2SLGBTQIA+ Experiences Accessing Abortion in Manitoba

by

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A Thesis submitted to the

Faculty of Graduate and Postdoctoral Studies

of the University of Manitoba

in partial fulfilment of the requirements of the degree of

Master of Social Work

Department of Social Work

University of Manitoba

Winnipeg

Table of Contents

Abstract

Abortion care is commonly accessed by 2SLGBTQIA+ people assigned female at birth, at rates comparable to cisgender and heterosexual women. However, existing research consistently demonstrates that abortion care systems remain rooted in cisheteronormativity, leading to the exclusion of 2SLGBTQIA+ people within abortion care settings. In Manitoba, abortion access is further shaped by geographic, social, and political constraints, producing uneven experiences of care across different identities, regions, and access to resources. This thesis draws on seven narrative interviews with 2SLGBTQIA+ individuals who accessed an abortion in Manitoba between 2020 and 2025. Guided by a queer reproductive justice approach and narrative analysis, the study centres participants' stories as sites of knowledge production while critically interrogating the cisheteronormative logics embedded within abortion care systems. The findings demonstrate that while 2SLGBTQIA+ abortion-seekers encounter many of the barriers and facilitators to care documented in the existing abortion literature, these are frequently intensified and reconfigured through experiences of cisheteronormativity. Across narratives, cisheteronormativity shaped every stage of care, producing experiences of invisibility, discomfort, and marginalization. At the same time, participants articulated moments of affirmation and agency, sharing moments of inclusion or resistance to cisheteronormativity. Participants also offered visions for queering abortion care, calling for decolonial and sex-positive approaches, recognition of abortion within gender-affirming care frameworks, and expanded understandings of reproduction and family beyond cisheteronormative scripts. Ultimately, this study underscores the need to dismantle cisheteronormativity within abortion care, and understandings of reproduction more broadly, to support inclusive, affirming, and dignified abortion care for 2SLGBTQIA+ people in Manitoba.

Acknowledgements

I hope this thesis can be a celebration of the resiliency, knowledge, love, and support that exists and is flourishing within the 2SLGBTQIA+ community. Thank you to queer and trans people for existing, and a special thank you to the seven who graciously shared their abortion stories with me for this project. This thesis was only possible because of their willingness to share their experiences and reimagine a better future.

I would also like to celebrate and thank my faculty advisor, Dr. Lindsay Larios. Thank you for your endless support and enthusiasm throughout the past few years. It has been such an honour to learn from you, and I have experienced immense academic and personal growth under your guidance. Thank you to my two thesis committee members, Dr. Rusty Souleymanov and Dr. Deborah McPhail, for all your support and invaluable insights that have strengthened this work.

I would also like to thank the Women's Health Clinic Kokums Circle, who have been so generously supportive of this research. Thank you to Elder Louise McKay for sharing teachings with me that have deepened my understanding of relational care within abortion spaces, and for always being so kind, encouraging, and uplifting throughout this work.

Thank you to Research Manitoba for the Masters Studentship Award, the Faculty of Social work for the Endowment Funding, and the Faculty of Graduate Studies for the Research Completion Scholarship. This funding was instrumental in supporting the completion of this thesis.

To the friends I made along the way - Ally, Grace, Maddy, and Marianne – thank you for becoming my family throughout this program. And last, but certainly not least, thank you to my

biggest supporter, Landon. There are not enough words to describe my gratitude for the endless ways you have supported and encouraged me throughout this process. So, thank you.

Introduction

Leith (she/they)[1], a Two-Spirit, non-binary, queer person needed to access abortion care but was unable to do so in their home community, Thompson. Learning of a medication abortion prescriber in The Pas, they travelled five hours to access a prescription for Mifegymiso. Upon arrival to the healthcare clinic in The Pas, Leith was repeatedly considered a woman by the provider. To get the prescription without fuss, Leith decided it was easiest to just go along with the assumption that they were a woman.

Olivia (she/her), a bisexual woman was accessing abortion care for the second time in her life. Having previously accessed care, she knew the process and felt more open talking about this experience with her friends. Her friends were part of the 2SLGBTQIA+ community, just like her, and Olivia felt that she could trust them with anything. However, upon sharing she was accessing abortion care again, her friends told her that she should "just stick to the girls," so that she would never have to access an abortion again. Olivia left feeling uneasy, feeling judged by her friends – both for being bisexual and for accessing abortion care.

Jordan (she/they) a non-binary bisexual person struggled with feelings of gender dysphoria when they discovered they were pregnant. Never wanting to be pregnant or have children, she immediately sought abortion care. The first barrier Jordan encountered was the name of the abortion provider site being the "Women's" Health Clinic. Experiencing discomfort for needing to access care from a "women's" clinic, Jordan attempted to hold space for their identity by ensuring the healthcare staff and practitioners knew their pronouns and gender identity. Despite these efforts, Jordan was repeatedly misgendered while accessing abortion care.

Leith, Olivia, and Jordan all have the right to access abortion care in Canada, as abortion has been decriminalized since 1988 and has since become governed under the Canada Health Act (Canada Health Act RSC 1985, c C-6). However, the legal right to access abortion services does

[1] Leith, Olivia, and Jordan are three individuals who participated in an interview, sharing their abortion stories, for this project. These narratives are true events. Pseudonyms are used throughout to protect participant confidentiality.

not guarantee that services are inclusive and affirming of queer and trans identities. While Leith, Olivia, Jordan, and other 2SLGBTQIA+ individuals in Canada, technically do have the right to access abortion care, they commonly face systemic barriers, including exclusion and stigma within healthcare settings (Bowler et al., 2023). These barriers manifest as homophobia, transphobia, misgendering, misinformation, and a general lack of awareness regarding 2SLGBTQIA+ reproductive health needs (Bowler et al., 2023; Ertl et al., 2024; Hoffman & Bergin, 2019; Wingo et al., 2018). Such challenges not only hinder access to abortion services but also contribute to significant health disparities among 2SLGBTQIA+ populations (Carpenter et al., 2021; Ertl et al., 2024; Fernández-Basanta et al., 2024; Goldberg et al., 2024). This underscores the need to approach queer and trans inclusive and affirming abortion care as a matter of reproductive justice that extends beyond mere legal access to abortion (Ross & Solinger, 2017).

The challenges faced by 2SLGBTQIA+ individuals in abortion care settings are reflective of cisheteronormativity, which is the societal privileging of cisgender and heterosexual identities over non-cisgender and non-heterosexual identities (VanDenn Berg, 2024). Cisheteronormativity is embedded into reproductive healthcare, shaping not only the policies and clinical practices but also the very ways in which abortion care is conceptualized. Queer theorists provide a critical lens to interrogate these normative structures, challenging the assumption that reproductive healthcare is universally experienced through a cisgender, heterosexual framework (Butler, 1990; Sedgwick, 1993). Rather than reinforcing the rigid binary understandings of gender and sexuality, queer theory highlights how abortion care is often designed around exclusionary assumptions that erase or marginalize 2SLGBTQIA+ people. This erasure reflects broader

societal structures that uphold normative reproductive narratives, prompting researchers to reimagine abortion care as inherently fluid, inclusive, and affirming of diverse identities.

To examine the issue of abortion care for 2SLGBTQIA+ communities, this research explores the lived experiences of 2SLGBTQIA+ individuals, as they navigate abortion care in Manitoba. While Manitoba is often considered a progressive province in terms of reproductive politics, its policies and services do not consistently reflect an inclusive approach to abortion care. The province is currently under New Democratic Party (NDP) leadership, which has publicly committed to supporting reproductive justice for all Manitobans (Government of Manitoba, 2025a). Since coming into leadership in 2023, the Manitoba NDP has implemented several reproductive healthcare policies, including the abortion protest buffer zone bylaw (The Canadian Press, 2025), the Manitoba Prescription Birth Control Program (Government of Manitoba, 2024c), being the first province to sign onto Federal Pharmacare (Chang, 2025), and helped secure a 10 million dollar federal grant for the province's main abortion provider, the Women's Health Clinic (Rosen, 2025). Despite these demonstrations of progressive reproductive politics, there are no trans-inclusive abortion guidelines in Manitoba (Lowik, n.d.), and abortion clinics in the province continue to reinforce cisheteronormativity outwardly, in their branding, service descriptions, and online materials (Health Sciences Centre, n.d.; Women's Health Clinic, n.d.). Additionally, previous research on abortion access in Manitoba found that 2SLGBTQIA+ individuals face some distinct challenges when accessing abortion care in Manitoba compared to non-2SLGBTQIA+ individuals, such as disproportionately long wait times and a sense of exclusion in abortion spaces (Cowman et al., 2026). However, this previous study does not provide an in-depth analysis of 2SLGBTQIA+ abortion access in Manitoba, signalling a need for

further research to examine these experiences. Given these realities, my research was guided by the following questions:

(1) *What have been the experiences of 2SLGBTQIA+ individuals accessing abortion care in Manitoba?*

(2) *What barriers or challenges to accessing affirming and inclusive abortion care do 2SLGBTQIA+ people in Manitoba face?*

(3) *How can abortion care be alternatively imagined in Manitoba to support access to affirming and inclusive abortion care for 2SLGBTQIA+ populations?*

To address these questions, I conducted narrative interviews with 2SLGBTQIA+ individuals in Manitoba who accessed abortion care between 2020 and 2025. By examining the experiences of 2SLGBTQIA+ access to abortion care using a queer reproductive justice approach, this study illustrates the intersecting social, political, and economic factors that shape access to care (Ross & Solinger, 2017), while also challenging the normative assumptions related to cisheteronormativity, reproduction, and family (Butler, 2007). The study reveals that 2SLGBTQIA+ individuals in Manitoba face similar barriers to abortion care as heterosexual and cisgender counterparts, as previously documented (Cowman et al., 2026). However, these barriers are experienced alongside the cisheternormativity embedded into abortion care services, which was carefully navigated by participants and, at times, resisted. Ultimately, this study demands the need to dismantle cisheteronormativity, within abortion care and broader understandings of reproduction, to support inclusive, affirming, and dignified abortion care for 2SLGBTQIA+ people in Manitoba. Overall, this research contributes to a growing body of knowledge that advocates for inclusive, affirming, and equitable reproductive healthcare for all individuals, regardless of gender identity or sexual orientation.

Positionality Statement

Recognizing my positionality as a researcher was crucial to acknowledge how my personal experiences, identities, and social location shaped the lens through which this research was developed and conducted. My social location as a queer, white settler of Ukrainian and English descent, cisgender woman positions me uniquely in between certain categories of privileged and unprivileged, especially in regard to the queer community. As someone who is cisgender, I experience a great deal of privilege as I do not face judgement for my cisgender identity. I am able to move through everyday interactions without being misgendered because I experience the privilege of living according to the gender I was assigned at birth. At the same time, while I am cisgender and experience privilege from that, being a woman continues to be a gender identity that is marked with discrimination through the ongoing realities of sexism and misogyny. Further, my queerness marks me as outside the norm of a heteronormative society. However, I am married to a straight cisgender man which makes my queerness inconspicuous to many of those around me, resulting in privilege through the invisibility of my queerness and outward appearance of heteronormativity. To my surprise, this experience became a source of connection to participants in this research, who commonly expressed similar feelings about privilege in abortion spaces through the invisibility of queerness in seemingly heteronormative relationships.

My social location as a white person is one that reflects substantial privilege, especially when using the framework of reproductive justice in my research. I feel that it is a great privilege for me to use the framework of reproductive justice in my research. This framework was created from the experiences and activism of Black women who were excluded from the second wave of feminisms' reproductive rights movement by women who were white, like me. As a white

person, I have largely had the option of reproductive choice available to me, which is not reflective in the experiences of many Black, Indigenous, and other racialized people. As a researcher, I am committed to being reflexive of my privilege while centring the realities and perspectives of Black, Indigenous, and other marginalized groups, so that their voices are included and heard while we work collectively towards the vision of reproductive justice.

Lastly, as a researcher I hold a great deal of power in how I interpret participants' experiences and produce knowledge from their lived experiences. My personal perspectives and experiences shape the ways that I engage with and understand the world around me, which also impacts the ways in which I interpret the narratives of participants in this research. As a researcher, I practiced critical reflexivity while using narrative methods and a queer reproductive justice approach to ensure that power is given to the participants through the interpretation of their stories and production of knowledge from their standpoints that considers their unique knowledge, experiences, and identities.

Terminology

Medication abortion and procedural abortion are the terms used to describe the different forms of abortion care. Their use is guided by the language used by Canadian reproductive justice scholar, Dr. Martha Paynter (2025). Medication abortion uses a combination of Mifepristone and Misoprostol medications (together are called Mifegymiso) to terminate a pregnancy and is approved for use up to 10 weeks' gestation in Canada. Procedural abortion involves the insertion of instruments into the vagina and cervix by a physician to manually remove the products of conception (Paynter, 2025). Procedural abortion has no legal gestational limits in Canada but is only available up to 19 weeks and six days gestation in Manitoba (Women's Health Clinic, n.d.-b).

Following the lead of other queer researchers, the abbreviation 2SLGBTQIA+ will be used interchangeably with queer and trans to describe individuals with diverse sexual orientations and gender identities (Davidson et al., 2024). The acronym 2SLGBTQIA+ stands for Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex, and asexual, with the "+" signifying additional identities that fall under this broad spectrum. The terms queer and trans are widely used umbrella terms that capture the complexity and fluidity of gender and sexual diversity (Davidson et al., 2024). Queer is often used to encompass a range of non-heterosexual identities, including but not limited to lesbian, gay, bisexual, pansexual, and demisexual. Similarly, trans serves as an inclusive term for individuals whose gender identity differs from the gender they were assigned at birth. This includes transgender, non-binary, agender, genderqueer, gender non-conforming, and other gender-expansive identities (Lowik, 2020). Using queer and trans interchangeably with 2SLGBTQIA+ demonstrates a commitment to both specificity and inclusivity. It acknowledges the broad and evolving nature of these identities, while also recognizing that language and self-identification can vary across individuals and communities. Further, using the word *queer* acts as a reclamation of a word that was once considered derogatory and a slur to 2SLGBTQIA+ people (Davidson et al., 2024).

Lastly, this thesis will use the acronym AFAB, which stands for *assigned female at birth* (Adams & Ellithorpe, 2024). This term is commonly used to describe the gender designation that individuals were assigned by the healthcare system when they were born. It is a descriptive, rather than an identity-based term, recognizing that gender identity is distinct from the gender assigned to at birth, which is based solely on the appearance of one's genitalia.

Overview of Thesis

The following chapters of this thesis begin with a literature review, which provides a comprehensive review of the relevant literature to this research. The next chapter outlines the epistemological stance, conceptual framework, and theoretical foundations for this research, including critical theory, reproductive justice, and queer theory. The theory and conceptual framework chapter describes the queer reproductive justice approach, which guided the analysis and interpretation of the participants' narratives. Following this, the methodology chapter details the use of narrative methods, including narrative interviewing and narrative analysis, in addition to highlighting participant demographics information. Following this, begins the three findings chapters, starting with the barriers and facilitators to care experienced, then the experiences of cisheterosexism in abortion care, and lastly, a chapter broadly about queering abortion care in Manitoba. The thesis concludes with a chapter that summarizes and discusses the implications of these findings.

Literature Review

Abortion is a vital component of sexual and reproductive healthcare, yet access to inclusive and affirming abortion care remains a significant challenge for 2SLGBTQIA+ individuals (Bowler et al., 2023). Despite a growing recognition of the healthcare disparities faced by 2SLGBTQIA+ people, this demographic continues to be largely overlooked within the fields of sexual and reproductive health, and particularly within abortion care. This is in part due to the systemic influence of cisheterosexism, which perpetuates assumptions about who can become pregnant and might need access to abortion. Cisheterosexism creates additional barriers for 2SLGBTQIA+ individuals seeking abortion care, as these settings have been predominantly designed for cisgender heterosexual women (Barnett et al., 2024; Ertl et al., 2024). These often exclusive service models not only fail to address the unique needs and challenges of 2SLGBTQIA+ individuals, but they also reinforce harmful ideas about who ought to access abortion care (Wingo et al., 2018). This is the case in Manitoba, where there are gendered abortion sites and a lack of specific 2SLGBTQIA+ abortion service policies (Lowik, n.d.). Additionally, previous research in Manitoba found that 2SLGBTQIA+ people who have accessed abortion care reported longer wait times than the broader population and a sense of exclusion within abortion care settings (Cowman et al., 2026). Altogether, the previous literature and Manitoba abortion context demonstrates a need for research that provides an in-depth exploration of 2SLGBTQIA+ experiences accessing abortion care in Manitoba, Canada.

This chapter provides an overview of the existing literature, largely exploring how cisheterosexism and other systems of oppression shape the experiences of 2SLGBTQIA+ people within abortion and reproductive healthcare settings. This literature describes the ways cisheterosexism shapes normative assumptions of who seeks these forms of care, while also

shaping the barriers and challenges faced by 2SLGBTQIA+ individuals as they navigate through binarized and gendered healthcare systems. These issues are further examined through the interlocking systems of oppression, highlighting the structural violence faced by 2SLBGTQIA+ individuals in abortion and reproductive healthcare settings. The chapter closes with an exploration of the current Manitoba abortion care landscape.

Cisheterosexism & Healthcare Stereotype Threat

Cisheterosexism provides context for understanding the many health inequities that 2SLGBTQIA+ individuals experience in sexual and reproductive healthcare settings, including in abortion care settings (Ertl et al., 2024). Defined as the societal privileging of certain genders and sexualities over others, cisheterosexism marginalizes those who deviate from sexual and gender norms while privileging cisgender heterosexuality (Van Den Berg, 2024). It is impossible to separate cisheterosexism from other forms of oppression, as the overlapping patriarchal, racialized, and gender-based power dynamics reproduce cisheterosexism, prominently shaping AFAB 2SLGBTQIA+ individuals' experiences accessing sexual and reproductive healthcare (Ertl et al., 2024). Cisheterosexism manifests externally through healthcare system barriers, non-affirmative care environments, and discrimination enacted by healthcare providers, and is linked to delayed initiation of care, poorer health outcomes, and lower satisfaction with care providers (Ertl et al., 2024). Internally, cisheterosexism may take the form of internalized bias and stigma, resulting in 2SLGBTQIA+ individuals anticipating cisheterosexism in care environments.

Internalized cisheterosexism may lead to the anticipation of prejudice and stigma in sexual and reproductive healthcare settings, which is a phenomenon that been coined healthcare stereotype threat (HCST) (Ertl et al., 2024). HCST is defined as the fear and threat of being perceived negatively based on identity-related stereotypes (Ertl et al., 2024; LeBlanc et al.,

2024). HCST manifests through healthcare providers beliefs and held stereotypes of 2SLGBTQIA+ people, such as stereotypes of promiscuity among 2SLGBTQIA+ people and the idea that queer and trans people are more likely to engage in risky sexual behaviours (Jensen et al., 2023). Alternatively, healthcare providers may wrongfully assume a heterosexual or cisgender identity, leading to misgendering, invalidation, or inappropriate questions about relationships and sexual practices (Bowler et al., 2023; Wingo et al., 2018). These stereotypes have created discomfort and mistrust between 2SLGBTQIA+ communities and healthcare providers (Bowler et al., 2023). Furthermore, HCST has been found to influence 2SLGBTQIA+ health and healthcare experiences, as HCST is associated with a greater likelihood of not having a primary care provider and experiencing poorer health outcomes (LeBlanc et al., 2024).

In addition to influencing health disparities among 2SLGBTQIA+ people, HCST decreases the willingness to self-disclose one's queer or trans identity to healthcare providers (Ertl et al., 2024). 2SLGBTQIA+ people manage identity disclosure situationally to protect themselves from discrimination and bias from healthcare providers (Carpenter, 2021; Hoskin et al., 2016). A 2018 US study revealed that AFAB 2SLGBTQIA+ peoples' identity disclosure in reproductive healthcare settings can increase their vulnerability to experiencing inappropriate and irrelevant questions, discriminatory remarks, and transphobic mistreatment (Wingo et al., 2018). While non-disclosure of one's identity has short-term benefits, such as avoiding transphobia and stigma (Bowler et al., 2023), identity concealment is associated with psychological distress, a lack of appropriately tailored medical care, and decreased physical health outcomes (Bowler et al., 2023; Ertl et al., 2024).

Certain queer and trans people are particularly vulnerable to the challenges of identity disclosure in reproductive healthcare settings. For example, AFAB 2SLGBTQIA+ people who

are masculine presenting and conceal their identity in reproductive healthcare settings have been found to experience increased HCST, reduced access to care, and lower quality care (Ertl et al., 2024). Intersecting marginalized identities face exacerbated challenges. Notably, racialized 2SLGBTQIA+ people face the compounded challenge of navigating both racial and ethnic discrimination, in addition to sexual or gender discrimination in healthcare settings (Adams & Ellithorpe, 2024). For individuals whose racial identity is visibly recognizable, the risk of racism and bias is heightened, necessitating a careful assessment of whether disclosing their 2SLGBTQIA+ identity would be beneficial for their care or expose them to further and compounded discrimination (Bowler et al., 2023).

Barriers to Sexual & Reproductive Healthcare for AFAB 2SLGBTQIA+ People

While cisheteronormativity and HCST are common across various health systems, they are particularly pronounced in sexual and reproductive healthcare. Previous literature has demonstrated that 2SLGBTQIA+ individuals frequently encounter discrimination in sexual and reproductive healthcare, including homophobia and transphobia, stigma, bias, misgendering, misinformation, and provider ignorance on 2SLGBTQIA+ specific needs (Bowler et al., 2023; Ertl et al., 2024; Hoffman & Bergin, 2019; Wingo et al., 2018). These issues not only create barriers to accessing sexual and reproductive healthcare but also contribute to significant health disparities for 2SLGBTQIA+ populations (Carpenter et al., 2021; Ertl et al., 2024; Fernández-Basanta et al., 2024; Goldberg et al., 2024).

AFAB 2SLGBTQIA+ individuals have been long overlooked in the field of sexual and reproductive health as services are commonly designed for cisgender heterosexual women, resulting in systemic homophobia and transphobia (Ertl et al., 2024). Within sexual and reproductive healthcare settings, systemic homophobia and transphobia manifest through

entrenched practices, policies, and norms, which intentionally or unintentionally, marginalize AFAB 2SLGBTQIA+ individuals, while also reinforcing inequities and creating barriers to care (Bowler et al., 2023). These systemic issues go beyond individual acts of bias or prejudice and are deeply embedded in the structures and functions of healthcare systems. This impacts the appropriateness of care for 2SLGBTQIA+ populations and may be especially pronounced when they must access sexual and reproductive healthcare from a clinic with an inherently gendered name (Bowler et al., 2023; Kenner et al., 2023). AFAB 2SLGBTQIA+ people may experience systemic homophobia and transphobia due to sexual and reproductive healthcare being situated in venues named, "*Women's* [clinic, hospital, centre, etcetera]" or through needing to accessing care from clinics that do not have 2SLGBTQIA+ specific materials and knowledge (Bowler et al., 2023; Fix et al., 2020).

The systemic homophobia, transphobia, and resulting exclusion of 2SLGBTQIA+ people within sexual and reproductive healthcare settings may also indicate that healthcare providers are commonly uneducated or misinformed on 2SLGBTQIA+ people's unique needs (Ertl et al., 2024; Fernández-Basanta et al., 2024; Hoskin et al., 2016). Healthcare provider education and trainings often fail to include comprehensive information on 2SLGBTQIA+ health, leaving providers unprepared to address specific reproductive health concerns, such as the relevance of hormone therapy, fertility, contraception, and family planning in 2SLGBTQIA+ sexual and reproductive healthcare (Carpenter et al., 2020). This educational gap leads to the reliance on harmful stereotypes and misconceptions, resulting in bias, mistreatment, and discrimination, while reproducing HCST (Hoffman & Bergin, 2019). Furthermore, providers may be uninformed regarding elements of gender-affirming care, such as appropriate pronoun use and sensitive communication, which can further alienate trans patients. As a result, 2SLGBTQIA+ people

commonly experience invalidation, misinformation, and fear of judgment in sexual and reproductive healthcare settings, which discourages them from seeking care and contributes to poorer health outcomes (Bowler et al., 2023; Hoskin et al., 2016).

In a 2016 Ontario-based study, titled “Dignity versus Diagnosis,” Hoskin and colleagues interviewed people with a diversity of sexual and gender identities, asking about their experiences accessing sexual health examinations. The overarching results from this study found that the cisgender heterosexual participants were primarily concerned about their health and potential diagnoses when accessing a sexual health examination. In contrast, the 2SLGBTQIA+ participants were primarily concerned with the possibility of experiencing discriminatory interpersonal interactions during their examinations. The 2SLGBTQIA+ participants in this study reported that their primary concerns when accessing sexual health examinations included fears of prejudice, ignorance, lack of confidentiality, lack of dignity, and not having their health needs met by their healthcare provider. This study highlighted how 2SLGBTQIA+ routinely face fear of mistreatment or discrimination, which is deeply embedded in the systemic cisheterosexism of the healthcare system, leading to increased barriers to accessing care and poorer health outcomes (Hoskins et al., 2016).

