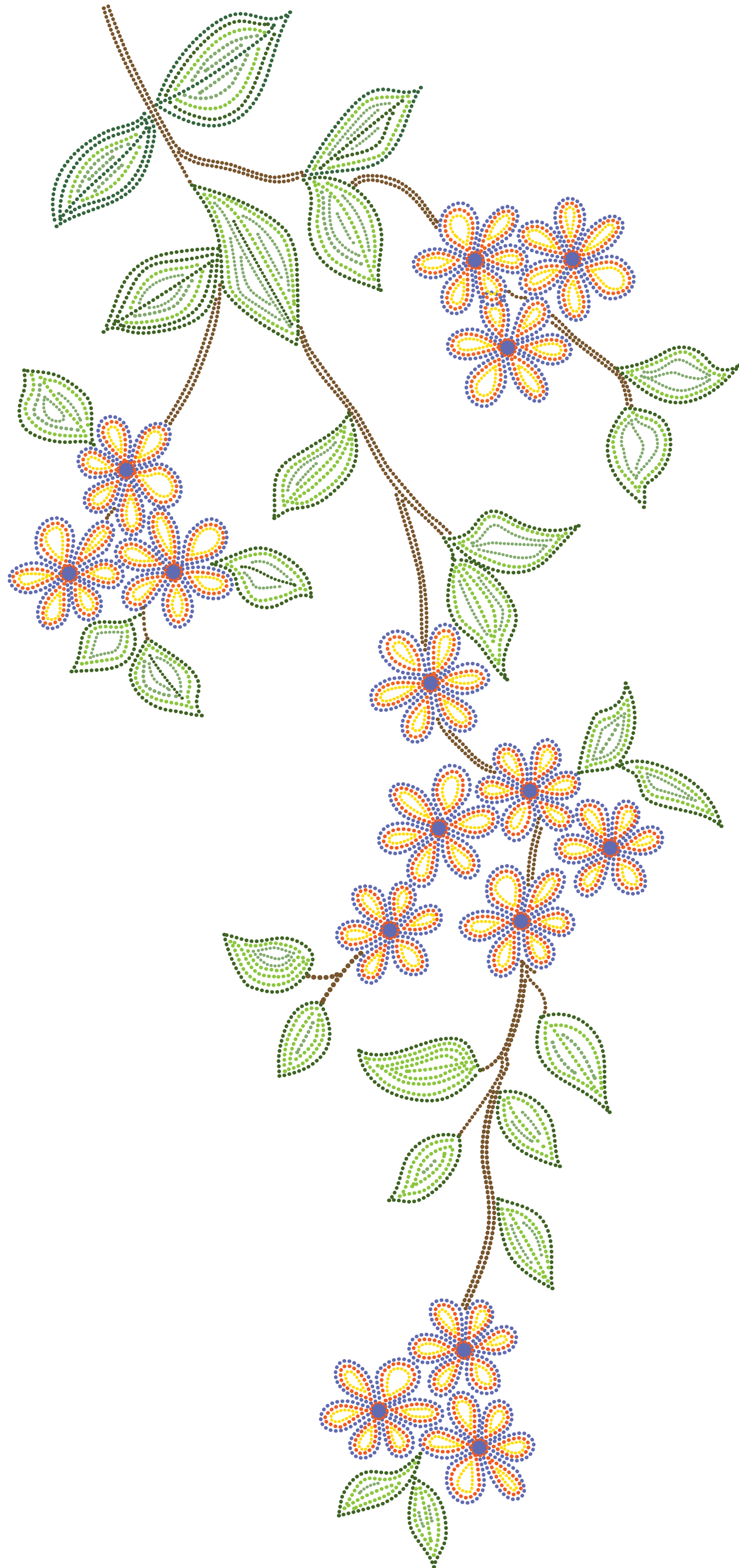
POLICY SCAN: Reproductive Justice

Sexual and Reproductive Health for Métis Women in Canada | 2026



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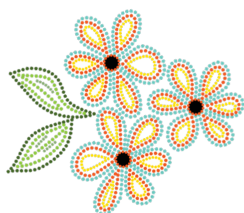
Executive Summary

