

INDIGENOUS WOMEN’S REPRODUCTIVE (IN)JUSTICE(S) AND  
SELF-DETERMINATION: ENVISIONING FUTURES THROUGH A COLLABORATIVE  
RESEARCH PROJECT

by

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## **Abstract**

This dissertation traces the process and shares the findings of a collaborative project with urban Indigenous women on the homelands of the Métis Nation and Treaty One (Winnipeg), Treaty Four (Regina) and Treaty Six (Saskatoon) territories. The purpose of this project was to explore:

- 1) How do Indigenous women living in three prairie cities (Winnipeg, Saskatoon and Regina) define and understand reproductive justice and reproductive sovereignty?
- 2) How do urban Indigenous women claim and exercise their rights to reproductive justice?
- 3) What changes to social and health services will respect and support urban Indigenous women's rights to reproductive justice?
- 4) What political, economic and community changes will respect and support urban Indigenous women's rights to reproductive justice?

I engaged a collaborative action-oriented methodological approach, informed by Indigenous storytelling (Kovach, 2009), post-critical ethnography (Lather, 2007), Hankivsky's (2012) Intersectionality-Based Policy Analysis Framework and Clark's (2012) Indigenous Intersectional-Based Policy Analysis Framework. The study demonstrates that self-determination is central to Indigenous women's reproductive justice, which is interconnected with sexual justice. Within the context of Indigenous women's reproductive and sexual lives, self-determination is activated in intergenerational and relational ways, meaning that women and their relationships to kin, animals, communities, land and cosmos are the primary influences governing their experiences. Indigenous women determine their reproductive and sexual futures within a context of various sociopolitical forces, including: colonial policies, processes and narratives; inclusive and responsive care; and Indigenous survivance (moving beyond survival to exercise anti-colonial resistance and sovereignty (Vizenor, 1994, 1998)). This analysis demonstrates that colonial narratives of Indigenous women as hypersexual and irresponsible mothers place Indigenous

women ‘at risk’ of violations to their rights to free, full and informed consent and free, prior and informed consent. In particular, Indigenous women experience patterns of healthcare and service providers coercing them to use long-term contraceptives, and undergo tubal ligation and abortion procedures. Indigenous women build self-determining pathways within these coercive contexts through acts of refusal, negotiation and sharing community knowledge. It is crucial to transform organizations and institutions through processes grounded in decolonizing aims to reduce the harms of colonial heteropatriarchy on Indigenous women’s reproductive and sexual lives.

## **Lay Summary**

This dissertation shares the process and findings of a collaborative project with urban Indigenous women on the homelands of the Métis Nation and Treaty One (Winnipeg), Treaty Four (Regina) and Treaty Six (Saskatoon) territories. This project's purpose was to explore: 1) How do Indigenous women living in three prairie cities (Winnipeg, Saskatoon and Regina) define and understand reproductive justice and reproductive sovereignty? 2) How do urban Indigenous women claim and exercise their rights to reproductive justice? 3) What changes to social and health services will respect and support urban Indigenous women's rights to reproductive justice? 4) What political, economic and community changes will respect and support urban Indigenous women's rights to reproductive justice? This study highlights that self-determination is central to Indigenous women's reproductive justice, which is interconnected with sexual justice. It is necessary to transform organizations and institutions in order to support Indigenous women's reproductive and sexual self-determination.

## **Preface**

The body of this dissertation is original, unpublished intellectual work by the author, Holly Ann McKenzie. Appendix F is a policy brief that was submitted to representatives at the Saskatoon Health Region as well as the Saskatchewan and Canadian Governments in September 2016 with the following authors: Holly A. McKenzie, M.R.L.P, Jillian Arkles Schwandt, Karen Olsen Lawford and Colleen Varcoe. Karen Stevens provided transcription assistance and Penny McKinlay provided copy editing, proofreading and stylistic editing support. The Behavioural Research Ethics Board (BREB) at the University of British Columbia (UBC) approved the research design and implementation described in Chapter Three for Phase One (BREB Certificate number H15-00283), and Phase Two and Three (BREB Certificate number H16-00939).

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To those Indigenous women, two-spirit and trans\* people and accomplices/allies that collaborated with me on this project. Thank you for your generosity and analytical insights. It was an honour learning from and with you.

Two Indigenous women filed a class-action lawsuit in October 2017 concerning acts of forced and coerced sterilization against all health regions across Saskatchewan, the federal and provincial governments, as well as individual medical professionals. There is a ban on the publication of the representative plaintiffs' names and information that could identify them. I was informed some of the original work of this dissertation is affected by this ban in fall of 2021. Recognizing this ban, but more importantly representative plaintiffs' decision to remain anonymous, I removed names, information and references affected by this ban on October 22, 2021.