AFAB 2SLGBTQIA+ people who are multiply marginalized may face additional barriers to accessing dignified sexual and reproductive healthcare, as they must navigate cisheterosexism alongside other systems of oppression. For instance, in Manitoba, AFAB 2SLGBTQIA+ who are Indigenous face systemic racism, colonialism, and gender oppression, resulting in inequities to accessing STBBI care and receiving culturally relevant care (Neumann et al., 2025). Fatphobia within reproductive healthcare settings is also a reality for AFAB 2SLGBTQIA+ people in Manitoba, resulting in feelings of stigma and poorer health outcomes (Bombak et al., 2016). As

cisheterosexism is deeply interconnected with other systems of oppression, 2SLGBTQIA+ people who belong to other marginalized communities face greater risks of experiencing compounded oppression in healthcare settings.

Framing Abortion as a 2SLGBTQIA+ Issue

Abortion and pregnancy have long been considered events that only heterosexual cisgender women experience. However, AFAB queer and trans people also experience the possibility of pregnancy, and thus they also face the possibility of seeking access to abortion care. Existing literature provides evidence that suggests queer people in the US seek abortion-related care at higher rates than their heterosexual counterparts (Adams & Ellithorpe, 2024). There are several factors that may result in AFAB 2SLGBTQIA+ individuals seeking abortion care at higher rates, including a heightened chance of pregnancy due to a lack of relevant sexual education and contraception counselling, and an increased risk of experiencing sexual violence (Bordogna et al., 2023; Carpenter et al., 2020; Charley et al., 2023; Goldberg et al., 2024; Jaffray, 2020). Further, AFAB 2SLGBTQIA+ people are at a higher risk of experiencing pregnancy complications and disparities compared to cisgender heterosexual women, including ectopic pregnancy, miscarriage, stillbirth, preterm births, and low birth weight (Adams & Ellithorpe, 2024; Goldberg et al., 2024). Higher risks of pregnancy complications among this population have been largely attributed to the intersecting vulnerabilities of AFAB 2SLGBTQIA+ people within cisheteronormative healthcare systems (Goldberg et al., 2024). Lastly, AFAB 2SLGBTQIA+ individuals may experience or conceptualize pregnancy differently than cisgender and heterosexual people due to their identity as a sexually or gender diverse person. This can result in desires to access abortion care as a way resolve feelings of dysphoria

or disconnection from oneself (Adams & Ellithorpe, 2024; Kirczenow MacDonald et al., 2020). In these ways, the accessibility and inclusiveness of abortion services is a queer and trans issue.

Heightened Chances of Pregnancy

Previous research has shown that AFAB queer and trans folks experience a heightened chance of pregnancy when compared to their heterosexual cisgender counterparts (Goldberg et al., 2024). This is in part due to the failure of sexual education and contraceptive counselling in addressing the needs of 2SLGBTQIA+ communities, and more particularly AFAB 2SLGBTQIA+ individuals (Bordogna et al., 2023; Charley et al., 2023; Goldberg et al., 2024). Sexual education is typically geared towards cisgender heterosexual individuals, often purposefully excluding specific sexual education for 2SLGBTQIA+ communities, thereby putting them at a greater risk for experiencing unintended pregnancies (Bordogna et al., 2023; Charley et al., 2023). Further, the language and framing of contraception are predominantly tailored towards cisgender heterosexual women (Fix et al., 2020), resulting in misconceptions about 2SLGBTQIA+ fertility and pregnancy (Ertl et al., 2024; Fix et al., 2020). These misconceptions have been found to disproportionately affect bisexual cisgender women and AFAB trans individuals, who report lower levels of contraceptive use due to a lack of provider knowledge and inclusive practices (Goldberg et al., 2024). Despite many AFAB 2SLGBTQIA+ people engaging in behaviours that could result in pregnancy, this demographic is commonly overlooked in contraceptive counselling, as healthcare providers fail to recognize their specific reproductive health needs (Ertl et al., 2024). This systemic oversight results in the increased chances of unintended pregnancy among AFAB 2SLGBTQIA+ individuals and the corresponding prevalence of accessing abortion care among this demographic.

2SLGBTQIA+ people also face an elevated risk of experiencing violence, which may result in unintended pregnancies (Goldberg et al., 2024; Jones et al., 2018). In particular, a US-based study with participants who had accessed an abortion care found that sexual minority women faced greater exposure to sexual violence than cisgender heterosexual women (Jones et al., 2018). This heightened vulnerability stems from misogyny and heterosexism, which are factors that directly contribute to heightened exposure to sexual violence. While abortion is not a solution to sexual violence, it is a crucial form of healthcare that grants bodily autonomy to those who experience an unintended pregnancy after sexual violence.

Heightened Risk of Pregnancy Complications

Access to abortion care encompasses access to lifesaving care which may be needed in the event of pregnancy complications, ectopic pregnancy, or miscarriage, making abortion care especially important for AFAB queer and trans folks (Goldberg et al., 2024). A mixed-methods study focusing on six AFAB non-binary parents with young children in the US following the *Dobbs v. Jackson Women's Health Organization* decision[2] found high levels of birth trauma, pregnancy loss, and pregnancy complications among LGBTQ new parents (Goldberg et al., 2024). Another US study used narrative methods to centre gestation-based stories from ten Black queer birthing people, finding that they experienced disparities in pregnancy and birthing outcomes, including a greater likelihood of miscarriage, stillbirth, preterm births, and low birth weight (Adams & Ellithorpe, 2024). Taken together, these studies point to the heightened risk of pregnancy complications experienced by AFAB 2SLGBTQIA+ people as reflective of the

[2] *Dobbs v. Jackson Women's Health Organization* (2022) is a landmark US Supreme Court decision that overturned *Roe v. Wade* (1973) and *Planned Parenthood v. Casey* (1992). This ruling declared that the US Constitution does not confer a right to abortion. This decision gave authority to state legislatures to regulate or prohibit abortion, which has effectively resulted in abortion services being limited and, in thirteen states, fully criminalized (Legal Information Institute, n.d.).

intersecting vulnerabilities of queer and trans people within dominant cisheteronormative healthcare systems that perpetuate other oppressions, including racism (Adams & Ellithorpe, 2024; Goldberg et al., 2024). These studies emphasize that the dominant oppressive systems must be dismantled to ensure equitable pregnancy outcomes for AFAB 2SLGBTQIA+ people. However, these studies also underscore the need for inclusive abortion care for queer and trans people, especially as they remain at a heightened risk of pregnancy complications.

Abortion as Gender-Affirming Care

Access to abortion is a component of essential healthcare that guarantees the full range of human rights, including bodily autonomy, which is especially crucial for trans folks, as abortion can be considered a form of gender-affirming care (Barnett et al., 2024; Goldberg et al., 2024). Gender-affirming care is a widely recognized medical intervention that can range from hormone treatments to affirming language (Barnett et al., 2024). Gender-affirming care has been found to increase social, emotional, and physical health outcomes among trans, non-binary, and gender expansive individuals. Accessible abortion care has been deemed an important form of gender-affirming care by the World Professional Association for Transgender Health (Barnett et al., 2024), as abortion care supports individuals to exercise autonomy over their bodies through aligning their reproductive choices with their gender identities. However, abortion is not widely acknowledged as a form of gender-affirming care due to the binary assumptions of who can experience pregnancy, which can create significant barriers for trans people seeking abortion care (Hoffman & Bergin, 2019).

Normative societal expectations of reproduction associate pregnancy with femininity, wherein maternity and motherhood are a measure of traditional feminine success (Doyle, 2009; Fernández-Basanta et al., 2024). Pregnancy, then, commonly becomes entrenched in feminine

and cisheteronormative ideals where women are the ultimate cultural representations of childbearing figures (Doyle, 2009). These norms overlook the experiences of trans folks, while simultaneously disenfranchising them from the experience of pregnancy. As pregnancy is commonly associated with femininity, trans individuals may experience feelings of distress, isolation, and gender dysphoria (Fernández-Basanta et al., 2024; Kirczenow-MacDonald et al., 2020).

Gender dysphoria may also arise from the physical changes associated with the process of pregnancy (Fernández-Basanta et al., 2024). Pregnancy results in numerous physical changes, in which the body becomes more feminized through muscle loss, increased fat reserves, softening of the voice, and breast growth. A 2024 meta-ethnography examining 10 qualitative studies focused on transgender men's experiences of conception, pregnancy, and childbirth, found that the pregnancy-related breast growth was the physical attribute most commonly resulting in gender dysphoria among transmaculine people. Pregnancy-related breast growth was associated with feeling sick, self-loathing of one's own appearance, and extreme discomfort (Fernández-Basanta et al., 2024).

Another challenge faced by pregnant trans individuals is stopping hormone therapy if they choose to continue a pregnancy. While not all trans people undergo hormone therapy, many do seek hormone therapy as part of the transition process and as a form of gender-affirming care (Unger, 2016). Stopping hormone therapy further results in physical changes and a loss of masculinization (Fernández-Basanta et al., 2024). Being able to access a desired abortion enables trans people to maintain their hormone therapy, avoiding the physical changes associated with pregnancy. Overall, reframing abortion as a queer and trans matter enables service providers to envision the many gender-affirming reasons one might access care.

Abortion as Gender Transgression

Another way of understanding abortion is as a queerly disruptive act that stands outside the "natural" order of sexual reproduction (Doyle, 2009). Abortion is an act of refusing parenthood and thereby subverts the very gendered and heteronormative expectations of womanhood (Ertl et al., 2024; Price et al., 2020). AFAB individuals are generally positioned as "naturally" bound more closely to motherhood, reproduction, and domesticity (Doyle, 2009). Gendered norms and expectations reinforce heteronormative paradigms that position women to carry the burden of childbearing and rearing. This frames abortive bodies as disruptive, as they reject these expectations by freeing themselves from the socially constructed femininized tasks of reproduction. In this way, the abortive woman is framed as queer, as she challenges and steps outside the norms and expectations of what it means to be a woman (Doyle, 2009).

Not only is the abortive body disruptive, but it is a form of gender transgression. By rejecting the feminine expectations of childrearing and motherhood, the abortive body goes against gender norms and may be considered the "wrong" way of doing gender (Ertl et al., 2024; Thomsen & Morrison, 2020). Approaching abortion as a form of gender transgression enables the recognition of the deeper connections between 2SLGBTQIA+ and reproductive issues. Reproductive issues, specifically abortion, are often discussed within a heteronormative universe, wherein making a family is represented as simply a matter of the *right time* for the *right choice* (Doyle, 2009). This discourse neglects many queer and trans experiences of family planning, while reinforcing cisheteronormativity within abortion discourse. Further, this cisheteronormative universe reinforces gendered norms that moralize pregnancy and heteronormativity as "good" or "natural," while simultaneously constructing abortion and queerness to be disruptive or even criminal (Doyle, 2009; Price et al., 2020). Freeing the body

from the task of reproduction, while also freeing the body from the constraints of cisheteronormative expectations, are acts of liberation that challenge the deeply entrenched norms tethering femininity and morality to reproduction. Challenging these norms allows for a reframing of abortion as a means of resistance, not only for women eschewing socio-cultural expeditions of motherhood, but also for 2SLGBTQIA+ people, as it enables them to navigate and reject imposed reproductive expectations (Thomsen & Morrison, 2020). Altogether, AFAB queer and trans people may seek abortion care as a means of affirming their gender identity, resisting societal norms around reproduction, and challenging the expectations of cisheteronormativity.

2SLGBTQIA+ Experiences Accessing Abortion Care

Previous literature exploring AFAB 2SLGBTQIA+ experiences of accessing abortion care is extremely limited, despite the fact that 2SLGBTQIA+ people are just as likely, or more than likely, to experience an abortion in their lifetime when compared to cisgender and heterosexual counterparts (Bowler et al., 2023). AFAB 2SLGBTQIA+ people face significant barriers to accessing abortion, which can lead to disparities in health outcomes (Hoffman & Bergin, 2019), have a negative impact on their wellbeing, and may lead some to seek unsafe abortion methods instead of accessing professional care (Bowler et al., 2023). Previous literature demonstrates the barriers 2SLGBTQIA+ folks face when accessing abortion care include isolation, exclusion, misgendering, lack of provider knowledge, and in-clinic stigmatization (Barnett et al., 2024; Bowler et al., 2023), in addition to the general abortion access barriers faced by many, which include transportation, abortion stigma, and insurance coverage (Barnett et al., 2024; Bowler et al., 2023; Hoffman & Bergin, 2019). The barriers that 2SLGBTQIA+ people face when seeking abortion care are further reflected through the infrastructure of abortion clinics, including the use of binary language, intake forms, decorations, and a lack of

2SLGBTQIA+ resources (Bowler et al., 2023; Carpenter et al., 2020; Fernández-Basanta et al., 2024; Moseson et al., 2021; Wingo et al., 2018).

Binary & Gendered Systems

The experience of gender dysphoria may also be a result of the current binarized systems of abortion and reproductive healthcare that are highly feminized and discriminatory towards 2SLGBTQIA+ people (Fernández-Basanta et al., 2024; Kirczenow-MacDonald et al., 2020). Abortion and reproductive healthcare settings often lack acknowledgement of the many trans, non-binary, and gender expansive people who use their services, and in this way fail to be gender-affirming through rigidly gendered clinics geared towards women that results in exclusionary spaces (Barnett et al., 2024; Fix et al., 2020). Entering an exclusively women-centred environment as a trans individual may result in experiences of inappropriate and intrusive behaviours, harassment, incitement to hatred, as well as legal, health, psychological, and physical violence (Fernández-Basanta et al., 2024).

The gendering of abortion clinics is further exacerbated by the misinformation and lack of adequate training and education of healthcare staff regarding trans healthcare needs (Barnett et al., 2024; Bowler et al., 2023; Fernández-Basanta et al., 2024; Fix et al., 2020). Further, healthcare providers may feel uncomfortable providing care to transgender populations, shaping disparities for trans, non-binary, and gender expansive people in healthcare settings (Fernández-Basanta et al., 2024). While many healthcare providers remain uninformed on trans needs in healthcare spaces, all reproductive healthcare providers see gender expansive patients whether they realize it or not (Barnett et al., 2024). Proper training and education are essential to address these gaps and ensure that reproductive healthcare is inclusive and affirming for trans, non-binary, and gender-expansive individuals (Barnett et al., 2024). Implementing comprehensive

gender-affirming practices has been suggested to help dismantle the rigidly gendered structures within abortion care spaces and foster environments where trans, non-binary, and gender expansive patients feel safe, respected, and supported (Bowler et al., 2023).

Gender-affirming and inclusive healthcare settings are essential for providing abortion care that not only meets the needs of AFAB trans folks, but also to overcome generations of healthcare mistrust within 2SLGBTQIA+ communities (Bowler et al., 2023). Previous literature suggests that best practices for abortion clinics is the adoption of gender inclusive intake forms, providing gender-affirming materials and resources to patients, increase privacy in clinics, display more inclusive decorations throughout their space, and use gender-affirming language (Bowler et al., 2023; Fernández-Basanta et al., 2024; Kenner et al., 2023; Moseson et al., 2021; Wingo et al., 2018). Gender-affirming language may include asking about a patient's preferred language when referencing their body parts (Bowler et al., 2023). For example, trans patients may prefer the term "opening" rather than vagina. Particularly as trans patients report a sense of fracture between their sex and gender when accessing sexual health services through the exposure of their genitals to medical professionals (Hoskin et al., 2016), asking for the individual's preference of terminology is imperative. Additionally, rather than using gender neutral language, asking for one's preference can be more affirming to ones' identity, and can help mitigate feelings of gender dysphoria within abortion care settings (Bowler et al., 2023; Hoskin et al., 2016).

The most prominent suggestion in the literature for creating gender-affirming abortion care spaces is comprehensive training for service providers on how to deliver gender-inclusive and affirming abortion care (Barnett et al., 2024; Bowler et al., 2023; Ertl et al., 2024; Fernández-Basanta et al., 2024; Fix et al., 2020; Hoffman & Bergin, 2019; Kenner et al., 2023;

Moseson et al., 2021; Wingo et al., 2018). Only through such training can abortion clinics truly transform into non-binarized spaces that are affirming and supportive of AFAB 2SLGBTQIA+ people and communities.

Interlocking Systems of Oppression & Structural Violence

The barriers to abortion care that 2SLGBTQIA+ people face are compounded by other identity factors, such as race (Bowler et al., 2023). Adams & Ellithorpe's (2024) US study found that Black sexual and gender-diverse people experience compounding forms of oppression, including racism, sexism, heterosexism, homophobia, and transphobia, when accessing abortion care. Similarly, Black birthing people's birth preferences have been found to be the least likely to be listened to by health providers when compared to other racial or ethnic groups (Sakala et al., 2018), in addition to both Black and queer birthing people experiencing disparities in pregnancy and birthing outcomes (Artiga et al., 2022; Everett et al., 2019). Further, Adams & Ellithorpe (2024) note how Black queer persons who access abortion care may experience compounding forms of shame due to the stigma surrounding their identity and the abortion procedure itself. Multiple participants in Adams & Ellithorpe's study reported feelings of disconnection between themselves and their body post-abortion. These feelings of disconnection are under-researched and silenced through the shame and stigma experienced by Black queer persons who have accessed abortion care. These compounded barriers not only hinder access to abortion care but also contribute to a broader sense of isolation, stigma, and disempowerment within racialized 2SLGBTQIA+ communities (Adams & Ellithorpe, 2024).

The many interlocking systems of oppression, including heteronormativity, cisnormativity, patriarchy, and white supremacy, create and perpetuate structural violence against 2SLGBTQIA+ people in all aspects of their lives. Structural violence refers to systemic,

institutionalized harm that is embedded in social, political, and economic structures, which disproportionately marginalize certain groups by restricting their access to essential rights and resources (Galtung, 1969). Oftentimes, structural violence goes unnoticed in everyday practices and interactions, as it is ingrained in the way a societal system functions. In the context of abortion access, structural violence plays a significant role in 2SLGBTQIA+ peoples experiences accessing abortion care, as anti-abortion rhetoric is closely tied to anti-2SLGBTQIA+ discourse. Anti-abortion and anti-2SLGBTQIA+ discourses are both a part of a broader anti-feminist ideology that emphasizes the traditional nuclear family and traditional gender roles (Goldberg et al., 2024) in favour of heteronormativity, cisnormativity, and patriarchy.

Furthermore, regions where abortion care is restricted or inaccessible are also often regions where there are prevalent anti-2SLGBTQIA+ policies (Goldberg et al., 2024). Anti-abortion and anti-2SLGBTQIA+ policies function as interconnected forms of structural violence, disproportionately harming AFAB 2SLGBTQIA+ individuals who must navigate both systems simultaneously. These structural inequities compound within existing cisheteronormative barriers in reproductive healthcare, further marginalizing queer and trans individuals who seek abortion care. The stigma, exclusion, and discrimination faced by 2SLGBTQIA+ people in reproductive healthcare settings (Bowler et al., 2023; Ertl et al., 2024; Hoffman & Bergin, 2019; Wingo et al., 2018) are not just isolated experiences but are reinforced by the broader political landscape that weaponizes both reproductive control and cisheteronormativity. The accumulation of these barriers may further disenfranchise 2SLGBTQIA+ people, making abortion access even more precarious within a structurally violent system.

2SLGBTQIA+ Abortion Care in Manitoba

In Manitoba, abortion clinics are highly gendered, as the main abortion clinics in the province are named "HSC Winnipeg *Women's* Hospital" and "*Women's* Health Clinic." These names symbolize a tailoring of services towards cisgender heterosexual women, resulting in the potential exclusion of 2SLGBTQIA+ individuals from these spaces through institutionalized cisheterosexism. Moreso, the websites and online resources for these clinics where patients access information about Manitoban abortion services are commonly entrenched in cisheterosexism. For example, the HSC Winnipeg Women's Hospital website uses the gendered language of "women who are pregnant" and does not clearly state any 2SLGBTQIA+ policies on their website (Health Sciences Centre, n.d.). The Women's Health Clinic uses gender neutral language of "pregnant persons" and states that they are inclusive of 2SLGBTQIA+ people, however, the images plastered across every page of their website are of cisgender feminine-presenting individuals (Women's Health Clinic, n.d.-b).

Another distinction of 2SLGBTQIA+ abortion care in Manitoba is the lack of specific trans-inclusive policies for abortion services. Dr. A.J. Lowik, a Canadian researcher, has created trans-inclusive abortion service manuals for every province in Canada, except for Manitoba (Lowik, n.d.). Their website states that they "have yet to find an agency or organization in Manitoba interested and available to adapt this manual for use," (Lowik, n.d.) despite having reached out to three community organizations and clinics, which were well-positioned to champion the creation of a Manitoba-specific adaption (A. J. Lowik, personal communication, February 23, 2025). The lack of trans-inclusive policies further binarizes the current state of abortion care in Manitoba.

A recent mixed-methods study, *Abortion in Manitoba: An overview of care,* explored the general experiences of accessing abortion care in Manitoba (Cowman et al., 2026). The study found that abortion access is experienced as deeply uneven across the province, as information about abortion is hidden or confusing, travelling to access care is a common experience, and interpersonal treatment from abortion providers is not always supportive. Further, participants from the *Abortion in Manitoba* project highlighted pervasive abortion stigma in the province, from family or friends, healthcare providers, and anti-abortion groups, resulting in fears about the security of reproductive rights in Manitoba. The study had two specific findings related to 2SLGBTQIA+ people in Manitoba, reporting that 2SLGBTQIA+ participants were more likely to experience longer wait times and face a sense of exclusion within abortion spaces (Cowman et al., 2026). This study demonstrates further need to understand the unique experiences of 2SLGBTQIA+ abortion seekers in Manitoba.

The gap in 2SLGBTQIA+-specific abortion research and policies in Manitoba raises questions concerning how 2SLGBTQIA+ people access and experience abortion care in Manitoba, signally a need for further research and attention. The absence of specific 2SLGBTQIA+ inclusive guidelines, combined with the gendered language and imagery at existing clinics, likely shapes barriers to accessible and affirming care for AFAB 2SLGBTQIA+ people in Manitoba. The lack of any evidence of Manitoba-specific 2SLGBTQIA+ abortion service guidelines further emphasize the need for targeted, inclusive policies to ensure that 2SLGBTQIA+ individuals are not excluded from necessary reproductive healthcare services. This research sought to fill these gaps by centring the narratives and lived experiences of 2SLGBTQIA+ people who have accessed abortion care in Manitoba to document barriers and

facilitators to care, and ultimately advance the inclusion and affirmation of AFAB 2SLGBTQIA+ people in Manitoba's abortion settings.

Theory & Conceptual Framework

This chapter outlines the key frameworks that guided this research, including critical theory, the reproductive justice conceptual framework, and queer theory. Critical theory, with its emphasis on power, social structures, and the production of inequality, epistemologically grounds this research by challenging dominant ideologies and highlighting how systems of oppression, such as patriarchy, racism, and colonialism, shape reproductive experiences. The reproductive justice conceptual framework provides a structural analysis of reproductive experiences and oppression by centring the voices of marginalized communities. Queer theory offers a critical lens to interrogate normative assumptions about gender, sexuality, and reproductive autonomy. By integrating the approaches of reproductive justice and queer theory, this research seeks to explore both the systemic barriers and the lived realities of 2SLGBTQIA+ individuals, highlighting the ways in which reproductive policies and practices reinforce or resist cisheteronormativity.

Critical Theory – Epistemology

This study is epistemologically grounded in critical theory, which posits that reality is not objective or singular, but, instead, is comprised of multiple, subjective realities that are shaped by social, political and cultural values (Creswell & Creswell, 2018). These realities are influenced by broader structures of power and inequality, meaning that knowledge itself is neither neutral nor universally applicable. Instead, knowledge is situated within particular historical and social contexts, contingent upon the dominant ideologies and discourses of a given time (Creswell & Creswell, 2018).

Furthermore, critical theory contends that because knowledge is socially constructed, it is often reflective of the perspectives and interests of those in power (Creswell & Creswell, 2018).

Dominant groups within society hold the ability to define what is considered legitimate knowledge and to control its dissemination through institutions such as academia, the media, and political systems. This reinforces existing power dynamics by privileging certain ways of knowing while marginalizing others. However, critical theory does not merely critique these systems, it also emphasizes the importance of resistance and transformation. Critical theory seeks to challenge dominant narratives by amplifying the voices and experiences of those who have been historically excluded from knowledge production. Through this lens, knowledge is not only a product of power, but also a potential tool for social change. By recognizing the ways in which knowledge is shaped by structures of oppression, critical theory seeks to create a more inclusive and socially just approach to knowledge production through the validation and legitimization of the lived experiences of marginalized communities (Creswell & Creswell, 2018).

As a core tenet of critical theory is its emphasis on the role of social structures in shaping knowledge production, this perspective aligns closely with the reproductive justice framework. Reproductive justice centres the lived experiences of marginalized communities, particularly those whose reproductive autonomy has historically been restricted. Further, reproductive justice critiques the dominant knowledge systems that prioritize the narrow, normative understandings of reproductive rights that erase the realities of racialized, queer, trans, and disabled individuals. Further, feminist standpoint theory, a theoretical foundation of the reproductive justice framework, aligns closely with critical theory through the assertion that knowledge is constructed from specific social positions, as individuals' lived experiences influence how they understand the world (Hekman, 1997).