Purpose: This report examines the environmental and policy landscape affecting the sexual and reproductive health (SRH) of Métis women in Canada. It aims to identify contextual factors, current policies, gaps, and opportunities to improve health outcomes and uphold reproductive justice. A scan of legislation, policy and laws regarding the sexual and reproductive health of Indigenous women, girls, and 2SLGBTQQIA+ individuals was conducted. The scan was performed from a distinctions-based lens, concentrating on the impact on Métis communities. It reviews international, constitutional and federal frameworks, Indigenous-specific initiatives, regional governance and programmatic frameworks, then identifies key issues, gaps, and sets out recommendations for advancing Métis reproductive justice.

Key findings: Métis women in Canada face significant barriers to sexual and reproductive health services, limited access to culturally safe care, mental health supports, and reproductive services such as contraception and abortion. They experience higher rates of chronic conditions, mental health challenges, and adverse pregnancy outcomes compared to non-Indigenous women. Historical and ongoing trauma, including discrimination, forced sterilization, and colonial child apprehension, has fostered mistrust in the healthcare system. Métis-led organizations play a critical role in addressing these gaps, advocating for culturally grounded care, and advancing reproductive justice. Yet, policies often fail to fully address Métis-specific needs or intersectional factors such as geography and socioeconomic status.

Recommendations: There needs to be a shift from reactive policies to proactive and protective legislation. Policies must move beyond crisis-driven maternal care to support the full spectrum of sexual and reproductive health needs, grounded in community-led, culturally safe, trauma-informed, and rights-based frameworks. This means investing in Métis-led organizations, supporting data sovereignty, and embedding SRH in approaches to healing, resilience, and social justice.



Introduction

Reproductive justice[1] is defined as the human right to maintain bodily autonomy, to have or not have children, and to parent in safe and sustainable communities. For Métis women and 2SLGBTQQIA+ kin, reproductive justice includes:

- Access to safe, culturally grounded reproductive and maternal healthcare
- Freedom from coerced or pressured reproductive interventions
- Support for traditional Métis birthing and parenting practices
- Protection from gender-based violence and colonial systems of child apprehension
- Equitable access to contraception, abortion, prenatal/postnatal care, fertility services, and sexual health services
- Access to mental health supports rooted in trauma-informed and Métis-specific approaches

Despite these rights, Métis women continue to experience disproportionate barriers. Available evidence shows Métis women experience:

- Higher rates of chronic disease (diabetes, hypertension)[2,3]
- Higher prevalence of depression, anxiety, substance use during pregnancy[4–6]
- Higher teen pregnancy and STI rates than non-Indigenous women[7]
- Higher rates of adverse pregnancy outcomes (stillbirth, low birth weight)[7,8]
- Lower cervical cancer screening and HPV vaccination uptake [9]
- Less access to abortion, contraception, fertility care in rural/northern regions[10]

Evidence is extremely limited, but shows that the 2SLGBTQQIA+ Metis population face:

- Higher rates of discrimination in health settings[11]
- Barriers to gender-affirming care[12]
- Limited fertility preservation and assisted reproduction access[13]
- Lack of Métis-led Two-Spirit health supports[12]

This drives invisibility in policy and program design.

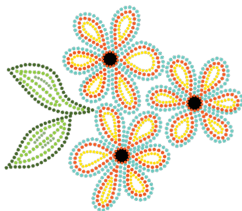
Métis women experience unique health challenges shaped by historical marginalization, systemic inequities, and limited culturally safe healthcare access.[14(pp2023-2024)] SRH outcomes, including maternal health, contraception access, and STI prevention, are influenced by social, economic, and geographic factors. Compared to non-Indigenous women, “off-reserve” Métis females of reproductive age report higher morbidity but are less likely to have a regular health-care provider, wait longer for appointments, and report more unmet needs, especially in mental-health care.[15]

A 2023 scoping review[4] found that Indigenous women across Canada, including Métis, face a range of maternal health disparities: higher rates of mental health issues (prenatal/postnatal), increased incidence of chronic conditions (e.g., diabetes), substance use, and greater risk of adverse pregnancy outcomes (including low birth weight, stillbirth) compared to non-Indigenous populations.

