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Misconduct, Missing, and Murdered:

The Experiences of Anti-Indigenous Racism in Reproductive Healthcare among Indigenous Women, Girls, Two-Spirit, Transgender, and Gender-Diverse People, and the MMIWG2S+ Genocide

5 Five Policy Research Papers on Missing and Murdered Indigenous Women, Girls, Two-Spirit, Transgender, and Gender-Diverse People

NATIVE WOMEN'S ASSOCIATION OF CANADA

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TABLE OF CONTENTS

INTRODUCTION 4

I: BACKGROUND: 4

MMIWG2S+, NWAC AND ADDRESSING TRC AND THE CALLS TO ACTION 5

II: METHODOLOGY: 8

SECTION I: ANTI-INDIGENOUS SYSTEMIC RACISM IN REPRODUCTIVE HEALTHCARE 14

SECTION II: SYSTEMIC RACISM AND CASE STUDIES: 19

PLACES FOR ACTION AND CHANGE: 26

SECTION III: MEASUREMENT TOOLS NEEDED: 29

CONCLUSION AND RECOMMENDATIONS: 39

REFERENCES: 40

APPENDIX: 47

CRISIS LINES: 52

INTRODUCTION

I: BACKGROUND:

Indigenous Peoples across Turtle Island and Inuit Nunangat experience higher rates of poverty, malnutrition, diabetes, tuberculosis, a twenty-year reduction in life expectancy, and report poorer health levels overall (United Nations, n.d.). Statistics Canada claims the life expectancy for those living in Canada is 84 years among women and 79.9 years among men (2019, n.p); however, Indigenous Peoples are excluded from this data set to skew the national average because of low life expectancies. In 2011, non-Indigenous peoples' life expectancy was 87.3. In comparison, First Nations men had a life expectancy of 72.5 years, and 77.7 years for women; for Métis men life expectancy was 76.9 years and 82.3 for Métis women; and for Inuit men life expectancy was 70 years and 76.1 for Inuit women[1] (Tjepkema et al., 2019). To adequately address the complex, systemic, structural, and institutional issues contributing to poorer health, there needs to be intercultural approaches to health incorporating, and prioritizing, Indigenous voices, Knowledge, and perspectives (United Nations). Racism in health care systems, "must be understood in terms of injustice rather than disrespect," to provide, "a fuller account of how institutions are related to the beliefs, actions, and intentions of individuals, and thus how they can come to embody a certain kind of agency," (Pierce, 2014, p. 23).

In the Canadian healthcare system, the deaths of Indigenous Peoples at the hands of medical professionals and staff are often a result of institutional and systemic forms of anti-Indigenous racism (AIR), contributing to the overwhelming and disproportionate violence that Indigenous Women, Girls, Two-Spirit, Transgender, and Gender-Diverse (WG2STGD+) Peoples experience. More specifically, Indigenous WG2STGD+ People experience systemic racism in reproductive care with, "Inequity, injustice and racism is rampant within the Canadian sexual and reproductive health and rights realm," (El-Mowafi et al., 2021, p.1)., There is an immediate and ongoing need to address the causes, effects, and interconnections between the Missing and Murdered Indigenous Women, Girls, Two-Spirit, Transgender, and Gender-Diverse People (MMIWG2S+) genocide and forms of anti-Indigenous racism in reproductive care.

The Native Women's Association of Canada (NWAC) is a leading voice on research and policy for Indigenous WG2STGD+ People, especially concerning systemic, structural, and institutional issues that, including healthcare, contribute to the ongoing genocide of MMIWG2S+. As per NWAC's Call to Action Plan (CAP), which addresses systemic issues related to MMIWG2S+, a recognition of distinct Indigenous identities, cultural safety, and a

1 Note this data is based on the availability of Indigenous Peoples completing Statistics Canada surveys. Some Indigenous Peoples distrust government agencies based on their continued and historical misrepresentation of Indigenous demographics and information.

trauma-informed approach must be upheld and respected to achieve substantive equality and human rights, a decolonized approach to healthcare, the inclusion of families and survivors, self-determination, and Indigenous-led solutions and services, (NWAC, 2021).

In 2021, NWAC made eight recommendations on urgent needs to investigate and eradicate systemic racism in healthcare policies and services, a significant issue pertaining to the MMIWG2S+ genocide. This research paper looks to fulfill the work of NWAC's guiding principles and more carefully engage with recommendations from this earlier research. To achieve this, this paper explores Indigenous WG2STGD+ sexual health, pregnancy, and post-birth care. A culturally relevant gender-based analysis (CRGBA+) data framework is considered to determine the preferred practices and tools required to measure cause and effects of MMIWG2S+ on the quality of reproductive care received. This paper uses a CRGBA+ data framework, alongside these three examples, to determine preferred practices and measurement tools required to measure outcomes of anti-Indigenous, systemic racism in reproductive healthcare with regards to on the ongoing genocide of MMIWG2S+ for WG2STGD+ people. Finally, this paper will examine these three cases to address how to measure AIR in the education system, training provided, and medical practice.

This research project aimed to:

1. Determine the cause and effects MMIWG2S+ has on systemic racism in reproductive care.
2. Establish a measurement tool to be used to measure qualitative and quantitative data regarding MMIWG2S+ and systemics in reproductive care.
3. Examine how stereotypes in reproductive healthcare continue to perpetuate genocide of MMIWG2S+ people.
4. Create a toolkit to inform medical providers, staff, and practitioners on preferred practices for measuring and reducing systemic racism in three key areas, including education, training, and practice.

MMIWG2S+, NWAC AND ADDRESSING TRC AND THE CALLS TO ACTION

As outlined above, NWAC has a proud history of research and policy that seeks to address the ongoing crisis of MMIWG2S+ and AIR racism on Turtle Island and Inuit Nunangat. NWAC's 2021, "Our Calls, Our Actions" plan was a direct response to the lacklustre nature of the Canadian Government's 231 Action Plan. NWAC continues its dedicated for the

need for recognition of distinct Indigenous identities and cultural safety. NWAC maintains that a trauma-informed approach must be upheld and respected to achieve substantive equality and human rights, a decolonized approach to healthcare, the inclusion of families and survivors, self-determination, and Indigenous-led solutions and services (NWAC, 2021). Moreover, NWAC developed 65 concrete actions that speak to specific and unique needs of Indigenous communities in Canada that are "holistic", "decolonizing" and "trauma-informed" (NWAC, 2021, p. 9). NWAC's analysis and recommendations respond to the National Inquiry Calls For Justice and our Call to Action Plan. This research project speaks to the continued journey toward truth and reconciliation, and needs for additional support for survivors of the MMIWG2S+ genocide. This project speaks to the following National Inquiry Calls for Justice:

- Section 3.2: Fund accessible, Indigenous-centered, community-based, health and wellness services for the MMIWG2S+ Calls for Action.
- Section 4.1: Ensure Indigenous Peoples have services and infrastructures to meet social and economic needs.
- Section 4.4: Provide support and resources for educational and employment opportunities for Indigenous WG2STGD+ people.
- Section 7.3: Support Indigenous-led preventative initiatives.

This project speaks to the following recommendations, posed in NWAC's Call to Action Plan:

- NWAC's dedication to continuing ongoing health, policy, research, training, and programing to support Indigenous-led health initiatives. These include initiatives toward ending forced sterilization and providing mental health and wellness.
- Establish land-based Resiliency Lodges across Canada for holistic healing.
- Develop and deliver a financial health and wealth program for Indigenous WG2STGD+ people.
- Preserve NWAC's MMIWG2S+ database.
- Advocate for, and assert, legal rights to self-determination.

Not only does TRC encompass the Calls the Action put into place by the Canadian Government, but it can incorporate principles set in place by the United Nations Declaration for the Rights of Indigenous Peoples (UNDRIP), which states Indigenous Peoples' rights

to use Traditional Medicine in their HSCP, rights for accessing all social services without discrimination, rights to attain the highest level of healthcare for their physical and mental health, and rights for conservation of sacred plants, animals, and minerals (Council of the Atikamekw of Manawan and the Council de la Nation Atikamekw, 2020). Interviewees stressed that despite the Calls for Action made by Indigenous communities, little action had been made. Mercredi asserts, "What haven't we done? ... Is the other point here that needs to be really made clear. What haven't we done? We have done everything. We've created these organizations. There isn't much that we haven't done from the grassroots to whatever organization has been created by women, Indigenous, Métis, Inuit, and Two-Spirit women, at some point ... "the recommendations are not being followed through. That's not to say the work isn't being done," (2022). While interviewees emphasized a lack of action regarding the promises made through TRC, Rickard also questioned accountability and credibility of the CAP, stating, "a lot of people are using the statements to call for using the Call for Actions. They're putting programs into place, but nobody's evaluating those calls for action within the organization. Yes, it looks pretty on paper but has not been evaluated. And they still don't know how and I'm sure you've heard that statement as well," (2022). Rickard said, "the heart" of HSCP is to provide care. Despite the impressions of Canadians, Rickard said the quality of care is not there for all individuals. She added, "We're there to care for people, but yet we're not," (2022). TRC and the Canadian Government's CAPs must not only be put into place but must be accountable for projects being done with a governing body ensuring the Calls are thoughtfully, and considerately, implemented.

For Browne et al. (2021), the most recent document, Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (National Inquiry into Missing and Murdered Indigenous Women and Girls (2019) has, "reinforced the urgent need for Indigenous and non-Indigenous people to work together to mitigate the ongoing effects of Canada's colonial context," (p. 1). Collaboration strengthens TRC and highlights a need for decolonizing practices. This paper seeks to provide structural and institutional examples of how training, education, and practice can be made culturally relevant and trauma-informed through efforts of non-Indigenous

Summary:

This research project determined distinct, and complex, links between AIR and MMIWG2S+ by exploring case studies of sexual health, pregnancy, and post-birth reproductive healthcare. It examines three specific healthcare settings where healthcare can be decolonized including education, training, and practice. Data was collected using in-depth, semi-structured interviews, secondary source data, thematic analysis, and a framework incorporating CRGBA+, intersectionality, FPIC, TIC, and Two-Eyed Seeing/ Etuaptmumk. Interviews were conducted, coded, and sent to each interviewee to ensure FPIC and TIC models were employed. Three Interviews were conducted with Indigenous

scholars, artists, storytellers, and HSCP. The following themes were found: 2SLGBTQQIA+ healthcare needs; accountability and reporting; TRC and acknowledgement; access; measurement tools recommendations/methods; creation of safe spaces; bias, stereotypes, settler colonialism, education and training, funding needs, and what is needed from organizations. Excerpts from interviews were used verbatim through the research paper.

II: METHODOLOGY:

This section outlines methodological frameworks for this research project, including the use of in-depth, semi-structured interviews, secondary source data, thematic analysis, and a framework incorporating CRGBA+, intersectionality, FPIC, TIC, and Two-Eyed Seeing/ Etuaptmumk. Interviews were conducted, coded, and sent to each interviewee to ensure FPIC and TIC models were employed.

