to health.[300] Campaigns to inform and educate the public are part of the fulfilment of right to health, to promote health, and General Comment 14 mentions campaigns for STBBIs and general sexual and reproductive health. [301] Part of the governments commitments must be to "meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality."[302]

Abortion

While a "right to abortion," is not enshrined in any human rights treaty, it is implicated in many. The right to health and the right to be free of cruel, inhuman, and degrading treatment that is forced pregnancy.[303] The right to benefit from scientific progress is also implicated in abortion.[304] Abortion is free of cost for everyone with a Manitoba Health Card or other provincial health coverage.[305] Overall, there is no violation of respect in terms of abortion as there are no policies against accessing abortion. In regard to the obligation to protect, this includes providers being properly trained in providing abortion care. Currently, it is not known how many abortion providers are in Canada.[306] A 2018 study of family medical residents in Canada, 80% of respondents received less than one hour of training or abortion, and 57% received no training at

[299] Action Canada, "Pharmacare Should Provide Access to Contraception," 3.
[300] CESCR, "Highest Attainable Standard of Health," para. 37.
[301] CESCR, para. 36.
[302] UN Population Fund, "Programme of Action," para. 7.3.
[303] General Assembly, "International Covenant on Civil and Political Rights," December 16, 1966, art. 7, https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights; General Assembly, "International Covenant on Economic, Social and Cultural Rights (ICESCR)," December 16, 1966, art. 12, https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights.
[304] General Assembly, "ICESCR," art. 15(b).
[305] Women's Health Clinic, "Abortion."
[306] Regina M. Renner et al., "Telemedicine for First-Trimester Medical Abortion in Canada: Results of a 2019 Survey," *Telemedicine Journal and E-Health: The Official Journal of the American Telemedicine Association* 29, no. 5 (May 2023): 693, https://doi.org/10.1089/tmj.2022.0245.

all.[307] To protect Manitobans seeking abortion and abortion providers, the government of Manitoba passed *The Safe Access to Abortion Services Act* in 2024.[308]

In the obligation to fulfill the state must take all necessary steps for the realization for right to adequate health.[309] To facilitate, a state must take positive measures to support the right. Access to abortion care is difficult in Canada as there are great "costs and logistics associated with travelling sometimes up to hundreds of kilometers and across provincial or national boarders to access services, especially for those in rural or northern communities."[310] Action Canada notes that individuals who face the most barriers to healthcare, including those living rurally are "also the ones most likely to face significant and persistent barriers when needing to access abortion services."[311] The same is true in Manitoba, where aspiration abortion is only available in two cities, Winnipeg (WHRA) and Brandon (PMH).

Aspiration abortion is available in the province until a gestational age of 19 weeks and six days and medication abortion is available up to 9 gestational weeks.[312] Although gestational age limits are common, they are not supported by the WHO since prohibiting abortions based on gestational age is not science-backed and can be safely preformed throughout a pregnancy.[313] This is a violation of Manitoba's obligation to facilitate and provide adequate care.

In Manitoba, individuals seeking abortion must go to an appointment with a practitioner where they are given instruction and the medications. Those living rurally may face extra challenges attending appointments, such as long travel time. In 2018 and 2022, the WHO judged that self-managed medication abortion was safe – that is, can be done by an individual without a practitioners direct oversight.[314] The WHO recommendation is that medication abortion can be provided by doctors, nurses, midwives, and pharmacists.[315] Action Canada has also reported that direct primary care abortion provision can "address inequitable abortion access in Canada," and

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[307] Daniel T. Myran et al., "Abortion Education in Canadian Family Medicine Residency Programs," *BMC Medical Education* 18, no. 1 (June 1, 2018): sec. "Methods", "Results," https://doi.org/10.1186/s12909-018-1237-8.
[308] The Safe Access to Abortion Services Act, SM 2024 c 5, <https://canlii.ca/t/569cq> retried on 2024-07-17.
[309] CESCR, "Highest Attainable Standard of Health," para. 52.
[310] Action Canada, "Midwife-Led Abortion Care," 2.
[311] Action Canada, 2.
[312] Health Sciences Centre, "Pregnancy and Prenatal Care," sec. Pregnancy counselling; Abortion Rights Coalition of Canada, "Abortion Clinics and Services in Canada," 10–11.
[313] WHO, "Abortion Care Guideline," 28.
[314] WHO, "Medical Management of Abortion" 2; WHO, "Abortion Care Guideline," 98.
[315] WHO, "Medical Management of Abortion," 39.

is an evidence-based intervention that improves access.[316] Lack of access to self-guided medication abortion is a violation of the right to benefit from scientific progress.[317]

The WHO's "List of Essential Medicines" includes the medications used for medication abortion.[318] The abortion pill is also implicated as the Programme of Action makes mention of the need for states to "ensure the wide availability and accessibility" of drugs.[319] The availability of medications used in medication abortion is unclear, with a recent study reporting that approximately half of pharmacists surveyed regularly kept mifepristone in stock.[320] The pharmacists also reported that if their pharmacy was out of stock it was less than 30km to the nearest pharmacy with it in stock.[321] However there were less than six Manitoban pharmacists surveyed, so these may be different in a rural or remote Manitoban context.[322] It is unclear if this results in a violation of the right to facilitate.

Health Canada has invested $15.3 million to organizations supporting healthcare to youth, 2SLGBTQ+ individuals, and abortion access.[323] Additionally, $18.3 million will be invested in projects aiding healthcare workers to provide abortion care, as well as culturally safe and relevant care for Indigenous communities.[324] There is no mention of funding sexual and reproductive health (SRH) resources or care in rural or remote areas specifically. While this is progressive realization, there is still a lack of attention to facilitation for those living outside of urban centers, and it is a violation of the obligation to facilitate. While billboards and advertisements promoting anti-abortion rhetoric are common across the country,[325] Canada is also unique in that it is one of the only countries where abortion is not legal nor illegal, but

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[316] Action Canada, "Midwife-Led Abortion Care," 3.
[317] WHO, "Medical Management of Abortion," 2.
[318] WHO, "Medical Management of Abortion" (Geneva, 2018), 1, https://apps.who.int/iris/bitstream/handle/10665/278968/9789241550406-eng.pdf?ua=1.
[319] UN Population Fund, "Programme of Action," para. 8.9.
[320] Enav Z. Zusman et al., "Dispensing Mifepristone for Medical Abortion in Canada: Pharmacists' Experiences of the First Year," *Canadian Pharmacists Journal : CPJ* 156, no. 4 (June 8, 2023): 206, https://doi.org/10.1177/17151635231176270.
[321] Zusman et al., 206.
[322] Zusman et al., 207.
[323] Health Canada, "2023–24 Departmental Plan," 17.
[324] Health Canada, 17–18.
[325] Abortion Rights Coalition of Canada, "Take Action against Aborted Fetus Images in Public!," March 30, 2017, https://www.arcc-cdac.ca/media/2020/06/take-action-against-aborted-fetus-images.pdf; Daryl Newcombe, "Proposed Bylaw to Ban Graphic Anti-Abortion Posters Morphs into General Rules for All Protest Signs," London, July 12, 2024, https://london.ctvnews.ca/proposed-bylaw-to-ban-graphic-anti-abortion-posters-morphs-into-general-rules-for-all-protest-signs-1.6962300.

simply regulated as a medical procedure.[326] It is unclear if there is a violation on the obligation to promote.

Overall, there is no violation of respect in terms of abortion as there are no policies against anyone accessing abortion or not allowing certain individuals to access. Due to lack of available information on abortion providers in the province, it is not clear if there are violations to protect. There are violations to facilitate as seeking abortion in rural and northern areas is difficult across Canada, as well as gestational limits that are not backed by science but rather the limitations of trained providers. Additionally, individuals must self-fund travel expenses when having an abortion in an urban centre, which is a violation of the obligation to provide. This is also a violation of the right to facilitate. It is unclear if regularly stocking the abortion pill results in a violation to facilitate. There is a lack of progressive realization and a violation to facilitate rural reproductive healthcare. It is unclear if there is a violation on the obligation to promote.

Contraception

Contraception is available to all and is not limited by the government, and there is no violation to respect. Manitoba ranks low nationally in the Contraception Policy Atlas, with only New Brunswick, Yukon, and Newfoundland and Labrador rating lower.[327] A violation to protect and fulfill in relation to contraception is that cost is a large barrier for people to access and to fully exercise their right to health. The Government of Manitoba announced that it has plans to provide free prescription contraception in the province.[328] With this in place and progressive realization taken into account, contraceptive care does not amount to a violation. Promoting right to health in relation to contraception involves public education, which is provided to students in grade 5 and 7.[329]

However, cost is not the only barrier for rural individuals in access contraption. Poor sexual health education, outdated information given from a practitioner or negative personal beliefs, as well as lack of access to a primary health provider to prescribe are all issues

[326] Clare Szalay Timbo and Andrea Rodriguez, “Decriminalizing Abortion: A Journey Towards Access and Equity,” Action Canada, December 6, 2023, https://www.actioncanadashr.org/news/2023-12-06-decriminalizing-abortion-journey-towards-access-and-equity.
[327] Action Canada, Kelly Bowden, and Insiya Mankani, eds., “Contraception Policy Atlas Canada,” July 2023, https://www.actioncanadashr.org/sites/default/files/2023-09/CCInfoCAN_A3_EN_2023_SEP20_0.pdf.
[328] “Speech from the Throne." sec. A New Vision for Health Care”
[329] Government of Manitoba, “Physical Education/Health Education,” accessed January 17, 2024, https://www.edu.gov.mb.ca/k12/cur/physhlth/hs_k-8/.

throughout Canada.[330] There are additional issues for those living rurally and northern, as well for those living on-reserve.[331] Confidentiality remains a concern within small communities, where anonymity is not possible if all clinic staff are known to the patient.[332] There are still failures within the obligation to provide healthcare and promote sexual and reproductive health through education.