Metis women have experienced discrimination, abuse, and have been left out of previous provincial and federal health plans.[11,16] Forced and coerced sterilization of Indigenous women is ongoing and remains a pressing concern prioritized by Canadian governing bodies.[17] Women's voices have historically not been heard, and due to historical injustices, the Metis community has little trust in the Canadian healthcare system.

This scan is in alignment with the Reproductive Justice project funded through the Public Health Agency of Canada (PHAC) called Ohpikihaawashow: Métis Reproductive Justice from Hospital to Home. As a Métis-led organization, the LFMO, is undertaking a review of the political and governing climate in Canada to support the welfare, safety, and health of Métis women nationally.

While national Indigenous health strategies exist, Métis-specific SRH needs are often overlooked. Understanding both the context and policy landscape is critical for informed interventions. This policy scan reviews laws, policies, and frameworks shaping the sexual and reproductive health (SRH) of Indigenous women and girls, with a focus on Métis communities. It highlights both enabling frameworks and significant policy gaps affecting Métis reproductive health and justice.



Methodology

Policy Scan

- Sources: Federal, provincial/territorial, and local policies; Indigenous health strategies; program evaluations.
- Approach: Policy mapping by jurisdiction and relevance to Métis SRH.

Limitations

- Limited Métis-specific data; much information aggregated with other Indigenous groups.
- Rapidly evolving policy context; some programs may be newly implemented or pilot projects.

Key findings

Federal and provincial policies addressing Indigenous SRH exist, but Métis-specific strategies are limited, often focusing on First Nations and Inuit populations.

1. International Legal Instruments

These instruments provide normative foundations that support SRH rights, gender equality, Indigenous self-determination, and cultural safety.

United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP):[18] UNDRIP frames health as a holistic and collective right, encompassing spiritual, cultural, social, and environmental well-being.

- Article 24 states that Indigenous people have the right to access healthcare without discrimination.
- Recognizes the right of Indigenous peoples to health "in all its dimensions" (spiritual, physical, cultural, social, environmental) and to access health care without discrimination.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW):[19] CEDAW is an international treaty that mandates signatory countries to incorporate gender equality, abolish discriminatory laws, and aim to eliminate gender-based discrimination in healthcare and law.

International Covenant on Economic, Social and Cultural Rights (ICESCR):[20] obligates members to work towards granting citizens, under the Bill of Rights, the right to work, education, health, adequate living standards, and participation in cultural life.

2. Canadian Constitutional & Legal Context

Canadian Charter of Rights and Freedoms:
Section 7:[21] Protects everyone's right to life, liberty and security of a person.
Section 15:[22(p15)] Protects equality rights, guaranteeing everyone the right to equal protection and the benefit of the law without discrimination based on grounds such as race, place of origin, religion, sex, and disability.

R. v. Morgentaler (1988):[23] The Supreme Court of Canada struck down Section 251 of the Criminal Code, which had restricted abortion access. It was found unconstitutional because it violated the Charter of Rights and Freedoms' guarantee of "security of the person". The ruling meant abortion was now considered a healthcare service in Canada.

Section 35 (1) of the Constitution (1982):[24] Recognizes and affirms existing treaty rights of Indigenous peoples of Canada, including First Nations, Inuit, and Métis peoples.

3. Métis Rights & Constitutional Context

Constitution Act, 1982 - Section 35(1-2)[25] recognizes and affirms Métis as a distinct Indigenous people with inherent rights. "Aboriginal peoples of Canada" includes the Indian, Inuit and Métis peoples of Canada.

2016 Daniels decision:[26,27] The Supreme Court held that Métis (and non-Status Indians) fall within the scope of federal Parliament's legislative authority under Section 91(24) of the **Constitution Act, 1867**, which clarifies that the federal government has jurisdictional responsibility for Métis peoples.