## Chapter 1: Introduction

Indigenous women and two-spirit people's self-determination operates in relation to kin, animals, community, land and cosmos and is embedded within cultural, political and economic practices (Driskill, Finley, Gilley, & Morgensen, 2011; Kuokkanen, 2014, 2017; Lavell-Harvard & Lavall, 2006; Million, 2013; L. B. Simpson, 2011, 2017). In the face of colonial interventions that undermine Indigenous people's sovereignty, Indigenous women and two-spirit people have continued to sustain and build diverse pathways to foster reproductive and sexual justice for themselves, their families and their communities. This dissertation is the product of a collaborative action-oriented study facilitated on the homelands of the Métis Nation and Treaty One (Winnipeg), Treaty Four (Regina) and Treaty Six (Saskatoon) territories, which focused on urban Indigenous women's reproductive and sexual justice. This project gathered and holds many stories and this dissertation is one of them.

This study was constructed with the aim to: a) honour Indigenous women's community work, b) contribute to this ongoing work, and c) mobilize the knowledge gathered and generated in order to foster Indigenous women's reproductive sovereignty. In particular, this project's purpose was to explore: 1) How do Indigenous women living in three prairie cities (Winnipeg, Saskatoon and Regina) define and understand reproductive justice and reproductive sovereignty? 2) How do urban Indigenous women claim and exercise their rights to reproductive justice? 3) What changes to social and health services will respect and support urban Indigenous women's rights to reproductive justice? 4) What political, economic and community changes will respect and support urban Indigenous women's rights to reproductive justice? In order to situate this project, next I introduce myself, Kookum Betty McKenna (Guiding Knowledge Keeper) and the territories this project was facilitated on.

## **1.1 Introducing myself, Kookum Betty and this project**

As Indigenous scholars have emphasized, introducing ourselves is a step towards building relations and understanding (Absolon & Willett, 2005; Kovach, 2009). I introduce myself, my interest and relationship to the study and the study's guiding Knowledge Keeper in order to foster readers' understanding of what brought me to this project, an integral influence on this project (Kookum Betty McKenna) and the project itself. I, a white-settler, was born on a farm homesteaded on the homelands of the Métis Nation and Treaty Four territory near a small hamlet (Tribune) in what is also known as southern Saskatchewan, Canada. At 19, I moved to Regina and pursued undergraduate studies at the University of Regina and First Nations University of Canada. It was here that that instructors, colleagues and friends generously offered their analysis of how colonial ideologies shape values, norms and institutions, and I began my journey of unlearning and disrupting colonial intellectual and material practices and working in solidarity with Indigenous communities. I am honoured to continue to be mentored in this unlearning, disrupting and solidarity work by a number of Indigenous researchers, students, friends, Knowledge Keepers and radical accomplices (Fornssler et al., 2018; Indigenous Action Media, 2014).

During my undergraduate and Master's degree, my understanding of how colonial narratives influence reproductive health care and education grew. For instance, when I worked part-time at Planned Parenthood Regina facilitating an afterschool group with girls, most of who identified as Indigenous, I read the program's grant proposal and immediately felt a dis-ease. The proposal framed these young girls as inherently 'at risk,' which did not leave space for the smart, funny, family- and community-minded girls I had come to know. I now understand this grant proposal as one representation that is part of an enduring narrative that Indigenous women's,

girls', two-spirit and trans\* people's sexuality and reproduction is a 'risk' (to the settler state). This enduring narrative deflects attention from how the settler state places young Indigenous women, girls, two-spirit and trans\* people 'at risk' (National Indigenous Youth Council on Sexual Health, Canadian Aboriginal AIDS Network, Clark, & Hunt, 2017; Yee cited in Sparrow, 2013). While I, along with other program facilitators, resisted these colonial narratives in many ways, I was struck with how these narratives still drive funding opportunities and therefore shape programming. I could not shake this dis-ease throughout my time working with this program, or since.

When I started seriously thinking about pursuing a PhD, I wanted to put my time and energy into a project that resisted colonial narratives about Indigenous women's reproduction and sexuality and aligned with Indigenous women's experiential knowledge and activism. In my search for a framework that would allow me to do so, I learned about reproductive justice from books, articles and Native Youth Sexual Health Network's (NYSHN) community-based projects and advocacy (Native Youth Sexual Health Network [NYSHN], n.d.; Silliman, Fried, Ross, & Gutiérrez, 2004). Reproductive justice resonated with the activism and work that I had witnessed in my time working in solidarity with Indigenous women. I started to discuss this project with friends, colleagues and mentors who encouraged me to pursue this project, and discussed aspects of reproductive violence and justice with me. In the fall of 2012, I moved to traditional, ancestral and unceded Coast Salish territory to pursue this project through a PhD in Interdisciplinary Studies at the University of British Columbia where I was gifted with meeting a number of new mentors and learning from/on these lands. After I completed my coursework, I moved to the homelands of the Métis Nation and Treaty Six territory (Saskatoon) in preparation for this project's fieldwork with urban Indigenous women living on the homelands of the Métis Nation

and Treaty One (Winnipeg), Treaty Four (Regina) and Treaty Six (Saskatoon) territories. It is on these lands, which bear the marks of colonial policies and relations as well as Indigenous women's love, generosity and resurgence, that I have lived throughout my fieldwork and writing. I continue to identify strongly with feminist thought and action and anti-colonial struggles, focusing my actions on working in solidarity with local Indigenous women, two-spirit and trans\* people and communities. Indeed, this project is interconnected with my politics.