While primary healthcare providers can provide birth control as well as some STBBI care and prenatal care, many rural, remote, and Northern individuals do not have access to primary care providers. Some nursing stations provide this care, however not all do, and rarely specialized care. As per Health Canada's departmental plan, a priority is to improve access to family health services and enabling practitioners to provide care "in underserved rural and remote communities" which is promising.[333] In order to "ensure that Canadians have access to appropriate and effective health services" there will be a focus on improving the accessibility of SRH care.[334] While there is information on the funding allocation to support aging adults, dental care, organ donation, and substance use, there is not an allocation for SRH, rural health, or maternal health.[335] They support SRH service accessibility to underserved populations, which they include Indigenous populations but not rural, remote, or Northern.[336] They also provide 50% Canadian Student Loan forgiveness to nurses and doctors who work in rural and remote areas, up to $30,000 and $60,000, respectively.[337] Although long wait times for primary healthcare providers is common, these recent plans from Health Canada point to progressive realization of the obligation of the right to health. So, although there is still much to be desired in the current state of contraception access and primary care providers, it is evident that the Governments have been allocating funds and attention to improvement, and it is not a violation of the right to health.

Contraception is available and not limited, so there is no violation to respect. Although there is still much left to be desired, when taking progressive realization into account, both federal and provincial governments have made plans and provided funding for better education,

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[330] Jennifer Hulme et al., "Barriers and Facilitators to Family Planning Access in Canada," *Healthcare Policy = Politiques De Sante* 10, no. 3 (February 2015): sec. "Barriers to access."
[331] Hulme et al., sec. "Barriers to Access."
[332] Hulme et al., sec. "Barriers to Access."
[333] Health Canada, "2023–24 Departmental Plan," 7.
[334] Health Canada, 6.
[335] Health Canada, 10–11.
[336] Health Canada, 17.
[337] Health Canada, 17.

as well as funding for contraceptive coverage. There are no violations on the obligations to respect, protect, or fulfill in regard to contraception.

Maternity Care

In theory, Manitoba is respecting maternity care, as there are no laws or policies prohibiting those in rural areas from having children. However, closer scrutiny of the reality of rural, remote, and northern pregnancies tells a different story. Recall, that state violation of the obligation to respect the right to health include any acts, law, or policies that contradict the principles outlined in article 12 of the ICESCR and are "likely to result in bodily harm, unnecessary morbidity and preventable mortality."[338]

The NHR's Community Health Assessment defined inadequate prenatal care as "the proportion of women with a single, live, in-hospital birth receiving no or inadequate prenatal care, over a first-year time period."[339] The rates of inadequate prenatal care have declined in the NHR, however around three out of ten women still do not receive adequate prenatal care.[340] Depending on the area within the NHR, this changes as well. While less than 16% of pregnancies in zone one (a more southern area) experienced inadequate care, that number jumps to over 40% in zone two (a more northern area).[341]

> Women who access prenatal care and receive regular prenatal visits are more likely to experience better health outcomes including a lower risk for low birth weight infant compared to women who receive no prenatal care. Inadequate prenatal care is more likely to be found in women who had less than a Grade 12 education or were younger (less than 25), living in lower income areas, on income assistance, a lone parent, socially isolated, or multiple pregnancies.[342]

Specific communities had worse outcomes, such as Shamattawa and York Factory First Nations where women were approximately ten times more likely to have inadequate prenatal care in comparison to other communities in the Region.[343] Regardless, the rates of inadequate care is significantly higher in this region than other regions in Manitoba.[344]

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[338] CESCR, "Highest Attainable Standard of Health," para. 50.
[339] NHR, "Community Health Assessment 2019," 87.
[340] NHR, 87–88.
[341] NHR, 88.
[342] NHR, 87.
[343] NHR, 88.
[344] NHR, 88.

Preterm births are significantly higher in the NHR than the Manitoba average.[345] Both short and long term health issues are associated with preterm births, and it is the leading cause of infant mortality.[346] Although all regions, including NHR have seen declines in teen pregnancy rates, the NHR has the highest with approximately 100 pregnancies per 1,000 teen females.[347] Teens who are pregnant are "less likely to receive early prenatal care and more likely to experience anemia, eclampsia and depressive disorders. Teenage mothers tend to have lower socioeconomic status, as well as reduced educational opportunities."[348] More attention paid to the reproductive health needs of teenage and young women "could prevent the major share of maternal morbidity and mortality through prevention of unwanted pregnancies and any subsequent poorly managed abortion."[349]

As state violation of the obligation to respect include contradiction of the principles outlined in article 12 of the ICESCR and resulting in preventable morbidity or mortality, the outcomes for teen pregnancy, preterm births, and inadequate prenatal care increases morbidity.[350] This results in violation of the obligation to respect the right to health. To protect the right to health, states must implement policies, legislation, or other measures to ensure access to healthcare.[351] This is violated in rural, remote, and northern maternal care most evidently in the birth evacuation policy.

Birth Evacuation Policy

Undoubtedly the most egregious violation is the birth evacuation policy. The policy violates respect, protect, and fulfill. Recall that CEDAW states that healthcare services must be "consistent with the human rights of women including the rights to autonomy, privacy, confidentiality, informed consent and choice."[352] Within this policy First Nations women are unable to exercise their autonomous choice surrounding their pregnancy and birth. The birth evacuation policy is a violation of Manitoba and Canada's obligation to respect.

It is also a violation of the obligation to protect, as pregnant women who come to Winnipeg or other urban centres to give birth are vulnerable, and have been reported to be

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[345] NHR, 89.
[346] NHR, 89.
[347] NHR, 113.
[348] NHR, 113.
[349] UN Population Fund, "Programme of Action," para. 8.19.
[350] CESCR, "Highest Attainable Standard of Health," para. 50.
[351] CESCR, para. 35.
[352] CEDAW, para. 31(e).

recruited by gangs for prostitution.[353] The birth evacuation policy is a violation of the obligation to facilitate, since it does not support individuals exercising their right to health, nor include public health infrastructure that supports sexual and reproductive health services.[354]

The argument for the birth evacuation policy is that it "improves pregnancy outcomes by increasing access," however the disparities between First Nations and non-First Nations pregnancy outcomes "indicates care received requires improvement." [355] Lack of rural health infrastructure is not a lawful excuse for poor maternal health conditions as General Comment 14 states that infrastructure should provide for safe motherhood "particularly in rural areas".[356] So, regardless of the intent of this policy as one to provide adequate maternal care, it does not do so and amounts to a violation of the obligation to provide.

The birth evacuation policy is also a violation of the obligation to promote as actions must be taken by the state to "create, maintain and restore the health of the population," which is not the outcome of this policy.[357] Public education and information dissemination is also involved in the obligation to promote.[358] There is no printed or online material available that clearly outlines what is expected during the birth evacuation proves, and most information is given by friends or family who have experienced evacuation.[359] There is no information about the birth evacuation policy on the NHR website.

The birth evacuation policy is a clear violation of the obligations to respect, protect, and fulfill. Outside of this policy, there is still much to be desired regarding maternity care outside of urban centres in Manitoba. Inadequate prenatal care is common in rural areas, which is a violation of the right to respect, protect, and fulfill.

STBBIs

STBBI prevention, education, information, and care are the best and most accessible sexual and reproductive health service in rural, remote, and northern Manitoba. There is no denial or limitation to individuals attempting to access STBBI care, so there is no violation to

[353] Lawford, Bourgeault, and Giles, ""This Policy Sucks and It's Stupid," 1321.
[354] CESCR, "Highest Attainable Standard of Health," paras. 36, 37.
[355] Lawford, Bourgeault, and Giles, ""This Policy Sucks and It's Stupid," 1307.
[356] CESCR, para. 36, emphasis added.
[357] CESCR, para. 37.
[358] CESCR, para. 36.
[359] Lawford, Bourgeault, and Giles, ""This Policy Sucks and It's Stupid," 1325.

respect.[360] There is also no violation of the obligation to protect.[361] For facilitation, the state has taken positive measures through budgetary and other means for STBBI testing centres.[362] Manitoba health provides free medications for the treatment of STBBI's.[363]

Under the obligation to provide, there may be violations as states must ensure that cost does not prevent people from accessing SRH information, supplies, and services.[364] One instance of the Manitoba government properly fulfilling the right to adequate health is through the HPV vaccine Gardasil, which has been freely provided to Grade 6 girls since 2008, and later expanded to boys as well.[365] Additionally, pre-exposure Prophylaxis (PrEP), a preventative medication for those at risk of contracting HIV is provided to patients for free.[366] Southern Health provides free condoms and other safer sex and harm reduction supplies.[367] The Street Connections webpage with an interactive map to find harm reduction supplies, condoms and testing is available for all to access with an internet connection.[368] Promoting includes public education and awareness or STBBIs.[369] Education on STBBI's is included in the Manitoba school curriculum in grades 5 and 7, and there is no violation to promote.[370] STBBI prevention, education, information, and care are the best and most accessible service in rural, remote, and northern Manitoba. There is no violation to respect, protect, or fulfill.

Chapter IV: Recommendations

As discussed in the paragraphs above, improving reproductive healthcare access in rural, remote, and northern Manitoba is a challenging and requires a multi-prong approach. There is not one solution that improves everyone's access to care. As well there will not be one solution to improve care for different aspects of reproductive health. Solutions that may work well for

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[360] CESCR, "Highest Attainable Standard of Health," para. 34.
[361] CESCR, para. 35.
[362] CESCR, para. 37.
[363] Office of the Chief Provincial Public Health Officer, "Addressing the STBBI Epidemic in Manitoba" (Manitoba, January 18, 2022), sec. "Treatment Principles: Access to free medications," https://www.gov.mb.ca/health/publichealth/cdc/docs/stbbi-epidemic-mb.pdf.
[364] Action Canada, "Pharmacare Should Provide Access to Contraception," 3.
[365] Thompson et al., "Increasing Incidence of Anogenital Warts," sec. Background.
[366] Office of the Chief Provincial Public Health Officer, sec. "Treatment Principles: HIV Pre-exposure Prophylaxis (PrEP)."
[367] "Sexually Transmitted and Blood Borne Infections (STBBIs)," SHSS, accessed May 18, 2023, https://www.southernhealth.ca/en/finding-care/health-info-for-you/healthy-sexuality/sexually-transmitted-infections-stis/.
[368] Street Connections, "Find a Location - Interactive Map."
[369] CESCR, "Highest Attainable Standard of Health," para. 36.
[370] Government of Manitoba, "Physical Education/Health Education."

certain types of care may not work for another. Recommendations include improving telehealth, particularly for pregnancy services, including abortion, pre- and post- natal care. Bolstering midwifery and expanding their scope of practice is another avenue to improving care, including assisting with abortion. In particular, Indigenous midwifery will be looked to as a means to provide culturally competent reproductive healthcare to Indigenous women. Increasing capacity of rural clinics and hospitals is also an opportunity, especially if paired with improving sexual and reproductive healthcare training for providers, including those at nursing stations. Accessing contraception from a pharmacy without prescription would improve care, as well as pharmacists being able to direct dispense the abortion pill. Additionally, self-management of medication abortion is another avenue to reduce barriers.