2019–2023 Métis self-government agreements[28,29] recognize Métis governance authorities, with ongoing work toward health jurisdiction.

4. Federal Health & Program Frameworks

The Canada Health Act:[30] The Canada Health Act (CHA) is the federal legislation that sets the rules for Canada's universal, publicly funded healthcare system.

- The primary objective of Canadian healthcare policy is to protect, promote, and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."
- Issues of access, universality and equity are relevant to SRH for Indigenous peoples.

Non-Insured Health Benefits (NIHB) program [27] Provides eligible First Nations and Inuit in Canada with coverage of health-related services not covered by provincial health plans or private insurance.
- Métis are excluded from NIHB, creating a gap.

Indian Health Transfer Policy:[28] A Canadian government framework that enables First Nations and Inuit communities to take control over the design and delivery of their own health services to promote self-determination.
- Métis inclusion is less consistent.

The Sexual and Reproductive Health Fund:[30] In August 2023, the federal government announced over $4.3 million in SRH funding specifically to support Indigenous communities (including a Métis-specific project).

Distinctions-based health legislation and governance frameworks:[31] The federal commitment to co-develop distinctions-based Indigenous health legislation (via Indigenous Services Canada) to better reflect the distinct needs of First Nations, Inuit and Métis.

5. Indigenous-specific Initiatives

Jordan's Principle:[32] A human rights principle to ensure First Nations children receive timely access to health, social, and educational services without delays or denials caused by their identity.
- Does not formally apply to Métis children, there is a continued need for advocacy for broader Indigenous inclusion.

Joyce's Principle:[33] a call for the equitable, non-discriminatory access to health and social services for all Indigenous people, including Métis, First Nations, and Inuit.

Birth Alerts Policy Directive:[34] Provincial policy directives in Alberta, British Columbia (2019), Ontario (2020), Manitoba (2020), and Saskatchewan (2021) mandated the cessation of birth alerts. They called for the enforcement of support-focused alternatives, such as pre- and post-natal plans. These policies resulted from the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG) and were aligned with recommendations.

Data and governance: A 2025 Memorandum of Understanding between the Métis National Council (MNC) and the Canadian Institute for Health Information (CIHI)[35] aims to advance Métis-led data and health information systems, which are essential for monitoring SRH outcomes.

6. Major Inquiries

National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG) - Calls for Justice:[14,36] Developed by the National Inquiry into Missing and Murdered Indigenous Women

and Girls. The calls to justice are a series of recommendations to advocate for change, improving the safety and well-being of Indigenous women and girls.

- Calls for Indigenous-led and culturally appropriate health services, greater support for intergenerational trauma, and accessible services.
- Example: Implementation of Call for Justice 17.3 on Métis representation in policy & service delivery.

Truth and Reconciliation Commission - Calls to Action:[37] The Truth and Reconciliation Commission developed calls to action to address the systemic inequities experienced by Indigenous peoples due to the impacts of colonialism. Several calls to action advocate for the recognition of Indigenous healing practices, increasing the number of Indigenous health professionals, and implementing cultural competency training and courses on Indigenous health issues within the medical system.

- TRC Call to Action 19: Identify and close the gaps in health outcomes between Indigenous and non-Indigenous communities, including indicators such as infant mortality, maternal health, mental health, chronic diseases, and availability of health services.
- TRC Call to Action 20: Address the distinct needs of *Métis, Inuit,* and *off-reserve* Indigenous peoples in health-care delivery.
- TRC Call to Action 21: Provide sustainable funding for Indigenous healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools.
- TRC Call to Action 22. Recognize and respect Indigenous healing practices and, in collaboration with Indigenous healers and Elders, allow patients to integrate Indigenous healing into their treatment plans.
- TRC Call to Action 23: Increase representation of Indigenous professionals in health care.
- TRC Call to Action 24: Require all medical and nursing schools to provide mandatory courses addressing Indigenous health issues, including the history and legacy of residential schools, cultural safety, and anti-racism.

