BEYOND COMPLACENCY:

Challenges (and Opportunities) for Reproductive Justice in Canada

SEPTEMBER 2022

LEAF
FAEJ

Published by
Women's Legal Education and Action Fund (LEAF)
180 Dundas Street West, Suite 1420
Toronto, Ontario, Canada M5G 1C7
www.leaf.ca

LEAF is a national charitable organization that works towards ensuring the law guarantees substantive equality for all women, girls, trans, and non-binary people.

This publication was created as part of LEAF's **Reproductive Justice Project**. This project looks to advance reproductive justice in Canada through law reform advocacy at the provincial and territorial levels.

Notably, LEAF recognizes that Indigenous, Black, and racialized women and trans people have long led the struggle for reproductive justice. This foundational and continuous advocacy by the communities most affected by reproductive injustice make our work possible. You can learn more about the past and present of the reproductive justice movement **here**.

Kat Owens prepared this report. Special thanks to Jen Gammad for copy-editing and design; to Winnie Zhang for graphic design; and to Kendra Barlow, Maitland Shaheen, Kienna Shkopich-Hunter, and Yasaman Mohaddes Khorassani for project support. Thank you to Paige Jung for creating the illustrations and graphic elements used in this report.

Thank you as well to the many individuals and organizations outlined in Appendix A of the full report for shaping our understanding of the reproductive justice landscape in Canada.

The Reproductive Justice Project is supported by Women and Gender Equality Canada.

Women and Gender Equality Canada / Femmes et Égalité des genres Canada
Canada

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INTRODUCTION

We cannot have substantive gender equality for women, girls, trans, and non-binary people [1] without reproductive justice.

The idea of reproductive justice is not new. As SisterSong Women of Colour Reproductive Justice Collective explains:

> Indigenous women, women of color, and trans* people have always fought for Reproductive Justice, but the term was invented in 1994.
>
> Right before attending the International Conference on Population and Development in Cairo, where the entire world agreed that the individual right to plan your own family must be central to global development, a group of black women gathered in Chicago in June of 1994. They recognized that the women's rights movement, led by and representing middle class and wealthy white women, could not defend the needs of women of color and other marginalized women and trans* people. We needed to lead our own national movement to uplift the needs of the most marginalized women, families, and communities.
>
> These women named themselves Women of African Descent for Reproductive Justice, and RJ was born. [2]

For this report, we acknowledge, draw from, and build on the work of these individuals, communities, and movements. We understand reproductive justice to mean that every person can:

1. Make their own choices about having or not having children
2. Access sexual and reproductive health services like:
   - » Birth control
   - » Abortion
   - » Assisted reproductive technologies
   - » Sex education
   - » Proper care during pregnancy, during childbirth, and after childbirth
   - » Prevention, diagnosis, and treatment of sexually transmitted infections (STIs)
3. Raise their children in safe and healthy environments
4. Access the resources and supports they need to parent with dignity

We cannot be complacent in Canada. We need to push more for real reproductive justice.

- KEMLIN NEMBHARD, WOMEN'S HEALTH CLINIC, WINNIPEG

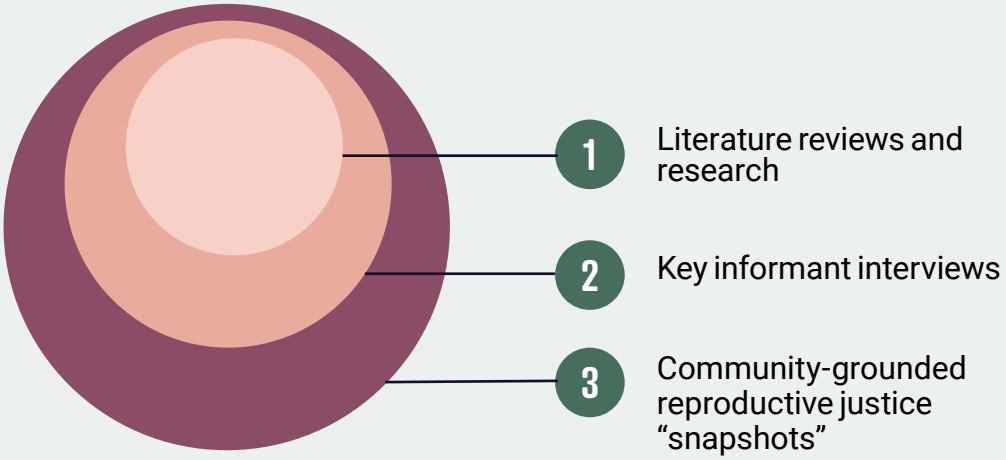
This report draws on academic and grey literature research, key informant interviews, and individual reflections to outline reproductive justice issues in Canada today. We highlight broad barriers and areas for law and policy reform in Canada relevant to all areas of reproductive justice, and provide suggestions we heard about what improvements could be made.

The issues identified here are far from exhaustive. The content of this report is informed by the positionality of the author and of LEAF. LEAF is a national non-profit organization, with a national office in Toronto, Ontario, and 11 volunteer branches located in five provinces. [3] We are a settler organization. While our mandate now explicitly includes non-binary people and all trans people, much of our work has been focused on cis women's rights. In addition, LEAF focuses on systems change, and does not engage in direct service delivery or front-line work. We do not work directly in communities, but instead benefit from the expertise and insights of organizations active in their communities, academics, and legal practitioners in carrying out our work. This report has also been shaped by the framing of the research questions, and the organizations and individuals involved in interviews and reflections.

With this work, however, we aim to continue the conversation, and provide a springboard for advocacy efforts. This report will advance LEAF's Reproductive Justice Project, providing a foundation on which LEAF branches can advocate for important legal and policy changes at the provincial and territorial levels. Through this advocacy, we will strive to move ever closer to realizing reproductive justice in Canada.

METHODOLOGY

IN CREATING THIS REPORT, WE RELIED ON THREE TYPES OF RESEARCH:



Literature reviews and research

We commissioned three literature reviews, asking authors to summarize recent law and policy issues related to four reproductive justice issues:

- Child welfare
- Pay equity
- Reproductive services (e.g., abortion, contraceptives, sexual health, assisted reproduction)
- Parental rights in 2SLGBTQQIA relationships

The literature reviews focused on five regions: Alberta and Manitoba, Ontario and Nova Scotia, and Quebec. We chose these regions as each had at least one LEAF branch active within it.

We also commissioned research on the legal framework for fertility clinics in Ontario, with a focus on the impacts on trans and non-binary people.

Finally, members of LEAF's Law Program Committee [4] and staff had the opportunity to submit relevant research or scholarship on reproductive justice law and policy issues.

Key informant interviews

We carried out 14 key informant interviews. Informants worked across different areas of reproductive justice, including abortion and contraception, sexual and reproductive health, doula and midwifery services, youth in care, and surrogacy. Some provided direct health services, while others focused on research and advocacy. The majority worked for organizations with a regional scope, while some worked for national organizations.

We asked each informant the following questions:

- Can you tell us about your organization and the work that you do?
- What are some of the barriers to reproductive justice for the communities you serve?
- Are there any particular laws, policies or programs that you think should change?
- Are there any laws, policies or programs that advance reproductive justice in your community?

We identified barriers shared by multiple interviewees, as well as barriers that appeared significant even if raised by only one or two interviewees.

Reproductive justice "snapshots"

To facilitate our reproductive justice "snapshots", we reached out to 22 different organizations. We prioritized organizations with relationships with marginalized and/or under-represented groups, including women, trans, and non-binary people who:

- Are Indigenous, Black, and/or racialized
- Face criminalization and/or incarceration
- Live in Northern and/or rural areas
- Are disabled
- Engage in sex work
- Are newcomers to Canada

We also tried to achieve geographic representation, and a mix of urban and rural participation.