Despite the need to address AIR throughout different systems, structures, and institutions, this paper investigates intricate links between MMIWG2S+ and AIR in healthcare. Connections between MMIWG2S+ and AIR is a significant, and critical site, where there are many forms of systemic, structural, institutional, and interpersonal forms of violence against Indigenous WG2STGD+ People. MMIWG2S+ is compounded in healthcare systems through its geographic or general inaccessibility, barriers, and AIR, which leads to many Indigenous WG2STGD+ People going missing and being murdered. Forced and coerced sterilization, disappearing during medical travel set forth by policies such as the birth evacuation policy, and forced use of contraceptive methods are among a few examples of this link. To explore this further, this paper uses examples of sexual health, pregnancy, and post-birth care to demonstrate how Indigenous WG2STGD+ People are particularly vulnerable to AIR and forms of settler colonial violence experienced in the healthcare system, especially during times of medical need. To situate these instances, this paper also highlights how education, training, and practices are three areas where decolonizing methods can help eradicate the ongoing genocide of MMIWG2S+. Using reproductive care as a case study, this paper explores how AIR exists in healthcare, and provides recommendations and measurement tools to demonstrate how non-Indigenous HSCP can become part of the solution.

To fulfil the purpose and aim of this research project, three semi-structured, two-hour-long interviews were conducted, in addition to completing a literature review of secondary source literature addressing racism in healthcare, AIR in healthcare, MMIWG2S+ and reproductive care, and AIR in reproductive care. Interviewees were chosen based on their expertise as Indigenous activists, authors, artists, scholars, and healthcare professionals (HSCP) specializing in Indigenous reproductive care and justice. Interviews focused on

how to better understand and create a measurement and preferred practices toolkit to measure systemic racism in healthcare, as well as causes and effects of the MMIWG2S+ genocide. Interviews took place over Zoom between July and August 2022, and interviewees were asked a set of pre-determined questions (See Appendix A) regarding measurement tools currently used to address AIR in healthcare.

As per UNDRIP's FPIC model and NWAC's dedication to trauma-informed consent, interviewees were provided with all 10 interview questions and an Informed Consent Letter at least 24 hours before their interview (See Appendix B). Interviews varied between 45 and 90 minutes in length and were conducted by one of NWAC's Indigenous Senior Project Officers. All participants provided consent for their interview to be audio recorded, before to the interview taking place.

Following each interview, the transcriptions were completed using the transcription tool Otter.ai. Once the transcription was completed, project members jointly read through the transcript. Once the transcript was edited, the interviewer emailed the transcript to the participant for their approval to continue to use of UNDRIP's FPIC and trauma-informed methodological frameworks. Some interviewees wanted to remain anonymous, and others wanted to be named. Based on the sensitive nature of the interview content, anonymity included excluding their name and any identifiers, including their occupation or research background. Only one participant wished to remain anonymous and will be addressed as Participant A. All participants consented to be quoted verbatim in the research project.

Interviews were coded using thematic analysis (TA). TA is an, "accessible and theoretically flexible" method of data analysis used to identify, explore, and show the existence of patterns within qualitative data sets (Braun & Clarke, 2006, p. 79). TA allowed for establishing day-to-day experiences and lived realities of those working with the researcher (Braun & Clarke, 2006). TA was used to determine the corpus or interviewees that would be beneficial for this research project. For Braun and Clarke, "a theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set," (p. 99). Interview questions were created with the desire to determine methodological tools for measuring AIR in reproductive healthcare, and coding was established based on interviewee responses.

Therefore, themes often spoke to this. Theme building was done by the senior researcher and/or the senior project officer. Based on themes in the data set, the following codes were created:

2SLGBTQQIA+ healthcare:	Accountability and reporting:	TRC and acknowledgement:	Access:	Measurement tools recommended / methods:
Creation of safe spaces.	Bias, stereotypes, and settler colonialism.	Decolonizing methodologies.	Education and training.	What is needed from organizations?
Funding needs.	Examples / recommendations.			

These themes were created during the initial coding process and confirmed during the second reading. Themes were created by the senior project office and senior researcher during the initial interview transcript review. Themes created during this transcript were then used in two other following interviews. During the reading of the second and third interview transcripts, one more theme was created: TRC and Acknowledgement. Once themes were established, the transcripts were coded, and codes were placed into a Microsoft Office Excel spreadsheet by the Senior Researcher/Senior Project Officer.

Transcripts were sent to all interviewees for their approval. Two of the three interviewees responded by approving their transcript, and the final interviewee did not respond. After writing the paper, all interviewees were provided with the initial draft, and their contributions were highlighted. All quotes and contributions were approved by the interviewee to be in the final paper.

The following methodological frameworks informed this research project:

Culturally Relevant Gender-Based Analysis (CRGBA+):

Until 2011 when NWAC recommended the CRGBA+ framework, many research and policy tools had not given proper justice to the complex intricacies of settler-colonialism and its implications on Indigenous WG2STGD+ People (Sanchez-Pimienta et al., 2021). In contrast, an Indigenous gender-based analysis (GBA) recognizes, "Patriarchal histories,

structures, and social norms imported from Europe imposed on Indigenous communities since contact, which have had devastating consequences for Indigenous governance, community, and family relations, with direct impacts on health and wellness." At the same time, understanding, "specific cultural, geographical, historical, and spiritual contexts and strengths of diverse Indigenous communities that have survived and resisted the imposition of patriarchal worldviews," (Sanchez-Pimienta et al., 2021, p. 11,575). NWAC calls for a distinctions-based GBA recognizing uniquenesses of First Nations, Inuit, and Métis, while noting shared experiences of AIR in Canada (NWAC, 2020), while acknowledging impacts and experiences, "Before colonization, early colonization and attempted assimilation, current social and political realities, and strategies and responses looking into the future," (Sanchez-Pimienta et al., 2021, p. 11,577). CRGBA+ incorporates a reflective lens signifying importance of settler colonialism in current experiences of AIR in healthcare.

A CRGBA+ framework provides critical structure to ensure investigations into healthcare incorporate the importance of settler-colonialism on Indigenous communities and its continuing legacy within structures, systems, and institutions of Canada. To determine best tools to measure AIR in healthcare, a foundation must be developed to establish the nexus of AIR in healthcare and establish strategies for structural, systemic, and institutional change.

Free, Prior, Informed Consent:

As per the guidance of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), this project strived to include free, prior, informed consent (FPIC) model. FPIC is a process centering self-determination among Indigenous Peoples, provides them with space to, "Give or withhold consent to a project that may affect them or their territories," and, "Conduct their own independent and collective discussions and decision-making," in an environment that is culturally safe, as well as, "Discuss in their own language, and in a culturally appropriate way, on matters affecting their rights, lands, natural resources, territories, livelihoods, knowledge, social fabric, traditions, governance systems, and culture or heritage [tangible and intangible]," (Food and Agriculture Organization of the United Nations, 2016, p. 13). FPIC was practiced in this project by providing a consent letter before each interview (Appendix B), providing interview questions before the interview (Appendix A), sending the final transcript for approval from participants, and allowing participants to view the way their interview was used in the paper.

Intersectionality:

An Intersectional approach was used throughout research project development. Originally coined in 1991, Kimberlé Crenshaw defines intersectionality as, "A lens, a prism, for seeing the way in which various forms of inequality often operate together and exacerbate each other," highlighting, "What's often missing is how some people are subject to all of these,

and the experience is not just the sum of its parts," (Crenshaw, quoted in Steinmetz, 2018). In the context of MMIWG2S+ research, intersectionality recognizes unique lived experience of each Indigenous person, noting perspectives based on gender, economic status, geographic location, and other factors. For Audre Lord (2007), "There is no such thing as a single-issue struggle because we do not live single-issue lives," (p. 138). Using intersectionality allows for an exploration of heteropatriarchy, and settler colonialism contributes to a strong correlation between race-based and gender-based violence (Tuck, Yang, and Morril, 2013). This can be revealed through unhealthy family and parenting practices, including abuse and neglect among Indigenous WG2STGD+ People (Parsloe & Campbell 2021). This research project uses intersectionality to explore how factors such as income, geographic location, language, and gender contribute to Indigenous WG2STGD+ Peoples' experiences navigating healthcare systems.

Trauma-Informed Consent:

NWAC defines trauma as, "A traumatic event can be a single event that occurred either recently, in the past, or a long-term and chronic experience," (NWAC, 2022). Therefore, trauma-informed care (TIC), "Is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma," seeking to emphasize, "Physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment," (Center for Health Strategies, 2006). TIC should also, "Aim at ensuring environments and services are welcoming and engaging for service recipients and staff," (Trauma Informed Oregon, 2016).

According to the Center for Health Strategies (CHCS), the following 10 steps are required for TIC: Lead and communicate, engage clients in planning, train all staff, create a safe environment, prevent secondary trauma, build an informed workforce, involve clients in treatment, screen for trauma, use trauma-specific treatment, and engage partners (Center for Health Strategies, n.d.). TIC was incorporated into this project through Section II's dedication to teaching how AIR occurs during education, training, and practice levels. TIC is a crucial tool all HSCP require to provide the most kind, informed, and considerate care to Indigenous Peoples. Applying these criteria to Indigenous care and support means allowing Indigenous Peoples to speak for themselves and centers them as experts on their needs. It also means acknowledging how intergenerational trauma, or traumatic experiences, influence the health and wellbeing of Indigenous Peoples, seeking not to retraumatize individuals seeking support. Workplaces and staff should be inclusive and culturally-competent to address the needs of all clients. NWAC also recommends incorporating compassion and avoiding patient burn-out from having to relive traumatic experiences (2022). Those working with Indigenous Peoples, "Incorporate these practices into their support to ensure they are considerate and knowledgeable about how care be inclusive and productive," (Trauma Informed Oregon, 2016).

Two-Eyed Seeing/Etuaptmumk:

Two-Eyed Seeing/Etuaptmumk integrates Western methodologies with Traditional Healing in a program-based setting (McKendrick et al., 2017; Waldram et al., 2018; Wright et al., 2019). It is an, "Overarching guiding principle for our collaborative work and has been picked up by diverse others across Canada," (Bartlett et al., 2012, p. 332). This project includes Traditional Knowledge, Indigenous Methodologies, and Western practices of the scientific method. This project interviewed Indigenous healthcare workers, activists, artists, and scholars to support the importance of integrating much-needed Indigenous Knowledge into Western forms of medical practice. The merging of Western practices with Indigenous wellbeing, medicine, and approaches benefits Indigenous and non-Indigenous communities, as well as decolonizes healthcare by acknowledging bias within Western healthcare systems. Finally, Two-Eyed Seeing is a means of providing TRC by providing opportunities for Indigenous Peoples to give birth in their communities, while utilizing Traditional Knowledge, ceremony, and Indigenous doulas.

This section has outlined methodological tools and approaches used throughout this research project.

Participants for this research project:

PARTICIPANT A wishes to remain anonymous in their name and professional information.

MORNINGSTAR MERCREDI (SHE/HER):

Morningstar Mercredi is an author, poet, artist, researcher, social activist, producer, and actress. She authored, "Morningstar: A Warrior's Spirit," and, "Fort Chipewyan Homecoming," as well as various articles. Her background is in multimedia communications. She produced and hosted a half-hour radio program on CKUA Radio in Edmonton, Alta, entitled: "First Voices," which explored and celebrated Indigenous artists throughout Turtle Island. Her documentary, "Sacred Spirit of Water," premiered at the United Nations Permanent Forum for Indigenous Peoples in New York, NY, in 2013.