TRC Calls to Action 20, 22 and MMIWG Calls for Justice 3.1, 7.3, 17.3 are especially relevant for SRH and Métis representation.

7. Criminal Laws

Criminal Code: criminal law and policing influence sexual assault, human trafficking and exploitation. These influence sexual and reproductive health by shaping the environment of sexual violence, access to justice, and trauma-informed health care needs.

- Bill S-228[38] would clarify that sterilization procedures performed without consent are acts of wounding or maiming under the Criminal Code.

8. 2SLGBTQQIA+ Policies

The Federal 2SLGBTQI+ Action Plan (2022)[39] is a coordinated strategy to advance the rights and wellbeing of 2SLGBTQI+ people, including Two-Spirit and Indigenous 2SLGBTQI+ peoples. It ties across federal departments to prevent discrimination based on gender identity, sexual orientation, and expression.

- The Action Plan also intersects with health system reforms, specifically aiming to address systemic racism and discrimination in health services for Indigenous and 2SLGBTQI+ populations.

The Federal Pathway to Address Missing and Murdered Indigenous Women, Girls and 2SLGBTQQIA+[36] *People* and the *National Action Plan*[39] explicitly include 2SLGBTQQIA+ people as part of a coordinated national response to systemic violence.

- These frameworks recognize health, safety, and wellbeing as interconnected with violence prevention and access to services, including gender-affirming and trauma-informed care.

Horizontal Initiative on MMIWG and 2SLGBTQI+ People (2021–2028)[40] involving Crown-Indigenous Relations, Indigenous Services Canada, Health Canada, Justice, and others prioritizes reducing violence and improving outcomes for Indigenous women, girls, and 2SLGBTQQIA+ people.

- It is explicitly intersectional in scope (gender, race, location).
- Reinforces the federal policy environment supporting 2SLGBTQQIA+ inclusion and cross-government collaboration on safety and wellbeing, which is foundational for addressing SRH inequities.

9. Provincial/Territorial Laws

Midwifery and Doula Regulations:[41–43] provincial regulations determine whether midwives can practice in the community, whether non-physicians can provide medical abortion, and whether services are available locally.

- Indigenous midwifery initiatives are expanding, but **Métis-specific midwifery remains underdeveloped compared to programs for First Nations and Inuit.**
- Provincial regulation of midwifery and reproductive health services, through statutes such as Midwifery Acts and Regulated Health Professions legislation, determines whether midwives can practise in community settings, access hospital privileges, or provide medical abortion. These regulatory frameworks vary by province and directly affect service availability in Métis communities.

Regional Governance: models of Indigenous-led health governance (i.e. First Nations Health Authority in BC) can shape health care delivery on local levels.

- **Comparable Métis-led health governance structures have not yet been established, limiting Métis influence over regional health system design.**

Indigenous midwifery initiatives represent an important policy dimension within midwifery regulation. Some provincial statutes include exemptions or recognition clauses that allow Indigenous midwives to practise traditional midwifery within their communities (e.g., Ontario's exemption for Aboriginal midwives under the *Midwifery Act*[44] and Quebec's conditional statutory provisions[45]).

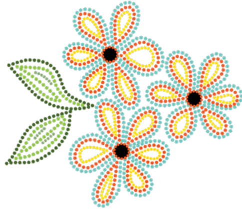
Diagram 1. Metis Reproductive Justice

What Métis Families Need | Métis midwifery & doulas | Free contraception & equitable abortion access | Youth sexual health education | Gender-affirming & Two-Spirit care | Wraparound supports (mental health, housing, transportation, land-based healing) ∞

Métis Reproductive Justice means | Bodily autonomy and freedom from coercion | Culturally grounded, Métis-led SRH care | Safe, sustainable communities ∞

Key Barriers | Coerced sterilization | Limited rural/northern SRH access | Child apprehension, violence, and policing harms | Policy gaps, NIHB exclusion, lack of Métis-specific data ∞