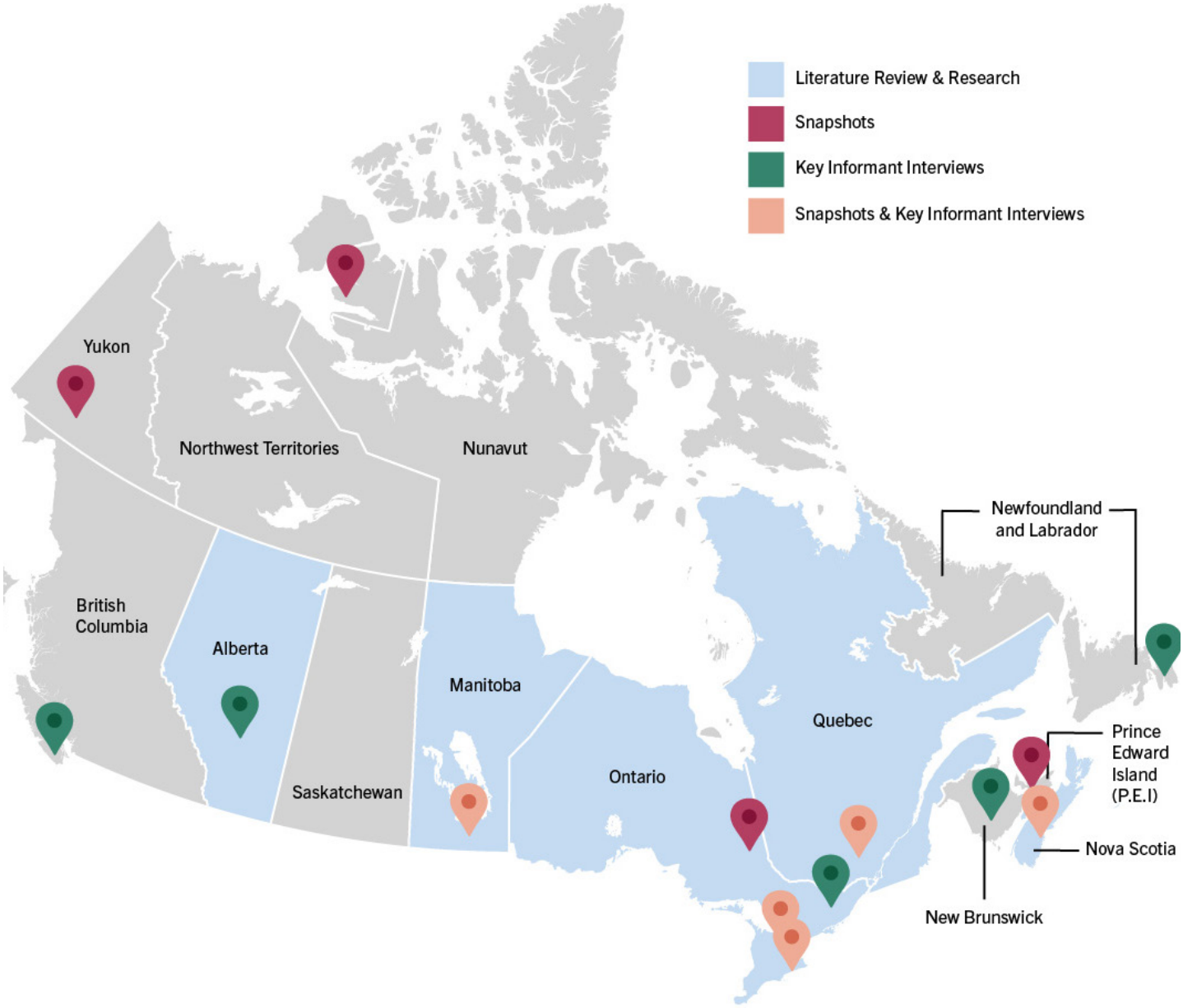
We asked the organizations if they could identify individuals to provide community-based information on reproductive justice needs for particular groups. We provided each organization with broad criteria to consider, but gave them autonomy in making the decision. We also provided organizations with an honorarium to acknowledge their contribution.

Ten organizations referred us to at least one person to participate in the snapshot activity. We also reached out to one individual directly.

We asked participants to reflect on the reproductive justice needs they see in their own lives and the lives of their communities. We invited them to identify existing barriers and potential reforms, as well as policies or programs that promote reproductive justice in their communities. We received 12 snapshots, which included written reflections, poetry, visual art, spoken reflections, and interviews.

We have compiled these snapshots into ***A Long Way to Go: Collective Struggles & Dreams of Reproductive Justice in Canada*** , a reproductive justice anthology.

Figure 1: Research locations for report



BARRIERS TO REPRODUCTIVE JUSTICE

Through our research, we identified many barriers to reproductive justice, as well as areas for law and policy reform to get closer to realizing reproductive justice. Some of these barriers were present in most if not all areas of Canada, while others were unique to specific regions. While women, trans, and non-binary people face barriers to reproductive justice, these barriers differ in type and in impact. Throughout the report, we have tried to emphasize the experiences of Indigenous, Black, racialized, disabled, and/or low-income women, girls, trans, and non-binary people wherever possible.

We have identified two main categories of barriers that limit the ability to choose to have or not have children, and to raise any children with dignity:

» Barriers to accessing sexual and reproductive health education and services
» Barriers to accessing the resources and supports necessary to parent with dignity

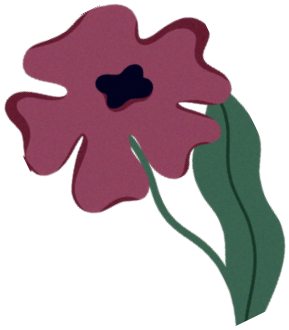
A: BARRIERS TO ACCESSING SEXUAL AND REPRODUCTIVE HEALTH EDUCATION AND SERVICES

Access to sexual and reproductive health education and services is critical to ensuring that women, girls, trans, and non-binary people are able to make their own decisions around whether or not to have children. This section begins by examining barriers to quality sexual and reproductive health education. It then looks at barriers to accessing sexual and reproductive health services, including contraception, abortion, fertility preservation, fertility treatments, and birthing supports.

I. ACCESSING SEXUAL AND REPRODUCTIVE HEALTH EDUCATION

Quality sexual and reproductive health education lays the groundwork for a person's understanding of key reproductive justice topics. It helps people understand healthy relationships and sexuality. It provides important information on contraceptives and abortion, but also pregnancy, childbirth, and supports available if a person has difficulties becoming pregnant.

Despite its importance, sexual health education greatly varies in quality and content across the country, and even within specific provinces and territories. Sexual education is particularly lacking for queer and trans youth. [5] In some instances, youth do not receive even basic sexual education. [6] In other cases, the quality of sexual education can be "a toss-up", as teachers do not receive sufficient training to provide this education. [7] Curricula also often change based on which political party is in power. [8]



The extent of my knowledge on safe sex and birth control was placing condoms on a banana one day in grade 9.

Other than that, our sexual education class was limited to a box that sat on our teacher's desk where we were able to anonymously place our questions into to be answered during class.

- KEKE

Bringing in outside supports can help fill gaps, subject to capacity limitations. We heard that sexual health educators and nurses can provide quality education, but not all schools have the resources to bring in these supports. [9] At the same time, there are risks with relying on external education providers without sufficient quality control. In Alberta, for example, crisis pregnancy centres have presented misinformation in schools. Some boards have banned presentations by these groups, but they appear to have continued in other areas. [10]

We heard that a national strategy on sexual education could help to promote better quality education throughout Canada. [11] It is also important to think about how to provide sexual education outside of the classroom, particularly for youth who do not regularly attend or drop out of school. [12]

There's definitely room to educate and support the youth. These are the people who are going to be coming up, and they will have a better way of passing that on to their children in the end, where they feel more confident and sounder about what they are doing in their lives as well.

- A MEMBER OF THE AFRICAN NOVA SCOTIAN COMMUNITY

II. ACCESSING SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Access to sexual and reproductive health services is unequal in Canada. This section begins by examining barriers to accessing sexual and reproductive healthcare broadly. It then looks at specific examples of sexual and reproductive health services, including contraceptives, abortion, fertility preservation, fertility treatments, and birthing supports.