Telehealth

Telehealth is not a novel recommendation to improve access to healthcare in rural and northern Canada. Within Health Canada's departmental plan, they acknowledge that their core responsibilities involve Canada's healthcare systems, promotion and protection of health.[371] A priority of the plan is to improve access to family health services and "enabling healthcare providers to work in underserved rural and remote communities."[372] Health Canada also pledges to support the development of digital and virtual healthcare, applying a specific focus to "rural and underserved communities".[373] Bolstering digital technology for healthcare includes abilities for patients to interact with providers digitally and access their health records electronically.[374]

During pregnancy, telehealth can improve access to care "for those living in underserved areas" while also increasing patient satisfaction.[375] The safety, accessibility, and quality of care can be improved with telehealth. [376] Multiple forms of healthcare can be provided through telehealth, including education.[377] Minimizing the time patients need to be away from family can

[371] Health Canada, "2023–24 Departmental Plan," 5.
[372] Health Canada, 7.
[373] Health Canada, 16.
[374] Health Canada, 5–6.
[375] Erinma P. Ukoha et al., "Ensuring Equitable Implementation of Telemedicine in Perinatal Care," *Obstetrics and Gynecology* 137, no. 3 (March 2021): 487–92, https://doi.org/10.1097/AOG.0000000000004276.
[376] Public Health Agency of Canada, "Chapter 8: Organization of Services," Family-Centred Maternity and Newborn Care: National Guidelines, 2022, 17, https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/healthy-living/maternity-newborn-care-guidelines-chapter-8/maternity-newborn-care-guidelines-chapter-8.pdf.
[377] Public Health Agency of Canada, 17.

reduce financial, physical, and psychological stress.[378] Canadian providers believe that telemedical care helps quality of care for the clients.[379]

Many Indigenous communities in remote areas believe telehealth can be both appropriate and helpful in improving healthcare access.[380] Culturally competent care can be provided through telehealth, and as one Australian study showed, can allow Indigenous healthcare workers or elders to attend appointments they may otherwise not be able to.[381] Current barriers to telemedical care include lack of stable internet and WIFI, or lack of access to private telephone.[382] Large financial investments must be made in order for telehealth to improve healthcare access.[383] Communities must be connected and have access to high-speed internet.[384]

Telehealth is already available in some communities and for certain types of care. In one study, Hui et al. developed a website, www.momsinmotion.ca, and a corresponding Facebook page, to provide educational prenatal videos and information.[385] The study was conducted in three communities: Garden Hill, Sagkeeng, and Sandy Bay.[386] All three communities have cellular phone coverage, radio stations, and Wi-Fi, with many public areas providing free access.[387] Garden Hill, which is a fly-in community in the northern part of the province, does not have Wi-Fi that can stream good quality video, but Sagkeeng and Sandy Bay, which are more southern with road access, have good service.[388] All three communities also have either a Health Centre or Nursing Station.[389]

Hui et al., found that prenatal education that is community-based and online was more accessible, even though most women did not have a home computer.[390] However, most women

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[378] Liam J Caffery et al., "How Telehealth Facilitates the Provision of Culturally Appropriate Healthcare for Indigenous Australians," *Journal of Telemedicine and Telecare* 24, no. 10 (December 1, 2018): 676, https://doi.org/10.1177/1357633X18795764.
[379] Public Health Agency of Canada, "Organization of Services," 17.
[380] Nam Hoang Nguyen et al., "Barriers and Mitigating Strategies to Healthcare Access in Indigenous Communities of Canada: A Narrative Review," *Healthcare* 8, no. 2 (June 2020): 7, https://doi.org/10.3390/healthcare8020112.
[381] Caffery et al., "Telehealth Facilitates the Provision of Culturally Appropriate Healthcare," 680.
[382] Ukoha et al, Patient Factors.
[383] Nguyen et al., "Healthcare Access in Indigenous Communities," 4.
[384] Nguyen et al., 4.
[385] Amy Hui et al., "Impact of Remote Prenatal Education on Program Participation and Breastfeeding of Women in Rural and Remote Indigenous Communities," *EClinicalMedicine* 35 (2021): 3, https://doi.org/10.1016/j.eclinm.2021.100851.
[386] Hui et al., 2.
[387] Hui et al., 2.
[388] Hui et al., 2.
[389] Hui et al., 2.
[390] Hui et al., 7.

had smartphones and accessed social media (Facebook) through them, which allowed for unlimited access to both chat groups and educational materials.[391] The authors noted that since the information was available on a social media page, it allowed for non-traditional communication and engagement by participants, such as by using "abbreviations, symbols (emojis), animations, or photos [that] may have facilitated the participation of FN pregnant women" by reducing literacy or language challenges.[392] The study demonstrated that:

> Community-based remote prenatal education significantly increased the participation of pregnant women in the prenatal program and increased breastfeeding initiation. The support from the community health authority, healthcare workers, and pregnant women was critical for the success of the program. The incorporation of Indigenous tradition and culture was crucial for the acceptance of prenatal programming for pregnant women.[393]

The communities stated that barriers to participating in the current forms of prenatal education included "lack of transportation, childcare, and advertisement for the prenatal classes."[394] Barriers that women in rural First Nations communities experienced when trying to attend in-person prenatal classes include "suboptimal road conditions, lack of private or public transportation in addition to physiological restrictions during pregnancy," as well as lack of childcare for women who already have children. [395] While many pregnant women living on reserve have smartphones, certain communities, especially those remote or northern, may have limited service or Wi-Fi.[396] In communities where the Wi-Fi access is more limited, an alternative way of remote prenatal education can be offered through community radio or TV broadcasts.[397]

Telehealth is not a complete solution, as it cannot provide care requiring physical exams or other in-person care.[398] Ultimately, communities having multiple modes of offering prenatal education results in the best access for women.[399] To meet the needs of mothers, both remote (online) and in-person prenatal education program should be options.[400] Community must be involved in the development of telehealth, otherwise culturally relevant care may not be

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[391] Hui et al., 7.
[392] Hui et al., 7.
[393] Hui et al., 7.
[394] Hui et al., 3.
[395] Hui et al., 7.
[396] Hui et al., 2.
[397] Hui et al., 7.
[398] Ukoha et al, Patient Factors.
[399] Hui et al., "Impact of Remote Prenatal Education," 7.
[400] Hui et al., 8.

provided.[401] In improving maternal healthcare to those living rurally and remotely, especially those living in Indigenous communities, telehealth can be one avenue – but cannot fully improve care by itself.[402]

Abortion Via Telehealth

In 2017, medication abortion became available in Canada, and became the standard for first-trimester abortion care.[403] Abortion providers perceived some barriers to providing telehealth medication abortion services.[404] For those who provided telemedical services, most found there were no significant barriers to their practice, while others found that the inability to confirm gestational age was a barrier. [405] Interestingly, more of those who *did not* provide medication abortion via telemedicine believed the inability to confirm gestational age was a barrier than those who *do* provide telemedical abortion.[406]

However, "it is still important to offer in-person care for those who have limited technological access, require an ultrasound, or prefer a face-to-face interaction." [407]

> While some respondents offered first-trimester medical abortion to patients living >2h from emergency uterine evacuation or emergency departments, some identified lack of access to emergency services as a barrier for provision of first-trimester medical abortion through telemedicine. This highlights the need for training providers in remote areas to perform manual uterine aspiration to provide emergency services for patients experiencing complications from an early pregnancy loss or first-trimester medical abortion alike.[408]

So, while telemedicine is one way that abortion access can be improved, it cannot be used alone. There are other barriers that cannot be addressed through telehealth alone.

Midwifery

Midwives are primary care providers that are trained and experienced in obstetric, maternal, and sexual and reproductive healthcare. [409] The *Midwifery Act* of 2000 legislated

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[401] Moecke et al, Discussion.
[402] Nguyen et al., "Healthcare Access in Indigenous Communities," 4.
[403] Renner et al., "Telemedicine for First-Trimester Medical Abortion in Canada," 687.
[404] Renner et al., 692.
[405] Renner et al., 692.
[406] Renner et al., 692.
[407] Renner et al., 692.
[408] Renner et al., 693.
[409] Canadian Association of Midwives, "Position Statement on Midwives Provision of Abortion" (Canadian Association of Midwives - Association canadienne des sages-femmes, n.d.), 1, https://canadianmidwives.org/sites/canadianmidwives.org/wp-content/uploads/2022/03/CAM_PSMidwivesAbortionProvision_ENG_VF_20220224.pdf.Action Canada, "Midwife-Led Abortion Care," 4.

midwifery in Manitoba, and authorized midwifery as a regulated health profession.[410] As part of the journey to legalize midwifery in Manitoba, a Working Group on midwifery was created which found that midwifery could improve care to women in rural areas and save money through midwifery's focus on prevention and lower rates of medical interventions and less reliance on the strained hospital system.[411] When providing care to patients, midwives also use less resources than OBGYNs.[412]

In one study done in Winnipeg, low-risk births with OBGYNs attending had the highest rate of caesarean sections, with midwives having the lowest.[413] While OBGYN attended births had lower odds of overall perineal tearing, midwife attended births had the lowest rates of NICU, less severe vaginal tearing, lower rates of episiotomy, and less epidural than births attended by OBGYNs.[414] Those who had midwife assisted births also had higher rates of breastfeeding.[415] One of the reasons that midwife-attended births had less adverse outcomes and less NICU is that midwives can suitably screen for low-risk pregnancies.[416] Overall, the study found that:

> Midwife-attended births were associated with lower odds of interventions such as episiotomy, epidural use, neonatal resuscitation, NICU admission, instrumental vaginal delivery, and caesarean delivery. Midwifery care was associated with lower perinatal mortality rates. These results remained consistent after controlling for socio-demographic and birth-related variables.[417]