Mercredi contributed to a five-part film entitled, "The Unforgotten," which explored the health and well-being of Indigenous Peoples living in Canada. She was honoured to do the voice-over work in the "Birth" segment (the first part of the film). "The Unforgotten" premiered on June 22, 2021, in Canada.

JUANITA RICKARD RN, BSCN (SHE/HER):

Canadian Indigenous Nurses Association Vice-President, Juanita Rickard, has been a registered nurse for 28 years working in First Nations communities in northern Ontario

and Manitoba. She dedicated her research to understanding opioid addictions over the past five years since witnessing devastating effects on clients, families, and communities during her nursing practice. She has taken several "Best Practice Workshops" through the Registered Nurses Association of Ontario, the most recent being: Mental Health and Addictions. She uses an innovative approaches to plan, implement, evaluate, and manage addictions and health care services. With her work with RNAO, she is a contributing expert panel member on developing Safe Injections Sites.

SECTION I: ANTI-INDIGENOUS SYSTEMIC RACISM IN REPRODUCTIVE HEALTHCARE

1a: Defining anti-Indigenous racism in Canadian healthcare:

Under Section 15 of the Canadian Charter of Rights and Freedoms (1985), all people living in Canada deserve equality and equal access to proper healthcare without discrimination. AIR is the discrimination and mistreatment of Indigenous Peoples based on indignity, which can include, "Stereotyping, stigmatization and violence, as well as through many of the structures of Canadian society," (Loppie et al., 2020). Despite the rights of Indigenous Peoples, AIR racism exists on systemic, structural, institutional, and interpersonal levels. Systemic racism illustrates how legal, political, healthcare, education, and criminal justice systems benefit some, while simultaneously discriminates against others (Braveman et al., 2022). Structural racism is "scaffolding," upholding systemic racism, which is to support a system in place to ensure the status quo is put in place (Bourke et al., 2019) and exists in the policies and practices within Canadian healthcare systems (Gunn, n.d.). For Bourke et al. (2019), institutional racism acts, "As the covert means operated by established and respected societal forces for the purpose of subordinating and maintaining control over a racial group; in effect, they regarded institutional racism as a form of colonialism," (p. 611). Regardless of definition, institutional racism, among others, can be, "Indirect and may or may not be intentional," (Bourke et al., 2019, p. 612). The three are commonly used interchangeably as they are simultaneously having profound influence over the experiences of Black, Indigenous, and People of Colour (BIPOC), especially in settings such as healthcare. These forms of systemic racism are, "So embedded in systems that it often is assumed to reflect the natural, inevitable order of things," (Braveman et al., 2022, p. 173). This naturalization allows for the marginalization of certain groups to go undetected, unacknowledged, or disregarded. Canada's colour-blind stance on race-based inequalities persists (Idriss-Wheeler et al., 2021), especially in the most vulnerable of settings.

One final aspect of racism that is critical to understand is interpersonal forms of racism commonly seen in the healthcare setting. For Krieger (2014), interpersonal racism is

the, "Directly perceived discriminatory interactions between individuals—whether in their institutional roles (e.g., employer/employee) or as public or private individuals (e.g., shopkeeper/shopper)," (Krieger, 2014, p. 650). Forms of interpersonal racism were discussed extensively by our interviewees, who demonstrated how Indigenous Peoples experience different forms of verbal discrimination based on preconceived notions and stereotypes. Interpersonal racism in healthcare commonly appears as assuming one's drug and alcohol use and assuming the needs of patients based on other stereotypes. Storytellers, such as Lombard (2021) and Mercredi (2022, interview), recant humiliation and distress experienced by Indigenous Peoples assumed they are consuming alcohol during pregnancy, or experience health issues due to alcohol use. Interpersonal racism is addressed in this paper by exploring ways training, education, and practices can be made more affirming, culturally relevant, and trauma-informed.

Despite institutions and organizations, such as the Canadian Institute for Health Information's (CIHI), there is little acknowledgement on the lack of race-based health data. Some argue, "The lack of disaggregated data reinforces the culture of colour-blindness," (Idriss-Wheeler et al., 2021). BIPOC folks continue to be, "Devalued, disempowered, and subjected to differential treatment in various institutions, including healthcare, resulting in negative material consequences affecting people's living conditions, everyday lives, including access to healthcare and health outcomes," (Hamed et al., 2022, p. 989). Poor health care is an example of how systemic racism remains a crisis in Canada. Healthcare for Indigenous Peoples in Canada continues, discrimination and lack of use of Traditional Medicines in Western healthcare caused by ongoing influences of settler colonialism. Meaning: Indigenous Peoples are unable to use their Knowledge, Teachings, or Medicine in meaningful ways when engaging with Western healthcare systems. As part of TRC, non-Indigenous HSCPs must encourage Indigenous practices in healthcare education, training, and practices.

Indigenous Peoples experience specific forms of racism based on settler-colonialism and its continued legacy within Canadian systems, structures, and institutions. AIR is defined as, "The ongoing race-based discrimination, negative stereotyping, and injustice experienced by Indigenous Peoples," including, "Ideas and practices that establish, maintain and perpetuate power imbalances, systemic barriers, and inequitable outcomes that stem from the legacy of colonial policies and practices in Canada," (Government of Ontario, 2022, n.p.). Indigenous Peoples and communities experience extensive barriers to proper healthcare, commonly making adequate care inaccessible due to geographic location, inadequacies in Non-Insured Health Benefits (NIHB) programs, long wait times, and high healthcare-adjacent costs (National Collaborating Centre for Indigenous Health, 2019). Despite financial coverage through provincial plans and NIHB, many expenses must be paid for by the patient up-front, including transportation costs, making travelling for

healthcare inaccessible. AIR can cause communities and individuals to not only avoid medical assistance when needed (National Collaborating Centre for Indigenous Health, 2019), but can cause individuals to unnecessarily travel, contributing to the ongoing genocide of missing and murdered Indigenous WG2STGD+ People. When Indigenous people travel to give birth, they can only travel with one individual, leaving important community members such as mothers, doulas, and other support providers behind. Moreover, AIR in healthcare contributes to overall poor care, misdiagnosis based on stigma or stereotypes (Wiley & McConkey, 2019), and horrific deaths from preventable causes. Stereotyping of Indigenous Peoples continues to contribute to this epidemic, contributing to the genocide of MMIWG2S+.

Based on previous experiences, many Indigenous Peoples are subjected to fear and distrust of HSCP. According to Justice Murray Sinclair, healthcare was among the tools of settler-colonialism used to oppress Indigenous Peoples, because the, "Medical system is often the emergency ward," and used only when Indigenous People have, "No choice but to engage," (Vogel, 2015, p. E10). Not only do Indigenous Peoples lack proper access to healthcare services, but when accessing them, Indigenous Peoples commonly experience extensive barriers, including lack of acknowledgement of the issue based on stereotyping, lack of empathy, and lack of care. Only days after the death of Joyce Echaquan, Georges-Hervé Awashish, a 53-year-old Obedjiway man, passed in hospital after writing to his cousin that healthcare staff were making racist and discriminatory comments (Feith, 2020). These factors add to pre-existing skepticism of healthcare systems experienced by many Indigenous Peoples, many of whom have been victim to forced and coerced sterilization, violence via scientific experimentation (Mercredi, 2022), and/or have been stereotyped based on ill-informed bias.

Interviewee Morningstar Mercredi provided stories of her loved ones experiencing undignified and inadequate access to medical care for both her father and an Elder. For her father, Mercredi recalls:

> **I literally got him there on time. However, the problem was that the doctors in cardiac surgery weren't going to operate on him. So, I went through five doctors until I was finally brought to the manager of cardiac surgery on that floor. I basically said, if I leave here without my dad receiving the surgery he needs and he passes away, I'm coming back here and suing you. Within the hour, my dad received the surgery he needed to remove blockage in his main artery and consequently, was able to be with us for another four years, (2022).**

Mercredi demonstrates how quality of care can mean life or death for many Indigenous People struggling for adequate attention. HSCP, with the power to provide affirmation

and care, commonly reduces Indigenous Peoples to stereotypes, using this as an excuse not to provide care or inadequate care. Mercredi notes this in another story of a friend, who is an Elder, storyteller, actor, and singer, in Saskatchewan. Mercredi recalls him going to a clinic because he was feeling ill:

> **The doctor didn't even examine him. The doctor just looked at him and said to him, 'you shouldn't drink.' My dear friend, who is an Elder, was so shocked and stunned by that comment, contempt prior to investigation, he had been shamed. All of this racialized violence, projection of stereotypes, were put onto him; so he walked away. Fortunately, he did go to the hospital the following day, because, obviously, his symptoms didn't improve. He was immediately diagnosed by a very kind nurse during intake and he finally received the medication he needed, (2022).**

These AIR experiences in healthcare remain familiar, with many communities experiencing similar stereotyping and lack of access to proper healthcare based on bias. Such instances are a reminder of why Indigenous Peoples feel alienated and distrustful of healthcare in Canada. While healthcare is provincially based, settler-colonial systems can exist on provincial or federal levels, with some provinces, such as Quebec, engaging in more outright forms of AIR. This leads to unnecessary and tragic death of Indigenous WG2STGD+ Peoples, such as Joyce Echaquan. For other provinces and territories, a more Indigenous-centred approach to training and healthcare education is needed, such as in the Yukon.

1b. Anti-Indigenous Racism Healthcare and the MMIWG2S+ Genocide:

While calls for attention, action, and acknowledgement of the ongoing genocide of MMIWG2S+ continue, AIR's systemic, structural, and institutional forms permeate the healthcare system as key contributing factors. The MMIWG2S+ genocide directly links to experiences of AIR in reproductive healthcare, such as forced and coerced sterilization and birth alerts. The MMIWG2S+ genocide demonstrates the need for Indigenous WG2STGD+ People to remain safe in all aspects of their lives. AIR in health care occurs and is often expected (Participant A, Interview, 2022) with Indigenous WG2STGD+ People experiencing barriers to reproductive care, poor healthcare experiences and outcomes, and additional harm to their wellbeing. AIR in reproductive healthcare demonstrates the continued settler-colonialist structure prioritizing reproductive justice of some, while neglecting reproductive needs of others.

The reproductive justice framework (RJF) outlines specific rights all people who can give birth need, including the right to reproduce, the right to choose against reproduction, and the right to parent. In 1994 Sister Song developed the RJF in response to the overwhelming need for reproductive rights and justice among BIPOC individuals (Sister Song, n.d.). The RJF combines reproductive rights, which is the, "Legal and advocacy-based model that

is concerned with protecting individual women's legal right to reproduce health care services," with reproductive justice, which is, "The movement-building organization framework that identifies how reproductive oppression is the result of the intersection of multiple oppressions and is inherently connected to the struggle for social justice and human rights," (Ross & Solinger, 2017, p. 65). RJF is a framework designed to explore and eradicate the reproductive inequalities and barriers to access experienced by marginalized people, globally. RJF outlines rights all those able to conceive deserve and require as fundamental human rights.