A. Barriers to accessing sexual and reproductive health services

At a fundamental level, many people in Canada lack access to basic primary healthcare. [13] Regular healthcare providers such as family doctors, specialists, or nurse practitioners act as a first point of contact for many people in Canada when it comes to the healthcare system. Despite this, as of 2019, approximately 4.6 million Canadians did not have a regular healthcare provider. [14] This is a problem throughout the country. For example, Nova Scotia has a family doctor shortage, with rural areas facing particular challenges. [15] In Ontario, it can also be difficult to find a family doctor, and more difficult still in rural and northern areas. [16]

We heard that the fee-for-service model used for public healthcare in Canada presents particular problems for quality sexual and reproductive healthcare. This model creates incentives for doctors to see as many patients as possible, even if they would rather provide slower and more thorough care. [17]

In some cases, these "incentives" constitute neoliberal efforts to make providers agree to do more for less, while in others they reflect intentional efforts to disrupt services. [18] In either case, the system is not set up to effectively support people with complex needs or who have experienced trauma, who may need more time with healthcare providers than the fee-for-service model allows. [19] Providers who want to offer adequate services then face significant financial and personal consequences, effectively volunteering and providing unpaid services. [20]

Other healthcare professionals do not have the same fee-for-service model, but are not allowed to provide the same types of care, or require doctor supervision to do so. In Quebec, for example, only nurses with prescription privileges can provide contraceptives, but others require a doctor to sign off before they do so.[21]

Sexual and reproductive health services do not receive sufficient government investment. One reason for this is misogyny, which causes reproductive health to be overlooked even though it affects every single person. [22] New Brunswick, for example, sees chronic underfunding of certain services, especially those that help women, queer, and trans people. [23] This is also the case in Nova Scotia, where there is "a chronic lack of investment in reproductive services." [24]

Even where there is funding, policy or other choices may still result in inadequate care. As one key informant noted: "If you have adequate pay, but refuse to hire gynecologists, is that investment? If you refuse to make doctors provide adequate services, where one or two specialists (often also women) have to pick up the slack until they burn out, are you really investing?" [25]

For women, girls, trans, and non-binary people, factors such as sexism, anti-Indigeneity, racism (and anti-Black racism in particular), transphobia, ableism, and fatphobia/sizeism shape their ability to access needed care:

- Black, Indigenous, and racialized women lack confidence in the healthcare system, which has historically mistreated them and continues to do so today. [26]
- Women who live in poverty, who are street-involved, or who are survivors of gender-based violence face additional barriers. [27]
- For newcomers to Canada, a lack of translation in hospitals can create barriers to accessing sexual and reproductive healthcare.[28]
- Trans people face transphobia, discrimination, and insufficient information in accessing healthcare, and doctors who may have had little or no training on key trans healthcare topics.[29]

Women, trans, and non-binary people who are criminalized and/or at risk of criminalization face significant barriers to accessing reproductive health services. In prisons, incarcerated women, trans, and non-binary people face inadequate healthcare and expertise. [30] A recent study found that incarcerated women in Ontario, for example, "had trouble initiating, discontinuing, and following up with contraception; and with addressing pregnancy-related needs regarding miscarriage, abortion, antenatal care, labour and delivery, and postpartum care." [31] Young adult sex workers in Ontario have reported barriers to accessing reproductive health services including judgment and insufficient knowledge about sex work on the part of healthcare providers. [32]

Healthcare providers make decisions based on their own biases, which include ableism, racism, and classism.[33] For example, Black women are not believed to feel pain in the same way as white women. Indigenous women are often assumed to be using drugs.[34] These beliefs racist are incorrect; worsen the care that Black, Indigenous, and racialized women receive; and discourage them from accessing the healthcare system.

We heard that our cultural conception of doctors, however, makes it difficult to challenge these behaviours. Seeing doctors as all knowing and infallible makes it harder to correct behaviours or to counter racial stereotypes.Medical schools are often unresponsive to changing or improving the education they provide students, or looking to enroll more racialized students. [35] As a result, many women, girls, trans, and non-binary people in Canada do not have access to adequate reproductive and sexual healthcare.

The biggest barrier to reproductive justice is systemic inequities around race and healthcare. Women of colour do not have a lot of confidence in the healthcare system, which has historically mistreated racialized women and continues to do so today.

- BOMA BROWN,
SUPPORT NETWORK FOR INDIGENOUS WOMEN AND WOMEN OF COLOUR

B. Barriers to accessing contraception

Canada does not have universal pharmacare. Individuals without insurance often have to pay for contraception. Insurance plans may not cover all types of contraceptives. They also typically favour long-lasting contraceptives like intrauterine devices (IUDs), which may not work for all people. [36]

Different provinces and territories have different regulations for who can prescribe contraceptives. In some regions, a wide variety of healthcare providers can issue prescriptions. In others, access is much more limited. There has been advocacy to make contraception available over the counter, to increase access, but this advocacy has not yet been successful. [37]

Figure 2: Healthcare providers and their ability to prescribe contraception, by province/territory [38]

PROVINCE/ TERRITORY	PHYSICIANS	NURSE PRACTITIONERS	REGISTERED NURSES	MIDWIVES	PHARMACISTS [39]
Yukon	Yes	Yes	No	Yes	No
Northwest Territories	Yes	Yes	No	Yes	No
Nunavut	Yes	Yes	No	Yes	No
British Columbia	Yes	Yes	Yes (but require additional training)	Yes (but require additional training)	No
Alberta	Yes	Yes (but require additional training)	Yes (but require additional training and also none prescribe)	Yes	Yes
Saskatchewan	Yes	Yes	Yes (but require additional training)	Yes	Yes (but cannot prescribe IUDs)
Manitoba	Yes	Yes (but require additional training)	Yes (but require additional training)	Yes	No
Ontario	Yes	Yes	No	No	No
Quebec	Yes	Yes (but only up to 6 month supply)	Yes (but require additional training)	Yes (but cannot prescribe IUD and can only prescribe contraceptives for a maximum of 6 months)	Yes
Newfoundland and Labrador	Yes	Yes	No	Yes (but require additional training)	No
Nova Scotia	Yes	Yes	Yes (but require additional training)	Yes	No
New Brunswick	Yes	Yes	No	No	Yes
Prince Edward Island	Yes	Yes	No	No	No

A key barrier to reproductive justice is that the healthcare, child welfare, education, and other systems are based on colonial models that harm Indigenous communities, and that still harm them.

- CLAIRE DION FLETCHER,
NATIONAL ABORIGINAL COUNCIL OF MIDWIVES

C. Barriers to accessing abortion

Abortion is not a crime in Canada. Canada regulates abortion care as a clinical procedure in the case of aspiration or surgical abortion, and as a pharmacological agent in the case of medical abortion. Policies governing abortion, however, indirectly create unequal access. Our key informants often mentioned frustration with their continued need to advocate for abortion access despite its legal status in Canada. They hoped to work on broader reproductive justice issues, but felt stuck in a never-ending battle for abortion access.

Aspiration abortion "is a procedure to end a pregnancy" where a healthcare provider "inserts instruments into the vagina and through the cervix to remove the contents of the uterus.

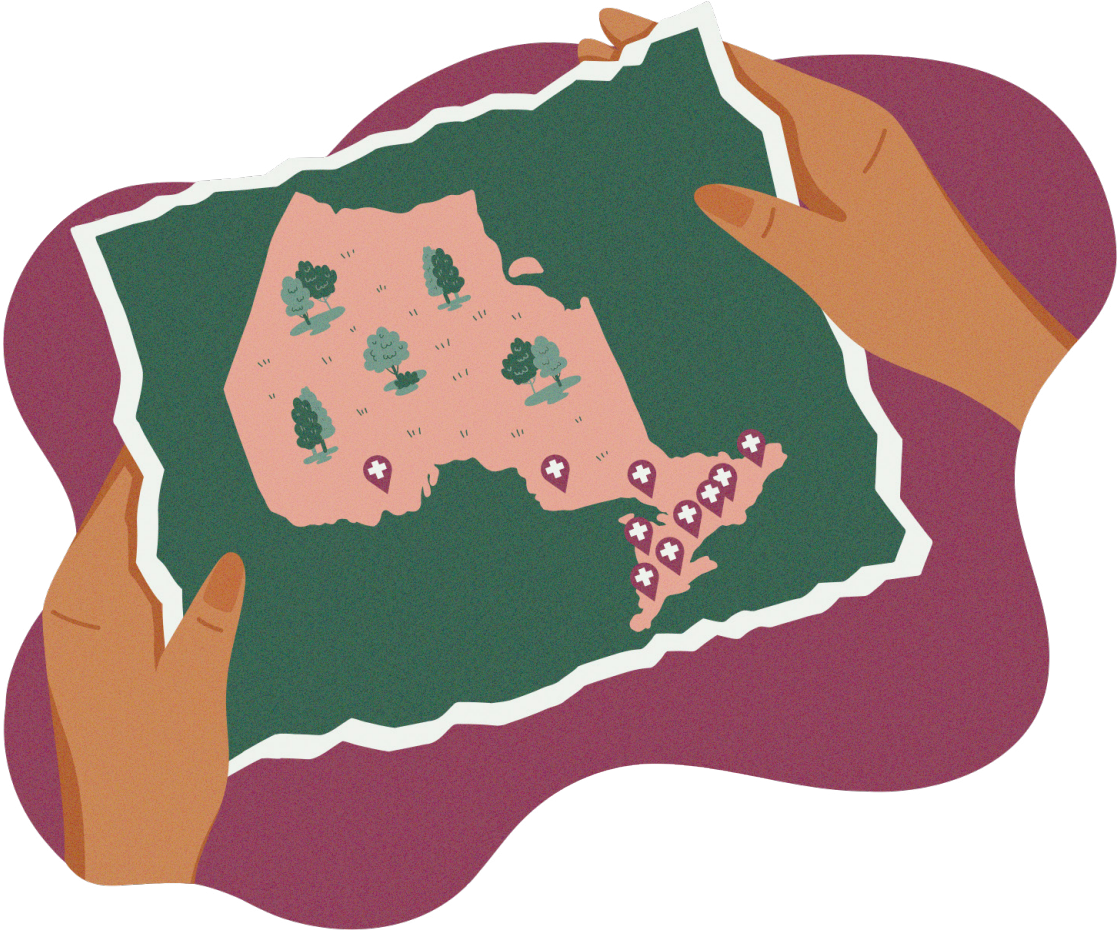
Medical abortion "ends pregnancy by using two different types of medication: mifepristone and misoprostal", similar to "an induced miscarriage."