This study focused on Winnipeg and while some of the pregnant women were from rural areas, they were not singled out in the study.[418] However, this study makes suggestions on how midwifery could improve care. There are no midwives in I-EHA, although services can be provided due to arrangements with another RHA.[419] Midwives are uniquely poised to increase

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[410] "The Midwifery Act, CCSM c M125, <https://canlii.ca/t/55d5s> retrieved on 2023-08-17; Carolyn Frost, "The Midwifery Act," *Manitoba Law Journal* 28, no. 2 (2001): 261.
[411] Frost, "The Midwifery Act," 263.
[412] Kellie Thiessen et al., "Maternity Outcomes in Manitoba Women: A Comparison between Midwifery-Led Care and Physician-Led Care at Birth," *Birth* 43, no. 2 (2016): 113, https://doi.org/10.1111/birt.12225.
[413] Thiessen et al., 110.
[414] Thiessen et al., 110, 111.
[415] Thiessen et al., 110.
[416] Thiessen et al., 114.
[417] Thiessen et al., 112.
[418] Thiessen et al., 110.
[419] Government of Manitoba, "Midwifery in Manitoba - Primary Care | Health," Province of Manitoba - Health, sec. Midwifery Services in Manitoba, accessed September 20, 2023, https://www.gov.mb.ca/health/primarycare/access/maternal/midwifery.html.

access to services but less than 10% of births were mid-wife assisted in 2021.[420] There is a shortage of midwives with only 69 practicing in the province.[421]

Indigenous Midwifery

The western biomedicalization of midwifery and formal recognition within midwifery colleges began in Canada in the 1990s, which exacerbated and accelerated the ongoing destruction of traditional Indigenous midwifery and birth practices. [422] Indigenous midwives are recognized as exempt from the *Regulated Health Professions Act,* and the act was legislated with "the explicit intent of serving the Aboriginal populations and the policy of evacuation."[423]

Indigenous midwifery is community-based, but also assists with births in other communities.[424] Having birth led by and within a community is "an essential component of restoring skills and pride and in capacity building in the community."[425] Women being able to give birth within their own community is also "a mechanism for building family and community relationships and intergenerational support and learning through promoting traditional knowledge and teaching transcultural skills."[426]

Indigenous midwives act as primary providers, unlike other birth practitioners, and can care for the pregnant person before, during, and after birth, as well as their babies and families.[427] There have been midwifery programs in remote areas, like Inuulitsivik midwifery Nunavik which "is a successful midwifery-based model for returning birth to the remote Hudson Coast communities" that includes physicians, midwives, and community members as providers.[428]

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[420] Canadian Association of Midwives, "Discover Midwifery Across Canada," Canadian Association of Midwives, accessed February 26, 2024, https://canadianmidwives.org/about-midwifery/.
[421] Canadian Association of Midwives.
[422] Lawford, Bourgeault, and Giles, ""This Policy Sucks and It's Stupid," 1308; Cidro, Dolin, and Queskekapow, "Experiences of Pregnant and Expectant First Nations Mothers," 75.
[423] Rachel Olson and Carol Couchie, "Returning Birth: The Politics of Midwifery Implementation on First Nations Reserves in Canada," *Midwifery* 29, no. 8 (August 1, 2013): 984, https://doi.org/10.1016/j.midw.2012.12.005.The Regulated Health Professions Act, CCSM c R117, <https://canlii.ca/t/5625l> retrieved on 2023-08-23.
[424] Cidro, Dolin, and Queskekapow, "Experiences of Pregnant and Expectant First Nations Mothers," 74.
[425] Cidro, Dolin, and Queskekapow, 76.
[426] Cidro, Dolin, and Queskekapow, 76.
[427] National Council of Indigenous Midwives, "Indigenous Midwifery in Canada," *NCIM* (blog), accessed April 17, 2023, https://indigenousmidwifery.ca/indigenous-midwifery-in-canada/.
[428] Terry O'Driscoll et al., "Traditional First Nations Birthing Practices: Interviews With Elders in Northwestern Ontario," *Journal of Obstetrics and Gynaecology Canada* 33, no. 1 (January 1, 2011): 25–26, https://doi.org/10.1016/S1701-2163(16)34768-5.

There have been reduced medical interventions and birth evacuations at Puvirnituq Hospital and nearby birth centres due to their midwifery programs.[429]

Abortion Access through Midwifery

Since Health Canada's approval of medication abortion in 2015, it has been supported as an evidence-based primary care intervention to improve abortion access. [430] Midwives are primary care providers, and can increase access to abortion.[431] Abortion care led by midwives also can reduce stigmatization of abortion and those who have them.[432] Instead of accessing abortion as a specialized procedure from a specialized practitioner, midwife-led care can be done within a community, by a provider that helps with all pregnancy-related care.[433] People may also be more comfortable receiving abortion care from a midwife who is familiar to them, and who they have received care from during prior pregnancies.[434] Action Canada outlines the ways midwives are well-suited to provide abortion care:

> They are primary care providers who have the necessary skills and experience to prescribe and manage medical abortion; they currently manage uncomplicated pregnancy loss, a process that is clinically similar to medical abortion; they frequently collaborate with health care providers from other sectors when additional care is needed, supporting collaborative approaches to person-centred care; they have the skills and ability to offer quality pre- and post- abortion counselling and; abortion care is a natural extension of existing midwifery philosophies, which include continuity of care, person-centred care, and informed choice decision-making.[435]

Abortion care provided by midwives could "increase access to abortion for patients […] who live in rural and remote communities served by the midwives.".[436] The Canadian Association of Midwives supports midwife provision of abortion, and notes that "abortion is a normal part of sexual reproductive health care" and that SRH care is part of the care provided by midwives.[437] Abortion can be provided by midwives, as per the official position of the ICM.[438]

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[429] Lindsay Allen et al., "Indigenous-Led Health Care Partnerships in Canada," *CMAJ* 192, no. 9 (March 2, 2020): E208–16, https://doi.org/10.1503/cmaj.190728.
[430] Action Canada, "Midwife-Led Abortion Care," 3.
[431] Action Canada, 3.
[432] Action Canada, 4.
[433] Action Canada, 4.
[434] Canadian Association of Midwives, "Position Statement on Midwives Provision of Abortion," 1.
[435] Action Canada, "Midwife-Led Abortion Care," 4.
[436] Action Canada, 3.
[437] Canadian Association of Midwives, "Position Statement on Midwives Provision of Abortion," 1.
[438] International Confederation of Midwives, "Position Statement: Midwives' Provision of Abortion-Related Services," 2014, https://www.internationalmidwives.org/assets/files/statement-files/2018/04/midwives-provision-of-abortion-related-services-eng.pdf.Judith Fullerton et al., "Abortion-Related Care and the Role of the Midwife: A

Unlike Canada, there have been abortions performed safely and effectively by midwives in countries around the world for multiple decades.[439] Action Canada stated that "midwife-led abortion care is also common practice in many other parts of the world" – so the evidence is there that it is viable, safe, and works.[440] Midwives providing medication abortion has been reviewed as safe and effective in multiple areas, such as rural Nepal and Sweden.[441] In 2022 Quebec legally allowed midwives to provide medical abortion care.[442] Abortion access is also important from a fiscal perspective, as early abortion is more cost effective and safer, reducing complications and the need for more specialized providers, clinics, and equipment that is used in surgical abortions.[443]

Rural Clinics and Nursing Stations

Medical services have become largely centralized Canada-wide, due to the majority of the population residing in southern areas as well as low budgets. Many rural clinics have closed due to lack of adequate funding.[444] Across Canada, less family physicians provide obstetric care, and specialized obstetricians and gynecologists are normally found in southern cities.[445] In Thompson, the obstetric unit was in a "very fragile state" in recent years, with the NHR admitting that at times staff were only minimally trained.[446] Attracting, keeping, and training rural healthcare providers is a challenge, even with Health Canada currently providing a 50% Canadian Student Loan forgiveness to nurses and doctors who work in rural and remote areas.[447]

As part of the Cairo Convention in 1984, the UN stated that countries should "re-examine training curricula and delegation of responsibilities within the health-care delivery system in order to reduce frequent, unnecessary and costly reliance on physicians and on secondary- and tertiary-care facilities."[448] The birth evacuation policy and the need for women from rural areas to give birth puts additional stress on tertiary hospitals in cities. In fact, travelling for birth

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Global Perspective," *International Journal of Women's Health* 10 (November 23, 2018): 752, https://doi.org/10.2147/IJWH.S178601.

[439] Fullerton et al., "Abortion-Related Care and the Role of the Midwife," 752.
[440] Action Canada, "Midwife-Led Abortion Care," 3.
[441] Fullerton et al., "Abortion-Related Care and the Role of the Midwife," 753.
[442] Action Canada, "Midwife-Led Abortion Care," 3.
[443] Canadian Association of Midwives, "Position Statement on Midwives Provision of Abortion," 1.
[444] Lawford, Bourgeault, and Giles, ""This Policy Sucks and It's Stupid," 1305.
[445] Lawford, Bourgeault, and Giles, 1305.
[446] NHR, "Annual Report 2021-22," 19, 24.
[447] Health Canada, "2023–24 Departmental Plan," 17.
[448] UN Population Fund, "Programme of Action," para. 8.8.

outside of the health authority of your residence is common in Manitoba, with nearly half (46.8%) of pregnant women doing so.[449] While not *all* births are possible in *all* communities, there should be great effort to restore birthing services throughout the province.