MMIWG2S+ is not just about those who have gone missing and murdered, but also about reproductive rights of Indigenous WG2STGD+ People overall. This section will outline how MMIWG2S+ and AIR in reproductive care are intrinsically linked. In doing so, it will demonstrate how the eradication of AIR in reproductive care will aid in the ongoing crisis of MMIWG2S+ by providing allyship among medical and HSCP, bringing light to ways settler-colonialism can be dismantled in healthcare for Indigenous WG2STGD+ People.

The ongoing MMIWG2S+ genocide is linked to all aspects of gender-based violence and settler-colonial violence against Indigenous WG2STGD+ People; however, AIR demonstrates a specific institution whereby HSCP are commonly influenced by stereotypes and racist thinking of broader society. When discussing direct links between MMIWG2S+ and AIR in healthcare, numerous aspects must be accounted for, including transportation, lack of access to medical needs in communities, and how Indigenous WG2STGD+ People are treated when seeking assistance for reproductive needs. While this will be explored in more detail using case studies of sexual health, pregnancy, and post-birth experiences, overarching experiences of AIR in reproductive care demonstrates specific instances of how MMIWG2S+ is not just about those who go missing and murdered. Rather, reproductive coercion, sterilization, birth evacuation policies, lack of access to services in a preferred language, and lack of community during birth, are areas where Indigenous WG2STGD+ People are not provided the same level of dignity and respect as non-Indigenous people.

Due to settler colonial histories and legacies, such as the Indian Act (1985) and NIHB policies, many Indigenous WG2STGD+ People lack necessary means of transportation to receive proper healthcare, especially in the case of remote and northern areas. For this reason, isolated Indigenous communities are at higher risk, with community members required to travel for even minor forms of healthcare. Travel is only one example of how anti-Indigenous sentiments occur within misconceptions of the MMIWG2S+ genocide. For some, "risky" (Morgan, 2016) behaviours, such as hitchhiking, are among the only options to seeking out care, since NIHB does not provide immediate and necessary financial relief. This leads some folks, especially WG2STGD+ People, to hitchhike to

a medical facility. In this instance, that individual has become increasingly vulnerable because of colonial policies and history. MMIWG2S+ is not only about the destination of reproductive healthcare, but also about how Indigenous WG2STGD+ People are placed at risk based on barriers experienced before stepping foot near a healthcare facility. This research paper has sought to illustrate complex inner workings of how AIR in healthcare and anti-Indigenous healthcare policies contribute to the ongoing genocide of MMIWG2S+ in intricate and unseen ways.

It is critical to note that HSCP, in all positions, remain overworked, underpaid, underfunded, and underappreciated for their efforts in providing healthcare. COVID-19 not only changed the landscape of healthcare requirements in Canada, but also provided increasingly emotional, physical, spiritual, and mentally draining working conditions, with 78 percent of nurses expressing feelings of burnout (Pelley, 2021). Severe burnout has been identified in 20 percent of all HSCP (Maunder et al. 2021, p. 1). More resources for HSCPs are required to ensure HSCPs are provided with tools, training, and education needed to ensure the enactment of Bill C-15: An Act respecting the United Nations Declaration on the Rights of Indigenous Peoples (2021). Doing so ensures equity in the care of both Indigenous and non-Indigenous Peoples. HSCPs must claim responsibility for recirculating settler colonialism and AIR in the healthcare system. However, many do not know how to access the tools, methods, and resources needed to accomplish this goal. This research project seeks to explore and provide tools to ensure ethical, kind, and considerate sdhealthcare of Indigenous Peoples, while also providing much-needed resources for HSCP to engage in culturally appropriate care.

SECTION II: SYSTEMIC RACISM AND CASE STUDIES:

Using the examples of sexual health, pregnancy, and after-birth care, this section will demonstrate connections between MMIWG2S+ and systemic racism in reproductive healthcare. Moreover, it will use three key sites: Education, training, and practice, to illustrate how AIR causes and effects the quality of reproductive health care, which Indigenous WG2STGD+ People experience, and how it links to MMIWG2S+. Doing so will demonstrate how foundations of reproductive justice are not met for Indigenous WG2STGD+ People[2] living in Canada. This section will also utilize wisdom and words of the following interviewees: Morningstar Mercredi (she/her), Junita Rickard (she/her), and Participant A, a scholar working on Indigenous methodologies and the MMIWG2S+ genocide.

2 The acronym: WG2STGD People, continues to be used through this paper when addressing sexual health, reproductive health, pregnancy, and post-birth health of Indigenous Peoples. This is intentionally done to acknowledge the reproductive needs of younger people who become pregnant. Moreover, this stands in solidarity and acknowledgement with Indigenous WG2STGD People who experience forms of sexual violence at young ages.

Case Study I: 2a. Sexual Health:

While there is no universal healthcare experience among Indigenous WG2STGD+ People, systemic racism, violence, and sexism, especially in areas such as healthcare, continue to be commonplace (Mercredi & Fire Keepers, 2021). Not only do Indigenous WG2STGGD People experience AIR in reproductive care, but it has also become expected by Indigenous Peoples when seeking medical care (Participant A). According to the World Health Organization (WHO), sexual health, "Is about well-being, not merely the absence of disease. Sexual health involves respect, safety and freedom from discrimination and violence," (2022, n.p). Sexual health is multi-faceted, encompassing legal rights, bodies, sexualities, spiritualities, lived experiences, experiences of others, cultures, religions, values and beliefs, and upbringing (Options for Sexual Health, 2022). Access to reproductive and sexual health resources for Indigenous WG2STGD+ People can be precariously based on geographic location; however, even for those with access to healthcare resources, quality of reproductive care remains saturated in colonialist discourse.

HSCPs may practice based on their wrongfully informed conceptions of Indigenous WG2STGD+ People, which are rooted in settler-colonialism. Indigenous WG2STGD+ People are commonly placed in situations of potential violence and then criticized for their "high risk" choices (Morton, 2016). Many stereotypes attributed to Indigenous WG2STGD+ People include misguided portrayals of overly sexual and attaching their morality and actions to these unjust stereotypes. For instance, when Indigenous WG2STGD+ Persons go missing, they may be accused of engaging in sex work, hitchhiking, alcohol abuse, or being runaways (Hunt, 2015). Indigenous WG2STGD+ People are systemically, structurally, and institutionally seen as sexually disposable (Razack, 2016), contributing to a lack of consequences or regard for victims of those who are murdered or go missing.

These misconceptions lead Indigenous WG2STGD+ People to be treated as lesser in the healthcare system. These stereotypes lead to unjust and ill-informed views many HSCP hold against Indigenous WG2STGD+ People, relaying these biases into healthcare work.

Indigenous activists, such as Morningstar Mercredi, suggest HSCPs need to, "Remove your racial indoctrinated stereotypes and bias of them, and just treat them as a patient and as a human being," (Interview, 2021). Mercredi asserts that HSCPs are not, "Going to work thinking, 'Oh, I want to make sure that they're culturally safe, whatever that means,'... I'm like, a dog with a bone. I'm not 'gonna let that one go. It's unacceptable, and it's inappropriate," (Interview, 2021). Others, such as Participant A, voice concerns about specific medical spaces, such as the emergency room, where less attention is paid and more work needs to be done. Specifically with sexual health, a lack of proper care provided to Indigenous WG2STGD+ People is not only indoctrinated, but also part of the care provided in all sites. Organizations such as NWAC encourage the use of the United Nations Declaration

on the Rights of Indigenous Peoples (UNDRIP), which provides free, prior, and informed consent. This is as a means of ensuring sexual health of Indigenous WG2STGD+ People is ethical, culturally informed, and prioritizes the needs of the individual. One way settler-colonialism persists in sexual health care is in the case of forced and coerced contraceptive use, especially in young Indigenous girls.

Just as Indigenous WG2STGD+ People continue to experience forced and coerced sterilization at the hands of HSCP, Indigenous WG2STGD+ People are also forced to use contraceptive methods. Historical legacy and continued efforts of the women's liberation movement have prioritized reproductive rights of white, middle-class women, neglecting the struggle of BIPOC women forced and coerced into using birth control methods. In 2021, A British Columbia-based Métis activist and lawyer asserted that young Indigenous girls, as young as nine, are being forced to have IUDs inserted to prevent them from becoming pregnant due to sexual violence in the foster care system, (Basu, 2021). Another Indigenous woman anonymously shared that in 2021, she was deceptively prescribed Depo Provera contraceptive injection at a travel vaccination appointment. She avoided coerced treatment only because she recognized the name of the medication. Forced and coerced contraceptive and birth control methods illustrate two foundational issues regarding the conception of Indigenous WG2STGD+ People. The first being Indigenous girls deserve protection to prevent experiences of sexual violence in the foster care system, and the second is that Indigenous WG2STGD+ People are unable to make their own decisions regarding sexual health and reproduction. NWAC and other organizations assert how forced and coerced IUD and contraception use is not only against the free, prior, informed consent model, but also reinforces devaluation of Indigenous WG2STGD+ People.

Case Study II: 2b. Pregnancy:

Indigenous WG2STGD+ People are far more likely than their non-Indigenous counterparts to experience sexually transmitted infections and blood-borne diseases (STIBBD), higher risk pregnancies, pregnancies in their teenage years, sexual violence, maternal mortality, infant mortality, and increased risks of HIV/AIDS (Yee et al., 2011). Despite these concerns, there remains a need for education, policy change, training, and practice change when assisting pregnancy and parenting journeys of Indigenous WG2STGD+ People. Pregnancy can be an exciting and challenging time for many pregnant people awaiting their sacred bundles. However, accounts from pregnant Indigenous People continue to illustrate how settler-colonial and AIR pollute the quality of care extended, with many recounting being asked about alcohol use during pregnancy (Mercredi, 2021; Lombard, 2021) and other offences, leading pregnant Indigenous Peoples to avoid Canadian public health centers altogether, resulting in undiagnosed issues (Burns-Pieper, 2020). Regardless of the steps raised by TRC and the government's CAP, pregnant Indigenous Peoples deal with barriers in their care on personal and policy levels. Policies such as the Birth Evacuation

Policy, outlined in the Non-Insured Health Benefits (NIHB), radically increases instances where pregnant Indigenous Peoples can experience violence, contributing to the ongoing genocide of MMIWG2S+.

The Birth Evacuation Policy is a stipulation under NIHB that requires those 36-38 weeks into their pregnancy living in remote communities to travel to give birth. For Indigenous WG2STGD+ People, the NIHB "birth evacuation" policy is a significant and dangerous issue. A birth evacuation occurs when, "A complex intersection of federal and provincial jurisdictional policies mandates the evacuation of women from rural and remote communities to give birth in hospitals located in southern metropolises," (Ciadro et al., 2020). This causes many pregnant Indigenous Peoples to avoid disclosing their pregnancy altogether (Vang et al., 2018). While this policy has been beneficial for some high-risk pregnancies, especially since pregnant Indigenous People tend to experience "less favourable" birthing outcomes (Statistics Canada, 2017), non-risk pregnancies should not be subjected to birth evacuations (Cerigo & Quesnel-Vallée, 2019). Indigenous Peoples must be able to maintain their Traditional birthing practices for both high-risk and non-high-risk pregnancies, as there are of sacred, cultural, and spiritual significance. For many Indigenous communities, birth, "Is a process of gifting, not of removal," (Finestone and Stirbys, 2016).