This project has been supported and made possible by many including my supervisory committee, collaborators, family, colleagues, and in particular, one of my mentors Kookum Betty McKenna, who is the Guiding Knowledge Keeper for this project. Kookum Betty is Ojibway from Shoal River. She was mentored by her own Kookum along with Kookums from many Nations. She shares her cultural teachings and lived/living experiences generously. She has done extensive work to protect, sustain and share the teachings of the moon lodge, and leads full moon ceremonies near Moose Jaw, Saskatchewan every month. She lives in Regina with her husband and two of her three children. She is a Kookum to many. She teaches at First Nations University of Canada, works with the Regina School Board as a Knowledge Keeper and is a Guiding Elder for Research and Education for Solutions to Violence and Abuse (RESOLVE) Saskatchewan. She advises and guides a number of research projects. Indeed, I first met Kookum Betty when I was working as a Research Assistant on a project led by Dr. Carrie Bourassa, "Aboriginal Grandmothers Caring for Grandchildren." When I started to think seriously about this project, I knew immediately that I wanted to approach her to see if she would guide this work. She agreed and during this study Kookum Betty led sharing circles, opened community meetings as well as shared her lived/living experiences and knowledge with me. She offered a robust analysis of the harms of intergenerational and ongoing colonial violence on reproductive

and sexual health teachings and practices in communities. She provided me with direction and connected the everyday practices and the vision of the project when I could not see it.

Near the end of Phase Two of the project, I was grappling with the reality that no matter what I did in the project to mitigate the harms of structural violence and inequities, I could not change the power and privilege differences between myself and collaborators, nor could I deny that completing this project and graduating with a PhD will benefit me more than any other collaborator who works with me. I spoke with Kookum Betty about this and she refocused me. She said, “Yes, you are doing your doctorate, but don’t disregard that there is going to be a woman going through something in 10 years and, because of the work you did, she is going to have some support or understanding. Your work will affect future women’s lives, but then again, I always think about the future generations.” I moved forward in this work with this teaching, trying to use the different resources I have at my disposal to share the knowledge gathered and co-generated within this study.

The fact that researchers are only beginning to center reproductive justice and sovereignty in their projects and processes (Gurr, 2014; Juschka, 2017; Stote, 2015, 2017) illustrates the need for projects such as this one, which explore communities’ definitions of reproductive and sexual justice. Simultaneously, the continuing appropriation of Indigenous gender relations, activism and issues by white feminist, queer and other social justice academics and activists to buttress their agendas (Arvin, Tuck, & Morrill, 2013; Cameron, 2005; Driskill et al., 2011; Stote, 2017), emphasizes the need for researchers to engage collaborative and decolonizing approaches within these projects. I made various efforts to embed and activate collaborative and decolonizing values within this project’s processes (discussed in Chapter Three). In addition, I attuned to the possibility that this project might unintentionally reproduce

oppressive power relations. This involved examining and re-examining project processes, decisions and products for benefits and (however unintentional) harms to collaborators with whom I work and urban Indigenous communities. For instance, cognizant of the long pattern of white-settler academics misinterpreting Indigenous people's experiences through white-settler methods and analytical frameworks (Chilisa, 2012; Cotera, 2010; L. T. Smith, 2012), during the early days of this project, I paid particular attention to whether the concept of reproductive justice aligned with Indigenous women's experiences and community work on these territories or whether another framework or concept would be more relevant. If another framework or term had come into focus during the early stages of this project, I was prepared to adapt the project's focus and process. However, collaborators did find reproductive justice a useful framework for analyzing their own experiences, programs, services and envisioning futures; therefore, it stuck.

I started the study with an initial phase of study conversations (Phase One) about reproductive justice. I opened these conversations with a commonly cited definition of reproductive justice: women being able to decide and control whether or not to have children, women being able to decide and control whether or not to continue or end pregnancies, women being able to control how and where they give birth, and women being able to raise the children they do have in safe and healthy ways, free from violence (Ross, 2006b). Through these Phase One study conversations, collaborators and I broadened the study's focus to reproductive and sexual justice, since they are interconnected and overlapping. Informed by study conversations, we further developed the definition above, articulating a conceptualization of reproductive and sexual justice specific to Indigenous women living on the homelands of the Métis Nation and Treaty One (Winnipeg), Treaty Four (Regina) and Treaty Six (Saskatoon) territories, which is discussed at length in Chapter Four.