Abortion is another issue that is rarely provided by health centres in rural and northern areas. Some providers across Canada reported that they prescribe the medication abortion pill to patients who live over two hours from hospitals that provide emergency care, many do not.[450] Providers working in rural, remote, and northern areas should be trained on how to preform manual uterine aspiration in case of emergency.[451]

Self-Management of Abortion

The WHO's recent report on abortion, "Abortion Care Guideline" outlines that medication abortion can be managed by the person undergoing the abortion, either completely or partially.[452] Medication abortion can be provided by midwives, nurses, doctors, and pharmacists.[453] The WHO recommends that medication abortion can be independently managed under 12 weeks' gestation.[454] Telephone birth control and pregnancy counselling that is currently provided at WHC could perhaps be available for those self-managing, if they wanted information or support.[455]

Pharmacists Assistance with Abortion

Another recommendation is pharmacists direct dispensing mifepristone, that is, providing the abortion pill to patients directly without prescription. A study on Canadian pharmacists willingness to directly dispense mifepristone found that pharmacists across the country showed interest in expanding their practice by offering mifepristone directly to patients. [456] Nine pharmacists from Manitoba were included in the study, eight of which were urban and one rural.[457] All expressed a willingness to directly dispense mifepristone.[458] Canadian pharmacists

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[449] Cidro, Dolin, and Queskekapow, "Experiences of Pregnant and Expectant First Nations Mothers," 79.
[450] Renner et al., "Telemedicine for First-Trimester Medical Abortion in Canada," 693.
[451] Renner et al., 693.
[452] WHO, "Abortion Care Guideline" (Geneva: WHO, 2022), 98, https://www.who.int/publications-detail-redirect/9789240039483.
[453] WHO, "Medical Management of Abortion," 39.
[454] WHO, "Abortion Care Guideline," 98.
[455] Women's Health Clinic, "Abortion."
[456] Enav Z. Zusman et al., "Pharmacist Direct Dispensing of Mifepristone for Medication Abortion in Canada: A Survey of Community Pharmacists," *BMJ Open*, Original research, 12, no. 10 (2022): e063370–e063370, https://doi.org/10.1136/bmjopen-2022-063370, 5.
[457] Zusman et al., 4.
[458] Zusman et al., 4.

felt that there are few barriers to implementing direct dispensing quickly and overall there is high acceptance and willingness by pharmacists.[459] An American pilot found high satisfaction among patients who accessed abortion through pharmacists.[460]

Improving reproductive healthcare access in rural, remote, and northern Manitoban communities is complex and requires a multi-pronged approach. Telehealth, especially for pregnancy service and abortion is an important aspect of improving care. Allowing midwives to practice with an expanded scope of care is important, including Indigenous midwives who can provide traditional and culturally competent care. Funding and training for rural clinics and nursing stations so they are able to provide sexual and reproductive care would improve access and reduce the strain on tertiary healthcare centres. Pharmacists are another target, as they have demonstrated a willingness to provide contraception without a prescription, as well as give the abortion pill over-the-counter. Pharmaceutical coverage for medications would reduce financial barriers to accessing medications, such as birth control. As well, self-management of abortion should be offered to those who do not want appointments with a practitioner and feel comfortable. Additionally, self-management of medication abortion is another avenue to reduce barriers to care.

Limitations

This research was limited to publicly available information. For example, the birth rates within RHAs are not available on all RHA websites or annual reports. Some RHAs have better reporting on relevant statistics or other information, impacting what was included in this research. Another limitation is the scoping review. The scoping review cannot be validated, as it was conducted by one researcher, not multiple as intended. That is a limitation congruent with independent thesis research.

A criticism of this research may be that there was not enough focus on Indigenous experiences and perspectives, or UNDRIP. However, the main focus of this research was rural women. Many Indigenous women live outside of urban areas of Manitoba, especially in northern and remote regions. However, they are not the only group of rural women, and there are other

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[459] Zusman et al., 8; Sarah Munro et al., "Pharmacist Dispensing of the Abortion Pill in Canada: Diffusion of Innovation Meets Integrated Knowledge Translation," *Implementation Science* 16, no. 1 (August 3, 2021): sec. Discussion, https://doi.org/10.1186/s13012-021-01144-w.

[460] Selina Sandoval et al., "Pharmacist Provision of Medication Abortion: A Pilot Study," *Contraception*, December 7, 2023, sec. 3. Results, https://doi.org/10.1016/j.contraception.2023.110346.

racial, ethnic, cultural, linguistic, and vulnerable populations living rurally. Additionally, UNDRIP is not a binding UN treaty. The analysis hinged upon comparing reproductive healthcare in Manitoba to Canada's legally binding international human rights obligations. While the *UNDRIP Act* is legally binding, it is not an international treaty. Another limitation is the author is from a southern urban centre (Winnipeg). This location undoubtably influenced the research design, methods, and final product.

Conclusion

There are benefits to living in urban areas, including access to a wider variety of amenities (options for education, programs, shops) that you might not have in rural areas. That is at least somewhat inherent to living urban. It is unlikely that Canada's premier neurosurgeon will ever practice in Gillam, Manitoba. However, reproductive healthcare is not specialist care. Access to contraception, pre- and post-natal care, birth, and abortion are not rare medical procedures for the sick. Pregnancy and family planning are not infirmary.

This research focused on human rights and reproductive healthcare outside of urban areas in the province of Manitoba. The research set out to analyze if there are human rights violations within the current state of reproductive healthcare, focusing on STBBIs, contraceptives, abortion, and maternity care. A scoping review was conducted as part of the research, and the tripartite typology of human rights, also known as the respect, protect, fulfill framework, was used for the analysis. The research consisted of four chapters with specific research questions in each.

Chapter one focused on international human rights obligations. It aimed to find what Canada's, and Manitoba's, obligations are to in regard to reproductive healthcare, specifically in relation to rural women. It looked to find what Canada had agreed to be legally bound by, based on international human rights treaties. The chapter focused on two main treaties, the ICESCR, and CEDAW. Also included in this chapter was an analysis on the Canada Health Act, the *Canadian Charter of Rights and Freedoms,* UNDRIP and the *UNDRIP Act*, and addressed why these other documents were not robust enough in the discussion of the right to health in relation to rural women's reproductive healthcare, and thus not the focus of this research.

Chapter two focused on the current state of healthcare in Manitoba. This chapter aimed to understand what the landscape of reproductive healthcare is currently. This chapter found that STBBI services were most readily available, barriers to contraception due to cost and provider accessibility, and issues with abortion access outside of Winnipeg and Brandon. The chapters

also found that maternity care, especially access to prenatal care, midwives, and birthing wards were an issue in most RHAs.

Chapter three married chapters one and two, and analyzed how healthcare in Manitoba meets and/or does not meet the international human rights obligations outlined in the ICESCR and CEDAW. This chapter found the most robust reproductive health services were STBBI prevention, education, information. It found there was no violation to respect, protect, or fulfill. Although there is still much left to be desired in regard to contraception in the province, when taking progressive realization into account, both federal and provincial governments have made plans and/or provided funding for better education, as well as funding for contraceptive coverage. There are no violations in regard to contraception.

The chapter also found the status of care for pregnancy worrying. The birth evacuation policy is clearly a violation of the obligations to respect, protect, and fulfill. Outside of this policy, there is still much to be desired regarding maternity care. Inadequate prenatal care is common in rural areas, which is a violation of the right to respect, protect, and fulfill. In relation to abortion, there is no violation to respect, and violation on protection is unclear due to limited information available. There are violations to facilitate, due to gestational limits and difficulty accessing and affording abortion as an individual living rurally. Out-of-pocket cost can be prohibitive for individuals to travel to urban areas to access abortion, which is a violation of the obligation to provide. There is no violation of the obligation to promote.

Chapter four made recommendations based on any violations or gaps found in chapter three. This chapter's recommendations were based on current literature as well as the WHO's most recent and relevant recommendations. The recommendations included expanding telehealth services in communities, increasing midwifery in the province, particularly Indigenous midwifery and birth work, as well as including abortion within midwives' scope of practice. Multiple recommendations involved pharmacists, including direct dispensing of contraception and the abortion pill.

The research expected to find human rights violations in the reproductive healthcare provided in rural, remote, and northern Manitoba. This was largely substantiated. While issues surround abortion were expected, an unexpected finding the many violations in relation to obligations surrounding maternity care. STBBI services and contraception were more robust than

anticipated. While violations to Manitobans right to health were found, there are also many options to increase access and bolster health services in the province.

Bibliography

Abortion Rights Coalition of Canada. “Abortion Clinics and Services in Canada,” March 2023. https://www.arcc-cdac.ca/media/2020/08/list-abortion-clinics-canada.pdf.

———. “Take Action against Aborted Fetus Images in Public!,” March 30, 2017. https://www.arcc-cdac.ca/media/2020/06/take-action-against-aborted-fetus-images.pdf.

Action Canada. “Policy Brief: Canada’s Pharmacare Plan Should Provide Access to All Forms of Contraception.” Action Canada for Sexual Health and Rights, 2022.

———. “Policy Brief: Increasing Abortion Access in Canada through Midwife-Led Care.” Action Canada for Sexual Health and Rights, 2023. https://www.actioncanadashr.org/resources/policy-briefs-submissions/2023-03-07-increasing-abortion-access-canada-through-midwife-led-care.

Action Canada, Kelly Bowden, and Insiya Mankani, eds. “Contraception Policy Atlas Canada,” July 2023. https://www.actioncanadashr.org/sites/default/files/2023-09/CCInfoCAN_A3_EN_2023_SEP20_0.pdf.

Action Canada, and National Abortion Federation Canada. “Trends in Barriers to Abortion Care.” Action Canada for Sexual Health and Rights, 2022. https://www.actioncanadashr.org/resources/reports-analysis/2022-12-14-trends-barriers-abortion-care.

Allen, Lindsay, Andrew Hatala, Sabina Ijaz, Elder David Courchene, and Elder Burma Bushie. “Indigenous-Led Health Care Partnerships in Canada.” *CMAJ* 192, no. 9 (March 2, 2020): E208–16. https://doi.org/10.1503/cmaj.190728.

Boyer, Yvonne, and Judith Bartlett. “External Review: Tubal Ligation in the Saskatoon Health Region: The Lived Experience of Aboriginal Women,” July 22, 2017.

British Columbia. An act Respecting Sexual Sterilization, Ch. 59 § (1933). https://www.bclaws.gov.bc.ca/civix/document/id/hstats/hstats/1887728313.

Brooks, Justin E. “Two Countries in Crisis: Man Camps and the Nightmare of Non-Indigenous Criminal Jurisdiction in the United States and Canada.” *Vanderbilt Law Review* 56, no. 533 (2023). https://scholarship.law.vanderbilt.edu/vjtl/vol56/iss2/4.

Caffery, Liam J, Natalie K Bradford, Anthony C Smith, and Danette Langbecker. “How Telehealth Facilitates the Provision of Culturally Appropriate Healthcare for Indigenous Australians.” *Journal of Telemedicine and Telecare* 24, no. 10 (December 1, 2018): 676–82. https://doi.org/10.1177/1357633X18795764.