Similarly, queer theory challenges dominant knowledge systems by deconstructing normative assumptions about gender, sexuality, and identity, revealing how these categories are

socially constructed and maintained through systems of power. Queer theory, like critical theory, resists fixed or universal truths, instead emphasizing fluidity, multiplicity, and the ways in which knowledge is shaped by social and political forces (Butler, 2007; Gamson, 1995). Together, critical theory, queer theory, and the reproductive justice conceptual framework offer some intersecting critiques of dominant power structures through challenging the assumption of an objective, value-free knowledge system. These approaches argue that knowledge is inherently situated, shaped by social location, embedded in relations of power, and produced and maintained through systems such as patriarchy, white supremacy, capitalism, and cisheteronormativity (Butler, 2007; Creswell & Creswell, 2018; Gamson, 1995; Harding, 1995; Hekman, 1997; Ross & Solinger, 2017).

Reproductive Justice Conceptual Framework

Reproductive justice is the conceptual framework and normative call-to-action that helped guide this research. Rooted in the activism of Black feminists in the US, reproductive justice moves analytic focus beyond abortion rights to encompass a broader vision of reproductive autonomy, health, and dignity. This framework integrates social justice and reproductive rights to explore how social, economic, and political factors shape individuals' ability to make informed choices about their bodies, families, and futures (Ross & Solinger, 2017). Intersectionality, (Black) feminist standpoint theory, and human rights conceptually ground reproductive justice, and guide the central question of how reproductive choice and autonomy are shaped by various systems of oppression. Altogether, reproductive justice is particularly well suited to guide this research, as this framework provides the conceptual tools to examine and address the systemic inequities that disproportionately impact marginalized communities, including the 2SLGBTQIA+ community.

Background

The reproductive justice movement was formed through the activism of Black women in the 1990s, after a long history of reproductive degradations, who spoke out against white-feminist pro-choice frameworks that excluded Black and other marginalized people. However, Black women and other women of colour have been fighting for reproductive justice long before the framework was even created. The 1977 Combahee River Collective's statement by Black feminists, such as Barbara Smith, Demita Frazier, and Beverly Smith, was deeply influential as it provided a theoretical foundational to examine the multifaceted and interconnected identities that constrain reproductive autonomy. These ideas were brought to the 1994 International Conference on Population and Development, which marked the coining and introduction of the reproductive justice conceptual framework to the international level by a group of women who named themselves Women of African Descent for Reproductive Justice.[3] A few years later, in 1997, a national multi-ethnic reproductive justice group was formed, named SisterSong.

Centring on the principles that everyone has the right to have children, not have children, and parent children in safe and health environments, the founders of reproductive justice pushed their analysis beyond a narrow focus on *choice* or the *right* to an abortion. Considering the many systemic factors that impact and restrict choice, proponents of reproductive justice centre the voices and realities of Black and other marginalized women and trans people. In this way, reproductive justice emphasizes that accessing abortion care and other forms of reproductive healthcare is more complex than the legality of the procedure. Reproductive justice underscores that abortion is not the only right that needs to be fought for, but also the rights to have children

[3] The original group of women who coined the term reproductive justice are Toni M. Bond Leonard, Reverend Alma Crawford, Evelyn S. Field, Terri James, Bisola Marignay, Cassandra McConnell, Cynthia Newbille, Loretta Ross, Elizabeth Terry, 'Able' Mable Thomas, Winnette P. Willis, and Kim Youngblood.

and raise them in safe and sustainable communities (Asian Communities for Reproductive Justice, 2009; Ross & Solinger, 2017).

The mission of reproductive justice, as stated by Asian Communities for Reproductive Justice (2009), is

> the complete physical, mental, spiritual, political, economic, and social well-being of women and girls [and AFAB folks] and will be achieved when women and girls [and AFAB folks] have the economic, social, and political power and resources to make healthy decisions about our bodies, sexuality, and reproduction for ourselves, our families, and our communities in all areas of our lives. (p.1)

In working towards these goals, reproductive justice mobilizes storytelling as a way for individuals to share their experiences and realities. In doing so, reproductive justice integrates feminist standpoint theory to ground the expertise of individuals in their own lives, intersectionality to examine unique social positions, and human rights theories to acknowledge normative claims (Ross & Solinger, 2017).

Feminist Standpoint Theory

One of the theoretical foundations conceptually grounding the reproductive justice framework is feminist standpoint theory, which examines how an individual's standpoint shapes their experiences, realities, and understanding of the world (Hekman, 1997). Feminist standpoint theory grounds reproductive justice by recognizing the significance of diverse standpoints and affirming that individuals are the best authorities on their own experiences and needs. Moreover, feminist standpoint theory emphasizes storytelling as a vital way to amplify marginalized voices, allowing those who are often silenced or left out of conversations to share their perspectives. Using feminist standpoint theory and storytelling are core aspects of reproductive justice, as

unified movements are created through the amplification of marginalized voices and the collective weaving together of stories (Ross & Solinger, 2017).

Feminist standpoint theory emerged during the second wave of feminism. The idea was first theorized by Nancy Hartsock in her 1983 publication, "Money, Sex, and Power," as an attempt to provide a methodological grounding that validates feminist claims and perspectives (Hekman, 1997). Drawing inspiration from Marxism, which aligns with the claims broadly articulated in critical theory, Hartsock asserted that women's unique standpoint in society provides the justification for the claims made by feminism, wherein women's standpoint can be a method to analyze the realities they experience (Hekman, 1997). Other feminist scholars, including Sandra Harding and Patricia Hill Collins, worked to further conceptualize this theory, making feminist standpoint a staple of feminist theory.

Harding (1995) specifically coined feminist standpoint theory through developing and expanding the concept to address issues of knowledge, power, and social location. Feminist standpoint theory recognizes that those who are unprivileged or oppressed, with respect to their social positions, are likely to be privileged with gaining knowledge of social reality (Harding, 1995; Rolin, 2009). In this way, feminist standpoint theory argues that those who are oppressed are positioned to have a clearer, or less distorted, picture of reality as they are outside of, or marginalized to, the dominant narrative, and therefore are considerably less invested in maintaining dominant narratives (Harding, 1995). Additionally, the knowledge of, awareness of, and sensitivity to both the dominant worldview of society and one's own reality is necessary for subordinate persons survival (Swigonski, 1994). For instance, the oppression of queer folks in society allows for them to perceive two worlds: the world of the oppressor and the world of the oppressed. This allows for queer folks to recognize the reality of homophobia, through an

understanding of the privileging of heteronormativity, while at the same time experiencing oppression and surviving under these heteronormative structures. Feminist standpoint theory engages with these unprivileged social positions as they are likely to generate perspectives that are less partial and less distorted, therefore constructing narratives that reflect relations of power and resistance to oppression (Harding, 1995; Rolin, 2009).

Collins (2000) drew inspiration from feminist standpoint theorists, while also recognizing the absence of Black women in feminist thought and the implications that intersectionality could have on the theory. Thus, Collins (2000) coined Black feminist standpoint theory, which considers the specialized knowledge produced from the standpoints of Black women (Hekman, 1997). Black feminist standpoint theory recognizes the intersecting hierarchies of race, gender, and class that Black women experience, and how these intersections create specific knowledges that have routinely been distorted within or excluded from what counts as knowledge (Collins, 2000). Collins' (2000) Black feminist standpoint has been incredibly influential to shaping feminist standpoint theory and its place within reproductive justice as it examines how these intersecting hierarchies shape the realities and experiences of Black women, individually and collectively, regarding the topic of reproduction and beyond.

Intersectionality

Another theoretical foundation conceptually grounding reproductive justice is intersectionality. Intersectionality recognizes that individuals experience multiple and overlapping forms of oppression that shape their realities. Coined by Kimberlé Crenshaw (1991), intersectionality examines how race, gender, sexuality, ability, class, and other social locations interact to create unique experiences of marginalization. Within the reproductive justice conceptual framework, intersectionality reveals how reproductive oppression is compounded for

those who exist at the intersections of multiple marginalized identities. For example, 2SLGBTQIA+ individuals seeking reproductive healthcare often navigate barriers related to both their gender and sexual identities, in addition to systemic healthcare discrimination (Bowler et al., 2023; Hoskin et al., 2016). Trans individuals may often encounter structural exclusions in reproductive care, where medical institutions fail to provide gender-affirming services (Bowler et al., 2023). These experiences may be further compounded by other systems of oppression, including racism, classism, or fatphobia, among others.

By integrating intersectionality, reproductive justice acknowledges that experiences of reproductive autonomy and oppression are unequal. Intersectionality is used to challenge the mainstream feminist and reproductive rights movements which have historically centered the experiences of white, cisgender, middle-class women while neglecting the diverse reproductive needs of racialized, queer, disabled, and low-income communities (Crenshaw, 1991). An intersectional approach within the reproductive justice framework strives to inform policy interventions, healthcare services, and advocacy efforts to be inclusive, equitable, and responsive to the specific needs of all individuals (Ross & Solinger, 2017).

Human Rights

A third foundation of the reproductive justice framework is human rights, which provides the normative calls-to-action that are oriented towards addressing oppression. The reproductive justice framework utilizes the concept of human rights to foreground the rights that all people possess in virtue of being human. In doing so, the foundation of human rights extends beyond a focus on a solely legal approach to reproductive rights. A human rights approach provides the basis for structural changes that enable all individuals to fully exercise their reproductive rights in ways that are meaningful and accessible to them (Ross & Solinger, 2017). The key human

rights principles that are foundational to reproductive justice include the right to bodily autonomy, the right to access healthcare without discrimination, and the right to parent and raise children in safe and supportive environments. These reproductive rights are enshrined in international human rights organizations such as the Universal Declaration of Human Rights (1948), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979), and the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966). Despite the global commitments to uplifting reproductive rights, systemic inequalities continue to restrict the ability of marginalized populations to exercise these rights fully.

Reproductive justice also applies a human rights framework to examine how governments and institutions fail to uphold these fundamental rights for all individuals (Ross & Solinger, 2017). The framework asserts that reproductive rights cannot just be legal entitlements, rather they require the social, economic, and political conditions that enable individuals to truly exercise autonomy over their bodies and lives. In this way, reproductive justice expands the conversation beyond formal legal protections, advocating for policies and practices that dismantle structural barriers and actively redistribute power and resources. Grounding itself in human rights, reproductive justice provides conceptual tools to envision a world where all individuals, regardless of race, gender identity, class, or ability, can make informed reproductive choices free from coercion, stigma, and discrimination.

By integrating human rights, intersectionality, and feminist standpoint theory, reproductive justice provides a transformative framework that moves beyond individual choice to address the many systemic inequities that shape reproductive experiences. The reproductive justice framework is foundational for this research, as it guides towards an analysis of

reproductive issues through a lens that centres the voices of participants, considers the personal as political, and ultimately pursues social justice and positive change.

Queer Theory

This research engaged with queer theory alongside reproductive justice, as queer theory offers a critical foundation for challenging the dominant cisheteronormative narratives of reproduction. By integrating these approaches in this research, I sought to deepen the analysis of how 2SLGBTQIA+ people's reproductive autonomy can be constrained by normative assumptions about gender, sexuality, and family. Queer theory is a way of thinking that dismantles traditional assumptions about gender and sexual identities through emphasizing the fluid and humanly performed nature of sexualities and gender (Hicks & Jeyasingham, 2016). By moving beyond simple identity politics, queer theory seeks to understand logics of heteronormativity and how society, culture, and institutions are constructed by this heteronormativity (Butler, 2007; Gamson, 1995).

Queer theory originated in the late 1980s through several academic conferences (Gamson, 1995), in which Teresa de Lauretis institutionalized queer theory into academia throughout multiple presentations and publications (Ryan & Naples, 2020). Other notable scholars who significantly shaped queer theory as it is known today are Michel Foucault, Eve Kosofsky Sedgwick, and Judith Butler. While queer theory's theoretical roots are found in a variety of fields, its strongest roots are in the humanities, with theoretical origins in postructuralism, social constructionism, gay and lesbian studies, philosophy, and critical theory (Ryan & Naples, 2020).

Some of the arguments central to queer theory originated from Foucault (1978), who argued that sexuality is a concept resulting from powerful knowledge systems, which constantly

shape and renew identities. Through these dynamics of power, the identities of homosexuality and heterosexuality become distinct and morally charged features of western culture's binary thinking. In this way, heterosexuality is positioned as the norm, while queer identities are positioned as different or "othered." These categorizations have long maintained rigid social norms that depict homosexuality as immoral, excessive, or in need of regulation (Hicks & Jeyasingham, 2016). However, queer theorists argue that *queer* is much more than a label, rather it is an approach that challenges the conventional views of gender and sexuality. Butler (2007) suggested that heterosexuality only appears as natural through the heteronormative language that has shaped societal norms. Further, Butler (2007) suggested that gender identity is not inherent, rather it is performative. Butler asserted that gender is made up of repeated social acts that create the illusion of a stable identity, often using drag as an example to expose the performative nature of gender. Butler (2007) presented the act of drag as an example that helps to reinterpret gender as a parody and an act, rather than a natural state of being (Butler, 2007).

In these ways, queer theory provides a critical lens to dismantle the essentialist assumptions that underpin traditional understandings of gender, sexuality, and reproduction. By emphasizing the fluid, constructed, and performative nature of these categories (Hicks & Jeyasingham, 2016), queer theory challenges the normative assumptions that position abortion as deviant or disruptive. From a queer theoretical perspective, the abortive body resists being confined to cisheteronormative scripts, which prioritize reproduction as a moral, natural, and expected aspect of femininity (Doyle, 2009). This resistance positions abortion as a radical act that queers dominant narratives and sexuality by refusing the assumption that AFAB bodies must fulfill reproductive roles. Through the lens of queer theory, abortion becomes not only an act of gender transgression (Thomsen & Morrison, 2020), but a destabilizing force revealing the

fragility of the norms that construct heteropatriarchy. Queer theory opens pathways to understand abortion as an experience that aligns with broader queer struggles for autonomy, self-determination, and the rejection of binary constructions of identity. This perspective reframes queerness and abortion as not only disruptions to reproductive expectations but also as reclamations of agency that unsettle the very categories of "womanhood" and "family" as fixed, natural, or universal (Doyle, 2009).

A Queer Reproductive Justice Approach

Reproductive justice and queer politics are deeply interconnected. Access to abortion services is a critical concern for many queer and trans people, but the overlap extends far beyond abortion (Price et al., 2020). The reproductive justice framework recognizes that reproduction is not an isolated experience, rather it intersects with broader social justice issues including racism, classism, homophobia, transphobia, and colonialism (Price et al., 2020; Ross & Solinger, 2017). As AFAB queer and trans people face numerous reproductive injustices, including disenfranchisement from reproductive healthcare, higher rates of pregnancy complications (Adams & Ellithorpe, 2024; Goldberg et al., 2024), and numerous barriers to accessing abortion care (Barnett et al., 2024; Bowler et al., 2023; Hoffman & Bergin, 2019), 2SLGBTQIA+ issues are inherently reproductive justice issues.

Reproductive justice and 2SLGBTQIA+ rights movements are grounded in the principles of autonomy, respect, human right to health, and desire for social change (Price, 2018; Price et al., 2020). Additionally, both movements have shared histories of oppression rooted in social control over marginalized bodies. Coercive laws, public policies, and medical practices, including eugenics, have targeted both women and queer communities. Furthermore, queer and trans folks have historically been deemed mentally ill, as homosexuality was classified as a

mental illness in the DSM and gender dysphoria continues to be classified as a "disorder" in the DSM to this day (Drescher, 2020). Historically, queer and trans people were forcibly treated with electric shock treatments, lobotomies, hysterectomies, clitoridectomies, vasectomies, and conversion therapies in hopes to "cure" them or prevent them from reproducing and passing on their queerness. These shared histories and ongoing struggles reveal how reproductive justice and queer issues intersect through bodily autonomy, sexual identity development, family formation, safe shelter, pregnancy, contraception, abortion, and sexual pleasure (Price et al., 2020). Queer reproductive justice is the freedom to live a truly liberated life that is free from the oppressive systems of the gender binary, heterosexism, transphobia, and racism.

Presently, in 2026, 2SLGBTQIA+ rights and reproductive justice are intimately connected through the mutual attacks on abortion access and queer or trans identities and bodies (Bond-Theriault, 2024). Abortion rights and 2SLGBTQIA+ rights are frequently depicted alongside one another in the media and continue to be two of the most divisive topics in North American politics (Bond-Theriault, 2024). A queer reproductive justice approach to this research allows for an exploration of how interlocking systems of oppression link abortion rights with 2SLGBTQIA+ rights. As a guiding framework, this prompts the following questions as central to analysis:

1. *How does cisheteronormativity and other systems of oppression (social, political, and economic) shape 2SLGBTQIA+ experiences accessing abortion care?*
2. *How do these systems of oppressions shape the right to dignified abortion care for 2SLGBTQIA+ people?*
3. *How do 2SLGBTQIA+ people narrate their experiences of accessing abortion care? How do they politicize and resist cisheteronormativity and other systems of oppression?*

Ultimately, the integration of queer theory into reproductive justice in this research seeks to identify, challenge, and resist the systems of oppression that shape AFAB 2SLGBTQIA+ peoples' experiences of accessing abortion care in Manitoba.

Tensions Between Queer Theory and Reproductive Justice

While this research integrates queer theory and reproductive justice as a guiding approach to this research, it is important to note the tensions between queer theory and reproductive justice, as they are grounded in differing feminist schools of thought. Queer theory stems from poststructuralist thought, which rejects notions of social categories as stable, objective truths, and instead emphasizes that identities such as gender and sexuality are socially constructed and continually produced through discourse and power relations (Butler, 2007; Weedon, 1997). Queer theory often seeks to destabilize identity categories altogether, questioning the political and analytical reliance on fixed labels. In contrast, reproductive justice is grounded in intersectional feminist frameworks that explicitly center social categories as crucial for understanding systems of oppression (Crenshaw, 1989; Collins, 2000). Within reproductive justice scholarship and activism, these social categories are not rejected, rather they are mobilized as essential tools for identifying structural inequalities related to reproductive oppression and advocating for reproductive rights, bodily autonomy, and family formation within marginalized communities (Ross & Solinger, 2017).

These differing theoretical orientations create tensions in how queer theory and reproductive justice conceptualize identity and power. While queer theory seeks to deconstruct or move beyond identity categories, reproductive justice relies on these categories to reveal inequities and mobilize collective political action. As a result, the two frameworks can diverge in their approaches to language, politics, and research methodologies. For instance, while narrative

methods are commonly employed within reproductive justice research to centre the lived experiences of marginalized communities and illuminate how structural inequalities shape reproductive lives, queer theory often approaches methodology differently. Rather than prioritizing narrative accounts as evidence of stable identity categories, queer theoretical approaches tend to focus on deconstructing the discourses and norms that produce and regulate sexuality, gender, and reproduction. As a result, queer methodologies frequently emphasize methods of textual analysis or discourse analysis as a way to critique normative knowledge production. While reproductive justice often prioritizes documenting experiences of inequity through identity-based narratives, queer theory interrogates the very categories and norms through which those experiences are made intelligible.

When brought together, however, these approaches may be used in a complementary way, wherein a queer reproductive justice approach employs narrative methods to illuminate material realities, while also critically engaging with and disrupting the assumptions that are embedded within dominant narratives of reproduction, family, and gender. This approach has been previously utilized by several scholars including Candace Bond-Theriault (2024) in *Queering Reproductive Justice,* where a queer reproductive justice approach was utilized to relate 2SLGBTQIA+ movements to reproductive justice movements. Tamara Lea Spira (2025) also utilized a queer reproductive justice approach in *Queering Families* to examine and challenge the normative model of family. Other scholars have used similar approaches to examine assisted reproductive technologies (Smietana et al., 2018; Tam, 2021) or to construct and analyze various forms of activism (Price, 2018; Price et al., 2020; Thomsen & Morrison, 2020). From the works of these scholars, the shared commonality is that a queer reproductive justice approach requires the questioning of cisheteronormativity and the normality of

reproduction, orienting towards a disruption of normative social categories in the pursuit of reproductive justice.

Queer Reproductive Justice in Social Work Research

The reproductive justice conceptual framework is well-suited to guide social work research, as the core ethics of social work include social justice, dignity, and self-determination, aligning with the core principles of reproductive justice (Canadian Association of Social Workers, 2022; Ross & Solinger, 2016). Social work research strives to advance fairness and social justice, including advancing equitable reproductive healthcare access for all individuals, regardless of their race, gender, sexuality, economic status, or abilities (Canadian Association of Social Workers, 2022). Through challenging and addressing forms of oppression through a social justice and human rights lens (Shaw, 2019), reproductive justice is well-suited to be a guiding framework for social work research.

At the same time, queer theory offers critical insights that can strengthen social work research. Through destabilizing rigid identity categories and questioning dominant narratives of reproduction and family, queer theory can help expand how social work conceptualizes reproductive experiences, family, and provide support for 2SLGBTQIA+ people and communities. Integrating queer theory with reproductive justice in social work research thus allows attention to the structural inequalities emphasizes within reproductive justice, while also critically examining the normative assumptions that shape the experiences of 2SLGBTQIA+ reproductive experiences. For the discipline of social work, this combined approach encourages more inclusive and reflexive approaches to studying reproductive experiences, ensuring that research does not reproduce knowledge rooted in cisheteronormative assumptions, while remaining committed to transformative social change.

Methodology

Guided by a queer reproductive justice approach, this research utilized qualitative narrative methods to explore the lived experiences of seven AFAB 2SLGBTQIA+ people who have accessed abortion care in Manitoba. Narrative interviews were used to hear the stories of participants in their own terms and in ways that reflect meaning-making. Their interviews were analyzed using narrative analysis alongside policy and resource mapping, which situated individual accounts within broader systemic and institutional contexts. Additionally, engagement with Elders through the Women's Health Clinic Kokums Circle was central to interpreting and writing about the narratives of Indigenous participants in a culturally relevant and good way.

Narrative approaches, including narrative inquiry, narrative interviewing, and narrative thematic analysis, are in clear alignment with the research questions and theories that guide this project as they centre stories as the main form of knowledge production (Clandinin, 2006).These methods are grounded in feminist standpoint theory, attending to how knowledge is shaped by social location and privileges the authority of those who are most directly impacted by systems of power and oppression. Overall, this methodological approach enabled an in-depth, story-centred analysis of abortion experiences within a queer reproductive justice approach.

Narrative Methods

A narrative inquiry approach was determined to be best suited as the primary research design because of its focus on understanding lived experiences through storytelling. Narrative inquiry is a design that is particularly well-suited for research that seeks to explore how individuals construct and convey meaning through their personal narratives. Grounded in qualitative methodology, with roots in realist, modernist, postmodern, and constructionist stands, this approach recognizes that people make sense of their lives by telling stories, which are

shaped by social, cultural, and political contexts (Clandinin, 2006). It is a relational way of producing knowledge, as stories link people to one another and help create meaning (Shaw, 2017).

Narrative inquiry emphasizes the temporal, relational, and contextual dimensions of experience (Shaw, 2017). It considers how stories unfold over time, how they are influenced by interactions with others, and how they are embedded within broader social structures. This approach acknowledges that narratives are not mere recollections of events but are actively constructed, with meaning emerging in the process of telling and retelling stories. A key feature of narrative inquiry is its collaborative nature, wherein the researcher and participant engage in a co-constructive process in which stories are shared, interpreted, and sometimes even reshaped through dialogue (Clandinin, 2006; Clandinin & Connelly, 2000). Clandinin & Connelly (2000) emphasize the collaborative nature of narrative inquiry through defining this methodology as,

> …a way of understanding experience. It is collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus. An inquirer enters this matric in the midst and progresses in the same spirit, concluding the inquiry still in the midst of living and telling, reliving and retelling, the stories of the experiences that made up people's lives, both individual and social (p. 2).

In this way, the reflexive role of myself as the researcher is essential, as my positionality inevitably influenced how narratives were elicited, interpreted, and presented (Shaw, 2017). As narrative inquiry is a collaborative approach to generating knowledge that is inherently relational, engaging in continuous reflexivity was essential for me, as the researcher, to consider how personal, social, and political contexts shaped my engagement with the participants, data, and analysis (Shaw, 2017).

Furthermore, data collection in narrative inquiry often involves in-depth interviews, personal narratives, and life histories, allowing participants to express their experiences in their own words and on their own terms. A narrative inquiry approach informed the use of narrative interviewing (Anderson & Kirkpatrick, 2016) and narrative thematic analysis (Riessman, 2008).

Narrative Interviewing

Anderson and Kirkpatrick's (2016) narrative interview method was used to place participants at the heart of the study through prioritizing their personal stories and lived experiences. Narrative interviews inform the use of asking broad questions which allowed participants to control the direction, content, and pace of the interview. Rather than imposing a rigid agenda, the narrative interviews provided an opportunity for the participants to share what they felt was most important to their story (Anderson & Kirkpatrick, 2016). The stories that were shared in the narrative interviews were an effective way for the narrator to explain, in their own voice, the social context and social structures in which they exist (Hill & Burrows, 2017).

While narrative interviewing enabled participants to guide the direction of the interviews, myself, as the researcher, did impose some structure through the selection of the topic, the ordering of the questions, and the wording of the questions (Jovchelovitch et al., 2000). The loose structure of the interview was carefully created with consideration to how these structural elements may affect the direction of the narratives being shared by participants. Each interview began with the open-ended question *"Can you tell me about your story of accessing abortion care?,"* which allowed participants to take the interview in their desired direction, before being prompted with follow-up questions.