## 1.2 Regina, Saskatoon and Winnipeg: Urban Spaces of Colonial Regulation and Indigenous Resistance

Colonial narratives frame urban spaces as incompatible with authentic Indigenous cultures and identities and colonial policies such as the pass system restricted First Nations people's movement off reserve lands (Daschuk, 2013).<sup>1</sup> Simultaneously, other colonial policies denied First Nations people status under the *Indian Act*<sup>2</sup> and pushed them to relocate in urban centres, for instance, the *Indian Act* stripped First Nations women of their status if they married non-status men between 1869 and 1985, which meant that women and their children could no longer live on reserve lands even if this marriage ended (Lawrence, 2001). Many cities are built on Indigenous settlements and gathering places and Indigenous people have long claimed urban spaces, resisting colonial forces and activating cultural practices, politics and identities within them (Lawrence, 2004; Peters & Andersen, 2013). Many urban Indigenous people build and sustain relations to homelands and connection to kin and traditional territories, which further disrupts the association of authentic Indigenous identities with non-urban spaces (Peters & Andersen, 2013). The provinces of Manitoba and Saskatchewan were constructed by colonial governments dividing and naming territories that First Nations (including Nêhiyaw [Plains Cree], Nêhinaw [Swampy Cree], Nîhithaw [Woodland Cree], Dene, Dakota, Nakota, Assiniboine, Anishinaabe [Ojibway, Oji-Cree and Saulteaux]) and Métis people lived on and in relation with. Indeed, the Red River Settlement, where Red River Métis identity and cultural practices further developed and the site of the 1869 Red River Resistance led by Louis Riel (Bourassa, 2011), was renamed Winnipeg in 1873. In 1874, the new Manitoba government introduced policies that undermined Métis people's rights to land and most Métis people migrated West to their maternal communities, to Batoche or South (Bourassa, 2011). Indeed, there is a long history of

displacement and migration within and among these First Nations territories and Métis homelands (Bourassa, 2011; Daschuk, 2013; Hogue, 2015), including to and among Regina, Saskatoon and Winnipeg. As of the 2016 census, 92,810 Indigenous people lived in Winnipeg (comprising approximately 12.2% of the city's population), 31,350 Indigenous people lived in Saskatoon (approximately 10.9% of the population) and 21,650 Indigenous people lived in Regina (approximately 9.3% of the population) (Statistics Canada, n.d.a). Indigenous people living in these three cities negotiate conditions of racism and socio-economic marginalization produced through similar colonial policies, processes and narratives (Comack, Deane, Morrissette & Silver, 2013; Environics Institute, 2011a, 2011b, 2011c; Kirmayer, Brass, & Tait, 2000; Newhouse & Peters, 2003; Peters & Lafond, 2013). For instance, many Indigenous people in Winnipeg, Regina and Saskatoon reported that non-Indigenous people perpetuate racist stereotypes that Indigenous people are prone to addictions, lazy and live in poverty (Environics Institute, 2011a, 2011b, 2011c). As Lawrence (2004) stated, urban Indigenous people in Western Canada

...must negotiate a society that is fundamentally still actively colonialist, where rigidly segregated spaces, a regime of tacitly organized police violence and one of the highest rates of imprisonment in the world ensure that Nativeness, particularly in urban centers, is contained in zones of fundamental illegality where universality does not apply. (p. 8).

Colonial and classist segregation continues to pervade these three cities, with specific areas long being known as 'home' to Indigenous people and people living on social assistance and disability benefits. Inadequate social assistance and disability benefit rates as well as high housing prices and racist housing practices in many other areas of these three cities prohibit Indigenous people, particularly Indigenous people living in situations of low income, from renting or owning there.

Due to colonial policies and conditions, many Indigenous women find their options limited to areas such as Saskatoon's West Side, Regina's North Central and Winnipeg's North End, areas known as inner-city neighbourhoods within these cities. In recent years, gentrifying forces have reconfigured specific blocks within these neighbourhoods as hip, trendy and up-and-coming (read: 'home' to young artists and young, white-settler homeowners). While more affordable rental properties are replaced by condos and 'starter homes' within these gentrified areas, adjacent blocks continue to be marked as dysfunctional, violent and troubled (read: home to Indigenous people, criminals and people who are unable or unwilling to work). Media and public narratives frame these areas as spaces of poverty, addiction, violence, dysfunction and Indigeneity, spaces that are outside of white-settler people's community or concern. These narratives obscure colonial and capitalist policies and practices that push Indigenous people and people dealing with harms related to structural inequities (violence, trauma and harmful substance use) into these areas, for instance inadequate mental health services, a child welfare system that does not sufficiently support Indigenous youth or families, and insufficient housing and programming for women dealing with intimate partner violence. These areas hold many stories of white-settler masculine entitlement to Indigenous women's bodies (Goulding, 2001; McKenzie, 2012; Razack, 2002), and landlords and police officers' exploitation and neglect. For instance, possibly the least-known serial murderer in North America, John Martin Crawford, killed three First Nations women he met in the West Side of Saskatoon. There was limited media coverage about Crawford's trial and more importantly, the lives and loss of the women he murdered, Eva Taysup, Shelley Napope and Calinda Waterhen (Goulding, 2001).