Canadian Association of Midwives. “Discover Midwifery Across Canada.” Canadian Association of Midwives. Accessed February 26, 2024. https://canadianmidwives.org/about-midwifery/.

———. “Position Statement on Midwives Provision of Abortion.” Canadian Association of Midwives - Association canadienne des sages-femmes, n.d. https://canadianmidwives.org/sites/canadianmidwives.org/wp-content/uploads/2022/03/CAM_PSMidwivesAbortionProvision_ENG_VF_20220224.pdf.

Canadian Charter of Rights and Freedoms, Part 1 of the Constitution Act, being Schedule B to the Canada Act, c 11 § (1982). https://canlii.ca/t/ldsx.

Canadian Human Rights Act, c H-6 RSC § (1985). https://canlii.ca/t/7vh5.

Canadian Institute for Health Information. “Induced Abortions Reported in Canada in 2021: Update.” Ottawa, ON: CIHI, June 2023.

Cano, Jennifer K., and Angel M. Foster. "'They Made Me Go through like Weeks of Appointments and Everything': Documenting Women's Experiences Seeking Abortion Care in Yukon Territory, Canada." *Contraception* 94, no. 5 (November 2016): 489–95. https://doi.org/10.1016/j.contraception.2016.06.015.

CCSM c M125 | The Midwifery Act. Accessed August 17, 2023. https://www.canlii.org/en/mb/laws/stat/ccsm-c-m125/latest/ccsm-c-m125.html.

CEDAW. "General Recommendation No. 24: Article 12 of the Convention (Women and Health)." Geneva, Switzerland: United Nations, 1999. file:///Users/eringobert/Downloads/INT_CEDAW_GEC_4738_E.pdf.

———. "General Recommendation No. 34 on the Rights of Rural Women." Geneva, Switzerland: United Nations. Accessed September 5, 2023. https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW%2FC%2FGC%2F34&Lang=en.

CESCR. "General Comment No. 14: The Right to the Highest Attainable Standard of Health." Office of the High Comissioner for Human Rights, August 11, 2000.

Cidro, Jaime, Elisabeth Dolin, and Christina Queskekapow. "Bored, Broke, and Alone: Experiences of Pregnant and Expectant First Nations Mothers Birthing in and out of the Community from Indigenous Experiences of Pregnancy and Birth." In *Indigenous Experiences of Birthing and Pregnancy*, edited by Jaime Cidro and Hannah Tait Neufeld. Bradford: Demeter Press, 2017. https://www-jstor-org.uml.idm.oclc.org/stable/j.ctt1vw0sbs.9.

Coast, Ernestina, Samantha R. Lattof, Yana van der Meulen Rodgers, Brittany Moore, and Cheri Poss. "The Microeconomics of Abortion: A Scoping Review and Analysis of the Economic Consequences for Abortion Care-Seekers." *PloS One* 16, no. 6 (2021): e0252005. https://doi.org/10.1371/journal.pone.0252005.

Corosky, Gregory J, and Astrid Blystad. "Staying Healthy '"under the Sheets"': Inuit Youth Experiences of Access to Sexual and Reproductive Health and Rights in Arviat, Nunavut, Canada." *International Journal of Circumpolar Health* 75, no. 1 (2016). https://doi.org/10.3402/ijch.v75.31812.

ESCR-Net. "Paschim Banga Khet Mazdoor Samity & Ors v State of West Bengal & Anor. Cited as: (1996) AIR SC 2426/ (1996) 4 SCC 37." Accessed September 5, 2023. https://www.escr-net.org/caselaw/2006/paschim-banga-khet-mazdoor-samity-ors-v-state-west-bengal-anor-cited-1996-air-sc-2426.

Ezer, Paulina, Beverly Leipert, Marilyn Evans, and Sandra Regan. "Heterosexual Female Adolescents' Decision-Making about Sexual Intercourse and Pregnancy in Rural Ontario, Canada." *Rural and Remote Health* 16, no. 1 (January 30, 2016). https://doi.org/10.22605/RRH3664.

Fetner, Tina, Michelle Dion, Melanie Heath, Nicole Andrejek, Sarah L. Newell, and Max Stick. "Condom Use in Penile-Vaginal Intercourse among Canadian Adults: Results from the Sex in Canada Survey." *PLoS ONE* 15, no. 2 (February 20, 2020). https://doi.org/10.1371/journal.pone.0228981.

FNHSSM. "Maternal Child Care." Accessed June 28, 2023. https://www.fnhssm.com/copy-10-of-new-page.

Fransoo, Randall, Jill Bucklaschuk, Heather Prior, Elaine Burland, Daniel Chateau, and Patricia Martens. "Social Gradients in Surgical Sterilization Rates: Opposing Patterns for Males

and Females." *Journal of Obstetrics and Gynaecology Canada* 35, no. 5 (2013): 454–60. https://doi.org/10.1016/S1701-2163(15)30936-1.

Frost, Carolyn. "The Midwifery Act." *Manitoba Law Journal* 28, no. 2 (2001): 261.

Fullerton, Judith, Michelle M Butler, Cheryl Aman, Tobi Reid, and Melanie Dowler. "Abortion-Related Care and the Role of the Midwife: A Global Perspective." *International Journal of Women's Health* 10 (November 23, 2018): 751–62. https://doi.org/10.2147/IJWH.S178601.

General Assembly. "Convention on the Elimination of All Forms of Discrimination Against Women." United Nations, Treaty Series, December 18, 1979. https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/cedaw.pdf.

———. "International Covenant on Civil and Political Rights," December 16, 1966. https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights.

———. "International Covenant on Economic, Social and Cultural Rights," December 16, 1966. https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights.

———. "United Nations Declaration on the Rights of Indigenous Peoples," 2007. https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf.

Gobert, Erin. "Aspiration Abortion Map Manitoba." Google My Maps. Accessed February 8, 2024. https://www.google.com/maps/d/new?hl=en&cid=mp&cv=tsAQOm8_ueg.en.

———. "Maternity Care Map Manitoba." Google My Maps. Accessed February 14, 2024. https://www.google.com/maps/d/new?hl=en&at=AAX3J7CtssNItRJhXLK5SS4_cHky_N65JA:1707922553167&hl=en.

Government of Manitoba. "Midwifery in Manitoba - Primary Care | Health." Province of Manitoba - Health. Accessed September 20, 2023. https://www.gov.mb.ca/health/primarycare/access/maternal/midwifery.html.

———. "Physical Education/Health Education." Accessed January 17, 2024. https://www.edu.gov.mb.ca/k12/cur/physhlth/hs_k-8/.

Healey, Gwen. "Youth Perspectives on Sexually Transmitted Infections and Sexual Health in Northern Canada and Implications for Public Health Practice." *International Journal of Circumpolar Health* 75 (2016): 30706. https://doi.org/10.3402/ijch.v75.30706.

Health Canada. "2023–24 Departmental Plan: Health Canada." Government of Canada, February 2023. https://www.canada.ca/en/health-canada/corporate/transparency/corporate-management-reporting/report-plans-priorities/2023-2024-departmental-plan.html.

Health Sciences Centre. "Pregnancy and Prenatal Care." Health Sciences Centre. Accessed August 16, 2023. https://hsc.mb.ca/adults/womens-health/our-services/pregnancy-and-prenatal-care/.

Hui, Amy, Wanda Philips-Beck, Rhonda Campbell, Stephanie Sinclair, Connie Kuzdak, Erin Courchene, Maxine Roulette, et al. "Impact of Remote Prenatal Education on Program Participation and Breastfeeding of Women in Rural and Remote Indigenous Communities." *EClinicalMedicine* 35 (2021): 100851–100851. https://doi.org/10.1016/j.eclinm.2021.100851.

Hulme, Jennifer, Sheila Dunn, Edith Guilbert, Judith Soon, and Wendy Norman. "Barriers and Facilitators to Family Planning Access in Canada." *Healthcare Policy = Politiques De Sante* 10, no. 3 (February 2015): 48–63.

Interlake-Eastern Regional Health Authority. “Annual Report: 2021-2022.” Interlake-Eastern Regional Health Authority, 2022. https://www.ierha.ca/files/Interlake-Eastern-RHA-Annual-Report-2021-2022-FINAL-POST.pdf.

———. “Annual Report 2022-2023.” Annual Report, 2023. https://www.ierha.ca/wp-content/uploads/Interlake-Eastern-RHA-Annual-Report-2022-2023-FINAL.pdf.

———. “Family Birthing Unit.” Interlake-Eastern RHA. Accessed May 24, 2023. https://www.ierha.ca/programs-services/public-health/family-birthing-unit/.

———. “Strategic Plan 2021-2028: Priorities for the Development of a Regional and Provincial Health-Care System,” 2023. https://www.ierha.ca/wp-content/uploads/FINAL-PRINT-VERSION-Interlake-Eastern-RHA-Strategic-Plan-2021-28-UPDATED-1.pdf.

International Confederation of Midwives. “Position Statement: Midwives’ Provision of Abortion-Related Services,” 2014. https://www.internationalmidwives.org/assets/files/statement-files/2018/04/midwives-provision-of-abortion-related-services-eng.pdf.

Jackman, Martha. “The Application of the Canadian Charter in the Health Care Context.” SSRN Scholarly Paper. Rochester, NY, 2001. https://papers.ssrn.com/abstract=2578206.

Jaworsky, Denise, Carmen H. Logie, Anne C. Wagner, Tracey Conway, Angela Kaida, Alexandra de Pokomandy, Kath Webster, et al. “Geographic Differences in the Experiences of HIV-Related Stigma for Women Living with HIV in Northern and Rural Communities of Ontario, Canada.” *Rural and Remote Health* 18, no. 3 (July 2018): 4522. https://doi.org/10.22605/RRH4522.

Kanem, Natalia. “Sexual and Reproductive Health and Rights: The Cornerstone of Sustainable Development.” *United Nations Chronicle* 55, no. 2 (2019 2018): 1–36.

Lawford, Karen M., Ivy L. Bourgeault, and Audrey R. Giles. “‘This Policy Sucks and It’s Stupid:’ Mapping Maternity Care for First Nations Women on Reserves in Manitoba, Canada.” *Health Care for Women International* 40, no. 12 (December 2, 2019): 1302–35. https://doi.org/10.1080/07399332.2019.1639706.