The narrative interviewing method is divided into four distinct phases (Anderson & Kirkpatrick, 2016; Jovchelovitch et al., 2000). Firstly, is the introduction phase, which involved

a brief explanation of the project, what the interview process would be like, and ensuring informed consent from the participant. Next is the narrative phase, wherein the participant shared their story with me. I engaged in active listening, while avoiding disrupting the narrative and allowing the participant to share until they reached the coda – which is determined by a pause or silence from the interviewee. Once the participant finished sharing their story, the questioning phase begun. In this phase, I followed a semi-structured interview guide to ask follow-up questions relevant to the participants' story [Appendix F]. Lastly, the conclusion phase marks the end of the interview. I explained the next steps of the research process, such as that the interviews would be transcribed and analyzed, then offered a summary of key findings to be sent to the participant if they were interested in receiving the findings (Anderson & Kirkpatrick, 2016; Jovchelovitch et al., 2000).

Narrative Methods, Social Work Research, & Queer Reproductive Justice

Despite narrative inquiry stemming from, and still heavily rooted in, the educational fields, narrative inquiry is a particularly well-suited research methodology for social work research, as stories are central to the social work profession (Shaw, 2017). Through the ontological, epistemological, and methodological commitments of narrative inquiry, social workers can conduct qualitative research that is inherently relational and contextual while engaging with diverse narratives, aligning this approach with social work practice and values (Shaw, 2017; Riessman & Quinney, 2005). Through this relational epistemological and methodological process, narrative inquiry is well-suited to guide community-based social justice work through centring the lived experiences of marginalized populations (Shaw, 2017; Staller, 2011).

Beyond being applicable to social work research, a narrative inquiry approach is also well aligned with the reproductive justice framework, particularly feminist standpoint theory, through the emphasis on storytelling as a form of knowledge production which can produce social change (Beck et al., 2024; Clandinin, 2006; Price, 2010; Ross & Solinger, 2017). Within reproductive justice, storytelling is not only a means of documenting individual and collective experiences, but also a tool to challenge dominant narratives that marginalize or erase the reproductive lives, in this case, of those who exist outside of cisheteronormative frameworks (Beck et al., 2024; Ross & Solinger, 2017).

Further, feminist standpoint theory asserts that knowledge is situated and shaped by lived experiences, with marginalized folk having immense knowledge (Price, 2010). Narrative methods align with this epistemological stance by prioritizing the voices of those most affected by systemic inequities, recognizing their insights as forms of expertise. Using storytelling, participants can articulate nuanced understandings of the context in which they exist, which provides clear alignment between the method and theory within this study (Clandinin, 2006). Through the prioritization of narratives, this approach resists the traditional hierarchies of knowledge production by valuing experiential knowledge as cardinal. Using narrative inquiry as the methodology for this research, guided by a queer reproductive justice approach, works to disrupt dominant discourses that often render invisible the reproductive experiences of AFAB 2SLGBTQIA+ people. This enables a deeper, more contextually grounded understanding of the issue at hand, while also affirming storytelling as a form of resistance and empowerment (Beck et al., 2024; Clandinin, 2006; Price, 2010; Ross & Solinger, 2017).

By adopting a narrative methods approach, this study sought to centre the voices of 2SLGBTQIA+ individuals and highlight the complexities of their abortion care experiences. This

methodological approach facilitated a nuanced exploration of both personal meaning-making and the broader socio-political forces that shape access to abortion care in Manitoba. On an individual level, narrative methods were used to capture the emotional, psychological, and relational dimensions of abortion experiences, acknowledging how identity, community, and personal histories shaped the narrative. While, at the same time, narrative methods situated these stories within the structural conditions that impact abortion access, such as healthcare policies, accessibility, and social stigma (Bowler et al., 2023).

Project Launch & Recruitment

As part of the research ethics application process, project materials were prepared, and an Indigenous advisory committee was established.[4] On July 21, 2025, this project received ethics approval from the University of Manitoba Research Ethics Board – Fort Garry [Appendix A]. Once ethical approval was granted, recruitment efforts began.

To be eligible to participate in the study, participants had to self-identify as 2SLGBTQIA+, accessed or attempted to access abortion care in Manitoba within the past five years, and were at least 18 years of age at the time of the interview. This study used convenience sampling to recruit participants through the use of recruitment posters and social media posts [Appendix B] that were shared with relevant 2SLGBTQIA+, sexual health, or reproductive health community organizations across Manitoba [Appendix C]. Community organizations, including the Women's Health Clinic, Rainbow Resource Centre, the Sexuality Education Resource Centre, Klinic Community Health, Nine Circles Community Health, Two-Spirit Manitoba, and Sunshine House were contacted via email invitations that included an explanation of the research study, and a request to distribute a recruitment poster in-person or via social

[4] See *Ethical Considerations* later in this chapter on page 59.

media [Appendix D]. Research networks, including the Centre for Human Rights Research, Village Lab, and Repro Justice Research Manitoba, were also invited to distribute recruitment materials. All recruitment material included an email address provided for interested participants to communicate questions or their interest in participating in an interview.

Data Collection Procedures

Semi-structured narrative interviews were conducted with 7 participants who self-identified as 2SLGBTQIA+, accessed or attempted to access abortion care in Manitoba within the past five years, and were 18 years or older at the time of the interview. Participants who replied to the shared recruitment materials were be contacted by me to confirm their interest in participating. Once their interest was confirmed, the participant and I scheduled the interview, and the participant received the consent form [Appendix E] for their review. The interviews were conducted via the UM Zoom video-conferencing platform.

Prior to beginning the interview, I reviewed the consent form with the participant, then asked for their verbal consent to participate and be audio-video recorded. After consent was given, I sent the participant a $40 honorarium via e-transfer and verbally confirmed that the honorarium was received. Once the pre-interview process was complete, I asked if the participant had any questions or if they were ready to begin the interview. When the participant said they were ready, the audio-video recording began. The interviews began by asking the participant demographic questions to clarify their gender and sexual identities, in addition to other relevant demographic factors. This was followed by an open-ended question, which prompted the participant to share their story of accessing abortion care in Manitoba as a 2SLGBTQIA+ person. After the participant shared their narrative, reaching the coda, I followed-up with prompting or clarifying questions as identified in the interview guide [Appendix F].

Before ending the interview, the participant was asked if they had anything left to say or add before the audio-video recording was turned off.

Each interview finished with a debrief, where I thanked the interviewee for their participation in the interview, reminded them of the support resources that were available to them, as listed on the consent form, and asked if they would like to receive a summary of the key findings from the project once they were complete. Participants were also offered the opportunity to review their transcript once it was completed. Those who requested to review their transcript were contacted via email [Appendix G] and provided a secure OneDrive link to their transcript, where they had two weeks to review and request revisions.

Demographics

Seven participants between the ages of 26-35 years old were interviewed. Five of these participants resided in Winnipeg at the time of the interview and two were located in Thompson. Participants accessed care from a variety of sites, including the Women's Health Clinic (WHC), Health Sciences Centre (HSC), and St. Boniface Hospital in Winnipeg, in addition to The Pas, and Thompson.

Participants had a variety of gender identities; three identified as cisgender women, two non-binary, one non-binary and Two-Spirit, and one described themselves as "cis-ish." Additionally, five participants described themselves as bisexual, one as queer, and one identified as queer, pansexual, and polyamorous.

Four participants identified themselves as Métis and the other three identified themselves as white. Three participants described themselves as disabled, which included ADHD, an autoimmune disorder, and generalized anxiety disorder (GAD) with complex post-traumatic stress disorder (C-PTSD). Only one participant had a child, and two participants were single, two

were dating, one was engaged, one married, and one common law. Participants had an income range of $20,000 to $200,000 annually and were all Canadian citizens.

Analysis

This study employed Riessman's (2008) narrative thematic analysis method, which is a qualitative approach that centres stories as the primary unit of analysis. Narrative thematic analysis provides insight into how individuals construct and interpret their experiences through storytelling, emphasizing both the structure and the meaning embedded within their narratives. Riessman's (2008) narrative thematic analysis method enables a nuanced, contextually grounded understanding of participants' experiences, ensuring that their voices and perspectives remain central throughout the research process.

The key narrative components identified by Riessman (2008) – abstract, orientation, complication, evaluation, resolution, and coda – served as analytical building blocks for analyzing participants' stories. The abstract provides a brief summary or introduction to the narrative, setting the stage for what follows. The *orientation* offers background details, such as time, place, and characters, which help to situate the narrative within a specific context. The *complication* introduces the central problem or conflict within the story, which often drives the narrative forward. The *evaluation* reflects on the significance of the events, allowing the narrator to convey emotions, perspectives, or interpretations. The *resolution* describes how the conflict or issue is addressed or resolved, while the *coda* serves as a closing remark, linking the narrative back to the present or providing a broader reflection. By analyzing these components, this study sought to uncover how participants constructed meaning within their narratives (Riessman, 2008)

The analytic process began with developing familiarity with the narratives through repeated engagement with the data. Initial narrative codes were generated, capturing significant

elements of participants' experiences. Both within-case and between-case analyses were conducted. Within-case analyses examined each individual narrative in depth, while between-case analyses identified commonalities across all narratives. This dual approach ensured that individual experiences were preserved, while also allowing for the identification of broader themes (Riessman, 2008).

The thematic development followed an iterative process, incorporating discussions with the Dr. Lindsay Larios and Elder Louise McKay to refine and validate emerging themes. This collaborative approach ensures analytical rigor and enhances the credibility of the findings (Riessman, 2008). NVivo qualitative software was utilized throughout the analysis to facilitate coding, pattern recognition, and thematic organization. Using this software, narrative data was systematically analyzed to identify meaning-based patterns that centred participants lived experiences.

Riessman's (2008) approach is distinct from other qualitative methods as it prioritizes the story rather than isolated thematic fragments. This story-centric approach enables a deeper understanding of how participants construct meaning within their specific social and cultural contexts. Close attention will be paid to the relationship between the interviewee and the context of their story. Riessman's (2008) model also highlights that narratives are inherently ambiguous and incomplete representations of people's experiences. Researchers are invisibly involved in framing the narrative as they conduct the interview and perform the analysis. Thus, the researcher is encouraged to focus on the events as they are narrated, how the story is structured, and the meanings ascribed by the narrator. Further, the researcher must assume a reflexive stance, acknowledging their role in shaping the interpretation of the narratives (Anderson & Kirkpatrick, 2016; Riessman, 2008).

In addition to narrative thematic analysis, policy and resource mapping was conducted to provide a contextual foundation for participants' narratives. This mapping helped situate individual experiences within the broader structural landscape, offering insight into how the relevant policies and available resources shaped 2SLGBTQIA+ experiences accessing abortion care. The goal of integrating policy and resource mapping alongside narrative thematic analysis was to deepen knowledge of the contexts in which participants sought and accessed care. This guided a more contextually aware analysis and interpretation of the narratives, as it considered the many policy factors that may constrain or facilitate access to abortion care. This included mapping the policies and resources explicitly discussed by participants, in addition to policies and resources that were relevant to the different barriers or facilitators experienced by participants. Ultimately, by utilizing a narrative thematic analysis (Riessman, 2008) and policy and resource mapping, this study sought to provide a comprehensive examination of both the personal and structural dimensions that shaped the lived experiences and broader 2SLGBTQIA+ reproductive justice in Manitoba.

Ethical Considerations

This research recieved ethical approval from the Human Research Ethics Board at the Fort Garry Campus of the University of Manitoba [Appendix A]. Given the nature of the study, all identifying information was kept confidential, using a code log to keep track of participants' contact information [Appendix H]. Additionally, access to the raw data has been restricted to the researcher and their supervisor (Dr. Larios). Participants were provided a consent form that was reviewed before the interview with the researcher, where key ethical and confidentiality concerns were addressed. Additionally, a debrief with the researcher following the interview took place,

where appropriate resources were highlighted to the participant to access if feelings of discomfort or emotional distress arise.

This research also engaged with the Kokums Circle from the Women's Health Clinic to ensure that the analysis of participants narratives and corresponding findings were respectful and culturally relevant [Appendix I]. In July 2025, the researcher and their supervisor (Dr. Larios) met with Elders Margaret Lavallee and Louise McKay from the Kokums Circle to discuss the project and offer tobacco as a request for their involvement, which was graciously accepted. Once the data was analyzed, the researcher met with Elder Louise McKay to talk about the findings and receive guidance on how to portray the stories of Indigenous participants in a good way. Engaging with the Kokums Circle Elders was an integral part of this projects' ethical protocol and obligation to hear and share the stories of Indigenous participants, as it guided the findings to be respectful, relevant, and grounded in the effects and ongoing realities of colonialism.

Presentation of Findings

The findings are broken into three chapters, including, *Barriers and Facilitators to Accessing Abortion, Cisheterosexism in Abortion Care,* and *Queering Abortion Care in Manitoba*. The *Barriers and Facilitators to Accessing Abortion* chapter examines the significant access factors experienced by participants when seeking care, while mapping relevant policies alongside the narratives. The second findings chapter, *Cisheterosexism in Abortion*, uses participant narratives to discuss the ways in which cisheterosexism manifests in abortion settings, how participants comply with cisheteronormativity, and how cisheterosexism is sometimes resisted. The findings conclude with the *Queering Abortion Care in Manitoba*

chapter, which reimagines abortion care as sex positive, gender-affirming, decolonial, and resisting the normative scripts of family and reproduction.

Barriers & Facilitators to Accessing Abortion

This chapter presents an examination of the barriers and facilitators to abortion care in Manitoba that were experienced by 2SLGBTQIA+ participants, while highlighting the contexts in which care was accessed through the use of policy and resource mapping. The identified barriers and facilitators to care are not solely faced by 2SLGBTQIA+ people, but they are reflective of the previously documented barriers to care in Manitoba and across Canada (Cowman et al., 2026; Monchalin et al., 2023), However, this chapter approaches these barriers and facilitators with particular attention to how they are experienced by queer and trans abortion seekers through a queer reproductive justice lens. Drawing on participant narratives, this chapter aims to illuminate how individuals navigate abortion care systems, considering how infrastructural, interpersonal, and systemic dynamics shape these experiences. In doing so, this chapter addresses the first research question by centring participants lived experiences of accessing abortion care, highlighting the many logistical and relational dimensions of their care journeys. The notable barriers to care experienced included geography, interpersonal barriers, and infrastructural constraints, while facilitators to care were supportive friends, family, partners, and healthcare providers. Through narrative accounts, this chapter demonstrates the diversity and complexity of these experiences, including moments of affirmation as well as marginalization. Overall, this chapter serves as a foundational component of this thesis, as it documents known challenges while also providing insight into how these barriers and facilitators are specifically experienced by 2SLGBTQIA+ people.

Geographical Barriers to Care

In Manitoba, abortion care is primarily available in the southern large urban centres, Brandon and Winnipeg. While the 2019 introduction and coverage of medication abortion under Manitoba Health has expanded availability, especially for the nearly 40% of Manitobans who live outside of urban-centres (Kelly et al., 2021), geography remains a significant barrier to accessing care in Manitoba. One-third of respondents to a Manitoba-based abortion survey reported needing to travel outside of their home community in order to access abortion care (Cowman et al., 2026).

As someone who resides in Northern Manitoba, Leith (she/they) experienced geographical barriers to care. Leith identified as a Two-Spirit, non-binary, queer, pansexual and polyamorous person. While medication abortion was covered by Manitoba Health at the time Leith sought care, there was no medication abortion provider in Thompson. The nearest provider to Leith was located in The Pas, a five-hour drive away.[5] Leith narrated this experience, illustrating the stress, anxiety, and anger they felt. Leith said,

> I wanted to access Mifegymiso - or like the abortion pills - which I contacted the [Northern Health Region], because originally I was just going to go to Winnipeg and just have a surgical abortion. But I was like wait a second, Mifegymiso - like the abortion pill - is available and it's legal so I should legally be able to access this medicine here. So, I had contacted the walk-in clinic here to confirm that I could access it and I was told, 'Yes, yes, come down.' So, you know, with abortion it's such a time sensitive thing, and also the fact that I [initially] wanted to keep this baby and that I was being forced into this situation, where I was fighting for something I didn't [initially] want to do. It was

[5] The Pas is 387km from Thompson. If Leith required access to procedural abortion care, they would have to travel to Winnipeg. Winnipeg is 761km from Thompson.

> heartbreaking, every moment. I just wanted to have an abortion, mourn, and be over with it, be able to take care of stuff. Anyway, I contacted the clinic [and] they said, 'Yes, come down.' When I got there, then it became, 'No, you can't actually get it here. But there is a doctor out of The Pas who is willing to prescribe it.' 'Cause that was the main thing, is that there was no prescribing doctors or healthcare professionals in Thompson, and they weren't offering like telehealth or any sort of virtual stuff. So, I was obviously pissed. I was really mad.

Leith ultimately travelled to The Pas to visit the medication abortion provider and access a prescription. However, once they had the prescription, Leith learned that no pharmacies in The Pas stocked Mifegymiso. This resulted in Leith having to travel back home and ask a pharmacy in Thompson to order Mifegymiso so that she could fill her prescription. These circumstances prolonged the wait to take the medication abortion pills, which was frustrating and anxiety-inducing for Leith.

Leith's travel and accommodations to access the Mifegymiso prescription was paid for out-of-pocket, which is, unfortunately, not a unique experience. A Manitoba study found that 77% of those who have travelled outside their home community to access abortion care paid for the costs of travel and accommodations out-of-pocket (Cowman et al., 2026). Recently, the Northern Health Region (NHR) (which includes Thompson and The Pas) implemented improved policies and procedures for those residing in the NHR to access medication abortion care. This includes the facilitation of medication abortion through increased prescribers and a rapid access abortion program (Northern Health Region, n.d.), wherein abortion prescriptions can be facilitated through The Pas clinic remotely, so that those without a nearby Mifegymiso prescriber can access care.

The NHR also facilitates the Northern Patient Transportation Program (NPTP), which is a program that provides coverage for transportation and accommodation costs incurred by those who reside in the NHR and require travel to access medical care, including abortion care (Northern Health Region, n.d.). Despite the operation of this program, abortion-seekers in the NHR who have utilized this program previously reported that it did not cover all their travel or accommodation expenses (Cowman et al., 2026). Others eligible for the NPTP reported that they did not know of their eligibility, or that they did not want to apply due to extra paperwork, and fear of stigma or judgement. While Leith paid out-of-pocket, the NHR eventually did offer some reimbursement for their travel and accommodations. However, Leith decided not to pursue this due to fear of judgement in the reimbursement process. Leith expressed,

> I had to pay out-of-pocket. That being said, I think that they were going to reimburse some of it, but I honestly didn't have the capacity to deal with these judgments. It's a small town, so the feeling of like, *okay everybody clearly knows what I'm already going in for and they can already see the things*. And because I'm very sensitive already to, like, what people might be thinking - even though I have no idea - but my own perceptions and assumptions and stuff, I didn't pursue any reimbursement or anything.

A couple years later, Lily (she/her), a bisexual woman, benefitted from the recent policies improving access to medication abortion in the NHR, facilitating her experience of straightforward access to care. Located in Thompson, Lily did not have to travel out of her community to access care, as she was able to do so through the NHR's rapid access abortion program. The rapid access abortion program facilitates coordination between the medication abortion provider in The Pas and healthcare providers in Thompson, so that medication abortion can be accessed without travelling to The Pas. Lily shared,

> I either contacted the Thompson clinic, or if you go onto the NHR website it shows abortion information on there. There's only a care provider in The Pas, so I contacted their secretary, or whatever, their admin, and said, 'I need a medication abortion, I'm in Thompson, what do I do?' They sent me to Thompson clinic, and I got a bundle of like diagnostics, like bloodwork and things to get done. And then it all started from there, and I think that it started on the Thursday - when I found out. And I had my ultrasound by that Saturday, so it was confirmed that I was four weeks pregnant. And then, that following week, I had everything [done]. I had gone to see the nurse practitioner at the clinic, who was the facilitator at the clinic in Thompson, who works with the [medication abortion prescriber] in The Pas. She got everything organized with me. […] I was able to take the medication at home.

Despite Lily's relative ease of accessing medication abortion in Thompson, she recognized that if she needed access to a procedural abortion, she would have faced significant geographical barriers to care. Lily described,

> I went in there knowing what I wanted, I didn't go in there asking for surgical abortion. I think that it might have been mentioned, but I was not really looking for that info because it was early and they knew. But in Thompson, they don't provide elective surgical abortions. You have to go down to the city [Winnipeg] to have that done. So, there is that barrier, that if you are unable to do that at home, if you don't have the ability to do it on your own, there's that barrier to get down to Winnipeg to have a surgical abortion.

Lily named the many barriers to travelling for abortion care that are experienced by others located in the NHR, saying "needing to have access to a vehicle, gas money, hotel money, food money […] there are so many barriers." Lily further reflected on how there are geographical

barriers to care within the city of Thompson itself, as healthcare facilities and pharmacies are spread apart, making it challenging to access for those who do not have a reliable vehicle. She shared,

> … even in Thompson alone, you go to the clinic and you get your blood requisition. Okay, but now you have to find a way to get to the hospital. And bus services here aren't reliable, so now you have to get a ride, and that's another barrier. And then you have to go back again when they call you for that ultrasound, and then you have to find your own way to get [there]. So, I think that's a huge thing, because I think that could be a huge thing that stops somebody. Cause there's all this jumping around town to do. And if you if you already have kids, if you don't have childcare, if you can't get time off work, it just creates so many barriers that it could be what stops somebody from fully accessing it, right?

Lily continued to discuss how going from one place to another can be a barrier for queer and trans abortion seekers specifically, explaining that each facility is going to be different in their sensitivity and treatment of the 2SLGBTQIA+ community Lily expressed,

> It's a huge challenge going into the hospital around people who are just working with the general public, and they're not being sensitive to what you're experiencing. Especially like, I can't imagine how much more emotionally taxing [it would be] to be a queer, trans person and trying to hold your identity and hold space for who you are, and then not feeling that the facilities, the health providers are also like aware and sensitive to that.

Lily highlighted the persistent stigma of 2SLGBTQIA+ people within healthcare settings in Thompson and other Northern communities in Manitoba. She attributed this to be a geographical barrier in itself, as the dominant culture of the region reflects traditional conservative views

toward sexuality and reproductive care that often silence discussions on abortion and 2SLGBTQIA+ identities. Leith (she/they) also noted this, as she described how the dominant culture in the NHR can perpetuate stigma and create undignified conditions in which herself and other 2SLGBTQIA+ people access reproductive healthcare,

> We still don't have abortion, surgical abortion available in Thompson. A huge reason why I have chosen not to have children is because I do not feel safe accessing reproductive care in the North. I wouldn't want to be cared for by an anti-choice person. I've had other really horrible experiences with other people when it comes to like my reproductive [healthcare]. And so, the thought of anybody touching me, and you know, all of that, just there's a lot of bad, bad stuff in my region. So, I definitely don't feel safe to access any kind of reproductive or sexual health services in Thompson. And then for the larger 2SLGBTQIA+ population in Manitoba, […] like masculine people - I cannot imagine a trans man having an easy time accessing abortion in Thompson. It would be very much a gamble of who are you going to get.

There are attempts at combatting the noted persistent abortion stigma in Northern Manitoba. Grassroots abortion care support and advocacy groups in Northern Manitoba, such as Northern Manitoba Abortion Support, provide support for those who have accessed abortion care in the North (Northern Manitoba Abortion Support, n.d.), and the Northern Reproductive Justice Network, is a diverse network of advocates working to improve and support abortion care in the North. These grassroots networks work hard, despite limited capacities, to support Northern abortion seekers, including 2SLGBTQIA+ abortion seekers, and improve their overall experiences of accessing care.

Jordan (she/they), a bisexual non-binary person, who resides in Winnipeg noted how geographic barriers persist for those located outside of Winnipeg. Despite being able to access care in their home community, Jordan was aware of the many geographical disparities faced by those not in Winnipeg, specifically regarding healthcare access or receiving support and dignified care as a 2SLGBTQIA+ person. Jordan expressed,

> I feel like, you know, [my reproductive justice] also has to do with the fact that I'm here, I'm in the city, versus I'm outside the city, I'm in Steinbach, I'm in Brandon, or even our Northern communities - they have no access to any healthcare. My friend is a high school teacher as well and he teaches Northern youths that fly in from these communities, and they live on campus, and they can't express their gender identity at home. They can't access healthcare at home. So, they don't have any of these options that I have, which is scary for them.

Jordan's awareness of geographic disparities are also reflected in findings from the *Abortion in Manitoba* study (Cowman et al., 2026), where abortion seekers from across Manitoba recognized that abortion access is a significant issue in rural and remote regions of the province. Geographic barriers to abortion care are well documented and known by people in Manitoba, often discussed as one of the most significant barriers to care.