Despite colonial and racist policies and narratives, these cities are also spaces of building, sustaining and protecting Indigenous women and communities. For instance, a group of women

in Winnipeg formed volunteer-based safe ride groups in response to the taxi-cab driver's harassment and violence towards Indigenous women, Ikwe Safe Rides and Ikwe Safe Rides for Everyone. Indigenous women living in these urban centers are engaged in diverse activist and community work, as illustrated by the emergence of the Idle No More movement in late 2012 from teach-ins led by Indigenous and non-Indigenous women in Saskatchewan (Kino-nda-niimi Collective, 2014). These three cities are fertile sites to co-generate knowledge about reproductive and sexual justice.

### 1.3 Key Terms

There are several terms I draw upon throughout this dissertation, in particular reproductive justice, colonial heteropatriarchy, settler-colonialism, Indigenous, women, two-spirit, trans\*, relational and traditional. Earlier, I introduced the definition of reproductive justice that I shared during initial study conversations, and in Chapter Four I will further discuss how reproductive and sexual justice were conceptualized through the collaborative processes of this study. I have already referred to the term **colonial heteropatriarchy** several times. Colonial heteropatriarchy is a system of gender/sex and sexuality colonial forces imposed upon Indigenous communities. This system normalizes and naturalizes heterosexuality and patriarchy, framing egalitarian, matriarchal and queer relations as abnormal and aberrant (Arvin et al., 2013). The system relies on a naturalized gender binary (male-masculine/female-feminine) and associates the male-masculine with a group of qualities (stable, rational and strong) constructed as superior to the female-feminine and associated qualities (vulnerable, irrational and weak) (Butler, 1990; Juschka, 2009). Gender identities and expressions outside this gender binary (e.g. two-spirit and genderqueer) are rendered invisible or demonized (Driskill et al., 2011). As Emberley (2001) cogently argues, the imposition of this system of

gender/sex/sexuality normalizes colonial relations of governance. Within Canada, colonial heteropatriarchy operates as a part of **settler colonialism** a project that seeks to a) eliminate Indigenous people as a distinct, collective group and b) replace Indigenous people with a settler collective in order to c) appropriate Indigenous lands (Wolfe, 2001).

Rather than relying on colonial heteropatriarchal system of gender/sex that naturalizes feminine/female, when discussing **women** in this study and dissertation, I emphasized the openness of this category and worked to involve a diverse group, including two-spirit and trans\* people who also identified (in some way) with the category women. Two-spirit is an English translation of an Anishinaabeg term niizh manitoag (Jacobs, Thomas, & Lang, 1997). At the Third Annual Native American Gay and Lesbian Gathering in 1994, delegates made the decision to engage **two-spirit** as a pan-Indigenous term that includes a diversity of Indigenous LGBTQ+ (lesbian, gay, bi-sexual, trans\*, queer and other gender and sexually-diverse) identities, as well as culturally-specific non-binary gender identities and expressions (Hunt, 2015). **Trans\*** recognizes the multiple ways people embody and express transgenderism and gender variance (Halberstam, 2016). Aware that Indigenous people may identify with one or both of these terms, I addressed both two-spirit and trans\* people when relevant within this dissertation. Some collaborators who became involved with the study prefer the pronouns they/their, many others prefer the pronouns she/her, and all spoke to ways that the system of colonial heteropatriarchy constrains Indigenous women.

The terms Indigenous, Indigeneity and traditional are evoked and utilized in different ways. **Indigenous** and Indigeneity are sites of colonial categorization and regulation within Canada and other settler-colonial nation-states (Barker, 2008; Bourassa, McKay-McNabb, & Hampton, 2004; Lawrence, 2001). The terms Indigenous and Aboriginal are often erroneously