Logie, Carmen H., Candice L. Lys, Kayley Mackay, Nancy MacNeill, Analaura Pauchulo, and Abdool S. Yasseen. “Syndemic Factors Associated with Safer Sex Efficacy Among Northern and Indigenous Adolescents in Arctic Canada.” *International Journal of Behavioral Medicine* 26, no. 4 (August 1, 2019): 449–53. https://doi.org/10.1007/s12529-019-09797-0.

Logie, Carmen H., Candice L. Lys, Moses Okumu, and Jamie Fujioka. “Exploring Factors Associated with Condom Use Self-Efficacy and Condom Use among Northern and Indigenous Adolescent Peer Leaders in Northern Canada.” *Vulnerable Children and Youth Studies* 14, no. 1 (2019): 50–62.

Logie, Carmen H., Candice Lys, Nina Sokolovic, Kalonde Malama, Kayley Inuksuk Mackay, Clara McNamee, Anoushka Lad, and Amanda Kanbari. “Examining Pathways from Food Insecurity to Safer Sex Efficacy Among Northern and Indigenous Adolescents in the Northwest Territories, Canada.” *International Journal of Behavioral Medicine*, July 6, 2023. https://doi.org/10.1007/s12529-023-10195-w.

Lys, Candice L., Carmen H. Logie, and Moses Okumu. “Pilot Testing Fostering Open eXpression among Youth (FOXY), an Arts-Based HIV/STI Prevention Approach for Adolescent Women in the Northwest Territories, Canada.” *International Journal of STD & AIDS* 29, no. 10 (September 2018): 980–86. https://doi.org/10.1177/0956462418770873.

Lys, Candice, Carmen H. Logie, Kayley Inuksuk Mackay, Nancy MacNeill, Charlotte Loppie, Lesley Gittings, and Abdool Yasseen. "Exploring Uptake of HIV/STI Knowledge and Safer Sex-Efficacy in an Arts-Based Sexual Health Workshop among Northern and Indigenous Adolescents in the Northwest Territories, Canada." *AIDS Care* 35, no. 3 (March 2023): 411–16. https://doi.org/10.1080/09540121.2022.2089617.

Machalek, Karolina, Brendan E. Hanley, Joy N. Kajiwara, Paula E. Pasquali, and Cathy J. Stannard. "Chlamydia Screening Practices among Physicians and Community Nurses in Yukon, Canada." *International Journal of Circumpolar Health* 72, no. 1 (January 31, 2013): 21607. https://doi.org/10.3402/ijch.v72i0.21607.

Manitoba Health. "Sexually Transmitted and Blood-Borne Infections (STBBI) Surveillance Report." Manitoba: Government of Manitoba, June 30, 2022. https://www.gov.mb.ca/health/publichealth/surveillance/stbbi/index.html.

MBTelehealth. "About Us." MBTelehealth. Accessed January 8, 2024. https://mbtelehealth.ca/about/.

McCavitt, Candice M. "Eugenics and Human Rights in Canada: The Alberta Sexual Sterilization Act of 1928." *Peace and Conflict: Journal of Peace Psychology* 19, no. 4 (November 2013): 362–66. https://doi.org/10.1037/a0034604.

McPherson, N, C Williams, P McTavish, A Allen, M Gaber, A Otash, N Tregunna, and P Allan. "Prairie Mountain Health Community Health Assessment 2019." PMH, 2019. https://prairiemountainhealth.ca/files/2019CHAFeb102020.pdf.

Mikhail, Hannah, Sarah E. Kelly, and Colleen M. Davison. "Reproductive Health Interventions for Inuit Youth in the North: A Scoping Review." *Reproductive Health* 18, no. 1 (March 20, 2021): 65. https://doi.org/10.1186/s12978-021-01119-6.

Moecke, Débora Petry, Travis Holyk, Madelaine Beckett, Sunaina Chopra, Polina Petlitsyna, Mirha Girt, Ashley Kirkham, et al. "Scoping Review of Telehealth Use by Indigenous Populations from Australia, Canada, New Zealand, and the United States." *Journal of Telemedicine and Telecare*, March 13, 2023, 1357633X231158835. https://doi.org/10.1177/1357633X231158835.

Moisan, Caroline, Chloé Baril, Gina Muckle, and Richard E. Belanger. "Teen Pregnancy in Inuit Communities - Gaps Still Needed to Be Filled." *International Journal of Circumpolar Health* 75 (2016): 31790. https://doi.org/10.3402/ijch.v75.31790.

Munro, Sarah, Kate Wahl, Judith A. Soon, Edith Guilbert, Elizabeth S. Wilcox, Genevieve Leduc-Robert, Nadra Ansari, Courtney Devane, and Wendy V. Norman. "Pharmacist Dispensing of the Abortion Pill in Canada: Diffusion of Innovation Meets Integrated Knowledge Translation." *Implementation Science* 16, no. 1 (August 3, 2021): 76. https://doi.org/10.1186/s13012-021-01144-w.

Myran, Daniel T., Jillian Bardsley, Tania El Hindi, and Kristine Whitehead. "Abortion Education in Canadian Family Medicine Residency Programs." *BMC Medical Education* 18, no. 1 (June 1, 2018): 121. https://doi.org/10.1186/s12909-018-1237-8.

Nampewo, Zahara, Jennifer Heaven Mike, and Jonathan Wolff. "Respecting, Protecting and Fulfilling the Human Right to Health." *International Journal for Equity in Health* 21, no. 1 (March 15, 2022): 36. https://doi.org/10.1186/s12939-022-01634-3.

National Council of Indigenous Midwives. "Indigenous Midwifery in Canada." *NCIM* (blog). Accessed April 17, 2023. https://indigenousmidwifery.ca/indigenous-midwifery-in-canada/.

Nelson, Erin. “Autonomy, Equality, and Access to Sexual and Reproductive Health Care.” *Alberta Law Review*, Special Issue: Health Law, 54, no. 3 (2017 2016): 707–26.

Nguyen, Nam Hoang, Fatheema B. Subhan, Kienan Williams, and Catherine B. Chan. “Barriers and Mitigating Strategies to Healthcare Access in Indigenous Communities of Canada: A Narrative Review.” *Healthcare* 8, no. 2 (June 2020): 112. https://doi.org/10.3390/healthcare8020112.

Northern Health Region. “Annual Report 2021-22,” 2022. https://northernhealthregion.com/wp-content/uploads/2022/09/NHR-Annual-Report-2021-22.pdf.

———. “Community Health Assessment 2019.” Northern Health Region, 2020. https://northernhealthregion.com/wp-content/uploads/2020/01/2019-NHR-CHA-Rev-Jan-27-2020.pdf.

———. “Gillam Public Health Services.” Northern Health Region. Accessed May 18, 2023. https://northernhealthregion.com/programs-and-services/public-health/gillam-public-health-services/.

———. “Northern Health Region Annual Report 2022-23.” Manitoba: NHR, 2023. https://northernhealthregion.com/wp-content/uploads/2023/09/NHR-Annual-Report-Draft-2022-23-Final-Sept-29.pdf.

———. “Snow Lake Public Health Services.” Northern Health Region. Accessed May 18, 2023. https://northernhealthregion.com/programs-and-services/public-health/snow-lake-public-health-services/.

———. “Wabowden Public Health Services.” Accessed May 18, 2023. https://northernhealthregion.com/programs-and-services/public-health/wabowden-public-health-services/.

O’Driscoll, Terry, Lauren Payne, Len Kelly, Helen Cromarty, Natalie St Pierre-Hansen, and Carol Terry. “Traditional First Nations Birthing Practices: Interviews With Elders in Northwestern Ontario.” *Journal of Obstetrics and Gynaecology Canada* 33, no. 1 (January 1, 2011): 24–29. https://doi.org/10.1016/S1701-2163(16)34768-5.

Office of the Chief Provincial Public Health Officer. “Addressing the STBBI Epidemic in Manitoba.” Manitoba, January 18, 2022. https://www.gov.mb.ca/health/publichealth/cdc/docs/stbbi-epidemic-mb.pdf.

Olson, Rachel. “Bearing Witness: Rural Indigenous Women’s Experiences of Childbirth in an Urban Hospital.” In *Indigenous Experiences of Pregnancy and Birth*, edited by Hannah Tait Neufeld and Jaime Cidro, 91–110. Demeter Press, 2017. https://doi.org/10.2307/j.ctt1vw0sbs.10.

Olson, Rachel, and Carol Couchie. “Returning Birth: The Politics of Midwifery Implementation on First Nations Reserves in Canada.” *Midwifery* 29, no. 8 (August 1, 2013): 981–87. https://doi.org/10.1016/j.midw.2012.12.005.

O’Neill, Onora. “The Dark Side of Human Rights.” *International Affairs (Royal Institute of International Affairs 1944-)* 81, no. 2 (2005): 427–39.

Prairie Mountain Health. “Health and Wellness for All: Annual Report 2021-2022.” Prairie Mountain Health, 2022. https://prairiemountainhealth.ca/wp-content/uploads/Annual-Report-2021-2022.pdf.

———. “Midwifery Services.” Prairie Mountain Health. Accessed May 24, 2023. https://prairiemountainhealth.ca/programs-and-services/primary-health-care/midwifery-services/.

Province of Manitoba. “Speech from the Throne,” 2023. https://www.gov.mb.ca/thronespeech/thronespeech-2023.html.

Public Health Agency of Canada. “Chapter 3: Care during Pregnancy: Family-Centred Maternity and Newborn Care National Guidelines.” Family-Centred Maternity and Newborn Care: National Guidelines, February 8, 2021. https://www.canada.ca/en/public-health/services/publications/healthy-living/maternity-newborn-care-guidelines-chapter-3.html.

———. “Chapter 8: Organization of Services.” Family-Centred Maternity and Newborn Care: National Guidelines, 2022. https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/healthy-living/maternity-newborn-care-guidelines-chapter-8/maternity-newborn-care-guidelines-chapter-8.pdf.

———. “Statement from the Chief Public Health Officer of Canada on Syphilis.” Government of Canada, February 14, 2024. https://www.canada.ca/en/public-health/news/2024/02/statement-from-the-chief-public-health-officer-of-canada-on-syphilis.html.