Policy Levers | Criminalize coerced sterilization | Distinctions-based health legislation | Stable Métis-governed SRH funding | Métis data sovereignty | Provincial and municipal Métis partnerships ∞



Policy Gaps: Gap Analysis

Without disaggregated and intersectional data (by Indigeneity, gender, geography, socioeconomic status, disability, and 2SLGBTQQIA+ identity), it is challenging to plan, fund, and deliver effective, tailored SRH services for Métis women and gender-diverse individuals. Forced/coerced sterilization policies disproportionately targeted Indigenous women, and federal/provincial legal accountability remains unresolved.

Despite growing recognition of Indigenous reproductive health inequities, significant gaps remain in policies, data systems, and service models affecting Métis women, girls, and gender-diverse people.

1. Lack of Disaggregated, Métis-Specific Data
Most federal and provincial health surveillance systems do not disaggregate data by Métis identity, gender, geography, disability, socioeconomic status, or 2SLGBTQQIA+ identity. This invisibility prevents accurate assessment of Métis reproductive and sexual health needs and undermines effective planning, funding, and evaluation.

2. Incomplete Accountability for Coerced and Forced Sterilization
Historical and ongoing coerced sterilization of Indigenous women—including Métis—remains insufficiently addressed in law and policy. There is no explicit federal offence for non-consensual sterilization, and mechanisms for redress, prevention, and monitoring remain fragmented or absent.

3. Harmful Maternal Care Policies Persist (Evacuation & Birth Alerts)
Evacuation policies that relocate pregnant Indigenous people to urban hospitals continue to disrupt cultural continuity, kin support, and community-based care. Although "birth alerts" have been banned in most provinces, their legacy persists: child apprehension at birth remains disproportionately high for Indigenous families, creating trauma, instability, and intergenerational harm.

4. Limited Access to Culturally Safe Perinatal Mental Health Supports
There are few culturally grounded perinatal mental health services for Métis people, despite elevated risks associated with trauma, colonization, and systemic discrimination. The lack of integrated mental health care within SRH services contributes to unmet needs.

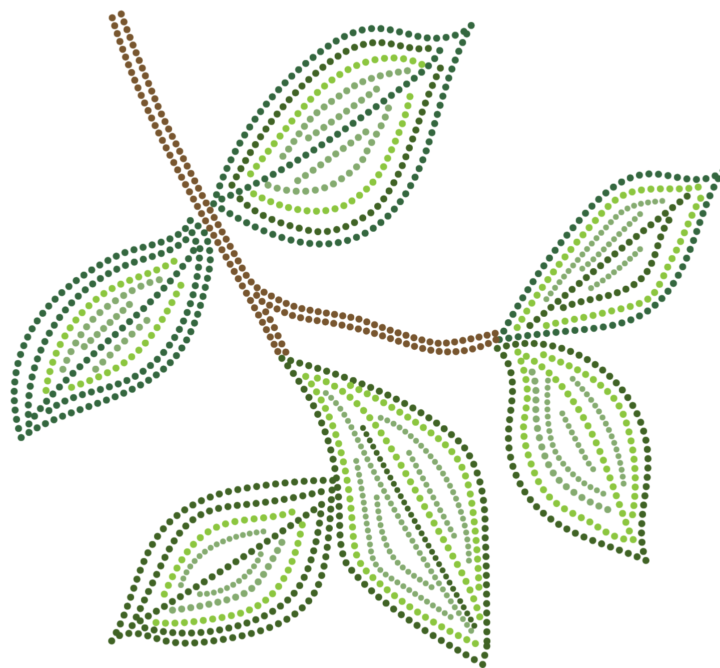
5. Gaps in Distinctions-Based Policy Implementation
Although distinctions-based approaches are now recognized in federal health legislation, Métis communities continue to report uneven implementation and limited representation in health governance tables. Many policies continue to treat Indigenous peoples as a single category, neglecting Métis-specific histories, rights, and cultural frameworks.