used within a Canadian context as a synonym for First Nations people with status under the *Indian Act* (see, for instance, Gao et al., 2008; Karmali et al., 2005). Rather than reinforce these colonial categories, this study follows from the United Nations definition of Indigenous people as the original inhabitants of the land we are discussing (2008). Within Canada, Indigenous people include people who identify as First Nations, Métis and Inuit people (Canada, 1996), and many others (e.g. Indigenous people with First Nations ancestry who do not have status under the *Indian Act* or membership at a Métis local). Much scholarly work about Indigenous gender relations, sexuality, reproduction and parenting contrasts and compares contemporary relations to pre-contact or **traditional** relations (see for instance Anderson, 2000; J. Green, 2007; Noel, 2006). While the contemporary/traditional binary is often evoked to expose colonial interventions and influences, this binary carries certain assumptions, particularly that traditional practices are historical or ‘in the past.’ Indigenous feminist and queer theorists are critically engaging with traditional practices and how they are utilized (Driskill et al., 2011; J. Green, 2007; L. B. Simpson, 2011, 2012, 2017; Women's Earth Alliance [WEA] and NYSHN, 2016). I follow from Indigenous scholars and community members who understand traditions to include teachings and practices from long ago, as well as new knowledge and learning that is enabled through diverse Indigenous practices, including, but not limited to, observation land-based practices and ceremonies (Goodwill, 2007; L. B. Simpson, 2011). As such, when discussing traditions within this dissertation, I include knowledge shared through oral history and written accounts, as well as recent articulations of reclaimed, revisioned and resurgent Indigenous relations.

**Relational**, relationality and relationships are integral to Indigenous and feminist ontologies and epistemologies and this text. I draw primarily on critical feminists’ and

Indigenous scholars' work about relational and relational context (Absolon & Willett, 2005; Doane & Varcoe, 2015; McLeod & Sherwin, 2000; Sherwin & Stockdale, 2017; S. Wilson, 2008), in particular Sherwin and Stockdale's (2017) conceptualization of:

...persons as essentially relational beings who exist and develop within a web of relationships: features such as their identities, perceptions, beliefs, emotions, values, habits of interaction and connections to the natural and social world are formed within these networks. Some of these relationships may be personal, even intimate, while others are structured by social and political understandings, but all play a role in forming and sustaining each human being. (p. 9)

Building on Sherwin and Stockdale's definition, I conceptualize the web of relations humans grow and live within to include kin, animals, communities, lands and spirits, structured by political and social understandings, an understanding that shapes and flows through this text.

#### **1.4 Overview of Chapters**

In **Chapter Two**, I offer a review of the field of traditional gender relations and reproduction as well as the reproductive choice and reproductive justice movements. This literature review illustrates that reproductive justice as a framework has potential to account for and respond to, Indigenous women's, two-spirit and trans\* people's lived experiences. It points to the need for research exploring how Indigenous women articulate and activate reproductive justice across various contexts. In **Chapter Three**, I describe the collaborative action-oriented methodology I engaged in this project, informed by Kovach's (2009) Indigenous Storytelling Approach, Lather's (2007) post-critical ethnographic approach, Hankivsky's (2012) Intersectionality-Based Policy Analysis Framework and Clark's (2012) Indigenous Intersectional-Based Policy Analysis Framework. I describe the project's processes and share my

reflections about how relationality shaped the study processes, as well as the relational tensions I negotiated with collaborators. Informed by collaborators' reflections about significant impacts of participating in the project, I caution that some of the most important 'impacts' are difficult to measure.

**Chapters Four and Five** present the study findings. In Chapter Four, I share how study conversations expanded the definition of reproductive justice. In particular, collaborators emphasized the interconnected nature of reproductive and sexual justice. Among Indigenous women, self-determination is the crux of reproductive and sexual justice. Within their reproductive and sexual lives, self-determination is articulated and activated as relational and intergenerational. Then, I offer my analysis of the context in which Indigenous women determine their sexual and reproductive futures through three themes: colonial policies, practices and narratives; inclusive and responsive care; and Indigenous survivance. I build on this analysis in Chapter Five, which demonstrates that enduring colonial narratives framing Indigenous women as hypersexual and irresponsible mothers continue to shape healthcare and service providers' actions and undermine Indigenous women's rights to free, full and informed consent across various contexts in relation to multiple reproductive technologies and procedures. Indigenous women negotiate these coercive encounters using multiple methods, including: acts of refusal, negotiation and sharing community knowledge.

In **Chapter Six**, I discuss how this study's findings can contribute to academic discussions about reproductive and sexual justice, Indigenous self-determination and reproductive coercion. Based on this study's findings, I argue that action is most needed to a) create alternative lifeways through acts of refusal, negotiation and resurgence, and b) reduce the harms of colonial heteropatriarchy through transforming organizations and institutions.

## **Chapter 2: A Review of the Field and Current Conversations: Traditional Practices, Reproductive Injustices and Reproductive Justice**