The Birth Evacuation Policy is directly linked to MMIWG2S+. According to The National Inquiry into Missing and Murdered Indigenous Women and Girls in Canada, "Survivors recall that, from the time of their birth, they were unsafe," (Cidro et al., 2022, p.1). The Birth Evacuation Policy pertains to MMIWG2S+ precisely because of the requirement that pregnant Indigenous Peoples travel unnecessarily, and with minimal support. Pregnant people are required to travel with one person, providing minimal birthing support and are often required to leave their loved ones, including other children, at home. Unnecessary transportation away from communities, especially when in vulnerable physical and economic states, can lead pregnant Indigenous Peoples to use less desirable forms of transportation, putting them in positions of potential violence and experiencing forms of, "Isolation, family disruption and racism," (Smylie et al., 2021, p. E948). Finally, leaving children behind when a pregnant Indigenous Person is required to travel to give birth puts children and parents in the precarious position of finding someone to care for their child(ren) while they are away. This puts children in potentially vulnerable situations when the person giving birth does not have a trusted person to leave their child(ren) with.

Not only are pregnant Indigenous Peoples required to travel, but financial coverage for birthing travel is only covered based on the most economical means of transportation. This means those individuals who can use their private vehicle are required to pay out of pocket any difference between using their vehicle and what is classified by the government as, "A more efficient and economical mode of transportation," (Government

of Canada, 2019). Indigenous WG2STGD+ People are commonly blamed when accessing basic needs through alternative modes of transportation, such as hitchhiking (Morton, 2016). Moreover, extensive travel to different destinations increases risk of harm to the pregnant person, and/or their baby. Pregnant people, and developing fetuses, are at additional risk of violence when they are required to remain in unfamiliar cities with little community support. For example, Indigenous women who participated in the Thunder Woman Lodge Research Project (2016) spoke about developing robust services focusing on Traditional parenting, positive pregnancy, family experiences, childcare considerations, and Traditional Ceremonies (Tabobondung, 2016).

Case Study III: 2c. Post-birth care:

Post-birth care is paramount to ensuring the health and safety of parents and infants. During childbirth, maternal and infant death remain higher among Indigenous WG2STGD+ People giving birth. Settler-colonial policies, such as the Indian Act (1876), enforces regulations and practices escalating the MMIWG2S+ genocide. Indigenous Peoples' lives and reproductive systens are erased and discouraged through harmful data reporting methods, forced and coerced sterilization, and until recently, the birth alert system. MMIWG2S+ includes intentional harm inflicted on Indigenous WG2STGD+ People, who continue to survive assaults of patriarchal, settler-colonial, and sexist systems.

Infant mortality rates continue to be underreported and under-acknowledged. In 2017, "Relatively little information … available at the national level for Indigenous people overall or for specific Indigenous identity groups," about birth outcomes of Indigenous WG2STGD+ People (Sheppard et al., 2017). However, this research found that in Inuit and First Nations communities, infants were seven times more likely to pass from sudden infant death syndrome (SIDS), which accounts for 24 percent of First Nations infant deaths, and 21 percent of Inuit infant deaths; in comparison to the seven percent rate for non-Indigenous infants (Sheppard et al., 2017, n.p). For infants born eligible for "status," Feir and Akee (2019) argue infant deaths could be underreported by the Indian Register Data with infants that die before having their birth registered. This means infant birth and deaths can go without recognition by the Indian Registry. The Indian Registry, as a part of settler-colonialism, is enforced by the Indian Act and requires Indigenous Peoples seeking "status" to register themselves and their offspring. By not recognizing Indigenous infants' death before registry, the Indian Registry contributes to the number of missing and murdered Indigenous children by refusing to accept the life of unregistered, Indigenous infants; nullifying much data on Indigenous Peoples. As explored with the birth evacuation policy, Indigenous Peoples who are about to give birth may be required through NIHB to deliver their child in an unknown and distant place from their community. Placed alongside the Indian Registry's reporting system, an Indigenous infant could be born, perish, and go missing without notice—adding to the horrors of MMIWG2S+.

Another means by which AIR in post-birth care is directly linked to the MMIWG2S+ genocide, is the forced and coerced sterilization of Indigenous WG2STGD+ People. While sterilization of Indigenous Peoples can occur at any stage of life, the high instances of C-Sections and with-it sterilization remain a horrifying reality for many Indigenous birthing People. A postpartum tubal ligation is a procedure that permanently prevents the individual from being able to become pregnant in the future. Sterilization occurs when a person is given postpartum tubal ligation, "Despite expressly denying consent, while other women are unduly pressured, and others are simply not asked," (INJRC, n.d, n.p). Enforcing sterilization on an individual without free, prior, informed consent is genocidal with the intention to remove someone's ability to reproduce in the future. Stereotypes that lead to the sterilization of Indigenous WG2STGD+ People are commonly associated with inaccurate and biased portrayals of poor parenting and hyper-sexualized beings engaging in high-risk behaviour (Fricklin et al., 2022). Instead, "These representations serve to devalue Native [sic] women, sustaining narratives that condone violence and suggest that the violence is not the fault of the inflictors, but the fault, at least in part, of the inflicted," (Fricklin et al., 2022, p. 61).

Forced and coerced sterilization has a strong and undeniable legacy of settler-colonialism, contributing to the ongoing genocide of MMIWG2S+. Forced and coerced sterilization can be defined as removing one's reproductive capacity without the individual's, "Free, prior, full, and informed consent," (IJRC, n.d, n.p). Sterilization was legal under some provincial legislation, such as the Alberta Sexual Sterilization Act (1928-1972), and the British Columbia Sterilization Act (1933-1973). During this time, 25 percent of those sterilized were Indigenous (Leeson & Ryan, 2019). The 1960s and 1970s showed over 70 sterilizations in Chesterfield Inlet, Naujaat, Kugaaruk, Gjoa Haven, Igloolik, and Rankin Inlet in Nunavut (Zingel, 2018), with a potential total of 1,145 sterilizations across Canada (Leeson & Ryan, 2019). Today, medical professionals still practice sterilization, even though tubular ligation, "Is an elective procedure," and is never a case of medical emergency or risk (Lombard, 2020, p. 70).

Forced and coerced sterilization against Indigenous Peoples is an act of genocide (Carranza Ko, 2020) and continues to be used as a tool against Indigenous WG2STGD+ People. Participant A noted how sterilization is commonly conducted after an unnecessary C-Section given to an Indigenous Person who had just given birth via a postpartum tubal ligation. HSCP may not sterilize Indigenous WG2STGD+ People themselves, but many know of others who are, placing blame elsewhere, making many HSCP feel they are without guilt for the ongoing genocide, (Participant A). Participant A discusses impacts of stereotypes and discrimination against Indigenous Peoples; claiming, "As far as the birthing part of the healthcare system goes, I think those are all really important outcomes to look at. How many times are people given a C-section? For example, if there's an emergency

C-section that happens, are people then being sterilized at the same time? And how is that procedure happening?" (2022). For Mercredi, the government needs to, "Criminalize forced sterilization, let's begin with that. To have practitioners be held liable and accountable for the deaths of our people in care who are neglected to death," (2022). Not only can criminalization be a part of TRC, but it upholds the right of Indigenous WG2STGS People to proper and safe healthcare free of discrimination.

Indigenous WG2STGD+ People experience a staggering fear of having their children removed from their care and their bodies. While some Indigenous WG2STGD+ People experience forced and coerced sterilization, other live through horrors of having their children taken from them forcefully. As a survivor who was sterilized at 14, Mercredi has also experienced a forced abortion at the hands of HSCPs (Dyck, 2018). Not only are pregnant Indigenous Peoples worried about their bodies, and future reproduction, they also worry deeply about what will happen in the future: Will they be able to give birth? Will they be able to parent that child? Will their children be taken? Even though birth alerts were banned in 2020 in Canada, a staggering 339 Indigenous babies were apprehended in 2021 (Malone, 2022, n.p). Birth alerts are, "When a social worker flags an expectant parent to hospital staff—without the parent's consent—because they believe the unborn baby is at risk," (Morgan, 2021, n.p). According to IndigiNews, at least 444 birth alerts were issued between January 2018, and September 2019, in British Columbia alone. Notably, 58 percent of these birth alerts were issued, targeting Indigenous parents (Marelj, 2021, n.p). Despite eradicating the birth alert system, pregnant Indigenous Peoples, and those who have just given birth, remain fearful of the possibility of a birth alert being called in. One Indigenous woman said, "I couldn't wait to get out of the hospital. I was like, 'I'm so terrified of being here,'" (Morgan, 2022, n.p). The forced separation of birthing parent and infant has detrimental mental health effects on the parent, contributing to deeper issues of intergeneration trauma experienced by Indigenous WG2STGD+ People.

For Indigenous survivors of the child welfare system, such as Nikida Steel, birth alerts only reinforced the traumatic experience of her past and did the same to her newborn (CBC News, 2021). This not only recirculates forms of intergeneration trauma, but also demonstrates how western society portrays and sees Indigenous WG2STGD+ People. Turpel-Lafond asserts, "When a girl, or woman, experiences a birth alert, the removal of her infant at birth, sterilization naked on assumptions about her capacity to parent, or a myriad of other judgements about her health, identity, gender, and behaviours, the health care system is effectively policing Indigenous women," (2021, p. 3). Indigenous WG2STGD+ People who have given birth are particularly vulnerable outside their communities, especially when forced to travel due to the Birth Evacuation Policy. While ending birth alerts in most provinces and territories was a step toward TRC (Cooke, 2001), the effects of the alert system has yet to fully end.

Sterilization and birth alerts pertain specifically to the ongoing genocide of MMIWG2S+ because they not only reinforce the systems, structures, and institutions that Indigenous WG2STGD+ People cannot parent their children, but it also promotes AIR in healthcare settings where Indigenous Peoples can feel defenceless. Even though birth alerts and sterilization are not permitted in Canada, these continue to cause Indigenous WG2STGD+ People to lose their rights under the RJF promoting their right to have children, not have children, and parent their children. For this reason, decolonizing practices must be explored in how non-Indigenous HSCP engage in education, training, and practice.

PLACES FOR ACTION AND CHANGE:

2d. Education:

According to El-Mowafi et al. (2021), inequalities in education regarding reproductive care needs of BIPOC people not only lead to disparities in healthcare but also reinforces pre-existing, colonial, white-centred systems already in place. This is done by enforcing health promotion among the white, middle-class, and reproductive criminalization for others. Healthcare education does not provide necessary tools, resources, or education for HSCP to ensure culturally relevant, trauma-informed, and intersectional healthcare for Indigenous Peoples. Based on NWAC's Calls to Action, providing required tools, resources, and education to better healthcare experiences and overall health of Indigenous Peoples is essential to implementing, "Ongoing health, policy, research, training, and programs to support Indigenous-led health initiatives, including ending forced sterilization and mental health and wellness," (2022). Moreover, engaging with decolonizing methods speaks not only to TRC but demonstrates the need for HSCP to learn about their role in providing culturally relevant and trauma-informed care.