Sources: "Aspiration Abortion FAQ's", online: *Women's Health Clinic* <https://womenshealthclinic.org/what-we-do/abortion/aspiration-abortion-faqs/>; "Medication Abortion FAQ's", online: *Women's Health Clinic* <https://womenshealthclinic.org/what-we-do/abortion/abortion-faq/>.

Our research highlighted five main barriers to accessing abortion in Canada:

1 Abortion providers are concentrated in urban areas, requiring significant travel for those outside of those specific cities.

In Manitoba, for example, aspiration or surgical abortions are only available in Winnipeg. [40] In Alberta, elective aspiration abortions are limited to three clinics, with two in Calgary and one in Edmonton. [41] In New Brunswick, only two cities have hospitals that provide abortion services. Unlike clinics located outside of hospitals, these hospitals arbitrarily and unnecessarily require attending appointments on two separate days, which may not be back to back. As a result, attending appointments can mean up to 17 hours of driving for people seeking care. [42]



Even relatively larger cities and regions may not have abortion providers, or may not have sufficient abortion capacity. For example, aspiration abortion is available in the Niagara region in Ontario, but it is often faster and easier to travel to larger cities, including Hamilton and Toronto. [43]

In Nova Scotia, the provincial self-referral line for abortion services has improved access, but access remains an issue in some parts of the province, particularly Cape Breton. While there are medication abortion prescribers in Cape Breton, Cape Bretoners must leave the island to access aspiration abortion care. [44] Sydney, the province's second-largest municipality, has a regional hospital that would be capable of providing aspiration abortion services, but apparently lacks the institutional will to do so. [45] As a result, Cape Breton residents requiring an aspiration abortion must travel to the mainland to access those services. For a Sydney resident, the distance could be approximately 300 kilometres to Truro or over 400 kilometres to Halifax. [46]

Quebec presents a different version of the urban/rural divide. Each of the province's 17 administrative regions are required to provide abortion services within the public system, either at local hospitals or Local Community Service Centres (CLSCs). Not all clinics, however, provide the same level or frequency of services. In some cases, it ends up being faster for pregnant people to travel to Montreal if they live in an underserved region. [47]

For those living in rural areas, accessing an abortion can require taking time off work, paying for travel, and figuring out childcare. While abortion clinics may require only one appointment, hospitals can require multiple, [48] further increasing costs. Those leaving small communities also face privacy challenges, with their departures raising questions from other community members. [49]

2 There is often insufficient professional capacity and/or willingness to provide abortions.

Not all healthcare providers are willing or able to provide either medication or aspiration abortions. In some cases, this is because of a lack of training. Abortion care is not adequately taught in medical and nursing programs, despite one in three people with a uterus requiring abortion care in their lifetimes. [50]

In other cases, there has been a lack of institutional effort to increase abortion capacity. For example, Newfoundland and Labrador has hospitals in almost every community, but there is a reluctance to "force" healthcare providers at these hospitals to provide abortion care. Those providers who would be willing to provide abortion services have not been asked to do so. [51]

We also heard specific challenges about medication abortion. Currently, doctors and nurse practitioners can prescribe Mifegymiso, the medications required for medication abortion. In Alberta, however, doctors have been overly cautious to provide medication abortion. [52] While some doctors outside of St. John's are willing to prescribe Mifegymiso, it can be a challenge to find pharmacies willing to dispense it. [53] In the Niagara region of Ontario, it has seemed to be more difficult to access medication abortion than aspiration abortion. [54]

3 Getting an abortion can be expensive.

This is the case for pregnant people who need to travel to an urban setting, who may need to pay for transportation, accommodation, and/or childcare. It is also the case for those who do not have health insurance, which includes people without documentation and some temporary foreign workers. [55]

Patients at private clinics may face extra fees, as fee-for-service billing is insufficient to cover the costs associated with providing surgical procedures outside of hospitals. Provincial and territorial governments are the most culpable for this shortcoming because they do not universally provide the additional or alternative funding that would be required to avoid user fees. Stricter requirements by physicians' colleges have magnified this pre-existing problem. [56]

4 Governments have not provided enough funding for providing or expanding abortion services outside of hospitals.

Hospitals are not considered best practice for providing abortion services. This is in part because of confidentiality concerns, given the number of staff, patients, and others present at a hospital. In addition, not all staff at the hospital will support providing abortion services, creating a less welcoming environment. [57]

Abortion services are only available in St. John's. The abortion clinic will travel outside the metropolitan area in Newfoundland once a month, but there are no services in labrador. To get an abortion, you'll need to get on a plane, which can cost $1200.

- NIKKI BALDWIN
PLANNED PARENTHOOD NEWFOUNDLAND AND LABRADOR SEXUAL HEALTH CENTRE

5 There are information gaps—and misinformation—surrounding abortion care.

Sometimes, this limits a pregnant person's ability to find a provider to access the care they need. For example, it can be difficult to find information about providers who will perform later term abortions due to the stigma associated with these procedures. [58]

Other times, pregnant people receive inaccurate information about abortion, with potentially harmful effects on their health. We repeatedly heard concerns about the role of Crisis Pregnancy Centres (CPCs). In the Niagara Region of Ontario, many CPCs spread misinformation about abortion and can delay pregnant people from getting abortions if that is what they decide to do. At the same time, they continue to receive referrals as they appear to provide needed supports to low-income parents and pregnant people. [59]

We also heard from interviewees about two key policy themes that can help improve abortion access:

1 Creating "bubble zone" legislation.

Bubble zone legislation establishes an area around abortion clinics in which people may not carry out certain activities, like protesting or telling a person not to access abortion care. Those who violate the legislation can face fines or imprisonment. While multiple provinces have this kind of legislation, [60] several do not. Manitoba, for instance, has not enacted bubble zone legislation. [61]

Importantly, this legislation has allowed pregnant people to feel safer going to clinics. [62] It has also lessened the burden on clinics, who previously would have needed to spend resources going to court to seek an injunction against anti-abortion protestors. [63] There are legitimate concerns with increasing abortion access through carceral means, but locating restrictions in provincial legislation rather than the Criminal Code may be a better approach. [64]

2 Make it easier to access medication abortion.

One way would be through "no touch" medication abortion, where an individual can speak to a provider over the phone who then sends the prescription to the pharmacy for pick up. [65] This could improve access for those without a family doctor, or who would have difficulty attending a doctor's appointment in person. Another way would be to make the pills required for a medication abortion available over-the-counter. [66] This would allow pregnant people to access the pills required for a medication abortion without a prescription.