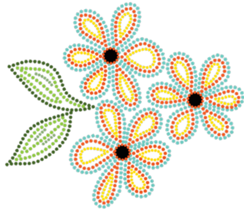
6. Inconsistent Investment and Short-Term Funding
While dedicated SRH funding streams that include Métis projects are emerging, investments remain largely short-term and pilot-based. Sustained Métis-led program development and evaluation are needed to ensure accountability and long-term impact.

7. Insufficient Recognition of Métis Governance and Autonomy in SRH
Policies often fail to fully recognize Métis rights to self-determined health governance. Without explicit Métis-led design and delivery, SRH services risk reproducing mistrust, cultural unsafety, and the harms associated with colonial medical control.

8. Weak Monitoring and Accountability Mechanisms
Current systems lack strong oversight and transparent monitoring of issues such as coerced sterilization, evacuation practices, SRH service accessibility, and outcomes for Métis women. Clear legislative protections, performance indicators, and accountability frameworks are still needed.

9. Failure to Reflect Métis Cultural, Multigenerational, and Land-Based Realities
Mainstream SRH policy frameworks often fail to adequately reflect the kinship systems, land relationships, and multigenerational nature of Métis community wellbeing. -This limits the cultural appropriateness and effectiveness of maternal, reproductive, and sexual health programming.





Recommendations from the LFMO

1. Protect Reproductive Autonomy and Criminalize Coercion
Establish clear federal legal protections (i.e., criminalization of forced or non-consensual sterilization) and enforce standardized informed consent, anti-coercion protocols, and patient advocacy pathways across all reproductive health settings.

2. Build a Métis-Led Reproductive Justice Strategy
Develop a national, distinctions-based Métis reproductive justice framework co-created with Métis governments, women's organizations, Elders, youth, 2SLGBTQQIA+ Métis people, and land-based knowledge holders, ensuring Métis governance over priorities, data, and resources.

3. Clarify Jurisdiction and Sustain Funding
Establish long-term, stable funding agreements between federal, provincial, and Métis governments. Reduce jurisdictional gaps that limit Métis access to reproductive healthcare.

4. Expand Métis-Governed SRH Services and Workforce
Provide sustained funding for Métis-designed and Métis-governed SRH programs (including midwifery, doulas, community birthing, mobile and telehealth supports, and perinatal mental health programs) rooted in Métis culture, kinship, and land-based practices.

Expand mandatory provider training in Métis cultural safety, colonial reproductive harms, anti-racism, and trauma-informed care.

5. Improve Access, Prevention, and Youth Supports
Increase access to contraception, abortion, STI testing, fertility care, and sexual health education through community-based and mobile services.

Develop Métis-led prevention and early intervention initiatives for youth, families, and gender-diverse Métis individuals.

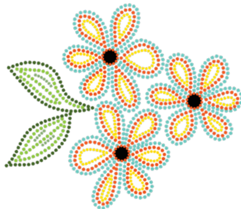
6. Strengthen Supports Addressing Trauma, Violence, and Social Determinants
Integrate SRH services with mental health, violence prevention, safe housing, transportation supports, and family wellness programming.

Recognize housing, poverty, education, food security, and land connection as core determinants of Métis reproductive health.

7. Advance Métis Self-Determination, Governance & Jurisdiction
Ensure long-term, stable funding and clear jurisdictional pathways that empower Métis governments to design, deliver, and evaluate SRH services within their own governance structures.