Decolonizing healthcare education begins by providing foundational training about how settler-colonialism shapes Indigenous Peoples' experience in the healthcare system. As noted, stereotypes, biases, and other forms of ignorance pollute the representations of Indigenous Peoples and fill the minds of non-Indigenous HSCPs. Wiley and McConkey (2019) argue education a foundation place to begin mending the broken healthcare system, and establishes how structures, systems, and institutions can take TRC seriously and prioritize de-stigmatization and re-learning Indigenous Peoples' healthcare needs. Implementing a decolonizing approach to healthcare and healthcare education would mean integrating decolonizing methods into all levels of healthcare education. It would provide the foundation to teach up, allowing new medical professionals to stress positive representation of Indigenous Peoples and ask about unique healthcare needs without essentializing to stereotypes. Moreover, incorporating decolonizing methods into the

educational system for HSCP contributes to the continued efforts for TRC needed to bridge trust with Indigenous Peoples in Canada.

During the interviews, interviewees provided specific ways that HSCP could learn how settler-colonialism impacts the healthcare of Indigenous Peoples, recommending HSCPs be required to read texts such as Sacred Bundles Unborn (Mercredi & Firekeepers, 2021), and integrate and encourage Indigenous Knowledge in healthcare (Mercredi, 2022). Participant A posed to enhance education for HSCP to provide a specialist fellowship, or an Indigenous-centered program, to truly highlight the diverse needs of Indigenous Peoples. In Canada, the University of Alberta offers a free, self-driven course about the history of Canada, Indigenous Peoples in Canada, and the impacts of settler-colonialism on the legal, healthcare, and other systems. Engaging in multiple forms of knowledge mobilization, where reading lists, courses, and workshops are required, ensures students are provided with essential tools, resources, and methods needed to decolonize healthcare on all levels.

2e. HSCP Training:

In the Truth Reconciliation Calls to Action, Action #23 addresses a lack of adequate training and incorporation of Indigenous medical professionals. This call declared a need to, "Increase the number of Aboriginal [sic] professionals working in the healthcare field," to Indigenous Methods, Practices, and Traditional Medicines to be incorporated into healthcare training. Doing so would provide, "Cultural competency training for all healthcare professionals," (Truth and Reconciliation Commission, 2015, p. 3). Despite this plea for adequate, trauma-informed, culturally sensitive, and inclusive training, Indigenous Peoples continue to experience AIR due to bias, stereotypes, and poor education. Qualitative studies have shown that Indigenous Peoples in Canada feel their healthcare needs are trivialization (Hamad, 2022). However, experience working with Indigenous communities can provide a more nuanced understanding of Indigenous Peoples' realities for non-Indigenous HSCPs (Sylvestre et al., 2019). For Silvestre et al. (2019), TRC has been an essential tool in calling for improved healthcare attention for Indigenous Peoples. However, HSCPs are limited by, "The degree to which such recommendations, as well as the success of Indigenous-led health initiatives, have intervened or shaped how we educate future health practitioners in settler colonial states," showing, "Significant challenges of addressing socially entrenched racial-colonial hierarchies," (p. 112,363). One of the ways to decolonize healthcare on a training level is to provide multi-faceted training and guides to ensure settler-colonial structures found in healthcare institutions are eradicated. This can be done by incorporating Indigenous Knowledge and Traditional Medicine into healthcare settings and training practices. For those unable to receive decolonized education or learn about ways of ensuring Indigenous healthcare practice education, training in the healthcare setting provides an additional opportunity to demystify stereotypes and biases impacting the quality of care that Indigenous Peoples receive.

This can be done by integrating culturally relevant training, such as the San'yas Cultural Safety Training Program, which has been offered throughout Canada for years. It has been in British Columbia since 2010, Ontario since 2013, and Manitoba since 2016 (Browne et al., 2022, p.1). This training program is, "An Indigenous-led, policy-driven, and systems-level educational intervention that, "Aims to foster health equity and mitigate the intersecting forms of interpersonal and structural racism experienced by Indigenous people in the health care system in Canada," (Browne et al., 2022, p. 1). This program integrates foundation information regarding the health, mental health, child welfare, and justice needs of Indigenous Peoples, showing how all aspects are interconnected. While some provinces and territories have comprehensive training regarding the needs of Indigenous WG2STGD+ People, federal-based training recommendations and guidelines must be implemented, despite the provincial jurisdiction of healthcare in Canada.

2f. Practice:

Lived experiences of pregnant Indigenous Peoples speak volumes to the value placed on Indigenous reproductive health in Canada. In interviews, not only did interviewees express that Indigenous People anticipate experiences of AIR (Participant A, 2022), showing AIR is, "Very evident in the health care system," (Rickard, 2022). Mercredi asserts, "It's best if you remove your racial indoctrinated stereotypes and bias of them, and just treat them as a patient and as a human being. There's no manual that provides that information," (Interview, 2022). As a nurse, Rickard affirms others need to "step up" in the healthcare community (2022). Rickard says HSCPs minimize the needs of Indigenous patients, "By trying to separate them or trying to release them as soon as possible out of the system without really assessing the whole individual or even giving them quality health care regarding the complaint," (2022).

Horrific and unjust deaths of Indigenous People in Canada have demonstrated a need for non-Indigenous HSCP to reflect on their discriminatory practices to better the treatment of Indigenous Patients. Cases such as the tragic death of 37-year-old Atikamekw mother and Sister Joyce Echaquan, in 2021, (Page, 2021); as swell as 45-year-old First Nations man, Brian Sinclair, in 2008, both highlight mistreatments of Indigenous WG2STGD+ People in the hospital setting. As a nurse, Richard asserts:

> **Everybody wants to lead with alcohol abuse and substance use, everybody wants to lead with that. And then they forget about everything else, that seems to be a specific area that they're focused on. And that's where all the discrimination starts. And if we were to lead with a different area of assessment, then that would give a different approach to how we interpret the individual accessing health services. That might be one area, that would definitely help. And some of the areas that I've worked on is this stigma campaign with addictions, policy development, in what they are new best**

> **practice, was trying to lead with more holistic first, versus focusing right on the substance and the violence. (interview, 2022).**

Instances of AIR in reproductive care are countless. During her pregnancy, Lombard recounts being asked during an appointment, "What's your nationality," followed by, "You know you're not supposed to drink during pregnancy, right?" When the HSCP found out she and her husband they were Indigenous (2021, p. 45). These forms of interpersonal AIR are common and demonstrate how HSCPs need culturally relevant and trauma-informed education and training. Decolonizing medical health care is, "A process of reclamation of political, cultural, economic and social self-determination, including the re-development of positive individual, familial, community and national level identities," (Eni et al., 2021, p. 2). Rickard points out that services such as the Midwifery Council in Ontario are "probing" for reproductive change and making culturally relevant and trauma-informed care a "standard practice," (2022, interview). Richard says the best way to go about this is through, "More insight and knowledge for the provider," which can translate into more informed practice. Some of the ways that non-Indigenous HSCPs can engage in decolonizing healthcare is to make themselves aware of medical practices that are culturally relevant and trauma informed. HSCPs should educate themselves on unique needs of Indigenous patients by speaking with other Indigenous-affirming HSCPs and utilizing toolkits to understand how to provide better care.

SECTION III: MEASUREMENT TOOLS NEEDED:

3a. Measurement Tools Used / Recommended:

Few measurement tools have been used to measure instances of AIR in reproductive healthcare, let alone healthcare generally. These measurement tools are critical for providing meaningful ways of transforming and decolonizing healthcare. For Ficklin et al. (2022), decolonizing can be seen, "As the undoing of such a narrative in the reclamation of sovereignty," and in doing so, "Dismantles these pervasive structures and the imbalanced power hierarchies that are inherent and ingrained in this Western system. It revitalizes, reclaims, and hono[u]rs Indigenous [K]nowledge and Indigenous [W]ays," (p. 54). Decolonizing reproductive care has been among some of the recommendations reinforced by scholars and our interviewees as a means of making positive change. MMIWG2S+ and reproductive care are intrinsically linked; therefore, the journey to eradicate AIR can provide two-fold results by also reducing instanceses of poor quality of care pertaining to sexual health, pregnancy, and post-birth care. The implementation of measurement tools, as outlined in this section, will demonstrate how medical practitioners, health workers, and others can provide care to Indigenous WG2STGD+ People by acknowledging specific reproductive care needs, while removing racist and colonialist mechanisms that provide

ill-informed decisions about their bodies. These measurement tools are foundational starting points for demonstrating how data collection regarding AIR in reproductive care contributes to the ongoing crisis of MMIWG2S+. This section provides a comprehensive chart outlining some measurement tools used to measure AIR in reproductive care.

3b. Measurement Tools and Their Uses:

Measurement Tool:	Qualitative or Quantitative:	Pros:	Cons:	How it Can be Used in Reproductive Health Care:	Tips:	What Can it be Used to Measure?
Case Study:	Qualitative.	• Provides a concrete example. • Is commonly used. • Able to show multiple themes in one example. • Detailed.	• Only one singular example. • HSCP could distance themselves if it has never happened in their experience. • Requires explanation and context. • Time-consuming.	• Provide case studies of how a situation was poorly dealt with in the past to show how improvement can be made. • Can be a great tool for teaching.	• Be sure to be considerate when creating case studies, as they can be dehumanizing and retraumatizing. • Incorporate a section on how to improve and provide examples following the case study; this will help to contextualize.	• Number of incidences of AIR. • Show barriers to reproductive and sexual health care. • Show where errors were made in past and create recommendations.
Charts:	Both.	• Relay information easily and efficiently. • Easy to replicate and implement.	• Does not contain lived experience from the perspective of an affected person. • Can be broad.	• Can be used to write the experiences of an individual. • Can be used to categorize different experiences. • Can be used to relay large amounts of information.	• Ensure charts are comprehensive, accessible, and easy to understand.	• Number of visits. • Reasons for visits. • Was the issue remedied? • Was a follow up required? • Did the person come back for their follow up?

Measurement Tool:	Qualitative or Quantitative:	Pros:	Cons:	How it Can be Used in Reproductive Health Care:	Tips:	What Can it be Used to Measure?
Comparative Analysis:	Qualitative.	• Shows differences in healthcare outcomes, as well as quality of healthcare across demographics.	• Can essentialize and generalize groups.	• Can be helpful to determine broad areas where healthcare needs improvement.	• Identities are complex, so be sure to ask people to self-identify.	• Compare the number of visits between Indigenous Peoples and non-Indigenous people, as well as reasoning for the visit. • Compare quality of care experienced by each. • Compare treatment of populations. • Compare questions asked to Indigenous vs. non-Indigenous patients regarding reproductive and sexual health.
Direct Personal Interviews:	Qualitative.	• Get to hear peoples' voices in their own words. • One-on-one can be intimate. • Private. • Personal and easy to develop rapport. • Can be done in-person or virtually.	• Time-consuming. • Requires high level of ethics. • Harder to find participants based on time commitment.	• Ask about first-hand experiences with specific HSCP and resources.	• Compensate people for their time. • Ensure you have ethical approval, if required. • Send questions and consent letter(s) before the interview.	• Experiences of AIR. • Thoughts and feelings about experiences. • Quality of care. • Recommendations.