Renner, Regina M., Madeleine Ennis, Ama Kyeremeh, Wendy V. Norman, Sheila Dunn, Helen Pymar, and Edith Guilbert. “Telemedicine for First-Trimester Medical Abortion in Canada: Results of a 2019 Survey.” *Telemedicine Journal and E-Health: The Official Journal of the American Telemedicine Association* 29, no. 5 (May 2023): 686–95. https://doi.org/10.1089/tmj.2022.0245.

Newcombe, Daryl. “Proposed Bylaw to Ban Graphic Anti-Abortion Posters Morphs into General Rules for All Protest Signs.” London, July 12, 2024. https://london.ctvnews.ca/proposed-bylaw-to-ban-graphic-anti-abortion-posters-morphs-into-general-rules-for-all-protest-signs-1.6962300.

“RSC 1985, c C-6 | Canada Health Act.” CanLII. Accessed February 6, 2023. https://www.canlii.org/en/ca/laws/stat/rsc-1985-c-c-6/latest/rsc-1985-c-c-6.html.

Ryan, Chaneesa, Abrar Ali, and Christine Shawna. “Forced or Coerced Sterilization in Canada: An Overview of Recommendations for Moving Forward.” *International Journal of Indigenous Health* 16, no. 1 (2021): 275–90.

Sandoval, Selina, Sally Rafie, Gennifer Kully, Sheila Mody, and Sarah Averbach. “Pharmacist Provision of Medication Abortion: A Pilot Study.” *Contraception*, December 7, 2023, 110346. https://doi.org/10.1016/j.contraception.2023.110346.

Sethna, Christabelle, and Marion Doull. “Spatial Disparities and Travel to Freestanding Abortion Clinics in Canada.”.” *Women’s Studies International Forum* 38 (2013): 52–62.

Shared Health. “Regional Map.” eChart Manitoba. Accessed January 31, 2024. https://echartmanitoba.ca/?da_image=510.

Silver, Hilah, Ivan Sarmiento, Juan-Pablo Pimentel, Richard Budgell, Anne Cockcroft, Zoua M. Vang, and Neil Andersson. “Childbirth Evacuation among Rural and Remote Indigenous Communities in Canada: A Scoping Review.” *Women and Birth* 35, no. 1 (February 1, 2022): 11–22. https://doi.org/10.1016/j.wombi.2021.03.003.

Southern Health-Santé Sud. “Annual Report 2021-22:...Meeting the Moment...” Annual Report. Manitoba, 2022. https://www.southernhealth.ca/assets/AnnualReports/Annual-Report-2021-2022-website.pdf.

Southern Health-Santé Sud. “Birthing Options.” Accessed May 18, 2023. https://www.southernhealth.ca/en/finding-care/care-by-topic/parents-parents-to-be/birthing-options/.

Southern Health-Santé Sud. “Boundary Trails Health Centre.” Accessed May 18, 2023. https://www.southernhealth.ca/en/finding-care/winkler/boundary-trails-health-centre/.

Southern Health-Santé Sud. “Midwifery Services.” Accessed May 18, 2023. https://www.southernhealth.ca/en/finding-care/find-a-service/midwifery-services/.

———. “Our Call to Action: Healthier People. Healthier Communties. Thriving Together.” 2023-2028 Strategic Plan, 2022. https://www.southernhealth.ca/assets/AnnualReports/2023-28-Strategic-Health-Plan.pdf.

———. “Pregnancy Testing, Birth Control & Counselling.” Southern Health-Santé Sud. Accessed May 18, 2023. https://www.southernhealth.ca/en/finding-care/health-info-for-you/healthy-sexuality/pregnancy-testing-birth-control-and-counselling/.

Southern Health-Santé Sud. “Sexually Transmitted and Blood Borne Infections (STBBIs).” Accessed May 18, 2023. https://www.southernhealth.ca/en/finding-care/health-info-for-you/healthy-sexuality/sexually-transmitted-infections-stis/.

Standing Senate Committee on Human Rights. “Forced and Coerced Sterilization of Persons in Canada,” June 2021. https://sencanada.ca/content/sen/committee/432/RIDR/reports/ForcedSterilization_Report_FINAL_E.pdf.

———. “The Scars That We Carry: Forced and Coerced Sterilization of Persons in Canada - Part II,” July 2022. https://sencanada.ca/content/sen/committee/441/RIDR/reports/2022-07-14_ForcedSterilization_E.pdf.

Street Connections. “Find a Location - Interactive Map.” Street Connections. Accessed May 24, 2023. https://streetconnections.ca/locations.

Szalay Timbo, Clare, and Andrea Rodriguez. “Decriminalizing Abortion: A Journey Towards Access and Equity.” Action Canada for Sexual Health and Rights, December 6, 2023. https://www.actioncanadashr.org/news/2023-12-06-decriminalizing-abortion-journey-towards-access-and-equity.

The Human Rights Code, c H175 CCSM § (1987). https://canlii.ca/t/55q5f.

The Regulated Health Professions Act, CCSM c R117, (n.d.). https://canlii.ca/t/8j22.

The Safe Access to Abortion Services Act, SM 2024, c 5, <https://canlii.ca/t/569cq> retrieved on 2024-07-17

Thiessen, Kellie, Nathan Nickel, Heather J. Prior, Ankona Banerjee, Margaret Morris, and Kristine Robinson. “Maternity Outcomes in Manitoba Women: A Comparison between Midwifery-Led Care and Physician-Led Care at Birth.” *Birth* 43, no. 2 (2016): 108–15. https://doi.org/10.1111/birt.12225.

Thompson, Laura H., Zoann Nugent, James F. Blanchard, Carla Ens, and Bo Nancy Yu. “Increasing Incidence of Anogenital Warts with an Urban-Rural Divide among Males in Manitoba, Canada, 1990-2011.” *BMC Public Health* 16, no. 224 (2016): 219–219. https://doi.org/10.1186/s12889-016-2885-4.

Thompson, Laura H., Zoann Nugent, John L. Wylie, Carla Loeppky, Paul Van Caeseele, James F. Blanchard, and Nancy Yu. “Laboratory Detection of First and Repeat Chlamydia Cases Influenced by Testing Patterns: A Population-Based Study.” *Microbiology Insights* 12 (2019): 1178636119827975–1178636119827975. https://doi.org/10.1177/1178636119827975.

Tordimah, Jasmine. “‘Man Camps’: Temporary Housing Facilities or Sites of Permanent Devastation? The Cases of British Columbia, Manitoba, and Nunavut".” MA Major

Research Papers, Western University, 2021. https://ir.lib.uwo.ca/politicalscience_maresearchpapers/6.

Ukoha, Erinma P., Kelly Davis, Meredith Yinger, Blythe Butler, Tamia Ross, Joia Crear-Perry, Misa Perron-Burdick, and Malini A. Nijagal. "Ensuring Equitable Implementation of Telemedicine in Perinatal Care." *Obstetrics and Gynecology* 137, no. 3 (March 2021): 487–92. https://doi.org/10.1097/AOG.0000000000004276.

UN General Assembly. "International Covenant on Economic, Social and Cultural Rights." Geneva: UN, December 16, 1966. https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights.

UN Human Rights Council, and Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. "Visit to Canada : Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health." Geneva: UN, June 19, 2019. https://www.ohchr.org/sites/default/files/HRBodies/HRC/RegularSessions/Session41/Documents/A_HRC_41_34_Add.2.docx.

United Nations Declaration on the Rights of Indigenous Peoples Act, c 14 SC § (2021). https://canlii.ca/t/554bd.

United Nations Human Rights Treaty Bodies. "Ratification Status for Canada." Office of the High Commissioner of Human Rights. Accessed September 3, 2023. https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=31&Lang=EN.

United Nations Population Fund. "Programme of Action: Adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994." United Nations, 2004. https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf.

Welkins. "So You Want to Impliment UNDRIP." *University of British Columbia Law Review* 53, no. 4 (September 2021): 1237–1305.

Wherry, Aaron Wherry. "Liberals and New Democrats Reach a Deal on Pharmacare | CBC News." CBC, February 23, 2024. https://www.cbc.ca/news/politics/liberals-ndp-pharmacare-deal-1.7123952.

Winnipeg Regional Health Authority. "WRHA Annual Report 2021/2022." Winnipeg, Man, 2022. https://wrha.mb.ca/files/wrha-annual-report-2122.pdf.

Women's Health Clinic. "Abortion." Women's Health Clinic. Accessed May 18, 2023. https://womenshealthclinic.org/what-we-do/abortion/.

———. "Access: Annual Report 2022/23." Winnipeg, Man: Women's Health Clinic, 2023. https://womenshealthclinic.org/wp-content/uploads/2023/06/Annual-Report-2023-FINAL.pdf.

World Health Organization. "Abortion Care Guideline." Geneva: World Health Organization, 2022. https://www.who.int/publications-detail-redirect/9789240039483.

———. "Medical Management of Abortion." Geneva, 2018. https://apps.who.int/iris/bitstream/handle/10665/278968/9789241550406-eng.pdf?ua=1.

———. "WHO Model List of Essential Medicines - 23rd List, 2023." Geneva: World Health Organization, 2023. https://www.who.int/publications-detail-redirect/WHO-MHP-HPS-EML-2023.02.

Zehbe, Ingeborg, Pamela Wakewich, Brianne Wood, Pauline Sameshima, Yvonne Banning, and Julian Little. "Engaging Canadian First Nations Women in Cervical Screening through

Education." *International Journal of Health Promotion and Education* 54, no. 5 (2016): 255–64. https://doi.org/10.1080/14635240.2016.1169942.

Zusman, Enav Z., Sarah Munro, Wendy V. Norman, and Judith A. Soon. "Dispensing Mifepristone for Medical Abortion in Canada: Pharmacists' Experiences of the First Year." *Canadian Pharmacists Journal : CPJ* 156, no. 4 (June 8, 2023): 204–14. https://doi.org/10.1177/17151635231176270.

———. "Pharmacist Direct Dispensing of Mifepristone for Medication Abortion in Canada: A Survey of Community Pharmacists." *BMJ Open*, Original research, 12, no. 10 (2022): e063370–e063370. https://doi.org/10.1136/bmjopen-2022-063370.