D. Barriers to accessing fertility preservation

Individuals seeking to preserve their genetic material can face significant expenses that may not be covered by health insurance. This is particularly relevant for trans people looking to begin hormone replacement therapy (HRT), which can cause fertility reduction or loss. In Quebec, for example, it can cost $4,000 to $5,000 to freeze eggs. That cost is no longer covered by provincial healthcare, and it is not covered by most private insurers. [67] Ontario covers the costs of one treatment cycle per patient, but will not cover the annual costs of storing genetic materials. [68] Preserving genetic material can also entail significant travel expenses for those outside of major urban centres, who may need to travel hours from home for multiple procedures. [69]

The medical system does not provide trans people with adequate information about how to start a family, including about their options to preserve their genetic material before starting HRT, which can cause fertility reduction or loss. This lack of information is even more pronounced for trans people who are also HIV positive. [70]

There are further challenges for HIV+ individuals, particularly trans people who are looking to preserve genetic materials before starting HRT. Individual sperm banks can decide whether they think a sample provided by an HIV+ person would pose a risk to the recipient or future child. As a result, many HIV+ people are unable to access sperm banks to preserve their genetic materials. [71]

E. Barriers to accessing fertility treatment

Women, trans, and non-binary people may require fertility treatments, such as artificial insemination or in vitro fertilization (IVF) to have children. About one in six couples in Canada experience infertility, meaning they cannot conceive despite making efforts to do so over a "reasonable period". [73] Others may also look to fertility treatments to have a child, including individual cis women, trans men, and lesbian couples.

Cost is a significant barrier when it comes to accessing fertility treatments. Women, trans, and non-binary people face different costs based on where they live. As of 2022, seven provinces provided financial support to residents undergoing fertility treatments. The form of support differs depending on the province, as illustrated in Figure 3.

Figure 3 – Provincial Financial Support for IVF

PROVINCE	FINANCIAL SUPPORT FOR IVF?	TYPE OF SUPPORT
British Columbia	No	N/A
Alberta	No	N/A
Saskatchewan	No	N/A
Manitoba	Yes	Tax credit for up to 40% of fertility treatment costs, to a maximum annual tax credit of $8,000[73]
Ontario	Yes	Will pay for one round of IVF treatment per patient, and one additional cycle if the person is acting as a surrogate. Sex, gender, sexual orientation or family status are not considered in determining eligibility[74]
Quebec	Yes	Will pay for one round of IVF treatment for female-male couples, female-female couples, and single women[75]
Newfoundland and Labrador	Yes	$5,000 subsidy per cycle, to a maximum of 3 cycles[76]
Nova Scotia	Yes	Tax credit for up to 40% of fertility treatment costs, to a maximum annual tax credit of $8,000[77]
New Brunswick	Yes	One time grant, where the person can claim 50% of costs of IVF up to a maximum of $5,000[78]
Prince Edward Island	Yes	$5,000 to $10,000 subsidy per cycle (tied to income), to a maximum of 3 cycles[79]

A lack of support, or insufficient support, means that fertility treatments are out of reach for many women, trans, and non-binary people. Specific provincial supports present their own unique barriers. Tax credits require that the person seeking IVF have the money to pay up front, and wait to receive a tax credit later. The Quebec system explicitly excludes IVF for surrogacy, ruling out financial supports for trans women and gay men looking to access IVF. In Ontario, funded IVF can be subject to significant wait times, and is only available to people under the age of 43. [80]

I want to underline the point about money. For most cis people, reproduction itself is not expensive. The possibility of having a child does not entail annual payments, but for all trans people it does.

At the same time, trans people disproportionately experience poverty. the idea of freezing sperm or eggs and paying thousands of dollars to do so is out of the cards for most people. Effectively having children is only possible for most trans people if they are upper middle class or rich.

- P2, A MEMBER OF THE TRANS COMMUNITY IN MONTREAL

F. Barriers when giving birth

Pregnant Indigenous people face many barriers when giving birth. There are few options for giving birth outside of a hospital. [81] A lack of adequate healthcare infrastructure, healthcare providers, and funding mean that pregnant Indigenous people often cannot give birth in their own communities. [82] As a result, they must leave their support systems to give birth elsewhere. [83]

Within the hospital setting, Indigenous women face barriers including a lack of culturally competent care. For example, Indigenous women in Nova Scotia reported barriers to Indigenous birth practices within hospitals, and negative treatment from healthcare providers. [84]

Increasing the number of Indigenous midwives could lessen these barriers. Currently, however, there are only six university programs for midwifery in the country. They are concentrated in urban and often Southern centres. They are colonial, and teach mainstream midwifery rather than Indigenous midwifery. [85]

In addition, regulations limit the work Indigenous midwives can do. In Ontario, for example, the *Midwifery Act, 1991* [86] allows Indigenous communities to regulate Indigenous midwives, instead of requiring regulation by the College of Midwives of Ontario. Indigenous midwives, however, face additional barriers to practice including barriers to hospital privileges, prescription writing, ordering of tests and, until very recently, billing numbers. [87]

indigenous midwifery is different from other health care providers. it is a traditional role in the communities, with a unique approach in centering the community. It creates a different approach to ensuring reproductive justice.

- CLARE DION FLETCHER
NATIONAL ABORIGINAL COUNCIL OF MIDWIVES

Allowing self-regulation by Indigenous communities is not problematic in itself, but the exemptions for Indigenous midwives can cause problems in their implementation. In Ontario, the exemption allows for greater self-determination, but requires communities to have sufficient resources to decide and enforce their own regulations. Other provinces have similar exceptions, but they are narrower and often not applied. In Northern Quebec, Indigenous midwives have practiced since before the introduction of midwifery legislation, but it took years for them to be recognized. [88]

Colonial regulation also means that Indigenous midwives cannot play the same larger role they traditionally held in community. They do not have the ability to provide more general reproductive and sexual health services outside of birth, and pre- and post-natal care. [89]

G. Barriers to accessing surrogacy, and impact on surrogate

The ability to access surrogacy services can enhance reproductive justice for intended parents who, for many reasons, may look to surrogacy as a means to have a child. For example, cis women or trans men may not be able to become pregnant, due to having had a hysterectomy or having medical conditions making pregnancy too risky to undertake. Trans men looking to have a child may face dysphoria and harassment if they become pregnant, [90] and so may pursue surrogacy as an alternative. Achieving reproductive justice, however, is not simply a matter of increasing access to surrogacy services. The regulation of surrogacy services must enable, protect, and respect the equality rights of surrogate mothers/parents.

In Canada, the *Assisted Human Reproduction Act* [91] prohibits compensating surrogate mothers and paying intermediaries to arrange for surrogacy services. The *Reimbursement Related to Assisted Human Reproduction Regulations* [92] allow surrogates to be reimbursed for certain expenses related to the surrogacy, including travel, counselling services, legal services, and maternity clothes. [93] As discussed below, provinces and territories take different approaches to legally recognizing the parental rights of intended parents.

We heard that, under this framework, surrogates carry the "ethical burden" of surrogacy, being expected to act altruistically while others financially benefit. For example, healthcare providers receive compensation for creating and inserting embryos. In addition, surrogacy agencies can earn thousands of dollars managing the financial aspect of a surrogacy. In contrast, surrogates who manage the financial aspects of a surrogacy without an agency cannot receive compensation for providing that same service. [94]

While surrogates can receive reimbursement for specific expenses, they can have a difficult time being reimbursed for expenses incurred after a surrogacy contract ends. This is particularly damaging for surrogates who experience long-term financial constraints due to health issues developed from pregnancy or birth. [95]Surrogates also face a lack of mental health and social supports, and well as the negative effects of a lack of education around surrogacy.[96]

Where surrogates and intended parents disagree about aspects of the surrogacy, they may be required to retain a lawyer and use the legal system. This is an expensive and time-consuming process, which may simply be inaccessible to many people.[97]

Surrogacy will always exist, so it should happen in a dignified way that protects surrogrates' health, autonomy, and equality according to the *Charter of Rights and Freedoms.*

- SHERAY SAUGSTAD,
FIRST MOTHERS SURROGACY SUPPORT FOUNDATION

B: BARRIERS TO ACCESSING THE RESOURCES AND SUPPORTS NECESSARY TO PARENT WITH DIGNITY

Access to the resources and supports necessary to parent with dignity allows women, trans, and non-binary people to choose to have children if they wish. It also allows them to raise those children in safe, healthy environments. This section looks at a broad range of issues and systems that shape a person's ability to have and raise children, and where barriers arise. These issues include parental recognition, paid leave, the child welfare system, employment and income, housing, childcare, and prison and the criminal justice system.

I. OBTAINING LEGAL PARENTAL RECOGNITION

The ability to be legally recognized as a parent, and the costs associated with doing so, plays a role in the decision to have or not have children. Parental recognition provides important legal rights. In addition, who can be recognized as a parent sends a message about how society understands and values particular forms of family.