Measurement Tool:	Qualitative or Quantitative:	Pros:	Cons:	How it Can be Used in Reproductive Health Care:	Tips:	What Can it be Used to Measure?
Focus Groups:	Qualitative.	• Able to speak with more people at one time. • Can have participants work from the energy and experience of one another. • Can provide a space to speak for those who are shy. • Can be done in-person or virtually.	• Can be challenging to find participants. • More challenging to incorporate a TIC model. • Can be too many voices at once. • Disrespect among participants.	• Host FG with those seeking better healthcare, i.e., medical professionals; patients.	• Ensure careful moderation. • Provide codes of conduct before FG. • Know the audience you want to speak with and the purpose of the groups. • In-person focus groups have much more success, since participants feel closer to one another.	• Experiences of AIR as a collective. • Create collective recommendations. • Analyze if experiences are with specific individuals or with multiple staff. • Ways of encouraging Indigenous patients to come to the practice. • Ask about specific instances of AIR and see how they reflected the possible experiences of others. • Experiences they have heard about regarding the healthcare system.
Indirect Personal Interviews:	Both.	• Can be answered in their own time. • Can be done online or via email. • More anonymity.	• Less personal. • Lowers ability to develop rapport. • Fewer concrete answers.	• Can be sent in via email, recording the experience of a patient. • Can have an email complaint or grievance email monitored by one staff member.	• Be sure to provide a private avenue for the individual to communicate. • Sometimes different forms of communication can be more difficult or less accessible, i.e. email versus a written letter.	• Ask for recommendations to better the quality of care provided to Indigenous Patients. • Ask about specific experiences of AIR.

Measurement Tool:	Qualitative or Quantitative:	Pros:	Cons:	How it Can be Used in Reproductive Health Care:	Tips:	What Can it be Used to Measure?
Medical Chart:	Both.	• Provides clear medical information. • Can be used to demonstrate levels of health.	• Lacks voice of the patient. • Lacks context.	• Have a system where HSCPs can indicate distress levels, or potential discomfort shown by the patient.	• Provide space for written notes on how to provide trauma-informed care.	• Medical history including visits, reasons, previous prescriptions. • Demographic information i.e.: Are there trends in age ranges?
Observation:	Qualitative.	• Can be done by anyone. • Easily implemented. • Easily conducted. • Allows others to notice interactions of each other. • Makes people accountable for actions.	• Can be subjective. • Can be time consuming.	• Have an Indigenous Liaison present to observe how the setting could be more inclusive.	• Indigenous Liaisons in all medical care settings.	• The way patients are spoken to/with. • Interactions between patients and HSCPs. • Body language.
Questionnaire:	Both.	• Provides anonymous data. • Quick for users. • Gains large amounts of data.	• Can be challenging to get people to complete.	• Can be used following appointments to ask about experiences.	• See survey.	• See survey.

Measurement Tool:	Qualitative or Quantitative:	Pros:	Cons:	How it Can be Used in Reproductive Health Care:	Tips:	What Can it be Used to Measure?
Reports:	Both.	• Helpful for implementing change. • Can be considered more official.	• May dehumanize patients. • Does not contain lived experience.	• Can provide general information to many HSCPs. • Can provide recommendations. • Can show trends.	• Use when dealing with formal policy and other more formal forums. • Can show healthcare outcomes. • Use alongside other measurement tools to report findings.	• Recommendations need to eradicate AIR in each setting. • Response from the other measurement tool used i.e.: What do the survey and questionnaire data show? What did you learn from the focus group?
Roleplaying:	Qualitative.	• Helpful to see the quality of care provided and what can be improved.	• Many do not like using this technique. • It can be timely. • Some will be unwilling.	• Can have HSCP ask questions and role play different scenarios. • Can help practice difficult conversations on sensitive topics to gain more empathy and comfort.	• Try to keep it light hearted, but educational. • Observe some the ways HSCP are interacting with patients, and then use it in the next role play scenario.	• Roleplay specific scenarios that happen in the office and use it as a teaching tool to show how HSCP can improve quality of care.

Measurement Tool:	Qualitative or Quantitative:	Pros:	Cons:	How it Can be Used in Reproductive Health Care:	Tips:	What Can it be Used to Measure?
Scale:	Quantitative.	• Can provide an easy way of expressing value. • Easily used and implemented. • Not very time consuming. • Easy for participants to use. • Easily understood.	• Can be vague and without context. • Provides fewer options when answering.	• Asking patients about their experience. • Rate quality of care. • Rate liveliness. • Rate previous experience.	• Can be used to rate a patient's experience, feelings, positivity, or thoughts about how HSCPs performed.	• Rate quality of care. • Rate professionalism of HSCPs. • Measure levels they believe their concerns were met. • Would they come again for the same reason? • Would they come for a different reason?
Scenario:	Qualitative.	• Can provide an easy way of expressing AIR, and how to fix mistakes. • Fun way to explore what can be improved in the future. • Can be in person, written, or presented. • Can be private.	• Can be time consuming to create. • Can be repetitive for some. • HSCPs may not acknowledge ongoing actions that contribute to AIR.	• Create scenarios where HSCP must find different ways AIR can impact an experience. • Have them outline how they would have resolved a situation.	• Start with overt forms of AIR seen in healthcare settings, and move onto more discreet forms. • Have them read the situation and act it out with another HSCP.	• Ask HSCP about a time when they wished they had done better, and provide time for reflection.

Measurement Tool:	Qualitative or Quantitative:	Pros:	Cons:	How it Can be Used in Reproductive Health Care:	Tips:	What Can it be Used to Measure?
Statistics:	Quantitative.	• Provides concrete numbers. • Shows general trends.	• Does not answer the why or how questions.	• Can be used to compare rates of violence against Indigenous WG2STGD+ People.	• Useful when needing quantitative data for recommendations and policy.	• Age demographics. • Number of visits. • Number of visits regarding sexual health or reproductive issues. • Distance traveled by the individual. • Number of patients who have experience forced and coerced sterilization.
Survey:	Both.	• Answers a specific question. • Can be qualitative and/or qualitative. • Can gain meaningful information from multiple sources. • Can use multiple methods, i.e. scale, essay, etc.	• Can be challenging to get people to complete. • Can gain extensive data.	• Can gain too much data if the survey is not made correctly	• Ensure your questions speak to the directive of the survey. What question do you want answered? How does each question on the survey help to answer that question?	• Quality of experience. • Did they experience AIR? • How do they feel about the quality of care? • Would they come back for the same issue?

Measurement Tool:	Qualitative or Quantitative:	Pros:	Cons:	How it Can be Used in Reproductive Health Care:	Tips:	What Can it be Used to Measure?
Test:	Qualitative.	• Can be at any time. • Can be easily implemented. • Can be reused. • Easy way to teach information.	• HSCPs may claim they do not have time.	• Asking pop quiz questions to each other regarding Indigenous Knowledge and Traditional Medicine.	• Have HSCP demonstrate their knowledge using fun activities and role-playing to ensure they are prepared for Indigenous Patients' needs.	• Understanding regarding TIC, FPIC, and unique healthcare needs. • Test of knowledge of Traditional Medicine.
Tracking:	Quantitative.	• Easily done. • Anyone can implement.	• Need demographic information. • Does not discuss why they may not be returning.	• Can be used to see individuals who are returning or no longer coming.	• Use in tandem with another tool to see why people are not returning.	• Can be used to track number of visits. • Track reasons for visit. • Track any follow up need(ed) to happen.
Word of Mouth:	Qualitative.	• Easily relayed. • Can communicate with people quickly.	• Can be inaccurate. • Can come across as gossip.	• When someone engages in a mistake, another HSCP can "call in" and let the HSCP know.	• Sharing experiences among HSCPs can help show how and how not to provide affirming care.	• Can spread information quickly i.e. if you think a HSCP needs support with an Indigenous Patient, you can have someone check in or assist by asking in person.

3c. Decolonizing Methodologies and Indigenous Resiliency:

Indigenous approaches to research are as, "Complex and multiple as Indigenous peoples themselves," (Miller et al., 2014, p. 179). Therefore, this research project was dedicated to Indigenous and decolonizing methods incorporating holistic, culturally safe, and intersectional thinking. Providing decolonizing methodologies meant that we, "Must recognize Indigenous Peoples as the authors of important theories about the world we all live in," (Arvin, Tuck, and Morril, 2013, p. 21). Despite barriers to reproductive care and healthcare experienced by Indigenous WG2STGD+ People, Indigenous communities continue to thrive. Indigenous communities remain strong, spiritual, and true to themselves, despite settler-colonialist efforts. In their research, Eni et al. (2021) found, "Work that the communities were doing was providing an actual ground upon which to build a decolonizing, and therefore, transformative agenda," (p. 5). Communities are not only capable of rebuilding the healthcare system and decolonizing the current system, structures, and institutions, but they are doing so while revitalizing the importance of Traditional Medicine, Traditional Knowledge, and practices.

Interviewee Mercredi affirms the importance of Indigenous Knowledge in healthcare and the wellbeing of Indigenous Peoples. Not only have Indigenous Knowledge and Traditional Medicine been used by Indigenous communities, but Mercredi adds: "Acknowledging that the medicines have always been there, our knowledge of the medicines, what our Mother Earth has always provided for us. And you know, and how we have procured that knowledge and the medicines, with protocol in the most respectful manner, has always existed and is still there," (2022). When working with First Nations Peoples, Eni et al. found decolonizing, "Meant having thoughts and behaviours understood and respected from within a perspective that acknowledges the values and meaningful existence, what it means to be a First Nation person," (2021, p. 6). The devaluing of Traditional Medicine was an act of colonialization imposed on Indigenous Peoples; therefore, returning Traditional Medicine back to Indigenous healthcare provides a decolonizing method, while allowing non-Indigenous Peoples a way to provide allyship and stay true to TRC.

Indigenous Midwifery:

From 2009 to 2015, midwife use among Indigenous Peoples increased from 4.9 percent to 12.9 percent, in British Columbia alone (First Nation Health Authority, 2021). Alongside Indigenous organizations such as the Nova Scotia Women's Association, midwives—such as Julien Reid from Millbrook First Nations—seek to restore ceremony into Mi'kmaw birthing practices to better support pregnant Indigenous People and decolonize pregnancy and birth (Fryday, 2022). For other Indigenous midwives, such as Ellen Blais, who is Director of Indigenous Midwifery at the Association of Ontario Midwives (AOM), Indigenous midwives can act as an intervention against taking Indigenous children by, "Reclaiming spaces so the

moms can have the births they want to have," (Baker III, 2022, n.p). Indigenous midwifery is only one instance of how Indigenous WG2STGD+ People uphold their rights under UNDRIP Articles 23, which stipulates a right to develop one's own health, housing, social, and economic programs, as well as the rights to use Traditional Medicines, under Article 24.1 (2007).