Through a queer reproductive justice lens, participants' narratives reveal that geography operates as both a physical barrier and as a site where multiple systems of oppression converge to shape access to abortion care as a 2SLGBTQIA+ person. Social, political, and economic inequities, such as uneven healthcare distribution, underfunding, and having to pay out-of-pocket to travel for care, structure who can access care, how, and under what conditions. These structural inequities are further compounded by social dynamics such as stigma, surveillance,

and the marginalization of 2SLGBTQIA+ identities within smaller communities. These intersecting oppressions fundamentally shape the conditions under which 2SLGBTQIA+ people can exercise their right to dignified abortion care. Dignity in this context extends beyond the legal availability of services to include geographical access, privacy, and freedom from judgment. As illustrated in Leith's narrative, the inability to access care locally, combined with the fear of community scrutiny and institutional judgment, constrained their ability to seek reimbursement and fully utilize available supports. Geography not only acted as a barrier and cost to care for Leith but also shaped the ways in which Leith interacted with the healthcare system to access abortion while engaging in self-preservation. In this way, geography operates as a social field that regulates belonging and exclusion, particularly for those whose identities disrupt the cisheteronormativity of abortion care itself.

Further, the connections participants made between geographical barriers, abortion stigma, homophobia, and transphobia is particularly revealing. While geographical barriers pertaining to distance, travel, time off work, childcare, and financial burdens have been well documented within the abortion and reproductive justice literature (Cartwright et al., 2018; Heller et al., 2016; Sethna & Doull, 2013), there is less focus on how geography can govern regional social or cultural barriers to care (Engle, 2022). "Abortion access and politics [are] shaped by and shape geography" (Engle, 2022, 8), thus an examination of the geographical barriers to abortion care must consider regional reproductions of abortion and 2SLGBTQIA+ stigma. Particularly in Northern Manitoba, where Lily, Leith, and Jordan highlighted how the dominant culture leans towards traditional conservative values that actively perpetuate the stigma surrounding abortion and 2SLGBTQIA+ identities. As participants noted that these attitudes can influence how care is accessed, they reveal that geographical barriers extend beyond physical

distance to include the social and cultural landscapes of place, which can intensify stigma and constrain access in distinct and localized ways. Thus, through a queer reproductive justice approach, geographical barriers are not only infrastructural concerns but are also constructed and reproduced through the dominant social norms of a particular region.

Interpersonal Barriers to Care

Interpersonal barriers to accessing abortion care were prevalent in many participants' narratives, aligning with challenges previously documented in Canadian abortion access literature (Cowman et al., 2026; Monchalin et al., 2023). Interpersonal barriers manifested in a number of ways throughout the narratives, including through anti-abortion protestors, stigma from family or friends, abusive intimate relationships, and interpersonal exchanges with healthcare practitioners.

In 2025, Manitoba implemented the Safe Access to Abortion Services Act, which protects access to abortion services by prohibiting protests, demonstrations, and picketing within specified buffer zones to protect providers and patients against harassment and intimidation (Government of Manitoba, 2025b). This includes a buffer zone of at least 50 metres around facilities that provide abortion services and around the homes of those who work in these facilities (CBC, 2025). Katie (she/her), a bisexual woman, accessed abortion care prior to the implementation of this policy and encountered anti-abortion protestors outside the hospital that she accessed care from. She discussed how witnessing this on the way to her abortion appointment felt, saying,

> … I remember when I went to the hospital there were people protesting outside at the time. I didn't get caught in it luckily enough, but I did see it as I was passing by and that

> was a nightmare to even experience. To see [the protest] happen and all the little pictures they were showing […] I was like, *okay I can't do this, I need somewhere private to go*.

In addition to harassment from strangers, Katie (she/her) endured emotional and psychological abuse from her partner at the time for wanting to access abortion care. Katie shared,

> …there was a lot of backlash with my ex-partner at the time. […] There was a lot of verbal abuse, mental abuse about it. I was called a baby killer at one point, and now I'm okay. It was a lot. And at the time I didn't really know how to defend myself, but it didn't make me feel a certain way. 'Cause I knew at the time it was the choice I had to make. And so, it was a lot of pretty heavy backlash from my ex at the time.

In Manitoba, and across Canada, no partner consent is required to access abortion care (Government of Canada, 2024), and many abortion providers will ask questions about the possibility of coercion or abuse. If an abortion-seeker is experiencing coercion or abuse, there are a number of gender-based violence resources in Manitoba that they will be connected to, including a 24-hour provincial gender-based violence crisis line (Government of Manitoba, n.d.). Katie was not referred to any gender-based violence resources during her abortion process, underscoring a potential gap in support, although she ultimately asserted autonomy by accessing care without influence from her ex-partner.

The fear of experiencing coercion and anti-abortion rhetoric was a barrier also faced by Jordan (she/they), a bisexual non-binary person, who was living with her anti-abortion in-laws at the time of her pregnancy. Jordan described having to keep the abortion a secret from their in-laws due to fears of being coerced into keeping the pregnancy or, at the very least, having her in-laws telling everyone they accessed abortion care. Jordan shared,

> I think the main reason that I didn't want to tell them is because I feel like I would have been pressured by them to keep the pregnancy. And, 'cause they have definitely talked about, like for example, a few years ago in the states, when abortions were stigmatized and like taken to court and *Roe v. Wade* was overturned and all of that - my father in-law was very much in support of like, 'Well these women shouldn't be fucking around if they don't want to get pregnant.' And I'm like, *okay, cool, got it. So, [you're] unsafe*. And my mother in-law is just very judgy, and I feel like if I told her, she would tell all of her friends at book club about it, or tell everybody at church about it, and then I'd have to hear it from other community members and I just, I didn't want to deal with it.

However, Jordan's pregnancy symptoms made it difficult to conceal her pregnancy as her in-laws noticed Jordan's morning sickness. To not reveal their pregnancy and upcoming abortion, Jordan described making up different explanations,

> And it was a little bit awkward, and it was really hard for me to explain away to my in-laws, because they're very Christian, as well. And they were like, 'Oh why are you so sick all the time?' or 'Why are you so sick this week?' and I'm like *little do you know* (laughs).

Lily (she/her), a bisexual woman, was also experiencing pregnancy symptoms while attempting to hide them from those around her. She purposely delayed taking her medication abortion pills until her stepchildren returned to their other parents' house. Prolonging the pregnancy symptoms and emotions was a laborious task in addition to childcare. Lily described,

> I was fully having a lot of nausea after every meal. My mood was just - I was just angry and emotional, crying a lot. Just like very chaotic and didn't know how to manage everything I was feeling. […] And also having children in the house and being like

> ‘ahhh!’ (laughs) […] and they don’t know what’s going on with you, and you can’t say [anything], right?

Having to conceal ones’ pregnancy and corresponding symptoms while waiting to undergo abortion care was commonly experienced as burdensome by participants.

Charlie (they/them), a bisexual non-binary person, described abortion stigma as a barrier to seeking support from the people in their life, despite accessing abortion care for medical reasons. Charlie described being nervous to tell others they were accessing abortion, sharing that they and their partner used strategic wording when talking about the abortion. They shared,

> As for the actual stigma against abortion, it was mostly in my head. It was kinda like okay when we’re telling people that I had an abortion, how do we want to word it? Like do you want to say, ‘Hey, we had an abortion.’ Or, ‘We lost our baby.’ Or do we want to say, ‘We terminated the pregnancy?’ Or like how are we going to word this if people are bitchy about it? Nobody was bitchy about it really. But we were saying that we lost our pregnancy. So, I feel like that, people are going to be less bitchy about (laughs).

Olivia (she/her), a bisexual cisgender woman, was similarly nervous to share about accessing abortion with others in her life, as she felt that she would have to defend herself and her choices. Olivia expressed, “I didn’t want to have that stigma. ‘Cause like […] I knew I was going to have to like defend myself quite a bit. But I found it wasn’t too awful.” For many participants, deciding whether to disclose or conceal one’s abortion was a significant factor in participants’ abortion care, creating interpersonal barriers to accessing abortion under the conditions of support and dignity, free from coercion or abuse.

Leith (she/they) spoke of experiencing interpersonal barriers from a number of people in her life and involved in her care, including her family, boyfriend, boyfriend’s family, healthcare

providers, and other healthcare staff. Leith accessed abortion care when she was a young adult but experienced a belief-based care denial that ultimately shaped how they perceived abortion stigma from the healthcare system during their medication abortion. Belief-based care denial is when a healthcare provider refuses to provide abortion care due to personal beliefs (Dixit et al., 2024). In Manitoba, physicians are allowed to deny a patient abortion care without the obligation to provide them a referral to another provider (Canadian Medical Association, 2018). Nurse practitioners in Manitoba are also allowed to deny a patient abortion care; however, they are required make a timely referral to support a patient to access care from an alternative provider (College of Registered Nurses of Manitoba, 2024). Leith, unfortunately, was denied care by a physician, therefore they left without a referral elsewhere and ended up travelling to Winnipeg to access care. Leith shared about how this affected their recent abortion experience as she was fearful of being denied care or experiencing judgment,

> [I experienced discrimination during my] first [abortion], experiencing denial of care from the doctor at the Thompson clinic. And then, I would say, the stigma and everything, or sort of the negative stuff from family, from my boyfriend's family. Even from my boyfriend after the fact. He tried to hold it against me […] The stigma of accessing abortion I did experience. In the second, in my medical abortion, the feeling of; because I know it's stigmatized [so] even if somebody is not treating me a certain way - they might be treating me poorly because they're just an asshole - but because I already have [experienced] this stigma then [I might perceive stigma]. For example, when I was getting bloodwork done […] the person who was taking my blood, he got me ready and then he saw what the [bloodwork] was for. Even though it wouldn't have said, 'Having an abortion.' But you know something like, 'Testing the levels of the [hCG] hormone,' or

> whatever. […] But then he kinda came back at me with some comment, something about how much he loves his family or something. And it was weird 'cause I think it was something I said - something about family or about kids. But then he said something like, 'Well, I love my kids so much'. […] I just felt like he knew that I was trying to access an abortion or that I was having an abortion. […] My perception of the situation, I was just like, 'Oh okay, are you hating on me because I'm trying to access this service?' Like I don't know? And then I suppose the not wanting to submit forms for the travel and stuff because of perceived discrimination.

Leith's experiences illustrate how interpersonal barriers are not always explicit acts, like belief-based care denial, but these barriers also manifest through subtle, perceived, and cumulative acts that are shaped by the awareness of abortion stigma or a previous negative experience.

Olivia (she/her), a bisexual woman, also faced judgements from healthcare providers, as abortion providers at HSC repeatedly questioned her decision to access an abortion. Olivia shared about this experience and how it affected her,

> I tried to book an appointment to terminate my pregnancy and at Health Sciences Centre - they actually had me rebook like three different appointments to determine that was really what I wanted, before actually giving me the opportunity to make my decisions on my first go. Like it was almost like they were questioning my sanity, and I was like I know this is what I want. It felt draining and the more they put off booking me into an appointment, the farther along I got and that was just harder for me too. And if you're [further] in the pregnancy and you're terminating, it is painful. So then pushing it back sucked.

Ultimately, Olivia was able to access care once she was referred to a new abortion provider, however, the process of explaining her decision repeatedly and not being believed was a significant access barrier she faced.

Interpersonal barriers were significant for many participants, as they shaped the conditions under which care was accessed. Through a queer reproductive justice lens, these findings demonstrate that abortion access is deeply embedded within relational contexts that are themselves structured by broader systems of oppression, such as patriarchy, cisheterosexism, and gender-based violence. Weaving participants' narratives together illustrates how stigma, coercion, and judgment operate interpersonally to regulate reproductive decision-making and constrain autonomy. These dynamics directly shaped the ability of participants to access care in safe, dignified and affirming ways, as many had to carefully manage disclosure or hide their pregnancy symptoms from the people around them.

Further, interpersonal barriers to abortion care reveal how cisheteronormativity is actively upheld through everyday interactions that shape whose right to abortion is recognized, supported, or contested. Participants' accounts demonstrate that assumptions about pregnancy, parenthood, and abortion are often grounded in cisgender and heterosexual norms, where pregnancy is expected to lead to motherhood and abortion is framed as deviant. These assumptions commonly surfaced in participants' interactions with partners, family members, and healthcare providers, where the decision to access abortion care was questioned or stigmatized. These dynamics become further intensified for 2SLGBTQIA+ people as their identities are already disruptive of the dominant sexual and gender norms, which can increase the complexity navigating support, disclosure, and judgement. Together, the abortive 2SLGBTQIA+ body

challenges the normative expectations of reproduction, sexuality, and gender, which necessitates affirming and relational environments to support their identities and autonomy.

Infrastructural Barriers to Care

Infrastructural barriers, such as lengthy wait times or confusing processes, manifested as constraints to accessing abortion care for many participants. For Ari (she/they), a bisexual 'cis-ish' woman, the wait time to access care was anxiety-inducing and frustrating. Ari shared that as soon as she found out she was pregnant she, "filled out the Women's Health Clinic [online] form immediately." However, it was a long weekend, and she knew that communication from WHC would be delayed due to the statutory holiday. When the long weekend ended, Ari anxiously waited for a response, however she shared that, "the Women's Health Clinic posted on their Instagram that their water boiler broke, and they were going to be closed for the week." This prompted Ari to look for an alternative provider, so they sought care from their primary physician. Ari described,

> I tried to make a doctor's appointment, I think maybe even on the Tuesday. Like as soon as I could I made a doctor's appointment, just with my primary care provider […]. Which is where it gets funny because, essentially, I called them and was like, 'Hey' and they were like, 'We can't see you until Monday.' And I was like deadass to the receptionist 'I'm pregnant and I want an abortion, I need to see somebody soon. I don't know how pregnant I am, and I would ideally want a medical abortion, not a surgical one. So, you gotta get me in sooner.' And they were like, 'No, no, no.' So, I called back a bunch of times, I was doing everything in my power to try and get [in]. I was like maybe if I talk to a different receptionist, they'll give me a sooner appointment. It turned out that my

> primary care provider was on vacation that week. But it's weird that they wouldn't put me with somebody else sooner when I told them the like direness of the situation.

While waiting for her appointment at her primary care provider, Ari described "project-managing" her abortion by contacting other abortion providers to try to get the earliest possible appointment. Ari shared, "I'm calling Health Sciences Centre, I'm calling anyone I can find on the Women's Health Clinic website that says that they will give abortions. And essentially at some point I'm at four different appointments." During each call to various facilities, Ari had to repeatedly go through the intake process, and not knowing when their last menstrual cycle was made this incredibly stressful. Ari shared,

> I spent like an hour on the phone with HSC doing an intake process, where then I messed up and accidentally told them that I hadn't gotten my period for longer than I had. Like essentially the biggest stressor during all of these conversations was, 'Well when was the last period you had?' and I was like 'I don't know, I don't know.' And then they'd get mad at me and be like, 'Well you need to give us an answer; we need to write it down.' And I was like, 'I don't know though, like bodies are bodies, I can't tell you.'

Ari's experience of lengthy wait times coupled with a lack of a centralized intake process, resulted in Ari completing multiple intakes at multiple facilities and greatly exacerbated the stress she was feeling during this time. Manitoba does not have a centralized abortion access program, unlike other provinces such as British Columbia, Nova Scotia, and Prince Edward Island (Action Canada, 2024). While there have been recommendations to implement a centralized abortion intake program in Manitoba, alongside increasing the capacity of abortion services (Cowman et al., 2026), there is no current program or policy in place to meet this need. Ultimately, infrastructural barriers, largely shaped by lengthy wait times and a lack of

streamlined intake processes, were significant to Ari's narrative and their ability to access their desired form of care in a timely manner.

Leith (she/they) similarly spoke about the difficulty of abortion intake processes, which increased her anxiety and frustrations. Abortion intake processes around the province vary by abortion provider, however, most require a phone call to schedule an appointment and complete an intake questionnaire (Cowman et al., 2026; Women's Health Clinic, n.d.-b; Health Sciences Centre, n.d.). Manitoba abortion seekers have reported that at many places they have to leave a voicemail and wait for a returning phone call to schedule an appointment and complete the intake process (Cowman et al., 2026). When calling WHC, this is the process Leith endured, causing frustrations. Leith shared,

> … when I was trying to call originally, when I was going to plan a surgical abortion, I was trying to call the Women's Health Clinic […]. And I had to play phone tag with them for so long, which just increased the anxiety and the feelings of why isn't there an easier way to do this?

Leith also discussed how their doctor in Northern Manitoba told them to book a procedural abortion at the WHC in case she could not access Mifegymiso or had an incomplete medication abortion. Leith described the emotional labour of facilitating their own care and the difficulties they faced when doing so,

> I was told by my healthcare provider to reach out to [WHC]. When I did that, they were so rude to me. And so, at the end of the call, she was like, 'You can't do that,' and just like going off on me. So, at the end of the call, I'm just like holding my phone and I didn't think she was on the phone anymore and I was just like, 'Fuck you!' Like I had the phone away from me. So, she calls me back to be like, 'I heard that' and then I was like,

> ‘Well, good! But it’s like honestly, ma’am, I’m calling in the most vulnerable state of my life doing something that my healthcare provider told me to do. And if you folks had your shit in order, you would all be coordinating.’ And I know it’s not this particular staff member, but you know what I mean - on the systems level, they should be coordinating together to facilitate my care. Not me calling around setting me up for these types of things.

Overall, Leith was overwhelmed with the number of infrastructural barriers she encountered when trying to access medication abortion care in the NHR, from not having a prescriber nearby to not being able to fill her Mifegymiso prescription in The Pas. Leith shared,

> What was unexpected was the amount of hoops I would have to jump through and meet barriers that still existed for just getting a prescription for a pill. I was totally baffled at the fact that, repeatedly, they gave me false hope and then would extend the process. Like in the sense of like getting me to go down to the [Thompson] clinic and only to be told that, ‘No you’re going to have to do this.’ And then it’s like, ‘Oh, yeah, of course you can just go to The Pas.’ […] and then the fact that when I got to The Pas that they didn’t have the medicine available.

While Lily (she/her) did not face as many infrastructural barriers accessing abortion care in the NHR, she did encounter some confusing steps to accessing care as she described a disconnect between healthcare providers in The Pas and Thompson. This resulted in Lily going to unnecessary appointments and having to describe her situation to more healthcare providers than necessary. Lily shared,

> The only thing I felt was that there was some disconnect between The Pas abortion care providers and the Thompson clinic because they had me go and sit in the clinic waiting

> room to sit and wait to speak to one of the family physicians who's in the walk-in. It ended up being that there was double blood ordered, because there was a package that came from The Pas clinic, and then also from the person I saw from the Thompson clinic. So, I was like I don't even think I had to go through that step of going to the walk-in. It should have just been The Pas clinic sends it to diagnostics and then I show up and say, 'Hey, my provider sent you bloodwork'. And I don't think I should have had to sit in that waiting room and have those conversations with everybody. […] So, it was just - then I had to talk to, you're talking to the nurses at triage and they're like why are you here? And it's like, I don't think this visit was even necessary.

As both Lily and Leith described the NHR as particularly stigmatizing for abortion seekers and 2SLGBTQIA+ people, Lily's multiple unnecessary interactions could have resulted in encountering stigma herself.

Lastly, Charlie (they/them) described infrastructural barriers related to emergency ultrasound capacities when terminating their pregnancy. Charlie described,

> [The nurse] was like, 'You can call this number tomorrow and it's like an emergency ultrasound unit. And like call this number tomorrow, and it gives you instructions on like what to expect kind of thing, like call this number between this time and this time and tell them you went to the ER.' So, I did that. I called when they opened, nobody answered me. And then I called like multiple times, nobody answered me.

Hours after their initial call, Charlie heard back from the emergency ultrasound unit. However, during the waiting period they experienced anxieties related to the urgency of their care.

Overall, infrastructure barriers were prevalent in participants' stories of accessing abortion, often delaying access to care resulting in increased anxiety and frustration. Through a

queer reproductive justice lens, these findings illustrate how healthcare infrastructures are shaped by broader political and institutional priorities that can reproduce inequities to access. Long wait times, fragmented intake processes, lack of coordination between providers, and limited service availability reflect systemic gaps that disproportionately burden those seeking time-sensitive care. While these barriers affect many abortion seekers, their impacts may be intensified for 2SLGBTQIA+ individuals who must navigate these systems alongside concerns about stigma, disclosure, and discrimination.

The infrastructural conditions directly shape the possibilities of accessing dignified and affirming abortion care, while also reproducing dominant norms through the design of care itself. The expectation that abortion-seekers can clearly articulate menstrual timelines, move seamlessly through confusing care pathways, and repeatedly disclose personal information reflects privileged assumptions about bodies, gender, and reproduction. The experiences of participants demonstrate how those who do not fit the expectations established by healthcare infrastructure are positioned as difficult or unintelligible within the system. However, these constraints were actively resisted by participants by "project-managing" their care, advocating for themselves, and navigating multiple entry points despite systemic barriers. These forms of resistance required significant labour and resources, but true equitable access cannot rely on individual persistence. A queer reproductive justice approach instead calls for reimagining abortion care infrastructure in Manitoba to be more coordinated, accessible, and responsive for all abortion-seekers, including 2SLGBTQIA+ abortion-seekers.

Social-Emotional Support as a Facilitator to Care

When discussing the factors that facilitated their access to abortion care, participants largely expressed how support from friends, partners, family, and healthcare practitioners were

central to accessing care in supportive and dignified ways. For instance, Ari was surrounded by supportive friends and family members when she accessed abortion care. Ari's partner was particularly supportive of the decision and involved throughout the process, which she deeply appreciated. Ari shared,

> My partner was there as I took the pregnancy test which was really nice and I feel like can't be underestimated; the emotional-ness of the support of having the person who got you pregnant going through it with you. Like obviously I still would have made the same decision if it had been someone I was more casually seeing, even moreso then, but it was like really nice to have someone to like send updates to and be like, 'Ahh Klinic finally answered and gave me an appointment,' and like blah blah blah. Having someone just to live through that everyday-ness of it with you and take care of you in those ways.

Ari also talked about finding small moments of joy and humour in the situation they were in, through making jokes with their partner. For Ari, this was felt as a supportive and uplifting way to process and cope with the unintended pregnancy and stress of accessing abortion care. Ari shared,

> We definitely made a bunch of jokes about it. He was like, 'I'm extra hungry, this is me training for dad bod.' Or like I'd be like, 'We have to do everything I want 'cause I'm pregnant.' […] I feel like there was actually a joy to it, and actually a privilege to it being funny. Because I was like, this is annoying and inconvenient and shitty, but also not. Like I'm gonna book the appointment, go, this is a passing thing that I do interviews about. Knowing that it's temporal is - like the privilege to know that. To know that it won't change how my family thinks of me or change my relationship.

Another main source of support for Ari was from her mom, who affirmed their decision and told her about all the people they know who have accessed abortion care, which effectively normalized the experience for Ari. Charlie (they/them) also shared about the support they received from their mom and their friends. Small things such as an Instagram reel or food delivery felt like care for Charlie, who was grateful to have their loved ones' rally around their pregnancy loss and abortion. Charlie shared,

> My mom messaged me every single day. In like various forms. Most of it was just like Instagram reel, Facebook meme. […] And then everyone was like let us know if you need food or whatever.

Olivia (she/her) also discussed how her family provided support, and which ultimately helped facilitate her access to care as her mom acted as her advocate in the process,

> My mom was involved, my sister was involved, my entire family did whatever they could to take care of me and be there and thank god for them. 'Cause I don't think I would have been able to survive that kind of ordeal that the hospitals were putting me through on my own. And my mom very, very much so became my advocate through that process.

Altogether, participants experienced support from partners, friends, and family members in various ways, each tailored to their needs. While some participants found support through humour, others found support through being able to cry with a loved one. Deep gratitude was expressed for the support received, and this support was often described as helping to facilitate access and affirm the decision to access care.

Some participants also mentioned that their healthcare practitioners were supportive in their access to abortion care. Specifically, Charlie (they/them) noted how supportive their genetic

counsellor was, as they described all possible outcomes and options for the pregnancy to them. Charlie described,

> They basically were like, 'Your options are you can either - we can induce labour now, you can carry to term but you will have a stillbirth, like there is no other option, this is a fatal thing.' And they gave me pros and cons of all the options. Or we [could] have a D&C, which is the option I ended up going for. But it was really nice they laid out all the like pros and cons of each. And like what benefits I would get for inducing labour, cause that one we'd be able to do an ultrasound – or an autopsy. To find out what caused it maybe? Or like just get definitive answers. But I didn't want to do that, 'cause that sounded awful. So, then I chose to do the D&C.

Olivia (she/her) was another participant who experienced supportive healthcare practitioners at WHC, who helped facilitate a quick and seamless medication abortion experience, with supportive follow-up throughout the process. Olivia shared,

> I caught an early pregnancy. I did not want it. It was a one-night stand thing where I was like, 'Oh shit, I can't.' And I was younger. But they were amazing, I called them on a Thursday. I had my first consultation Friday morning with them. At that point I was not very far along so there are like the pill abortions you can take. I did that Friday night. They called me Saturday and Sunday to see how I was doing. When it wasn't going well, they had me in a doctor's office, like in a bed, fixed and ready to go. They scheduled the [procedural] abortion that I needed to have to get everything else out because it was getting complicated. And they were just really helpful from beginning to end. And then the follow-up care with them was phenomenal. They had brochures, they had people to

> talk to, they would like call me and be like 'Hey, how are you doing? You had this procedure with us, we just want to know how you're doing."