Different provinces and territories have different rules and processes for legal recognition of parents. Alberta's legal framework provides an example of more limited parental recognition. Only two parents can be listed on the birth record, usually the birth mother or person who gave birth, and the father or co-parent. A co-parent can be the child's biological parent, the spouse of the mother or person who gave birth, or the "adult interdependent partner" of the mother or person who gave birth. [98]

In contrast, Ontario's legal framework allows up to four people to be registered as parents on a child's birth certificate. They must have entered into a "pre-conception parentage agreement", agreeing to be parents together, before the child is conceived. [99] This framework allows for the legal recognition of a broader range of families.

Where a child is born through surrogacy, the rules for providing legal parentage to intended parents can impose costs on these parents. In Nova Scotia, for example, regulations require that the surrogate mother be recorded on the birth certificate as the child's mother. Intended parents must apply to a court for a declaratory order to be listed as the child's parents on the birth certificate. They must meet several requirements, including that one of the intended parents has a genetic link to the child. [100] The Ontario process is less time- and cost-intensive. Under the All Families are Equal Act, intended parents can use a mail-in application to register themselves as legal parents. [101]

II. ACCESSING PAID LEAVE

Paid leave is a critical support for women, trans, and non-binary people looking to start families. In most cases, Employment Insurance (EI) maternity and parental benefits provide financial support to people who are not working because they are pregnant, have recently given birth, or are taking care of a newborn or newly-adopted child. In Quebec, eligible employees who reside in the province receive benefits under the Quebec Parental Insurance Plan (QPIP). EI and QPIP benefits do not cover a person's whole salary, however, so some employers provide top-up benefits.

Access to paid parental leave is far from equitable. Prior to the start of the COVID-19 pandemic, approximately one third of new mothers did not qualify for EI maternity and parental benefits. [102] Younger workers, part-time workers, and people working reduced hours have a more difficult time meeting the number of "insured hours" required to qualify. As EI maternity and parental benefits are based on a percentage of income, lower-income workers receive lower benefits compared to higher-income workers. [103]

Access to top-up benefits is also unequitable. Members of the trans community face profound employment discrimination. As a result, trans people are less likely to be involved in the formal economy, and less likely to have access to employer-provided top-up benefits. [104]

Those who experience pregnancy loss, including those who access abortion, do not have access to paid leave responding specifically to that loss. Existing forms of leave may apply, but have shortcomings: "[b]ereavement leave is brief, sickness leave raises privacy concerns, and maternity leave makes the female body normative and draws lines around the timing of loss" as well as being tied to restrictions on EI eligibility. [105]

III. INVOLVEMENT WITH THE CHILD WELFARE SYSTEM

Child welfare agencies have a dual and conflicting role: they are meant to support families, but they also monitor them. [106] These agencies have the power to remove a child from their home, either temporarily or permanently. As the Ontario Human Rights Commission has noted, "[w]hen child welfare authorities remove children from their caregivers because of concerns about abuse or neglect, it can be traumatic and tragic for everyone involved – children, their families, and even their communities". [107] When the child welfare system removes children from their families and communities, they can lose any connection to their community and culture. They can lose their sense of identity and belonging. [108]

As is the case for many institutions, child welfare agencies did not emerge or develop in a vacuum. They "have evolved within an historical context of white supremacy, colonialism, and anti-Black racism, all of which have been woven into the fabric of child welfare policies and practices, leading to the creation of long-standing disproportionalities" for Black and Indigenous communities. [109] One effort to address these disproportionalities is recent federal legislation [110] recognizing Indigenous people's jurisdiction over child and family services, and allowing Indigenous governments to create their own child welfare laws. [111]

Change cannot come soon enough. According to 2016 census data, Indigenous children made up 7.7% of children in Canada under age 14, but 52.2% of children in foster care. [112] In Alberta, 71% of children and youth in care in 2020 were Indigenous, despite making up only about 10% of children aged 0 to 17. [113] In Ontario, compared to white children, Black children were 2.2 times more likely to be investigated by child welfare authorities and 2.5 times as likely to be placed in out-of-home care during the investigation. [114]

Multiple structural factors lead to higher child welfare involvement for Indigenous and Black families. The high rates of Indigenous children in care cannot be separated from Canada's past colonial policies, including the residential school system and the "Sixties scoop", which tore Indigenous children away from their families and communities. [115] Indigenous families face high levels of poverty due to a history of deliberate attempts to impoverish Indigenous people in Canada, and continuing underfunding by government for social services for Indigenous communities. [116] Seeing this poverty as neglect, rather than the result of government action and inaction, increases the likelihood of involvement with the child welfare system. [117]

Birth alerts provide a stark example of child welfare policies disproportionately affecting Indigenous families. Birth alerts involve a social worker or healthcare provider flagging an expecting mother or parent, resulting in the apprehension of newborn babies. The person is not told about the alert. They can be flagged simply because they grew up in the child welfare system. [118]

Healthcare providers and social workers have often used birth alerts against Indigenous women. [119] As observed by the National Inquiry into Murdered and Missing Indigenous Women and Girls: "the use of birth alerts against Indigenous mothers, including mothers who were in care themselves, can be the sole basis for the apprehension of their newborn children. Birth alerts are racist and discriminatory and are a gross violation of the rights of the child, the mother, and the community." [120]While birth alerts have been officially banned in all Canadian jurisdictions except Quebec, there have been reports of the practice continuing. [121] In Quebec, birth alerts disproportionately impact Indigenous families. In the region of Abitibi-Témiscamingue, located in northwestern Quebec, over 30% of all birth alerts issued at the regional hospital were for Indigenous newborns. [122]

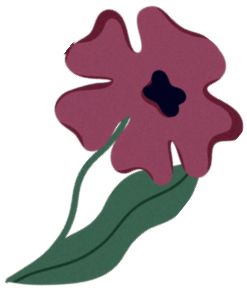
Research on child welfare involvement for Black families in Ontario highlights the way multiple levels of policies and practices contribute to worse outcomes for Black families and children. First, there are policies grounded in anti-Black racism, including "federal immigration laws that continue to separate parents living in Canada from their children, housing policies that result in the residential segregation of families, and employment barriers that contribute to income inequality". [123] These policies influence local institutional practices, including education, policing, and mental health, leading to "oversurveillance, stigmatization, criminalization, bias, and neglect" for Black families. [124] Child welfare policies exist and are applied in this context, resulting in higher child welfare involvement for Black families. [125]

Fear of involvement with the child welfare system shapes women, trans, and non-binary people's decisions to have children, and the healthcare they receive. The threat of birth alerts makes people fearful to access healthcare, and to start a family. [126] Even where birth alerts have been banned, expecting parents may not access supports out of a fear of risking child welfare involvement. [127]

In addition, women, trans, and non-binary people involved with the child welfare system may not receive the supports they need to start and raise a family in dignity, if this is what they want. Those in care may want to have children themselves, but often lack the supports necessary to raise their children. They face pressure to give their children up for adoption, and often do not receive other options. [128]
Once a person in care has "aged out" of the system, any supports they were receiving end. For most youth, this happens when they reach the age of majority in their province or territory, either at 18 or 19 years old. [129] There are limited extended supports available for youth, typically aimed at employed youth, those in school full-time, or those with diagnosed disabilities. [130] There are no national standards governing supports for youth transitioning out of care. [131]

Without access to supports, youth "aging out" of care face barriers accessing and completing education, which negatively affects their employment opportunities and increases the likelihood of living in poverty. [132] Youth "aging out" of care face increased risks of homelessness, contact with the criminal justice system, and negative health outcomes. [133]

We heard that youth should be able to access supports until at least 25 years old. There is simply no guarantee they will be ready once they turn 18. [134] It is also important, however, that supports be available and meaningful. In some cases, youth aging out of care decline to request an extension even if one is available, feeling there are no real supports available to them in any case. Youth in care need to be involved in the process. Supports can involve teaching life skills, like getting an apartment, developing positive relationships, starting a family, and working towards post-secondary education. [135]



There are no supports when people age out of care, and no bridging into adulthood. A good transition out seems to be the exception, not the standard.

- NATASHA REIMER-OKEMOW
YOUTH IN CARE CANADA

IV. SECURING EMPLOYMENT AND INCOME

A person's income can shape their decision about whether or not to have children, and their ability to care for the children they have. Women, trans, and non-binary people, however, face barriers to obtaining well-paying, stable work.