CONCLUSION AND RECOMMENDATIONS:

In listening to our expert interviewees' experiences, needs, and concerns, as well as using a gender-based and distinctions-based analysis, a list of recommendations for frontline HSCP, academics, and regulatory bodies was developed. It is necessary to acknowledge systematic inequities that create workplace challenges for HSCPs. Many HSCPs are chronically overworked and under-resourced; these conditions have been exacerbated during the COVID-19 pandemic. Keeping in mind these realities, the recommendations offer thoughtful considerations for HSCPs, their training institutions, and regulatory bodies.

1. **Address forms of lateral violence within HSCP's training organizations and employers, and create equitable opportunities for Indigenous HSCPs.**
2. **Improve access to primary care for WG2STGD+ People at all stages of the sexual and reproductive life cycle, and improve healthcare outcomes**
3. **Make space for Traditional Healing modalities in primary and reproductive healthcare settings by educating HSCPs on affirming, and culturally relevant care—particularly supporting pregnant people, and their families, to practice Traditional Ceremonies.**
4. **Address safety issues experienced by Indigenous Peoples seeking primary, and emergency care, by implementing Indigenous Liaisons at hospitals as third-party support workers.**

In conclusion, this research project sought to determine the cause and effects of MMIWG2S+ and its impact on AIR, establish a measurement tool, examine stereotypes experienced by Indigenous WG2STGD+ People regarding reproductive healthcare, and provide a toolkit tailored to medical providers, staff, and practitioners highlighting common practices. Using examples of sexual health, pregnancy, and post-birth care, this paper demonstrated complex connections between reproductive health and the ongoing genocide of MMIWG2S+. In doing so, it also provided three sites where decolonizing reproductive health can be implemented in education, training, and practice. By providing

how these sites can implement a culturally relevant and trauma-informed framework, this paper has also illustrated how AIR, specifically in healthcare, works against promises of the efforts of TRC. Finally, this paper provided a foundation for different qualitative and quantitative methods used to measure AIR in healthcare.

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Acronyms:

AIR	ANTI-INDIGENOUS RACISM
BIPOC	BLACK, INDIGENOUS, AND PEOPLE OF COLOUR
CAP	CALL TO ACTION PLAN
CRGBA+	CULTURALLY RELEVANT GENDER BASED ANALYSIS
FPIC	FREE, PRIOR INFORMED CONSENT
HSCP	HEALTH AND SOCIAL CARE PROVIDERS
MMIWG2S+	MISSING AND MURDERED INDIGENOUS WOMEN, GIRLS, TWO-SPIRIT, TRANSGENDER, AND GENDER-DIVERSE, PLUS
RJF	REPRODUCTIVE JUSTICE FRAMEWORK
STIBBD	SEXUALLY TRANSMITTED INFECTIONS AND BLOOD BORN DISEASES
TA	THEMATIC ANALYSIS
TIC	TRAUMA-INFORMED CONSENT
TRC	TRUTH AND RECONCILIATION
UNDRIP	UNITED NATIONS DECLARATION ON THE RIGHTS OF INDIGENOUS PEOPLES
WG2STGD+	WOMEN, GIRLS, TWO-SPIRIT, TRANSGENDER, AND GENDER-DIVERSE, PLUS
WHO	WORLD HEALTH ORGANIZATION

RESEARCH INTERVIEW QUESTIONS:

1. Are you aware of any measurement tools currently used to measure forms of anti-Indigenous racism in reproductive healthcare?

    a. What types of measurement tools do you think would be beneficial, moving forward?

    b. How can we measure the causes and effects MMIWG2S+ has had on anti-Indigenous racism in reproductive care?

2. What is the most beneficial way to discuss the interrelatedness between MMIWG2S+ and anti-Indigenous racism in reproductive healthcare?

3. Why do you think measuring anti-Indigenous racism in reproductive healthcare is important?

    a. What purpose do you believe it has, and how is it beneficial?

4. How do we use MMIWG2S+ measurement tools?

    a. What kinds of data do you believe it will yield?

    b. How can this data be best used to ensure ethical and trauma informed care in the future?

5. How will a measurement tool that indicated levels of anti-Indigenous racism in reproductive health care impact MMIWG2S+?

6. What do you believe a measurement tool dedicated to measuring anti-Indigenous racism in healthcare will accomplish?

    a. How do you believe this can be best placed in dialogue with MMIWG2S+ projects?

7. What are the best means to decolonize reproductive healthcare?

8. Do you believe incorporating Indigenous Knowledge and Traditional Medicine will help with the MMIWG2S+ genocide?

9. What methods do you think would be best suited to discover the best measurement tool for measuring anti-Indigenous racism in reproductive healthcare?

10. How do you believe anti-Indigenous racism in healthcare is connected to the MMIWG2S+ genocide?

    a. How do we bring awareness to this connection?

INFORMED CONSENT LETTER

TITLE OF PROJECT:

Five Policy Research Papers on Missing and Murdered Indigenous Women, Girls, and Two-Spirit+ People

Names, Titles, and Contact Information of Researchers

SUPERVISORS:	PRINCIPAL INVESTIGATORS:	VOLUNTEER:
Lee Allison Clark (she/her) **Director of Health** Native Women's Association of Canada 120 Promenade du Portage Gatineau, QC J8X 2K1 Phone: 343-996-4852 lclark@nwac.ca	**Marisa Blake (she/her)** **Senior Project Officer** Native Women's Association of Canada 120 Promenade du Portage Gatineau, QC J8X 2K mblake@nwac.ca	**Talitha MacIntyre (she/her)** **Volunteer** Native Women's Association of Canada 120 Promenade du Portage Gatineau, QC J8X 2K tmacintyre@nwac.ca
Elisha Corbett (she/her) **Manager MMIWG2S+** Native Women's Association of Canada 120 Promenade du Portage Gatineau, QC J8X 2K1 ecorbett@nwac.ca	**Marisa Blake (she/her)** **Senior Project Officer** Native Women's Association of Canada 120 Promenade du Portage Gatineau, QC J8X 2K epecjak@nwac.ca	

INTRODUCTION:

You have been invited to participate in a two-hour interview to help with data collection on the following project: Systemic Racism in Healthcare and MMIWG2S+. This project is funded through Crown-Indigenous Relations and Northern Development Canada (CIRNA). The Systemic Racism in Healthcare and MMIWG2S+ project is one of five projects begin conducted within the Native Women's Association of Canada (NWAC) as apart of our dedication and commitment to NWAC's Call to Action Plan (CAP). NWAC continues to conduct and collect data surrounding the ongoing crisis of Missing and Murdered Indigenous Women, Girls, Two-Spirit, Transgender, and Gender-Diverse plus (MMIWG2S+) people to eradicate anti-Indigenous and gender-based violence against Indigenous Women, Girls, Two-Spirit, Transgender, and Gender-Diverse (WG2STGD+) people. We thank you for honouring us with your time, Knowledge, and solidarity.

(NWAC) is the leading voice on research and policy for Indigenous WG2STGD+ people, especially as it pertains to systemic issues that, inclusive of healthcare, contribute to the ongoing genocide of MMIWG2S+. As per NWAC's Call to Action Plan (CAP), which addresses systemic issues related to MMIWG2S+, a recognition of distinct Indigenous identities, cultural safety, and a trauma-informed approach must be upheld and respected in order to achieve substantive equality and human rights, a decolonized approach to healthcare, the inclusion of families and survivors, self-determination, and Indigenous-led solutions and services, (NWAC, 2021).

BACKGROUND:

In 2021, NWAC made eight recommendations on the urgent need to investigate and eradicate systemic racism in healthcare policies and racism in healthcare, a significant issue as it pertains to the MMIWG2S+ genocide. This research project looks to fulfill the work of NWAC's guiding principles and more carefully engage with recommendations from this earlier research. To achieve this, this paper will use examples of sexual health, pregnancy, and post-birth care, with a CRGBA++ data framework to determine common practices and measurement tools to measure cause and effects of MMIWG2S+ on the quality of reproductive care received by Indigenous WG2STGD+ people. This paper will also use a CRGBA++ data framework, alongside these three examples, to determine the best-practices and measurement tools required to measure outcomes systemic racism in reproductive care healthcare have on the ongoing genocide of MMIWG2S+ for Indigenous WG2STGD+ People. Finally, this paper will examine these three cases to address how to measure systemic racism in the education system, determine what training should be provided, and determine the same for medical practice.

YOUR PARTICIPATION:

No formal approval from a research ethics board was required for this research, as per CINRA; however, NWAC is dedicated to acknowledging participation in this type of research may be challenging due to the nature of the topics being explored. All interviews will be virtual and a maximum of two hours in length. Participants in this interview can remain anonymous should they choose. With explicit prior permission of interviewees, interviews will be recorded for transcription and accuracy purposes. All interviewees can participate without being audio recorded. Interviewees may choose to withdraw their participation at any point for any reason, or request their contributions be withdrawn, and/or their transcript and audio recording be destroyed. All participants will be compensated for their time in the form of a $480 honorarium for their time. This will be provided even to those who withdraw their consent following the interview. NWAC is committed to interviewees being safe, comfortable, and free to share their experiences and thoughts without judgement. If there is any way the research team can provide additional assistance to ensure these parameters, please let us know.

DISCLAIMER:

The content covered in the interviews will pertain to the ongoing genocide of MMIWG2S+ and may contain sensitive questions regarding best ways to explore, collect data on, and distribute. The topics may be difficult or sensitive. On the next page are some resources if you wish to speak to a Grandmother, or support line following the interview.

CRISIS LINES:

Métis Crisis Line is a service of Métis Nation British Columbia.

Call 1-833-MétisBC (1-833-638-4722).

Hope for Wellness Help Line offers immediate mental health counselling and crisis intervention by phone or online chat. **Call toll-free: 1-855-242-3310** or start a confidential chat with a counsellor at **hopeforwellness.ca.**

Indian Residential School Crisis Line is a national service for anyone experiencing pain or distress due to their residential school experience. **Call toll-free: 1-866-925-4419.**

Kuu-Us Crisis Line Society provides crisis services for Indigenous people across BC. Reach the Adults/Elders line at **1-250-723-4050**; **www.kuu-uscrisisline.com**

NATIONAL WOMEN'S ASSOCIATION OF CANADA RESOURCES :

National Women's Association of Canada Resiliency Lodges

GRANDMOTHERS:

Available Mon-Fri 9 a.m. to noon; and 1 to 4 p.m. (EST). All numbers are toll-free.

Esther Ward
Grandmother
1-833-652-1381

Isabelle Meawasige
Grandmother
1-833-652-1382

2022

Misconduct, Missing, and Murdered:

The Experiences of Anti-Indigenous Racism in Reproductive Healthcare among Indigenous Women, Girls, Two-Spirit, Transgender, and Gender-Diverse People, and the MMIWG2S+ Genocide

Five Policy Research Papers on Missing and Murdered Indigenous Women, Girls, Two-Spirit, Transgender, and Gender-Diverse People

NATIVE WOMEN'S ASSOCIATION OF CANADA

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