Through a queer reproductive justice lens, participants' narratives demonstrate that social-emotional support is a critical facilitator that shapes the experience of care. Support from partners, friends, family, and healthcare practitioners helped mitigate the many structural, interpersonal, and infrastructural barriers participants faced, highlighting the relationality of care. In contrast to the identified barriers that constrain access, these narratives illustrate how supportive relationships can interrupt some effects caused by the many systems of oppression at play through emotional validation, practical assistance, and advocacy. Further, supportive relationships resisted normative scripts of abortion stigma, through unconditional support and the normalization of abortion. These moments of resistance are particularly significant, as they point toward alternative possibilities in which relationality is central to abortion care.

Conclusion

Overall, this chapter illustrated the complex interplay of barriers and facilitators shaping 2SLGBTQIA+ individuals' access to abortion care in Manitoba. Through participants' narratives, the barriers of geography, interpersonal dynamics, and infrastructural constraints emerged as key barriers, while social and emotional support from personal networks and healthcare providers was shown to meaningfully facilitate access. Notably, many of these barriers are not unique to 2SLGBTQIA+ people but rather reflect the broader challenges of accessing abortion care across Manitoba (Cowman et al., 2026), and even Canada (Monchalin, 2023; Paytner, 2025). As such, abortion care must be understood as an already and uniquely constrained healthcare context that participants had to navigate. However, these common barriers were revealed to be differently experienced, intensified, and navigated by 2SLGBTQIA+

individuals. For instance, geography is not only a matter of physical distance or infrastructure, but also of dominant cultures that can reproduce cisheteronormativity and stigma within specific regions. With limited care provider options, this can shape whether care feels safe, accessible, or even possible. Similarly, while infrastructure determines who can access care and how, it also intersects with identity, producing uneven and exclusionary experiences for those whose bodies, identities, and relationships fall outside normative expectations. Finally, interpersonal dynamics underscore these complexities as they can either constrain or facilitate access. Altogether, these findings demonstrate the ways in which access to abortion care is shaped by the broader social, cultural, and relational conditions in which care is embedded, shaping whose access is supported and under what conditions.

Cisheterosexism in Abortion Care

This chapter builds on the broader barriers and facilitators to abortion care identified in the previous chapter by turning specifically to the role of cisheterosexism in shaping 2SLGBTQIA+ individuals' experiences of abortion care in Manitoba. While the previous chapter demonstrated that access is structured through various geographical, interpersonal, and infrastructural factors, this chapter examines how these conditions are further shaped by normative assumptions of cisgender womanhood and heterosexual reproduction. Drawing on the participants narratives, this chapter explores how abortion care settings are often organized around cisheterosexist norms, and how these norms are reproduced through institutional practices, provider interactions, and care environments. Further, this chapter illustrates the ways in which participants navigated, complied, or resisted cisheteronormativity within abortion care. Altogether, this chapter extends the analysis of access beyond availability, demonstrating that even when services are technically accessible, cisheterosexism fundamentally shapes how care is experienced by 2SLGBTQIA+ people. Through a queer reproductive justice approach, the social, relational, and institutional conditions shape how care is experienced by 2SLGBTQIA+ individuals and reveals that dignified care is more than the mere presence of services.

Manifestations of Cisheterosexism

Participants' narratives revealed the ways in which cisheterosexism manifests throughout the experience of accessing abortion care in Manitoba, with all participants having expressed that their identity was largely assumed to be cisgender and heterosexual by those they interacted with in the healthcare system. The existence of cisheterosexism created barriers to accessing abortion care was commonly experienced by participants. Jordan (she/they), a bisexual non-binary person,

is one participant who experienced cisheterosexist barriers to care. Throughout their story, Jordan emphasized how the gendering of abortion and reproductive healthcare can create accessibility barriers for AFAB people who do not identify as women,

> When I reached out to them to book via the phone, I was explaining my situation to them and they go, 'Oh, well a lot of women have these issues,' and it's like I'm a non-binary person, and they go, 'Oh, well I'm sorry.' And then another five minutes into the call they go 'Oh, well this is primarily a women's issue' and I'm like 'No, no, no I'm just a person with a uterus please.' […] As a non-binary person, it's like, oh, I have to go to the *Women's* Health Clinic - not the People with Uterus Clinic (laughs), and I get why you'd call it that, but it should be more accessible to LGBTQ people. It should be a more tailored experience to everybody who needs that care, not just women who need that care.

Another participant, Ari (she/they) a bisexual "cis-ish" woman, similarly talked about the gendering of abortion care settings in Manitoba. They highlighted how the gendered naming of abortion care sites as *women's* spaces reinforce cisheteronormative assumptions of who can access abortion care from them. As a "cis-ish" woman, Ari felt that they needed to embody being wholly a woman to ensure their access to care. As a result, Ari allowed her "cis-ish" gender identity to be passive, going along with the assumptions of cisheteronormativity. Ari shared,

> I think like even the *Women's* Health Clinic, […] I'm a woman. I do have a uterus. There's something in it that I don't want – like, get it out. You're already making assumptions about me. I'm not like going to push back on them right now, 'cause, you know, I just want to get this done.

The experience of being presumed as cisgender and heterosexual in abortion care settings was common among participants. This often resulted in their gender and sexual identities being

overlooked by healthcare providers, and even "invisible" according to Leith (she/they), a queer, pansexual, polyamorous, non-binary, Two-Spirit person.

> I feel like in this circumstance, my gender, or my gender identity and sexual orientation, I don't really feel like came into [play]. Like it does come into play, but it's almost like it's invisible to the people who were providing me care. So, it's not like I was discriminated against, but it's not like [my identity] was considered or thought of.

Lily (she/her), a bisexual cisgender woman, also described their bisexual identity as a "secret" to care providers as she is commonly perceived by others to be in a cisheteronormative relationship. She shared,

> I didn't feel any [judgement or discrimination], but I think it's because I'm very like cisgender-hetero passing, that it's like that people see me with my man and they just assume that I'm just a happily married woman and that, you know, 'normal' relationship. And so, I feel like they don't know, right? It's a secret.

While many participants expressed that their identity was invisible or a secret, Jordan (she/they) made efforts to disclose their non-binary identity to care providers. They not only corrected the abortion intake worker on the phone (mentioned earlier, on page 90), but they also included their pronouns next to their name on their paperwork when accessing care. Despite disclosing their identity in two separate situations, they continued to be misgendered by care providers. They stated,

> On the paperwork it didn't ask me for my pronouns, so just beside my name I put in brackets '(she/they)' and the entire time they just referred to me as 'she.' And I'm like, 'Well, I'm non-binary so can you actually use the 'they' pronouns? I understand both of them are in there, but I do prefer the 'they' pronoun.'

Jordan's experience demonstrates how cisheterosexism in abortion care operates through everyday institutional practices, such as intake processes and provider interactions, that fail to recognize gender diversity. Even when identity is disclosed, the persistence of misgendering and gendered assumptions reinforces the idea that abortion care is intended solely for cisgender women, rendering 2SLGBTQIA+ identities invisible within these settings.

Cisheteronormativity functions as a structuring logic through which abortion care is organized, delivered, and made intelligible, shaping both institutional practices and interpersonal interactions within healthcare settings (Butler, 2007; Gamson, 1995). As participants' narratives illustrated, abortion care is both explicitly and implicitly constructed for cisgender and heterosexual women, through the positioning of womanhood as a prerequisite for reproductive capacity and abortion access. This is explicitly seen through the naming of abortion care settings as *women's* spaces or through healthcare staff repeatedly saying how abortion is a "women's issue." Implicitly, this manifests through misgendering and the invisibility of 2SLGBTQIA+ identities within abortion care. This highly gendered framing of abortion erases the experiences of trans, non-binary, Two-Spirit, and gender-diverse people with the capacity for pregnancy. Further, the routine assumptions of cisgender identity, heterosexual relationships, and binary gender categories operate not as overt acts of discrimination, but as normalized practices within abortion care.

When analyzed through a queer reproductive justice conceptual framework, participants' narratives illustrated how access to abortion care cannot be understood solely in terms of availability, but it must also account for the conditions under which care is accessed and experienced (Ross & Solinger, 2017). Rather than being neutral or affirming sites of care, abortion services reproduce dominant norms about gender and reproduction, upholding

traditional assumptions and othering those who deviate from the norms of cisheterosexuality. The application of a queer reproductive justice lens considers that while participants were able access care, they did not all receive inclusive, equitable, and responsive care affirming to their 2SLGBTQIA+ identities due to the structural exclusions faced within abortion care provision. In these ways, queer reproductive justice provides a framework to understand how cisheterosexism manifests as a form of exclusion within abortion care settings, constraining how participants were recognized within care settings and overall shaping the ideas of who can access abortion care and whose identities will be marginalized or invisible in the process.

Compliance with Cisheterosexism

Participants commonly expressed the feelings of being willing to overlook instances of cisheterosexism in abortion care settings due to the urgency of seeking abortion and the fear of getting denied access. Charlie (they/them), a bisexual non-binary person, shared about how they would "rather get misgendered but seen quickly." Similarly, Leith (she/they) shared, "I'm desperate. I don't have the privilege of my gender identity being thought of or anything." Leith also expressed, "I don't care if you need me to be a man, a woman – I don't care, just give me the damn [abortion] pills!"

Ari (she/they) explained how the stress of simply being able to access care at all was the priority and therefore they were willing to go along with any cisheteronormative assumptions from care providers. Ari expressed,

> I feel like in the experience of getting an abortion, [my gender/sexual identity] is not on my radar. I'm just going to be a woman and I'm going to tell you that my partner got me pregnant and I'm just going to do that and just go with the passing part and the parts of my identity that you'll assume with that.

It is not unusual for 2SLGBTQIA+ people to go along with cisheteronormative perceptions or conceal their identities in healthcare settings, as previous literature has demonstrated how healthcare stereotype threat (HCST), or internalized cisheterosexism, decreases the willingness to self-disclose one's queer or trans identity out of fear, to protect themselves from stigma, discrimination, and bias from healthcare providers (Carpenter, 2021; Ertl et al., 2024; Hoskin et al., 2016).

While not sharing one's 2SLGBTQIA+ identity with healthcare providers is a form of self-protection, Leith (she/they) described how the experience of cisheterosexism and identity concealment in abortion settings is felt as laborious and burdensome. Leith stressed that this labour should not be put on the 2SLGBTQIA+ person accessing care, but on the providers and systems themselves by sharing,

> I have to go in and pretend that I'm a woman in order to access this. Or like, you know I don't want to correct people on my pronouns because I'm already so nervous that they're going to deny me service, and I'm already so vulnerable and sensitive. So, I think it's really important as queer people to be able to access services just as ourselves and have healthcare providers and have society step up and do the work - not putting that on us.

For many participants, going along with cisheteronormative assumptions in healthcare settings was so routine to them that they struggled to reimagine affirming, safe, and inclusive abortion care settings. However, as Leith highlights, a major step forward is for the healthcare system to challenge their own assumptions of who might access care, especially traditionally gendered forms of care like abortion.

From a queer reproductive justice perspective, participants' willingness comply with cisheternormative assumptions can be understood as a form of strategic conformity within a

system that regulates whose bodies and identities are recognized as legitimate patients. Queer theory highlights how normative gender and sexual categories are actively produced and enforced within these institutions, thereby compelling individuals to perform intelligible identities to access resources and care (Butler, 2007). In abortion care settings, participants described temporarily performing the role of a cishet woman, not as an affirmation of that identity, but as a survival strategy in moments of urgency, vulnerability, and the fear of denial. These instances of passing illustrate how power operates not only through exclusion, but also through the subtle coercion of normativity, where deviation from cisheterosexist expectations is perceived as a risk to access abortion care. In these ways, participants' narratives reflect how institutional contexts discipline queer and trans bodies into legibility through compliance (Butler, 2007).

Additionally, participants' decisions to comply with cisheteronormative assumptions can be understood as the conditions under which reproductive autonomy was made possible. Participants' narratives demonstrate that concealing or downplaying aspects of their gender and sexual identities was often a deliberate strategy to avoid delays, denial, or additional scrutiny. This reveals how intersecting systems of power, such as cisheteronormativity or provider discretion, shape abortion access for 2SLGBTQIA+ people in ways that prioritize efficiency and normative understandings of gender over patients' safety, dignity, and self-determination. Further, this compliance with cisheteronormative assumptions required substantial emotional burdens and labour, which effectively shifted the responsibility for navigating potential harms from the health system and providers onto the patients themselves through the compliance with normative identities.

Instances of Inclusion and Safety

Despite the frequent occurrences of cisheterosexism experienced by participants when accessing abortion care, there were times in which participants felt that attempts at inclusion were made by care providers and abortion sites. While they were small acts, primarily centered around pronouns, they seemingly made a large impact on participants' feelings of inclusion and safety in abortion care environments.

Olivia (she/her), a bisexual cisgender woman, had accessed abortion care from multiple providers, narrating her experiences through comparing and contrasting her own experiences. She shared,

> The only people who even thought about [inclusion] or wanted to be like 'Hey, we're affirming, we're a safe space' was the Women's [Health] Clinic. Never in my other appointments did I ever even think about my sexuality or anything because it was not there. Women's Health Clinic was a very safe space. Very apparent it was a safe space. They asked me my pronouns just to have conversation.

Ari (she/they) shared how they appreciated the use of non-gendered pronouns when talking about the person who got her pregnant and not assuming that they are in a cisheteronormative relationship. She said,

> Because you're pregnant there is an assumption of *well someone clearly got you pregnant, somebody knocked you up.* But I like the fact that they didn't even ask those questions at Women's Health Clinic, which is great from a queer lens of knowing that they won't use pronouns about the person who got you pregnant. […] So, instead of having to navigate [disclosing my partner's identity], they didn't pry. I didn't have to navigate any of that.

Charlie (they/them) noticed how healthcare staff sharing their own pronouns, wearing rainbows, and using gender-neutral (they/them) pronouns for all patients created a feeling of safety for them and their identities when accessing care. Charlie noted,

> At HSC, the nurses, some of them, had little pronoun ribbons on their ID badges. The nurse that was [a constant in my care] had a rainbow watch band. And I know that isn't necessarily an indicator, but it made me feel safer. And generally, what I've noticed at HSC is that people will refer to everybody with 'They/Them' pronouns usually. I never told anybody at HSC [my pronouns], I wasn't like 'Oh, hey by the way'- I also was never asked, but what are you going to do. So that was kind of nice that they just referred to everybody as 'They/Them.'

These small moments of inclusion played a significant role in fostering some of the participants' feelings of safety when accessing abortion care. Although they were often informal and inconsistent across settings and providers, these practices demonstrate how small, intentional acts by providers can meaningfully counter cisheterosexism within abortion care settings.

From a queer reproductive justice perspective, these moments of inclusion demonstrate how institutional norms around gender and sexuality can be disrupted through everyday practices that expand who is recognized as a legitimate subject of care. Queer theory emphasizes that normative assumptions are not fixed, but are continually reproduced through mundane interactions, language, and symbols (Butler, 2007; Foucault 1978). Participants' narratives suggest that practices such as sharing pronouns, using non-gendered language, and avoiding assumptions about partners functioned as small but meaningful interruptions to the cisheteronormative scripts that typically structure abortion care. In this way, inclusion was not experienced simply as an affirmation, but as a reconfiguration of power, where care

environments momentarily shifted away from enforcing legibility through gender conformity and took a step towards a broader recognition of gender and sexual diversity.

These instances of inclusion and shifts of power highlight the importance of safety, dignity, and relational care as central components of reproductive justice and autonomy. The reproductive justice framework asserts that individuals must not only have access to abortion but must be able to access care in ways that affirm their full humanity, particularly for those who are structurally marginalized (Ross & Solinger, 2017). Participants' descriptions demonstrate how even informal practices alleviated fear, reduced emotional labour, and created a sense of safety within abortion care settings. While these small acts of inclusion can mitigate the harms of cisheterosexism and demonstrate a reconfiguration of power, reproductive justice demands systemic transformation, where affirming care is embedded institutionally rather than dependent on individual discretion.

Conclusion

Participants' narratives demonstrate how cisheterosexism shapes abortion care not only through overt exclusion, but through the everyday norms, assumptions, and practices that structure how care is delivered and who is recognized as a legitimate abortion seeker. While abortion services in Manitoba were available to participants, their experiences reveal how care environments continue to be organized around narrow assumptions of cisgender womanhood and heterosexual reproduction. These assumptions shaped how participants were addressed, how their identities were interpreted, and the extent to which they felt safe or visible within care settings. Participants further illustrated how they navigated these conditions through strategic compliance with cisheteronormative expectations. Temporarily performing legible identities enabled participants to access care within systems that privilege normative gender and sexual

categories, though this strategy often required emotional labour and self-silencing. At the same time, simple acts of inclusion, such as pronoun sharing, demonstrated how these norms can be disrupted through small practices that expand who is recognized within care. Altogether, abortion access cannot be understood solely as a matter of availability but must also account for the social and institutional conditions under which care is experienced. Cisheterosexism remains ever-present within abortion care settings and significantly affected how participants were recognized, included, and affirmed while navigating care.

This chapter demonstrates the pervasiveness of cisheteronormativity within abortion care, and how it can act as a barrier for 2SLGBTQIA+ people to access and receive care in ways that feel inclusive and affirming for their identities. At the same time, this chapter illustrates the ways in which cisheteronormativity is resisted through small acts and moments that facilitate inclusion and safety. Through a queer reproductive justice lens, these realities indicate that a reimagining of how abortion care is conceptualized and delivered is necessary to actualize the right to dignified abortion care for queer and trans people in Manitoba.

Queering Abortion Care in Manitoba

This chapter responds to the third research question guiding this study by exploring the ways in which participants reimagined the current state of abortion care in Manitoba to support more inclusive and affirming care for 2SLGBTQIA+ people. Incorporating sex positivity into abortion care, recognizing abortion as a form of gender-affirming care, decolonizing abortion care, and, lastly, reimagining reproduction and families, were the four overarching themes from participants narratives when alternatively imagining abortion care. Thus, this chapter provides a vision of queer reproductive justice in Manitoba, by centring the lived experiences and ideas shared by the 2SLGBTQIA+ participants that challenge the ongoing cisheteronormativity within abortion care, and within discourse of reproduction more broadly, through the practices of reimagination, inclusion, affirmation, and justice.

Sex Positive Abortion Care

Multiple participants emphasized the need to incorporate a sex positive lens into the way that abortion is discussed and delivered. Sex positivity can be understood as the belief that sex can be a pleasurable and positive aspect of a person's life, and involves non-judgmental attitudes towards sexual diversity in the context of consenting relationships (Ivanski & Kohut, 2017). Previous literature has deemed sex positivity as an important element of sexual health information and education (Ivanski & Kohut, 2017). In particular, sex positivity has a long legacy in queer public health initiatives, notably within the community-led HIV prevention efforts that began in the 1980s (Rhodes, 2026). However, within the context of abortion care, literature on sex positivity is negligible, possibly due to scholarship often prioritizing a focus on the stigma and challenges that shape access to abortion care (Kimport et al., 2024).

Ari (she/they), a "cis-ish" bisexual woman, described how her abortion experience at WHC lacked sex positivity, as she shared that there was "a lot of projection around the assumption that you'll never have sex again." When sex was discussed, Ari expressed that it was emphasized to use two forms of contraception, such as condoms and contraceptive pills, which felt overly precautionary. This was the only time sex was mentioned during Ari's abortion appointment, which left Ari with some unanswered questions about having sex again after the abortion. Ari shared,

> Probably three days after [the abortion], I was like when can I have sex again? This wasn't very painful, I'm ready to continue my life as I was before. And I feel like there wasn't a lot of answers to that. And I hadn't really thought of it at the time at Women's Health Clinic 'cause I was concerned about the abortion, not about having sex a few days after. And I was like I don't know if I'll want to do that. Maybe I'll still be bleeding. Maybe it'll still be painful. […] I do think that the Women's Health Clinic definitely wasn't sex-negative, but it definitely didn't feel affirming and celebratory that I will have sex again.

Leith (she/they), a Two-Spirit, non-binary, queer, pansexual, and polyamorous person, similarly discussed the need to incorporate a sex positive lens in abortion care, among other healthcare contexts. They spoke about sex positivity as a key disruptor of cisheterosexism in healthcare, explaining how sex positivity not only normalizes sexual diversity, but also allows for the consideration of different needs within different sexual relationships. They expressed,

> …when you're talking to people or to healthcare providers and it's like they wouldn't necessarily understand I'm hooking up with people, […] they don't understand that when I have multiple sexual partners. Or talking to different [healthcare providers], it's always

> through that very much heteronormative lens. And so, it's being able to [identify] the types of violence that we experience can look different, or the types of needs we have.

Ari (she/they) echoed this sentiment, sharing how incorporating a sex positive lens into abortion care considers sexual and gender diversity through "not assuming cis and heteronormativity" and by emphasizing "autonomy over pleasure." In this way, sex positivity orients towards the inclusion and affirmation of diverse sexual and gender identities within the traditionally cisheteronormative delivery of abortion care. This is accomplished through the fostering of positive and non-judgmental attitudes towards sex that centre consent and pleasure.

Sex positivity was further urged by Leith (she/they) when discussing sexual health information and education regarding pregnancy, relationship types, and abortion care. They discussed,

> …during school we did not talk about abortion. We didn't talk about sex beyond penis-vagina makes a baby. You know that kind of stuff. But even that, there was no consideration of when people are talking about sex or reproductive health, it's still a very much monogamous heterosexual relationship. […] There's a lot more expansion and education that could be done.

Leith continued talking about their desire to see sex positivity be incorporated into abortion care, specifically in Northern Manitoba,

> I would love to see an actual sexual health centre in the North. Somewhere you could access abortion and all types of stuff, in a very sex positive space. And I think that's really – I don't want to say all of Manitoba because I know that there's some places that do have this information – but just seeing more sex positive approach[es], versus a sort of science and fear mongering [approach].

Overall, Leith emphasized how sex positivity is an important lens for both healthcare delivery and sexual health education. They expressed how sex positivity is especially crucial to combat "fear mongering" approaches, which often reinforce cisheteronormativity through abstinence-based models of sexual education that fail to provide diverse, affirming, and positive information.

Within a queer reproductive justice framework, sex positivity is a necessary component; scholars who have engaged with a queer reproductive justice approach, or queer theory more broadly, have underscored its relevance (Bond-Theriault, 2024; Glick, 2000). Sex positivity is a construct that has partially emerged from queer theoretical traditions, wherein sexuality is understood as a site of simultaneous regulation and resistance. From this perspective, sex positivity can be understood as transgressive, as it challenges the dominant moral hierarchies that position certain forms of sexuality as acceptable while stigmatizing others (Glick, 2000). By affirming sexual pleasure, diversity, and autonomy, sex positivity disrupts the assumptions that sexuality should be oriented toward reproduction, monogamy, and heterosexual partnership.

In the context of abortion care, integrating sex positivity allows for a more expansive understanding and affirmation of the sexual and gender diversities of those who access abortion care. This perspective opens space for conversations about the distinct needs of 2SLGBTQIA+ people, while challenging the cisheteronormative assumptions that commonly exist in abortion care. Leith described how cisheteronormative assumptions obscure the needs and experiences of 2SLGBTQIA+ people, including their unique contraceptive needs, future pregnancy risk, or the identification of violence in different relationship structures and identities, as also noted in previous literature (Bordogna et al., 2023; Carpenter et al., 2020; Charley et al., 2023; Goldberg et al., 2024; Jaffray, 2020). Incorporating sex positivity into how abortion care is delivered

therefore not only affirms pleasure and autonomy, but it also requires abortion care to move beyond the pervasive binarized and cisheternormative assumptions of who can become pregnant and might access abortion care.

Importantly, sex positivity also functions as a counter-narrative to the broader stigma that surrounds abortion. Abortion stigma often operates by framing sexual activities that result in unintended pregnancy as inherently irresponsible, immoral, or shameful. This framing may result in delivery of abortion care that feels like Ari's experience, with a greater focus on pregnancy risk and prevention, than on the future possibilities of sex and intimacy. Instead, a sex positive approach challenges this narrative by recognizing that unintended pregnancies can occur within normal and healthy sexual lives, and that abortion is an important part of reproductive-decision making, as it is one of many pregnancy outcomes. This aligns closely with a queer reproductive justice approach, as the normalization of abortion care promotes bodily autonomy, self-determination, and the right to make decisions free from stigma or coercion (Ross & Solinger, 2017). Altogether, participants' narratives suggest that integrating sex positivity into abortion care and education can help dismantle abortion stigma and create an inclusive model of abortion care delivery and education that resists cisheteronormativity in favour of acknowledging and affirming the existence and value of sexual diversity, pleasure, and autonomy.

Abortion as Gender-Affirming Care

For some participants, accessing abortion care was a crucial form of gender-affirming care that enabled bodily autonomy and relieved some feelings of gender dysphoria. Leith (she/they), a Two-Spirit and non-binary person, described the experience of gender dysphoria when accessing care from traditionally *women's* spaces, as they shared,

> …going anywhere and being considered a woman, a mother, a nurturer, whatever […] [it's] always very difficult for me to go into women's spaces. […] I feel like it would be the experience of gender dysphoria, having to access women's spaces. And then also […] when you're going into spaces that is for pregnancy, it's always under the umbrella of 'motherhood' and 'healthy mothers' and all this stuff.