This review of the field first focuses on Indigenous conceptualizations of Indigenous gender relations and reproduction. Informed by reproductive justice organizations', activists' and researchers' cogent arguments that reclaiming and revisioning Indigenous traditional gender relations and practices related to sexual health and reproductive are crucial to fostering Indigenous reproductive justice for Indigenous women (Gurr, 2015; NYSHN & International Indigenous Working Group on HIV & AIDS, 2013; NYSHN & The National Aboriginal Council of Midwives, 2014, May 28; Silliman et al., 2004; WEA & and NYSHN, 2016), this review of the field first focuses on Indigenous conceptualizations of Indigenous gender relations and reproduction. I then examine how colonial heteropatriarchal policies and practices have undermined Indigenous gender relations, Indigenous women's and gender-diverse people's bodily self-determination, as well as familial and community self-determination. Next, I explore some of the ways Indigenous feminists, two-spirit and queer theorists are resisting colonial relations and processes, and reclaiming and re-envisioning Indigenous gender relations and practices. Then, this chapter shifts to focus on reproductive choice and reproductive justice movements. I highlight the limitations of the reproductive choice movement in analyzing reproductive violence affecting Indigenous people's lives and envisioning liberatory futures. Based on the available literature, I suggest that reproductive justice has much more potential to account for, and respond to, Indigenous women's, two-spirit and trans\* people's lived experiences. This review illustrates the need for further empirical research exploring how Indigenous women conceptualize and activate reproductive justice across various contexts.

## 2.1 Diverse Practices Related to Gender and Reproduction

While colonial policies and processes have undermined traditional conceptualizations and practices related to gender, sexuality and reproduction, Indigenous people continue to practice and share them. Indigenous theorists offer multiple articulations of Indigenous gender relations, sexuality and reproduction (Driskill et al., 2011; Evans-Campbell, Friedriksen-Goldsen, Walters, & Stately, 2007; LaRocque, 2007; Lavell-Harvard & Lavall, 2006). In these articulations, theorists often contrast and compare contemporary relations to pre-contact or traditional relations (see for instance Anderson, 2000; J. Green, 2007; Noel, 2006). While this contemporary/traditional binary is often evoked to expose colonial interventions and influences, it carries certain assumptions, particularly that traditional practices are historical or ‘in the past.’ Indigenous critical engagement with, and activation of, traditional practices disrupts this binary and related assumptions (Driskill et al., 2011; J. Green, 2007; L. B. Simpson, 2011, 2012, 2017).<sup>3</sup>

Traditional Indigenous communities take diverse formations, often categorized today as patriarchal, matriarchal, matrilineal and patrilineal (LaRocque, 2007; Mercredi & Turpel, 1993, pp. 21-22; Noel, 2006). These communities emphasize communal well-being and the responsibilities individuals have to each other and to other relations (for instance, Mother Earth, Grandmother Moon, animals, Grandfather Tree and Grandfather Rock), along with individual self-determination (Anderson, 2011; L. B. Simpson, 2011, 2017). Many Indigenous scholars and feminists describe traditional Indigenous gender relations (whether patriarchal, patrilineal, matriarchal, or matrilineal) as grounded in ‘gender balance,’ in which labour and responsibilities are gendered, but the contributions of all are equally respected (Anderson, 2000, 2011; Canada, 1996; Udel, 2001; Valaskakis, Dion Stout, & Guimond, 2009). Discursive and material practices

connect women's potential to produce life with the power of the land to produce and sustain lifeworlds (Anderson, 2000, 2011; S. S. McAdam, 2015; L. B. Simpson, 2011; Udel, 2001). For instance, various Nations celebrate Grandmother Moon, Mother Earth and women through practices and ceremonies, such as the moon lodge and full moon ceremonies (Anderson, 2000; McKenna, 2017; McKenna, Hampton, Bourassa, McKay-McNabb, & Baydala, 2010). In many communities, women and girls who have their moon time (are menstruating) will spend time in a moon lodge with Grandmothers where they learn about women's roles, sexuality and childbirth as well as the significance of Grandmother Moon (McKenna et al., 2010).

Grandmothers and midwives hold important roles and responsibilities within Indigenous communities. Midwives' responsibilities include treating women with medicines to increase the likelihood, prevent, or end a pregnancy; caring for pregnant women physically, mentally and spiritually; and providing post-natal care and support to women, children and their families. Midwives also have lifelong relationships with children they deliver (Anderson, 2011). These diverse forms of societies and families also respect children as community members with a strong connection to the spiritual world. Communities foster an environment of openness where parents, extended family members and other community members provide young children with teaching and guidance through stories, observation and experiences (Anderson, 2011; Fournier & Crey, 1997).

In many Nations, women's potential to be life-givers (even if this potential is never actualized through pregnancy, childbearing and child-rearing) and identities as mothers and grandmothers were and are interconnected with women's political and economic positions and practices (Anderson, 2011; Miles, 2009; Noel, 2006; Udel, 2001). For instance, among the Haudenosaunee, women were and are traditionally the guardians of the land and farmers and are

responsible for the distribution of resources.<sup>4</sup> Politically, women are involved in decision-making and convene their own councils who bring issues to their entire village, tribal council, or the grand council of the Confederacy for consideration (Noel, 2006, p. 82). Haudenosaunee clan mothers traditionally choose and remove chiefs from their political positions (Anderson, 2000, 2011; Noel, 2006). Similarly, Nêhiyaw scholar S. S. McAdam (2015) described the *okihcitâwiskwêwak* (translated from *nêhiyawêwin* to English as clan mothers or warrior women) as law keepers and knowledge keepers of the Nêhiyaw principles and customs. Sauteaux Knowledge Keeper Mosôm Danny Musqua related that among Sauteaux communities, women have jurisdiction over the tipi, with related community and organization responsibilities.