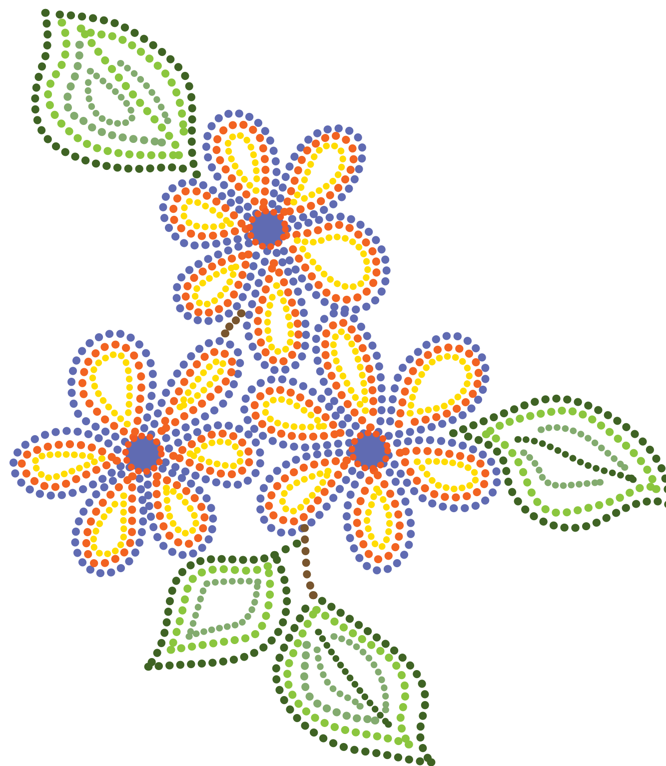
8. Improve Data, Research, and Métis Data Sovereignty
Collect and report disaggregated Métis-specific SRH data (e.g., birth outcomes, access to services, experiences of coercion, perinatal mental health). Support Métis-led research institutions and adopt Métis-specific data governance frameworks aligned with OCAP® principles.

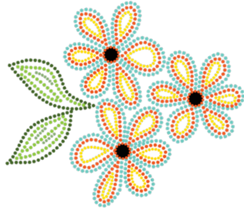
9. Policy & Program Alignment with Distinctions-Based Frameworks
Health policy should align with the distinctions-based health legislation process, ensuring Métis are not subsumed under generic Indigenous policy, but rather have recognition of their distinct rights, governance, identity, and cultural frameworks.



Conclusion

Métis sexual and reproductive health in Canada is shaped by a mix of strong international and constitutional rights frameworks as well as emerging Métis-specific governance and data initiatives. However, significant gaps remain around reproductive harms (forced sterilization), culturally safe care, distinctions-based policy implementation, data collection, and Métis self-determination in health service delivery. Advancing Métis reproductive justice will require legislative action, program investment, data systems, and meaningful Métis leadership embedded in policy and service design.





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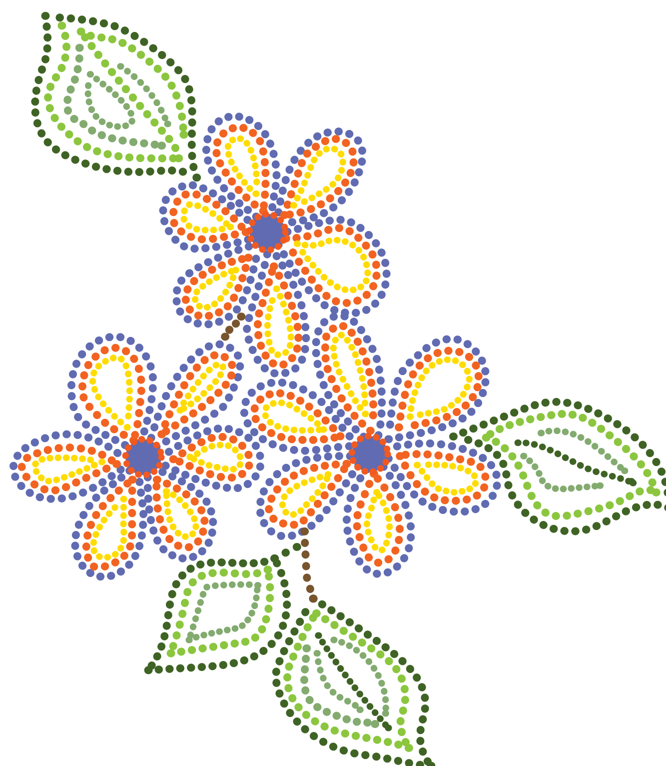

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