Throughout their interview, Leith commonly discussed how femininity, pregnancy, and motherhood are deeply intertwined, which does not feel affirming to their gender identity as a Two-Spirit and non-binary person who experienced pregnancy. The associations between femininity, pregnancy, and motherhood that Leith described have been previously explored in the existing literature, and have been related to experiences of distress, isolation, and gender dysphoria for pregnant trans and gender-diverse people (Doyle, 2009; Fernández-Basanta et al., 2024; Kirczenow-MacDonald et al., 2020).

Jordan (she/they), a non-binary person, experienced distress and gender dysphoria when they discovered their pregnancy. Jordan described experiencing an "identity crisis" when they found out they were pregnant,

> I was having a full-blown panic attack because there's a thing in me, there's something inside me that is stealing my nutrients, and I don't like it. I kept imagining myself with this giant baby belly, like swollen ankles, and I was just like *no, no, no, no, no, no*. The idea of it - it gave me almost an identity crisis in a way. I don't want to be perceived as a mother. I don't want to be perceived as a woman who is pregnant.

Jordan expressed that their pregnancy felt like "a foreign alien concept," where they constantly felt like, "what the fuck is going on?!" Never wanting to have children or experience pregnancy, Jordan immediately knew she wanted to access abortion care. Their ability to access abortion

care provided some relief to their feelings of distress and dysphoria, highlighting how abortion care can be a critical form of gender-affirming care. Jordan illustrated how closely related gender-affirming care and reproductive healthcare are, as they enable bodily autonomy. They said,

> Bodily autonomy, to me, is being able to control what happens with your body and 'my body my choice' is a big thing. So, I feel like having gender-affirming care as well as access to birth control or reproductive health[care] is very important to bodily autonomy. And if we didn't have that, a lot of people, I feel like, would suffer.

When asked directly if being able to access abortion care and receive an IUD to prevent future pregnancies felt like a form of gender-affirming care to them, Jordan answered,

> In a way, yes. It took the aspect and the scare of pregnancy away from me for a while. And I've always had this five-year plan, by the time I'm 35, 36, I'm going to have my tubes tied or I'm going to have a hysterectomy, so I won't have to deal with [the possibility of pregnancy] anymore.

Ultimately, the ability to prevent pregnancy through various means, including abortion care, contraception, and eventually a hysterectomy, are critical forms of gender-affirming care for Jordan. However, Jordan noted that they experience privilege when accessing these forms of care, as they describe themselves as a feminine-presenting person. To Jordan, being feminine-presenting has enabled easier access to reproductive healthcare when compared to the experiences of her transmasculine friends. Jordan shared,

> I have quite a few transgender friends that feel very isolated, where they feel they can't access these things. […] I present very feminine for the most part for most people, and I find it very easy for me to walk into a pharmacy and go 'I need birth control,' and they go

> ‘Yep, yep, here you go.’ But then I have a friend who is transgender, and he walks in and says, ‘I need birth control,’ and they go, ‘Uh, your girlfriend needs to be here.’ And it’s like no, it’s for him, he needs it.

Charlie (they/them), a non-binary person, also spoke of how they “generally present femininely” which they thought may be an enabling factor in their access to abortion care, versus “if a more non-binary or masc-leaning person attempted to access the Women’s Clinic or go to the Women’s Hospital, I understand they might be turned away.” While there were no transmasculine participants in this study and no evidence that transmasculine people are turned away from accessing abortion care in Manitoba, Charlie’s statement acknowledges the unique challenges likely faced by transmasculine abortion seekers in Manitoba. Previous literature has illustrated how transmasculine people in reproductive healthcare spaces may feel invisible or rejected due to reproductive healthcare being geared towards women and femininity (Fernandez-Basanta et al., 2024). Thus, transmasculine abortion seekers in Manitoba may face challenges accessing care that feels inclusive, affirming, and dignified for their gender expression.

Ari (she/they), a “cis-ish” woman, spoke of the challenges faced by various gender identities, imagining how others may experience pregnancy symptoms and the wait to access abortion care. Ari reflected on how their ability to access abortion care quickly meant that they did not have to undergo major bodily changes related to pregnancy, such as breast growth and the feminization of the body. While she shared that she was not overly concerned herself about bodily changes, Ari thought of the possible discomfort experienced by transmasculine persons within an unexpectantly pregnant body. Ari explained,

> …luckily because I was only 6 weeks, my body wasn’t changing at all. There were no shifts. But I was like, what would this feel like if I was a transmasc person? My body

> would be puberty-ing all over again. Not only do I have to sit here for two weeks, but I'd be thinking about like, what if my breasts get bigger? In a way that as cis-ish [person] - and I'm like 'kay whatever, if my boobs get bigger that'd be kinda slay - I'm not super concerned about that and how it would shape my feelings about my identity and my comfort and my body. But I think that part of reproductive justice is really important, especially now as there's more discomfort and contention around bodies.

Overall, many participants spoke of how abortion is a critical form of gender-affirming care for themselves and others as it stops pregnancy-related bodily changes, relieves feelings of gender dysphoria, and ultimately enables bodily autonomy for trans and gender-diverse people.

Within a queer reproductive justice framework, these narratives demonstrate that abortion care is not solely about pregnancy termination, but can be deeply intertwined with gender identity, embodiment, and the ability to move through the world without experiencing gender dysphoria or misgendering. Previous research demonstrates pregnancy itself may intensify experiences of gender dysphoria for trans and gender-diverse people (Fernández-Basanta et al., 2024; Kirczenow-MacDonald et al., 2020), which aligns with some participants' accounts of how abortion care felt particularly affirming for their gender expression. Jordan (she/they), specifically, described abortion as a form of gender-affirming care that allowed them to regain control over their body and identity. Abortion care allowed Jordan to align her body and reproductive capacities with their sense of self as a non-binary person, similar to other forms of gender-affirming medical care. This understanding expands the conventional understandings of gender-affirming care beyond hormone therapy or surgeries, reframing abortion care, among other forms of reproductive healthcare, as forms of gender-affirming care.

This reframing is imperative, as it not only reframes who might access care, but also how care ought to be delivered. The non-binary and Two-Spirit participants in this study often described feeling unaffirmed within abortion and reproductive healthcare spaces, as these spaces failed to acknowledge their gender expression. Further, abortion care spaces are commonly framed as *women's* spaces, excluding non-women identities, and specifically non-feminine presenting people. From a queer reproductive justice perspective, *women's* spaces reproduce the healthcare systems' legacy of regulating gender and reproduction by enforcing cisheterosexism. Thus, reframing abortion care as a form of gender-affirming care requires both a recognition of diverse identities among those seeking abortion and a transformation of how cisheterosexism continues to operate within healthcare systems to police and regulate gender and reproduction.

Decolonizing Abortion Care

Integral to the interrelations of reproductive rights and queer rights is decolonization, as colonial projects enforce Christian socio-political influences that have gendered and essentialized reproductive roles, and contributed to the policing of sexuality and gender diversity (Parent, 2025). Colonial belief systems have played a central role in shaping the contemporary stigma that surrounds both 2SLGBTQIA+ identities and abortion care. In recognizing these influences, decoloniality becomes central to queering abortion care for Indigenous and non-Indigenous abortion seekers alike. Proponents of decolonization seek to break down the heteropatriarchal belief system that positions abortion and queerness as inherently sinful (Parent, 2025), while restoring relational understandings of care, autonomy, and community responsibility.

Prior to the colonization of Turtle Island, many Indigenous communities used traditional methods, such as herbal medicines, as contraceptives and abortifacients (Wells et al., 2026). Elder Louise McKay shared a teaching related to traditional Indigenous views of abortion. She

shared that there is no specific word for abortion in some Indigenous languages. Instead of using a specific word to describe or talk about abortion, the practice was simply understood as caring for others and providing them with the medicines they needed. Abortion was not a stigmatized or taboo moral issue, rather abortion was a form of collective care for a person in the community. Abortion occurred as a normal part of personal and community life. However, these practices became disrupted and suppressed by colonialism and settler influences, as settlers labelled these practices as shameful, immoral, and stigmatizing.

Before settler contact, sexual and gender diversity were similarly widely accepted and normalized within many Indigenous nations. Two-Spirit people often held significant roles in their communities, often as healers, educators, or spiritual leaders (Beaudry et al., 2024). However, through the process of colonization, rigid binary gender norms were enforced and Two-Spirit people became demonized and persecuted for existing outside of these norms. While there has been a resurgence of reclaiming and honouring Two-Spirit identities, ongoing colonialism, homophobia, and transphobia continue to shape the experiences of Two-Spirit and LGBTQIA+ Indigenous people (Beaudry et al., 2024; Dykhuizen et al., 2022). Thus, decolonizing abortion care in the context of this research relates not only to the way in which care is delivered but also challenges the colonial belief systems that continue to stigmatize abortion and 2SLGBTQIA+ identities.

Olivia (she/her) is a Metis bisexual woman whose experience accessing abortion care at St. Boniface Hospital illustrated how these colonial and religious influences remain deeply embedded within healthcare systems. St. Boniface Hospital is a Catholic tertiary health care facility in Winnipeg (St. Boniface Hospital, n.d.), and while it does not provide elective abortion care, abortion may occur in cases of medical necessity. Olivia’s abortion at St. Boniface was a

medical necessity, as terminating her pregnancy was necessary for surgeons to remove an enlarged ovarian cyst. Catholic hospitals are a contentious site when considering queering and decolonizing abortion care, as many originated through Christian missionary colonial projects that sought to heal people of their physical ailments while attempting religious conversions (Grudmann, 2025). St. Boniface Hospital itself was established with the goal of introducing European medicine to those residing in the Red River region, as Indigenous medicines were considered insufficient by the colonial project (Société historique de Saint-Boniface, n.d.). For Olivia, the hospital's religious environment shaped how she experienced abortion care. She shared,

> St. Boniface on the other hand - there's a church space, like a Christian-based background, and that was harder to navigate through. As much as I loved having the option of a service or whatever, it did feel really weird having the eye of god watching over you while you're having [an abortion] - a sinful procedure. It was really messed up actually. I remember [thinking] I'm going to hell for this right after. But I also was a little medicated [laughs]. But it just felt weird to like have spirituality brought into something so controversial. […] [And my bisexuality was] definitely something I felt like I needed to keep to myself 'cause, first of all, I'm getting an abortion in the churchiest of churchies. I'm not adding to it to be like 'I'm queer too.'

Olivia reflected on how the presence of religious symbolism made her feel as though she was being judged for both accessing abortion and for her bisexual identity, which she felt compelled to conceal during her care. Olivia shared that she felt St. Boniface staff "were kind of judgy that I put my needs first over the fetus," illustrating the stigma she felt accessing abortion care from a Catholic hospital and the need to decolonize abortion care within healthcare spaces themselves.

Decolonizing abortion care also necessitates ensuring that abortion care can be accessed in people's home communities, on the land that they are connected to. Currently, this is not a reality for many abortion seekers in Manitoba, as a Manitoba-based study found that 33% of Manitoban abortion-seekers had to travel outside of their home community to access care (Cowman et al., 2026). This is in-part due to procedural abortion care only being available in Winnipeg or Brandon, which are located in the southern region of the province. Travelling to access abortion care in Manitoba is often afforded out-of-pocket by the abortion seeker and may require eight or more hours of travel for care (Cowman et al., 2026). Further, travelling to access care disproportionately impacts those living in the Northern region of the province, including many Indigenous communities. Leith (she/they) is a Two-Spirit, non-binary, polyamorous, queer, and pansexual Metis person in Northern Manitoba who spoke about the importance of being able to access reproductive healthcare within her home community, emphasizing her relational connections to land, family, animals, and community as deeply important in the context of reproductive justice. Leith shared,

> To be able to access care in my community is super important and the main thing that I think of when I think of reproductive justice. I mean there's so many layers to it, especially with living in - I mean like I know that all of Canada is Native land - but [in Northern Manitoba] it is especially. Being in my home community is just so important to me, being with my land, being with my animals, with my family. Being held in my safe community, as weird as Thompson can be, it is my safe weird. So, being able to access everything here, and that also having things made as easy and seamless as possible, where there's really no reason why it shouldn't be, […] we should have surgical abortion available in Thompson. But a huge other part of it, not that it's quite part of my story, but

> a lot of people are forced to leave their home communities to give birth. And that's fucked up. I think that's true for a lot of places in Northern Manitoba, whether it's reserves or small communities.

Decolonizing abortion care also involves revitalizing traditional knowledges and healing practices. Leith described how access to plant medicines, Matriarchs, and Medicine People could transform reproductive health experiences,

> I think reproductive justice for me, whether it's with having an abortion or having a baby, is being able to access plant medicine. And being able to have Matriarchs and other queer healers and Two-Spirit people around you. And having the ability for those knowledges to be flourishing and growing. Like for example, fireweed […] grows right beside my house. […] these plants are right here, and I wonder what my experience would have been like - cause literally I bought a house a few blocks away from the apartment that I was having an abortion in - and the fireweed grows right over there too. What if I had just known about the fireweed and had been able to access this medicine in still a safe and informed way? Like what if there were healers? What if this traditional knowledge would have been passed onto us? When I think of reproductive justice I think of what could have been if we hadn't experienced colonization or things had gone a different way? But then how can we still access [traditional medicines] and bring that into this reality?

Leith's reflections also highlighted the importance of culturally grounded resources and healing practices in supportive abortion care. While sites like the Women's Health Clinic in Winnipeg have begun to incorporate more culturally grounded practices into their abortion care services (Fortner & Roberts, 2023; Women's Health Clinic, n.d.-a), this is not available throughout the province. Leith shared,

> … our family friend […] does like grief counselling and that type of stuff. And she had a really nice - she's not Indigenous - but she had a really nice workbook and sort of ceremony type thing. And it had a little teaching, and it was about an Indigenous couple who was sending their baby back across the river to the ancestors. So, I had talked with her, and I feel like there was other stuff. […] But I did a little bit of, I guess like the workbook and stuff just to process things that [the family friend] had shared with me.

Being able to access some culturally grounded care, specifically the teaching about sending their baby back across the river to the ancestors, was particularly meaningful for Leith while they processed their abortion.

Finally, Leith also spoke to the need for more resources for 2SLGBTQIA+ people, Indigenous people, as well as for other cultures. They expressed the idea that more resources and sharing traditional knowledges may be healing and empowering for those who access abortion care. Leith said,

> I would love to see very specific resources - like print resources, stuff online - that is specific for Manitoba that talks about reproductive justice and abortion for 2SLGBTQIA+ people and the intersecting issues that might exist for different groups. […] And I would love to see more stuff for Indigenous people, and also more cultural stuff. Not even just for Indigenous people, but just generally, culture and healing and traditional knowledges being brought to the forefront is very healing and empowering. And knowing that women and queer people have always been doing this in all parts of the world.

These narratives demonstrate that decolonizing abortion care requires a variety of measures. From a queer reproductive justice perspective, decolonization involves challenging the colonial

belief systems that have historically stigmatized both abortion and gender and sexual diversity, while also rebuilding systems of care that are grounded in Indigenous and queer knowledges.

As colonial and Christian moral frameworks continue to position both abortion and 2SLGBTQIA+ identities as deviant, this reproduces conditions where participants, like Olivia, experienced care as stigmatizing and morally fraught. From a queer reproductive justice perspective, the embedded colonial and Christian beliefs within facilities and systems constrain the true bodily autonomy of 2SLGBTQIA+ people through the reproduction of stigma. In this way, decolonizing abortion care necessitates a transformation of the ideological foundations of care so that abortion and 2SLGBTQIA+ identities are not positioned as inherently sinful or stigmatized. Decolonizing belief systems to support the reproductive knowledge and practices of Indigenous communities is something that has been previously discussed by a Canadian-based Indigenous reproductive justice scholar, Dr. Renée Monchalin. Throughout *The Fireweed Project*, Monchalin and colleagues reported that settler religious beliefs have suppressed Indigenous knowledges of how to end a pregnancy, while also making these practices taboo and stigmatized (Monchalin et al., 2023; Wells et al., 2026).

Leith also highlighted how colonialism has restructured relationships to land, community, and care in ways that directly impede abortion access. The need to leave one's home community to access services reflects a disruption of relational, place-based care that is central to many Indigenous understandings of wellbeing, while undermining how connection to the land is a determinant of wellbeing and a crucial aspect of reproductive justice for Indigenous peoples (Jubinville et al., 2022). Examining this through a queer reproductive justice lens, Leith's emphasis on remaining connected to their land, family, and community illustrates that achieving reproductive justice for Indigenous people and communities requires the ability to experience

care on one's own land and in one's own community. A Canadian reproductive justice scholar, Dr. Holly McKenzie, has previously written about the close ties between land relations and reproductive justice, asserting that "Indigenous individuals', families', and communities' self-determination cannot be fully achieved without deconstructing colonial genocidal relations and returning Indigenous lands to Indigenous peoples" (McKenzie et al., 2022, p. 1044). Therefore, decolonizing abortion care and supporting the reproductive justice of Indigenous peoples requires not only the availability of care in one's community, but ultimately requires land restitution.

Further, self-determination is another critical element of reproductive justice, as Leith reflected on how the absence of traditional Indigenous knowledges is a colonial harm that has ultimately shaped their inability to use fireweed and undergo abortion care in their home community through traditional means. Findings from *The Fireweed Project* (Wells et al., 2026) illustrate the importance of traditional Indigenous knowledges and medicines in honouring self-determination over one's own body. In terms of abortion care, fireweed was understood by some as a tradition of self-determination, but this tradition was disrupted through the demonization of plant medicines (e.g. fireweed), and abortion care (Wells et al., 2026). Decolonizing abortion care, therefore, requires honouring Indigenous self-determination through the resurgence of Indigenous knowledges and medicines that support bodily autonomy.

Ultimately, decolonizing abortion care is necessary to queer abortion care. As 2SLGBTQIA+ Indigenous participants navigated compounding oppressions within abortion care, challenging the racism and colonialism present within abortion care must be done alongside challenging the homophobia and transphobia.

Reimagining Reproduction & Family

When talking about queering and reimagining abortion care, participants talked not only about reimagining the way abortion care is orchestrated within the healthcare system, but how reimagining abortion care for 2SLGBTQIA+ people and communities requires a rethinking of family and reproduction more broadly.

Envisioning a heterosexual and nuclear family model within their former relationship, Leith (she/they) spoke to how the pressures of compulsory heterosexuality shaped the circumstances surrounding their abortion. Compulsory heterosexuality is the idea that heterosexuality is constructed, reinforced, and institutionalized as the only normal or acceptable form of sexuality (Rich, 1980). When Leith became pregnant within this relationship, they were forced to reckon with their identity, relationship, and impending abortion. They shared,

> I felt a lot of pressure to get myself into a heterosexual relationship where I'm just going to be a normal heterosexual. Yes, I'm queer but that's just a part of me that I can put aside and let out when I'm having a threesome or whatever. […] I got pregnant probably after just a few months of us being together. And once I was actually pregnant it became obvious that he was actually like, 'No, I don't want anything to do with this.' […] So, dealing with all of that and coming to terms with the fact that this is not a good relationship, and mourning the loss of what I thought was going to be a cute happy little family. And then it's like oh, I'm not having the baby, I have to have an abortion, and me and this guy are breaking up. Dealing with all of that was just so sad.

In face of the sadness and difficult circumstances Leith experienced, she also highlighted the plethora of queer and female support from those around them. This support not only helped them

to feel empowered and cared for during their abortion but helped to reimagine what family might look like in their own life. Leith expressed,

> I think it was a lesson in: what is family, what is community? Being a queer person, I'm never going to be a person who can be married to a heterosexual cis male. Like that's not who I am; I'm not going to have that type of family. And letting go of that and looking at what a family could look like for me.

Another participant, Lily (she/her), similarly reflected on what abortion meant for herself in terms of reproduction and family. Lily emphasized how being able to access abortion also enabled her to reimagine what family means in her life, through the refusal to birth biological children. She shared,

> Being able to access abortion both of those times, saved me from a life of despair, it saved me from repeating the life that I've watched my parents and my ancestors and everyone just repeat over and over again. Having children for the sake of status, for God, for whatever the reasons are, and being able to access these abortions, and be able to just choose to not have children is just - it's amazing. […] no women in my family lineage have ever chosen that.

While Lily decided against birthing children, she shared about being a stepmother throughout her interview and the joy of that role in her life. Through enacting this nontraditional model of family, Lily's own family structure is, in itself, queerly reimaginative, as she has resisted "sexual reproduction as the structuring centre of kin relations" (Butler, 2022, p.27).

In addition to the reckoning and reimagining of what reproduction and family may look like in their lives following accessing abortion care, some participants also spoke about their desire for future parenthood. Discussing future parenthood alongside abortion is inherently re-

imaginative as accessing abortion is commonly removed from the possibilities of future pregnancy and parenthood. Literature has theorized that this could be in part due to abortion representing a rejection of maternity and motherhood, thereby informing the assumption that those who access abortion care do not want to be mothers or parents at any point of their lives (Kumar et al., 2009). Ari disrupted this understanding, expressing her desire for future children, by insisting on "not having my one choice, one time, to have an abortion, be a blanket for my reproductive choices for the rest of my life." Ari also shared how affirming it felt to have a nurse practitioner and a friend speak about her abortion and future possibility of children,

> The nurse practitioner at Women's Health Clinic was asking me if I wanted to know if I had twin genetics and things, it actually felt like really affirming to talk about the fact that I might be pregnant again - that there might be another time where [accessing abortion care] isn't the case. 'Cause I think it would have felt un-affirming to my reproductive justice if it had been like, 'You're probably never going to have kids, you got an abortion when you were 25.' And like similarly a friend told me a story that her mom had an abortion when she was like 25 and then had kids when she was 30. So, like that felt like an integral part to me of like knowing and acknowledging that.

Along with talking about the possibility of future children alongside abortion, Jordan (she/they) described accessing abortion as a form of care for themselves, their partner, and for the possibility of having a child in the future. They shared about wanting to feel prepared if and when they choose to have a child, so that they can provide any possible child with a stable and supportive environment. Jordan expressed,

> I thought about it for like the first couple of years - they would have been this age, they would have been this old, and how would I have parented them if they had come into this

> world? Or if I had a child, what would have happened to me? Where would I be? Where would my partner be? And it was a very scary thought because we don't make a lot of money, so I feel like it wouldn't have been a good environment for them. So, to me, choosing what I did was a very big mercy upon us and upon themselves.

Ari, similarly, reflected on what her abortion means for the future children she would like to have,

> I'm just not prepared to have [a child]. And it also gives me the opportunity for me and my maybe future children that I get to have them with intention, hopefully. But that I get to have that in a way that I get to control and like oversee. […] You know there's that really micro scale of like I went through less pain, but also like, generationally, like my future offspring will be better off and I get to have control over that. And there's not just some baby floating around in the world that I'm unprepared to birth and care for.

Ultimately, participants described seeking abortion care as one way of exercising reproductive agency and shaping their reproductive lives with intention, including their desire to become parents at a time that felt right for them.

Beyond themselves and their own families, participants spoke to the necessity for the broader population to embrace reimaginative forms of reproduction and family structures that exist outside of the traditional nuclear cisheteronormative ideals. Katie (she/her) shared that not only should 2SLGBTQIA+ people be able to access abortion, but also to have the right to be parents in whatever form that may be. She expressed,

> I feel like every person should have the right to access abortion, to be allowed to have children within a safe and healthy environment, whether that be as a single parent, as a non-single parent, as like - whatever you identify as.

Olivia (she/her) similarly spoke to how she hoped for a future where herself, her partner, and future children do not face oppression simply for being a queer family,

> When I do eventually have children, I want them to have every right. Like I don't ever want to have them feel judged or you know? Based on anything. As someone in the queer community, reproductive justice is so important because what happens if me and their father break up and now it's me and their stepmom? So, having like the right to parent my kids the way that they should - that I see fit, or like my partner sees fit based on our lifestyles. And we're very, we're loving people who are very understanding and not oppressive, so like I would rather not have oppression brought into my children's life.

Through a queer reproductive justice lens, participants' narratives illustrate that the issue of 2SLGBTQIA+ abortion care is deeply entangled with the broader processes of reimagining kinship, reproduction, and the conditions under which families are formed beyond cisheteronormative ideals. Experiences such as Leith's demonstrate how cisheteronormativity shape expectations of what a "successful" reproductive life should look like, often centring the nuclear heterosexual family as both natural and desirable. The disruption of this imagined future, through relationship dissolution and abortion, was experienced as a loss, but it simultaneously acted as an opening to reconsider what family could mean outside of these constraints. In this sense, abortion was inherently transgressive for many participants, functioning as a critical moment of rupture that enabled them to disentangle themselves from the cisheteronormative scripts of reproduction, while also reimagining what community and family means for their identities and lives.

For participants, reimagining reproduction and family also challenged the dominant assumptions that position biological reproduction as central to the role of those assigned female

at birth. Lily's refusal of biological motherhood, alongside her embrace of step-parenting, disrupts the privileging of genetic ties and biological family making. Other participants, like Ari, challenged dominant assumptions of reproductive roles by resisting the notion that abortion forecloses future possibilities of parenthood. Instead, participants framed their abortion as a means of fostering intentionality with the conditions under which they might choose to reproduce. Rather than accepting the cisheteronormative scripts of reproduction and motherhood, participants disrupted and reimagined what family and the possibility of children means for them.