As outlined in LEAF's 2021 report *Basic Income & The Care Economy,* [136] low-income women, trans, and non-binary people disproportionately carry out unpaid acts of care labour, reducing their ability to participate in the waged labour market. This is particularly the case for those who are Black, Indigenous, racialized, disabled, and/or migrant workers. As discussed below, there is also a lack of available and affordable childcare in Canada. As a result, women are more likely than men to work part-time, or in temporary employment, and to accept precarious work. [137]

Trans people face significant discrimination in the workplace and in seeking employment. Participants in an Ontario focus group and interviews reported being denied employment opportunities or being fired because they were trans. They also reported harassment and assault at the workplace. [138]

Even if women, trans, and non-binary people secure employment, in some cases they do not receive the same pay as men despite doing substantially the same work (also known as equal pay for equal work). For example, a female engineer may make less than a male engineer, even though they do substantially the same work and have the same experience. To address this discrimination, the person would need to file a claim or complaint under the applicable employment, labour standards or human rights legislation. Nova Scotia's *Labour Standards Code,* for example, prohibits paying women, non-binary people, and men different rates based on their gender. [139]

In other cases, however, women, trans, and non-binary people may carry out work of equal value to an employer, but still receive lower wages. This is a pay equity problem. It reflects the reality that jobs commonly held by women receive lower compensation than jobs commonly held by men, even when these roles provide the same value to the employer. [140]

Not all provinces and territories have legislation protecting and promoting pay equity. In Ontario, under the *Pay Equity Act*, [141] public sector employers, and private sector employers with more than 10 employees, must take steps to eliminate sex-based pay discrimination. [142] Quebec also imposes pay equity obligations on public and private sector employers with 10 or more employees, with different requirements based on employer size. [143] In contrast, in jurisdictions such as Manitoba, Nova Scotia, New Brunswick, and Prince Edward Island, pay equity legislation applies only to public sector employers. [144] Alberta does not have pay equity legislation at all. [145]

It is important to note the limitations of pay equity legislation focusing exclusively on discrimination tied to sex. This approach hides the impact of intersecting systems of oppression on wages, and makes it harder to achieve pay equity for all women, trans, and non-binary people. Trans women, for example, face a larger wage gap than cis women. [146] Research shows that Black, Indigenous, and racialized women earn less than both white men and white women. [147] Women with disabilities have lower average incomes than women without disabilities, and men with or without disabilities. [148]

Pay transparency laws are another approach to promoting pay equity. For example, Ontario's *Pay Transparency Act, 2018* [149] would require employers with 100 or more employees to submit pay transparency reports providing information about compensation differences relating to gender, race, and other characteristics. [150] In Nova Scotia, employers cannot prohibit employees from discussing wages or discipline employees who do so. [151] Expanding these requirements to provinces and territories without them could be one way to better promote pay equity.

V. ACCESSING HOUSING

Having access to affordable and adequate housing is a key requirement for having and raising a family. In many parts of Canada, this is not the reality. This is particularly true in the North. Communities in the Northwest Territories, for example, face poor living conditions, overcrowding, and a lack of accessible housing. There are not enough materials for renovations, so houses may "have no doors, no kitchen cupboards, broken floor tiles, and mould around the sinks/floors." [152] Many individuals lack homes altogether, and end up having to live in cabins, shacks, or with family. They may also end up homeless, including in the winter months. [153]

VI. ACCESSING CHILDCARE

Accessible and affordable childcare is a critical component of reproductive justice. Having access to affordable childcare shapes the family planning decisions made by women, trans, and non-binary people, particularly those who are marginalized. [154] This includes whether or not to have children, and how many children. It also influences whether or not women, trans, and non-binary people will remain in the workplace full-time, exit the labour market, or switch to part-time work.

One of the hardest things to hear are the ones who share their stories of sleeping outside in -30 or more because they get kicked out of the shelters or the shelter is at their capacity.

- JANINE HARVEY

Different women, trans, and non-binary people face different levels of access to high-quality childcare. Access is more difficult for "Indigenous communities, people with disabilities, racialized groups, rural communities and women and their families reliant on precarious employment," [155] as well as for newcomer women, poor women, and single mothers. [156] Part of this is due to cost, but the concentration of daycare centres in urban centres also plays a role. [157]

Increasing access to affordable, high quality childcare is key to promoting reproductive justice in Canada. The current federal government's commitment to providing $10-a-day childcare to every province and territory is an important step in this direction. [158] It will also be important to ensure that childcare workers, who are often racialized women, receive adequate compensation for their labour in this sector. [159]

VVI. CRIMINALIZATION AND INCARCERATION

The right to parent and to have access to your children is a critical component of reproductive justice, yet incarcerated parents are regularly denied that contact. [160] A recent study on the experience of provincially-incarcerated mothers in Nova Scotia found that even short periods of incarceration "caused lasting harm to their relationships with their children". [161]

The impact of incarceration does not stop when a person is released from custody. Women leaving provincial custody in Nova Scotia identified "a laundry list of basic needs unaccommodated for when they left the prison: clothing, subsistence income, food, transportation, phones and a place to lay their heads." [162] Criminal records also limit employment opportunities for criminalized women, trans, and non-binary people. [163] A 2014 study found that barriers to finding employment after serving a federal sentence disproportionately affected women and Indigenous people, with average annual earnings of just under $10,000 for women and just over $10,000 for Indigenous people. [164]

CONCLUSION

Much remains to be done to realize reproductive justice in Canada.

This report outlined many different barriers that limit women, trans, and non-binary people's ability to choose to have or not have children, and to raise any children with dignity. These include barriers to accessing sexual and reproductive health education and services. They also include barriers to accessing the resources and supports necessary to parent with dignity.

In the face of these barriers, we must acknowledge the incredible work being done by individuals and groups across Canada, including those with whom we spoke. Organizations in community play a key role in providing family supports, including financial supports, education, physical and mental healthcare, and childcare. [165]

We hope that this report complements this work, and helps lead to legal and policy changes necessary to advance reproductive justice in Canada.

APPENDIX A

Key Informants

Kara Gillies, Action Canada for Sexual Health and Rights

Alberta Society for the Promotion of Sexual Health

Boma Brown, The Support Network for Indigenous Women and Women of Colour

Claire Dion Fletcher, National Aboriginal Council of Midwives

Jennifer Taylor and Julianne Stevenson

Jessi Taylor, Reproductive Justice New Brunswick

Kelley Day, Youth in Care Canada

Kemlin Nembhard, Women's Health Clinic

Marianne Rodrigue and Geneviève Landry, Centre de Santé des Femmes de Montréal

Martha Paynter, Wellness Within

Natasha Reimer-Okemow, Youth in Care Canada

Niagara Reproductive Justice

Nikki Baldwin, Planned Parenthood Newfoundland and Labrador Sexual Health Centre

Sheray Saugstad, First Mothers Surrogacy Support Foundation

Literature Review Authors

Danica Fitzsimmons, Keltie Hamilton, Shannon Hiebert, and Newsha Mahinpey

Elgin Pecjak

Julie Lassonde

Kimberley Nesbeth

Snapshot Organizations

Action Santé Travesti(e)s et Transsexuel(le)s du Québec (ASTT(e) Q)

Black Queer Youth Collective

Butterfly: Asian and Migrant Sex Worker Support Network

Elizabeth Fry Society of Mainland Nova Scotia

Keepers of the Circle

Midwives Association of Manitoba

Nova Scotia Association of Black Social Workers

PEERS Alliance

Tahiuqtiit Women's Society

Yukon Status of Women Council

Snapshot Participants

A member of the African Nova Scotian community

Members of the trans community in Montréal

Ashley Fraser

Charlotte Hunter

Clare Heggie

Elene Lam

Gloria, Mei, Annie, and Ching Ching

Janine Harvey

Keke Chambers

Khiaja

Mabelle Silva

Michelle Stimson

Syd Kurbis

END NOTES

[1] This report focuses on discrimination faced by women, girls, trans, and non-binary people, reflecting LEAF's mandate. When we use the term "women" in this report, it refers to both cisgender and transgender women. It is important to note, however, that few statistics distinguish adequately among genders, and data often only account for cisgender women's experiences. We use the language "women" to signal that information refers only to women (and not non-binary people), though even using this language is incorrect, because the data likely does not include trans women.