Importantly, participants extended these insights beyond their individual experiences, calling for broader societal recognition of diverse and non-normative family structures. Their reflections illustrate that reproductive justice ought to be queer, as reproductive justice must include the right to form families in ways that are affirmed, supported, and free from discrimination. Queering reproductive justice, therefore, must not only improve abortion services for 2SLGBTQIA+ communities, but it also necessitates a fundamental shift in how reproduction and family are conceptualized, moving away from cisheteronormative models and towards inclusive understandings of reproduction and family.

Conclusion

Altogether, participants' narratives reveal that queering abortion care in Manitoba requires more than just the inclusion of 2SLGBTQIA+ people within existing systems. Rather, it demands a fundamental transformation of how abortion care, reproduction, and family is understood and practiced. Participants emphasized the importance of integrating sex-positive approaches, recognizing abortion as a form of gender-affirming care, decolonizing reproductive healthcare, and reimagining dominant assumptions about reproduction and family. Through

resisting cisheteronormative and colonial understandings of abortion, participants point toward the possibility of care that is genuinely inclusive, affirming, and responsive to diverse identities and experiences.

Further, participants' narratives suggest that abortion can be reimagined through models of care closely aligned with reproductive justice. In challenging the stigma surrounding both abortion and queerness, participants resist the norms that position certain bodies, identities, and families as more legitimate than others. Importantly, this queering of abortion care seeks to shape systems of care that are more flexible, compassionate, and responsive to all abortion seekers, not only 2SLGBTQIA+ people. In this way, queering abortion becomes not just a resistance of norms, but a broader project towards collective reproductive justice.

Conclusion

This thesis set out to explore the experiences of 2SLGBTQIA+ people who have accessed abortion care in Manitoba, with particular attention to the barriers, facilitators, and possibilities for reimagining more inclusive and affirming systems of care. Using a queer reproductive justice approach and drawing on participants' narratives, this research demonstrates that abortion access for 2SLGBTQIA+ is deeply shaped by complex and intersecting structural, interpersonal, and infrastructural systems. 2SLGBTQIA+ participants encountered barriers to abortion care in Manitoba that have been broadly noted (Cowman et al., 2026), but these barriers are exacerbated through the entrenched cisheteronormativity in abortion care spaces. Altogether, this study argues that dismantling cisheteronormativity within abortion care and broader understandings of reproduction through reimagining systems of care is necessary to support access to affirming, inclusive, and dignified abortion care for 2SLGBTQIA+ people in Manitoba.

Participants' experiences revealed that 2SLGBTQIA+ abortion seekers in Manitoba navigate many of the same barriers and facilitators to care that have been previously documented in the Manitoba-based and Canadian literature (Cowman et al., 2026; Monchalin, 2023; Paytner, 2025). Geography, interpersonal dynamics, and fragmented healthcare systems acted as significant barriers for participants that often produced delays, stress, and socio-political conditions that undermined dignity in care. At the same time, social and emotional support from partners, family, friends, and healthcare providers emerged as a critical facilitator that enabled participants to navigate barriers and access care in supported ways. Importantly, these findings do not suggest that such barriers and facilitators are unique to 2SLGBTQIA+ people, rather they demonstrate how these well-documented structural conditions are experienced differently under different systems of oppression, such as cisheterosexism. From a queer reproductive justice

perspective, these experiences highlight how access to abortion is shaped through overlapping relations of power rather than as a neutral system of care.

Building on barriers and facilitators to accessing abortion care, this research highlights the persistence of cisheterosexism within abortion care settings in Manitoba and the ways it shapes 2SLGBTQIA+ participants' experience of care. The participants' narratives revealed that cisheteronormative assumptions are deeply embedded within healthcare interactions and institutional processes, often rendering 2SLGBTQIA+ identities as invisible. These dynamics often required participants to engage in additional emotional labour, such as managing disclosure, anticipating stigma, and navigating environments that may not affirm their identities. Informed by a queer reproductive justice approach, the findings point to how cisheterosexism is a significant barrier for 2SLGBTQIA+ people to access inclusive, affirming, and dignified ways.

Lastly, participants' narratives suggest alternative ways of conceptualizing and reimagining abortion care and reproduction more broadly. By centring sex positivity, understanding abortion as a form of gender-affirming care, and emphasizing decolonial approaches to reproduction and kinship, participants gestured toward more expansive and inclusive possibilities for care. Through a queer reproductive justice approach, these reimagining's challenge dominant cisheteronormative frameworks by recognizing diverse bodies, identities, and family formations, underscoring the need for abortion care that is ultimately affirming and inclusive of all identities.

Limitations

While this study provides important insights into the experiences of 2SLGBTQIA+ individuals who have accessed abortion care in Manitoba, several limitations should be acknowledged. First, the small sample size, Manitoba context, and qualitative design mean that

the findings are not generalizable to all 2SLGBTQIA+ individuals who have accessed abortion care. While this research sought to capture diverse identities and perspectives, not every 2SLGBTQIA+ identity was included in this study, and not every identity is homogenous. Additionally, as all participants in this study described themselves as feminine presenting, a significant limitation of this research is the lack of narratives from gender nonconforming or masculine presenting individuals. Despite these limitations, the study provides important insights into an area that has received very limited scholarly attention in Canada, contributing to a growing body of literature on queer and trans reproductive health.

Contributions

This research offers contributions to both practice and research, with particular relevance for social workers and other professions who are engaged in abortion and reproductive healthcare settings.

In terms of practice, this study highlights the urgent need to strengthen abortion care systems so that they are responsive to the diverse realities of 2SLGBTQIA+ individuals. Participants' narratives demonstrated how improving abortion care requires attention to both the structural and relational dimensions of practice. This includes implementing affirming and inclusive language, redesigning intake forms to reflect gender diversity, and ensuring that providers are trained in 2SLGBTQIA+ competent and affirming care. Participants' experiences also underscore the importance of improving system coordination to reduce fragmentation, minimize unnecessary delays, and reduce the burden placed on individuals to navigate complex and disconnected services. For social work practice specifically, these findings reinforce the profession's role in advancing anti-oppression, trauma-informed, and person-centred care within reproductive health contexts. Social workers are well positioned to support clients navigating

abortion care by providing emotional support, advocacy, system navigation assistance, and by actively challenging stigma within healthcare settings.

In terms of research, this study contributes to a growing, but still limited, body of literature on 2SLGBTQIA+ reproductive justice in Canada and is among a few studies to focus specifically on abortion care experiences within this population (Lowik, n.d.; Lowik, 2020). By centring the participants' narratives, this research contributes qualitative and justice-oriented knowledge that challenges dominant cisheteronormative framings of abortion access. For social work research specifically, this study aligns with social work's commitment to anti-oppressive practice by highlighting the systemic barriers gender-diverse individuals face and advocating for more inclusive, affirming, and equity-driven reproductive healthcare policies and practices.

This work is also consistent with the Canadian Association of Social Workers' (CASW) positions on both abortion rights and the rights of 2SLGBTQIA+ people, which affirm access to comprehensive, non-judgmental reproductive healthcare and the dignity, autonomy, and self-determination of all individuals. In grounding the analysis within these commitments, this research reinforces social work's ethical responsibility to challenge systemic inequities, including those embedded within healthcare systems, and to support policies and practices that uphold reproductive justice and 2SLGBTQIA+ rights.

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Appendices

Appendix A – Research Ethics Approval

Human Research Ethics - Fort Garry
[address]
[email address]

PROTOCOL APPROVAL

Effective: July 21, 2025 Expiry: July 20, 2026

Principal Investigator:	Emma Cowman
Advisor(s):	Lindsay Larios
Protocol Number:	HE2025-0148
Protocol Title:	*2SLGBTQIA+ Abortion Access in Manitoba*

Merissa Daborn, Chair, REB1

Research Ethics Board 1 has reviewed and approved the above research. The Office of Human Research Ethics (OHRE) is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans- TCPS 2 (2022)*.

Please note the following important information about your protocol approval:

i. Approval is granted for the research and purposes described in the protocol only.

ii. Any changes to the protocol or research materials must be approved by the OHRE **before implementation**.

iii. Any **deviations** to the research or **adverse events** must be reported to the OHRE immediately through an **REB Event**.

iv. This approval is valid **for one year only.** A Renewal Request must be submitted and approved prior to the above expiry date.

v. A **Protocol Closure** must be submitted to the OHRE when the research is complete or if the research is terminated.

vi. The University of Manitoba may request to audit your research documentation to confirm compliance with this approved protocol, and with the UM *Ethics of Research Involving Humans* policies and procedures.

Appendix B – Recruitment Poster and Social Media Post

Appendix C – List of Organizations Contacted for Recruitment

Preliminary list of organizations and research networks to ask for help with recruitment:

- Rainbow Resource Centre
- Women's Health Clinic
- Northern Reproductive Justice Network
- Northern Manitoba Abortion Support
- Sexuality Education Resource Centre
- Klinic Community Health
- Nine Circles Community Health
- Mount Carmel
- 2Spirit Manitoba
- The Graduate Queer & Trans Student Group at the University of Manitoba
- Alliance Allo Sexuelle-Hétérosexuelle – University of Saint Boniface
- LGBTQQ+ Collective – Brandon University
- Rainbow Lounge – University of Winnipeg
- Centre for Human Rights Research
- Village Lab
- Repro Justice Research Team Manitoba

Appendix D – Email Script to Distribute Recruitment Materials

SUBJECT LINE: *Request to Help Share Recruitment Call for 2SLGBTQIA+ Participants who have Accessed Abortion in Manitoba*

Hello,

My name is Emma Cowman and I am a Master of Social Work student at the University of Manitoba. I am currently working on a project for my MSW thesis, titled *2SLGBTQIA+ Barriers to Accessing Abortion Care in Manitoba*. The goal of this project is to explore the experiences of 2SLGBTQIA+ folks who have accessed or sought access to abortion care in Manitoba in the past five years. Exploring these individual experiences will help to uncover the unique issues, gaps, and barriers to abortion care that 2SLGBTQIA+ people face in Manitoba.

I am reaching out because I think this study is relevant to the work that you do and believe that you might be able to assist with the distribution of the recruitment poster on your social media and/or as a poster in your physical space. The poster is attached to this email as a PDF for your reference. If you choose to share the poster on social media, I have a caption for the post that I can share with you as well.

This project is looking for 2SLGBTQIA+ folks who are 18+ years old, and have accessed or sought access to abortion care since 2020 in Manitoba. This research involves a 1-1.5 hour virtual interview that will be conducted via Zoom. All participants will receive a $40 honorarium for their time and knowledge. The identities of participants will be kept confidential.

The results of the research will be used for my MSW thesis, along with possible academic and non-academic publications. All participants will be made aware of publications relating to this project, if they are interested. Furthermore, if you think this project would be of particular interest to others in your organization or could be useful in your work, I would be very interested in talking with you further about how we can work together, and I would be happy to share a summary of the findings with you once the project is complete.

Thank you for your time and please let me know if you have any questions or concerns or want to chat more about the project. Thank you for your consideration, I am looking forward to hearing from you!

Thank you!

Emma Cowman (she/they)

The faculty supervisor on this project is Dr. Lindsay Larios at the University of Manitoba. Her contact information is [email address].

Appendix E – Information and Consent Form

Faculty of Social Work – Fort Garry
[address]

[email address]

INFORMATION AND CONSENT FORM
Interview

Project Title: *2SLGBTQIA+ Barriers to Accessing Abortion Care in Manitoba*

Student Principle Investigator: Emma Cowman, Master's Student, Department of Social Work Student, University of Manitoba [email address].

Student Advisor: Dr. Lindsay Larios, Assistant Professor, Department of Social Work, University of Manitoba [email address].

Funder: Research Manitoba Master's Studentship Award

Conflicts of Interest: The researchers do not have any conflicts of interest in this study/research.

You are being invited to participate in an interview as part of the *2SLGBTQIA+ Barriers to Accessing Abortion Care in Manitoba* project. The following information will describe the purpose of this interview and what's involved in your possible participation. We strongly recommend that you print or download this page and keep it for your records. This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

What is the goal of this project?
The purpose of the research is to hear the experiences of those who identify as 2SLGBTQIA+ and have accessed abortion care in the province of Manitoba, in order to understand the key gaps and challenges to abortion care for 2SLGBTQIA+ individuals and communities in Manitoba.

What is the interview process?
If you consent to participate, you will be asked to take part in an interview about your experiences accessing abortion care in Manitoba. This interview will be recorded using our UMZoom account; video and audio are automatically recorded in separate files. The video file will be destroyed immediately after the interview and only the audio file will be

stored. This audio will be manually transcribed by the lead researcher using the ExpressScribe software, and will only be used for the purpose of the transcript. Your participation in this interview should take approximately 1 to 1.5 hours of your time.

As abortion can be a sensitive topic to discuss, please feel encouraged to have a support person (partner, friend, family member, counsellor, etc.) present with you for the duration of the interview. Please inform the researcher that you have a support person present with you before the interview begins as they will be asked to sign an Oath of Confidentiality prior to participating.

If you need an interpreter, please inform the lead researcher and an interpreter will be made available for your interview. The interpreter will be required to sign an Oath of Confidentiality prior to participating.

You will also be given the opportunity to review your anonymized interview transcript. This is a optional part of the process, where you will receive a OneDrive link in the following 2-3 weeks after your interview and will have an additional two weeks to respond or make changes to your transcript. If no feedback is offered, the transcript will proceed to be analyzed.

What are the possible risks?
The overall risks associated with this research are minimal. However, we do acknowledge that discussing abortion could be considered sensitive subject matter for some participants. As such, there could be some feelings of discomfort. The researcher is trained in trauma-informed interviewing and there will be time to debrief with them following the interview. You can take breaks at any time throughout the interview, or end the interview altogether at any point. Additionally, there is a list of resources located at the end of this consent form that you can contact if needed.

What are the possible benefits?
This research is not intended to benefit you personally. However, participating in the study will allow you to share your experiences and have your voice represented in a body of research that may one day have a positive impact on people seeking reproductive care in Manitoba.

Compensation
Participants will receive a $40 honorarium for their participation in this study. The honorarium will be delivered to participants via e-transfer or mail, depending on the participants' preference. If e-transfer is chosen, the participant will receive the honorarium immediately after consenting to participate in this study and before beginning the interview. If mail is chosen, the honorarium will be mailed as soon as possible after the interview concludes. If the participant stops the interview or withdraws their participation, they will keep the honorarium.

How will confidentiality be protected?

All your responses and information you provide will be kept anonymized, coded, and stored on a secure web-based server at the University of Manitoba. Only members of the research team will have access to this server, and we will only use the information for the purposes of the research described in this form.

Your interview will be assigned a code and your name and contact information will never be connected with your data. There will be a document that contains a list of codes and corresponding participant names, however this document will be securely stored on the project's UM OneDrive file and kept in a separate folder from the interview file. All anonymized and stored information will be destroyed approximately five years after this interview takes place (2030). The results of this research will be used in a master's thesis at the University of Manitoba and possibly in other publications. However, it will not be possible to identify you in the published results. If direct quotations from your interview are used, they will be attributed to a pseudonym or broad descriptors – for example, "One Winnipeg resident noted…"

If any information you give reveals a current danger to yourself or another person, or if a child that is possibly in danger of abuse or neglect, the researcher will be required to share this information with other individuals. This may include child protection authorities, police, professional regulatory bodies, or offices responsible for the investigation of vulnerable adults. Information would only be reported to police in cases of a risk of harm to either yourself or another identifiable person. In the case of information involving a child being harmed or at risk of being harmed, the researcher will report the information upon which the concern is based and any identifiable information they have to the local child welfare authority.

What will be done with interview responses?
This research will be used in a Master of Social Work thesis at the University of Manitoba. A summary of key research findings will be compiled and made available to interested participants of this study by approximately June 2026. Additionally, the results of this study may be presented in a variety of venues, including academic publications and conferences, media spots, online presentations, and public talks.

What happens if you want to stop?
You do not have to participate in this research. It is purely your decision. If you do participate, you are free to withdraw from the study during the interview. Simply say to the interviewer that you no longer wish to participate, and the process will immediately end. You can also ask that the information you provided not be used, and your choice will be respected. If you decide at a later date that you don't want your information to be used in the study, you must tell the researcher via email within 1 month of your interview. After this point, your information will have already been incorporated into the analysis.

How do you proceed?

If you would like to continue with the interview, please provide oral consent to the interviewer to confirm that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask the interviewer for clarification or new information at any point throughout the process.

For participating in this research, you will receive $40 at the time of the interview. This will not be impacted if you choose to withdraw from the study. There are no negative consequences for not participating, stopping in the middle, or asking us not to use your information.

After the interview is finished, there will be time to debrief with the interviewer. The interviewer will ensure that you were comfortable with the process and provide an overview of the next steps. This will also be an opportunity to ask any remaining questions you have or voice any concerns.

If you request to review your anonymized transcript from the interview, you will receive a OneDrive link within the 2-3 weeks following the interview. You will have one week from the day you receive the transcript to respond or make any changes.

Questions or Concerns?

The University of Manitoba may look at our research records to see that the research is being done in a safe and proper way. This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus. If you have any concerns or complaints about this project, you may contact any of the above-named persons, or the Human Ethics Officer at [phone number] or [email address]

If you have any additional questions about the survey, you may contact the lead researcher via [email address].

Consent

By signing this document, I agree that:
I have read the above information or had it read to me.
I have had the opportunity to ask and have had all of my questions answered.
I understand what is being asked of me.
I will be taking part in a research study.
I may freely stop or leave the research study activities at any time.
I understand what the researchers will do with the information I give them.
I do not waive my legal rights by participating in the study.

Notice Regarding Collection, Use, and Disclosure of Personal Information

Your personal information is being collected under the authority of *The University of Manitoba Act*. The University of Manitoba is committed to preserving your right to privacy. The information you provide will be used by the University to support our research. Your personal information will not be used or disclosed for other purposes, unless permitted by *The Freedom of Information and Protection of Privacy Act* or *The Personal Health Information Act*. If you have any questions about the collection of personal information: Ph: [phone number] or Email: [email address]

Participant-Interviewer Declaration

Date of Interview: _____

Participant Name: _____

Participant consents to participate:	YES _____	NO _____
Participant agrees to be audio recorded:	YES _____	NO _____
Participant agrees to be video recorded:	YES _____	NO _____
Participant wants to review their transcript:	YES _____	NO _____
Participant wants to receive a summary of research findings:	YES _____	NO _____
Honorarium sent to participant:	YES _____	NO _____

Interviewer Name: _____

Interviewer Signature: _____

Helpful Resources

If you feel you need additional support at any point, please reach out to one of the following agencies.

Crisis Lines:
WRHA Mobile Crisis Service
[contact information]

Manitoba Suicide Line (operated by Klinic Community Health Centre)
[contact information]

First Nations & Inuit Hope for Wellness Help Line

[contact information]

Organizations that Support Reproductive and Sexual Health & 2SLGBTQIA+ Communities

Women's Health Clinic
[address, website, and phone number]

Klinic Community Health Centre
[address, website, and phone number]

Rainbow Resource Centre
[address, website, and phone number]

Appendix F – Interview Guide

Interview Guide

Preamble

Thank you so much for being here today to participate in my study about 2SLGBTQIA+ experiences accessing abortion care in Manitoba. [Personal introduction]. I am conducting this research for my Master of Social Work thesis at the University of Manitoba.

Can I ask what your preferred name and pronouns are?

Thank you for sharing! I emailed you the consent form when we confirmed the interview date, however I am going to pull it up and go through it one more time with you, and then ask for your verbal consent to participate. Once I receive your verbal consent I will send you the honorarium via e-transfer, or if you would prefer a mailed honorarium I will send it out to you as soon as possible.

[Review consent form]

Today I am going to start by asking a few demographic questions to get to know a bit more about you before we begin the interview questions. The interview involves a few broad open-ended questions for you to share your story with me, and I have some follow-up questions that I may ask for additional clarity.

If you do not want to answer any questions that I ask, please let me know and we will skip them. Additionally, if you would like to take a break from the interview or withdraw your participation at any point, please let me know.

Do you have any questions before we begin?

Demographic Questions

- How would you describe your gender identity?
- How would you describe your sexual orientation?
- What is your age?
- How would you describe your racial, ethnic, or cultural identity?
- Do you have a disability status that you are willing to disclose?
- Where are you located?
- How would you describe your current relationship status?
- Do you have any children?
- What is your annual income, or alternatively how would you describe your socio-economic status?

- Are you a Canadian citizen or what is your immigration status?

Narrative Interview Questions

Can you share with me your story of accessing abortion care in Manitoba?

[Potential follow-up questions that may be asked depending on how the participant shares their story]

- What influenced your decision to access abortion care?
- How did you find out where or how to access care?
- Where did you access abortion care from?
- What method of abortion care did you access? What was your experience with this type of care?
- Did you receive any birth control counselling or education?
- Did you receive any emotional or mental health support before, during, or after your abortion care? Was this provided by the clinic or did you seek this type of support elsewhere?
- Did you receive anything for pain management during your abortion care?
- What support did you receive throughout your abortion care process? This might include support from family, friends, partner, online communities, or care providers.
- Did you experience anything that was unexpected?

In some communities, 2SLGBTQIA+ identities are stigmatized. Additionally, in some communities abortion care is stigmatized.

Did you experience any stigma, judgment, or discrimination related to your 2SLGBTQIA+ identity and/or accessing abortion care?

- If yes to both; can you explain what feeling doubly stigmatized was like?
- Were there any elements of your abortion care experience that were inclusive or affirming to you and your identities?
- Were there any elements of your abortion care experience that were not inclusive or affirming to you and your identities?

This project uses a reproductive justice framework. Reproductive justice includes the right to have children, the right to not have children, and the right to parent those children in safe and healthy environments.

What does reproductive justice mean to you in the context of your experience and identity?

- What do you think is the significance of reproductive justice for 2SLGBTQIA+ people and communities?
- When you hear the term "*queering* reproductive justice" what do you think of?
- What does bodily autonomy mean to you?
- Do you think you, personally, have reproductive justice in Manitoba?
- Do you think all 2SLGBTQIA+ people in Manitoba have reproductive justice?

How might you reimagine abortion care for 2SLGBTQIA+ people in Manitoba?

- What would you reimagine or recommend at the provincial or healthcare system level?
- What would you reimagine or recommend for healthcare providers or clinics?
- What would you reimagine or recommend for broader communities?

Lastly, I would like to ask; what did it mean for your life to have been able to access abortion care?

Is there anything else that you would like to share or add before we end?

Debrief

Thank you so much for sharing your experiences with me today, your insights and lived experience is incredibly valuable for this project and to shape recommendations to improve abortion care in Manitoba for 2SLGBTQIA+ people.

If you decide that you do not want your data included in this project anymore and would like to withdraw your participation, you can do so within a month from today's interview. After this point, your data will already have been included in the analysis. You do not need an explanation to withdraw, and can do so by sending me an email any time before [state date 1-month from today].

If this interview brought up any emotional or mental health concerns, I want to mention that there is a list of relevant emotional and mental health resources at the bottom of the consent form that you can reach out to at any time.

Lastly, if you have any questions in the future, please feel free to reach out to me using my email, which can be found on the consent form.

Thank you again for your participation today!

Appendix G – Transcript Review Email Script

Transcript Review Email Script

Subject line: *Optional: Transcript Review*

Hello,

Thank you again for your participation in my project about 2SLGBTQIA+ abortion care in Manitoba, and for sharing your experiences with me.

I am reaching out today because you indicated that you would like to review your interview transcript. Your interview has been transcribed, and it is available for you to review before I begin my analysis. Reviewing your transcript is entirely optional and there is no pressure to do so. If you would still like to review your transcript, you may provide comments, suggest changes to the wording or content to assist with accuracy and clarification, or request retractions. All revisions will be honoured and implemented. The transcript will be sent via email through a OneDrive link, and you will have two weeks from the day you receive the link to complete your review.

Please respond to this email confirming that you would like to review your transcript and I will send the OneDrive link as soon as you do so. If you no longer want to review your transcript, no response to this email is necessary.

If you have any questions or concerns, please do not hesitate to reach out.

Sincerely,

Emma Cowman (she/they)

Appendix H – Participant Code Log

Code Log

Code Name	Participant Name	Participant Email
P1		
P2		
P3		

Appendix I – Kokum's Circle Engagement

Kokum's Circle Engagement

On July 16, 2025, I (Emma Cowman) and my advisor (Dr. Larios) met with Elder Louise McKay and Elder Margaret Lavallee from the Kokums Circle at the Women's Health Clinic to discuss this project and invite the Kokums Circle to offer guidance throughout this project. Tobacco was passed, and the Kokums orally accepted the invite to provide guidance on this project.

The Kokums agreed to meet with Emma up to four times over the next year, via Zoom. Each Kokum will receive a $200 honoraria per meeting, with meetings lasting 1-1.5 hours each time.

Emma will reach out to the Kokums throughout the year, to schedule these meetings and bring questions to them about how to discuss the participants stories and represent the participants in a good way throughout the research. In these meetings, Emma will orally provide a brief anonymized summary of the relevant participants' stories accessing abortion care, followed by any relevant questions they have for the Kokums.