[2] "Reproductive Justice" (no date), online: *SisterSong* <https://www.sistersong.net/reproductive-justice>.

[3] LEAF branches run public education programs for youth, hold events on gender equality in their communities, and engage in law reform initiatives at the local level. Branches are largely volunteer run.

[4] LEAF's Law Program Committee advises and makes recommendations concerning the litigation undertaken by LEAF. It also advises and makes recommendations concerning LEAF's law reform and policy projects. The Law Program Committee is made up of legal academics and practitioners with diverse subject matter expertise and lived experiences.

[5] Interview with anonymous participant, 24 February 2022.

[6] *Ibid*.

[7] Interview with Nikki Baldwin, Planned Parenthood Newfoundland and Labrador Sexual Health Centre, 11 March 2022; Interview with Marianne Rodrigue and Genevieve Landry, Centre de Santé des Femmes de Montreal, 28 March 2022.

[8] Interview with anonymous participant, 24 February 2022.

[9] Interview with Nikki Baldwin, Planned Parenthood Newfoundland and Labrador Sexual Health Centre, 11 March 2022; Interview with Marianne Rodrigue and Genevieve Landry, Centre de Santé des Femmes de Montreal, 28 March 2022.

[10] Interview with Melanie Anderson, Alberta Society for the Promotion of Sexual Health, 4 March 2022.

[11] Interview with anonymous participant, 24 February 2022.

[12] *A Long Way to Go: Collective Struggles & Dreams of Reproductive Justice in Canada* (Toronto: LEAF, 2022) at 5.

[13] Interview with Kemlin Nembhard, Women's Health Clinic, 11 March 2022.

[14] "Health Fact Sheets: Primary Care Providers, 2019" (22 October 2020), online: *Statistics Canada* <https://www150.statcan.gc.ca/n1/pub/82-625-x/2020001/article/00004-eng.htm>.

[15] *A Long Way to Go: Collective Struggles & Dreams of Reproductive Justice in Canada* (Toronto: LEAF, 2022) at 27.

[16] *Ibid* at 48.

[17] Interview with Marianne Rodrigue and Genevieve Landry, Centre de Santé des Femmes de Montreal, 28 March 2022.

[18] Email from Jessi Taylor, Reproductive Justice New Brunswick, 15 August 2022.

[19] Interview with Jessi Taylor, Reproductive Justice New Brunswick, 4 March 2022.

[20] Email from Jessi Taylor, Reproductive Justice New Brunswick, 15 August 2022.

[21] Interview with Marianne Rodrigue and Genevieve Landry, Centre de Santé des Femmes de Montreal, 28 March 2022.

[22] Interview with Martha Paynter, Wellness Within, 9 February 2022.

[23] Interview with Jessi Taylor, Reproductive Justice New Brunswick, 4 March 2022.

[24] *A Long Way to Go: Collective Struggles & Dreams of Reproductive Justice in Canada* (Toronto: LEAF, 2022) at 28.

[25] Email from Jessi Taylor, Reproductive Justice New Brunswick, 15 August 2022.

[26] Interview with Boma Brown, Support Network for Indigenous Women and Women of Colour, 7 April 2022.

[27] *Ibid*.

[28] Interview with Jessi Taylor, Reproductive Justice New Brunswick, 4 March 2022.

[29] *A Long Way to Go: Collective Struggles & Dreams of Reproductive Justice in Canada* (Toronto: LEAF, 2022) at 37-39, 48.

[30] Interview with Martha Paynter, Wellness Within, 9 February 2022.

[31] Jessica Liauw et al., "Reproductive healthcare in prison: A qualitative study of women's experiences and perspectives in Ontario, Canada" (2021) 16(5) PLoS ONE 1 at 11.

[32] See the discussion in Lori E. Ross et al., "Access to sexual and reproductive health care among young adult sex workers in Toronto, Ontario: a mixed-methods study" (2021) 9(2) CMAJ OPEN E482.

[33] Interview with anonymous participant, 24 February 2022.

[34] Interview with Boma Brown, Support Network for Indigenous Women and Women of Colour, 7 April 2022.

[35] *Ibid*.

[36] Interview with anonymous participant, 24 February 2022.

[37] *Ibid*.

[38] This chart was compiled based on a review of provincial and territorial regulations, and conversations with health regulators in different jurisdictions, and is current as of June 2022. We encourage you to confirm current prescribing powers with the relevant regulators in your province or territory.

[39] Note that pharmacists in all provinces and territories except Nunavut can renew or extend an existing birth control prescription if the patient is having difficulties getting in touch with her doctor: "Community Pharmacists in Canada Contraceptive Prescribing" (no date), online (pdf): *Canadian Pharmacists Association* <https://www.pharmacists.ca/cpha-ca/assets/File/cpha-on-the-issues/Contraception-Infographic.pdf>.

[40] Interview with Kemlin Nembhard, Women's Health Clinic, 11 March 2022.

[41] "Abortion Services" (2022), online: *Alberta Health Services* <https://www.albertahealthservices.ca/info/page14011.aspx>.

[42] Interview with Jessi Taylor, Reproductive Justice New Brunswick, 4 March 2022.

[43] Interview with Niagara Reproductive Justice (21 February 2022).

[44] Interview with Jennifer Taylor and Julianne Stevenson, 28 February 2022.

[45] *Ibid*.

[46] *Ibid*.

[47] Interview with Marianne Rodrigue and Genevieve Landry, Centre de Santé des Femmes de Montreal, 28 March 2022.

[48] Interview with Kemlin Nembhard, Women's Health Clinic, 11 March 2022.

[49] Interview with Nikki Baldwin, Planned Parenthood Newfoundland and Labrador Sexual Health Centre, 11 March 2022.

[50] Interview with Martha Paynter, Wellness Within, 9 February 2022.

[51] Interview with Nikki Baldwin, Planned Parenthood Newfoundland and Labrador Sexual Health Centre, 11 March 2022.

[52] Interview with Melanie Anderson, Alberta Society for the Promotion of Sexual Health, 4 March 2022.

[53] Interview with Nikki Baldwin, Planned Parenthood Newfoundland and Labrador Sexual Health Centre, 11 March 2022.

[54] Interview with Niagara Reproductive Justice, 21 February 2022.

[55] Interview with anonymous participant, 24 February 2022.

[56] *Ibid*.

[57] Interview with Jessi Taylor, Reproductive Justice New Brunswick, 4 March 2022.

[58] Interview with Jennifer Taylor and Julianne Stevenson, 28 February 2022.

[59] Interview with Niagara Reproductive Justice, 21 February 2022.

[60] See, e.g., British Columbia's *Access to Abortion Services Act*, RSBC 1996, c 1; and Ontario's *Safe Access to Abortion Services Act, 2017*, SO 2017, c 19, sched 1.

[61] Interview with Kemlin Nembhard, Women's Health Clinic, 11 March 2022.

[62] Interview with Nikki Baldwin, Planned Parenthood Newfoundland and Labrador Sexual Health Centre, 11 March 2022.

[63] Interview with Melanie Anderson, Alberta Society for the Promotion of Sexual Health, 4 March 2022.

[64] Interview with anonymous participant, 24 February 2022.

[65] Interview with Kemlin Nembhard, Women's Health Clinic, 11 March 2022.

[66] For a more in-depth discussion of the treatment of medication abortion in Canada, and potential changes to the legal framework, see Julianne Stevenson and Jennifer Taylor, *Self-Managed Abortion in Canada: A Status Report* (Toronto: LEAF, 2022), online (pdf): *LEAF* <https://www.leaf.ca/wp-content/uploads/2022/04/SMA-Report-April-2022.pdf>.

[67] *A Long Way to Go: Collective Struggles & Dreams of Reproductive Justice in Canada* (Toronto: LEAF, 2022) at 37.

[68] "Get fertility treatments" (21 October 2021), online: *Ontario* <https://www.ontario.ca/page/get-fertility-treatments>.

[69] *A Long Way to Go: Collective Struggles & Dreams of Reproductive Justice in Canada* (Toronto: LEAF, 2022) at 38.

[70] *Ibid* at 37-38.

[71] *Ibid* at 37-39.

[72] "Fertility" (28 May 2019), online: *Government of Canada* <https://www.canada.ca/en/public-health/services/fertility/fertility.html>.

[73] "FAQ's About the Fertility Treatment Tax Credit" (no date), online: *Manitoba* <https://www.gov.mb.ca/finance/tao/fttc_faq.html>.

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