As discussed above, there are diverse conceptualizations of traditional gender relations (see, for instance, LaRocque, 2007; L. B. Simpson, 2017; A. Wilson, 2009). There is evidence from archival research and Indigenous languages that men, women and two-spirit people's roles and responsibilities were fluid during early colonial relations. An individual's responsibilities were developed through their strengths and interests in relation to the needs of their families and communities. For instance, Métis feminist LaRocque critiqued narratives about Indigenous womanhood that hinge on women's roles as mothers. She pointed to the limits of these narratives and highlighted archival records documenting some Nations where women and men had very similar roles, style of dress and physical strength (LaRocque, 2007). Similarly, A. Wilson (2009), a two-spirit scholar from Opaskwayak Cree Nation related that in the Nêhinaw (Swampy Cree) language there is no word for two-spirit people and no gendered pronouns. Rather, the language focuses on differentiating between that which is animate and inanimate. In her qualitative research with two-spirit Cree and Ojibway people, Wilson's analysis described two-spirit people's process of "coming in" to an identity that reflects their sexuality, culture, gender

and other aspects of their lives, and is grounded in their Nations' histories of people whose gender identities did not fit the binary of female/male (p. 89). These histories include people who cared for children, family members, older people as well as the wider community (Evans-Campbell et al., 2007).

## **2.2 Reproductive Injustices and Colonial Disruption of Indigenous Gender and Familial Relations**

Colonial interventions have taken aim at Indigenous family formations and gender relations, subjecting Indigenous women, girls, boys and gender-diverse people to sexual and reproductive injustices as part of the project to assert, and maintain, control over Indigenous lands. As Emberley (2001), drawing on Stoler (1995) demonstrated, in order to naturalize the proper bourgeois heteropatriarchal family within Canada, England and other English colonies, colonial forces framed Indigenous gender relations and families as unnatural and in need of intervention during the eighteenth and nineteenth centuries. For instance, colonial forces demonized culturally-specific non-binary expressions of gender and imposed notions that only binary (female/male) gender and heterosexual identities were acceptable, moral and natural (Cannon, 1998; Hunt, 2015; Jacobs et. al., 1997; L. B. Simpson, 2017).

Government officials and media forces used emergent colonial images of Indigenous women as either 'Indian Princesses' or 'Squaw-Drudges' to justify the apprehension of Indigenous children, poor housing conditions on-reserve as well as sexual violence against Indigenous women (Anderson, 2000; S. Carter, 1997; R. Green, 2007; L. B. Simpson, 2017). Simultaneously, colonial forces positioned white-settler femininity as the ideal womanhood and Indigenous masculinity as inherently violent, framing Indigenous men as inherently dangerous to white-settler women (S. Carter, 1997; Emberley, 2001; Kelm, 2005). Emberley (2001) offers a

materialist feminist analysis of how colonial forces positioned Indigenous gender relations and societies as less developed than European cultures in order to naturalize the patriarchal bourgeois family.

Drawing on Foucault's theorizing of how familial relations work in alliance with governance structures, Emberley (2001) illustrated the relationship between colonial forces' imposition of the patriarchal bourgeois familial structures onto Indigenous communities (which rely on binary gender relations and compulsory heterosexuality) and the naturalization of the colonial structures of governance through a) *Indian Act* governance in First Nations and b) paternalistic relations between the Canadian government and Indigenous peoples. By naturalizing the colonial imagery of a) Indigenous women as either Indian Princesses or Squaws, b) proper or ideal white bourgeois motherhood, c) Indigenous masculinity as inherently violent, and d) the binary of male/female and corresponding gender and heteropatriarchal family structure (associated with proper nationhood and nation-building rhetoric), the discursive constraints were well cast for regulating the embodiment of femininity and masculinity, as well as the reproductive and sexual autonomy afforded to Indigenous women and gender-diverse people, in the service of the colonial project to disempower Indigenous people and to disrupt Indigenous ways of relating and governance.

The process of naturalizing the bourgeois family in Canada is a violent one involving invasive policies and associated practices such as the *Indian Act*, residential schools, the sixties scoop, and child welfare today (Emberley, 2001; Lawrence, 2004; Sinclair, 2007; Tait, Henry, & Walker, 2013). As Jamieson (1978) argues, when the early iterations of the *Indian Act* were written during the latter part of the nineteenth century, since the Canadian federal government was most familiar with matriarchal, communal Haudenosaunee and Anishinaabe people, the act

was structured to undermine matriarchal ways of being and governing. Provisions of the *Indian Act* undermined Indigenous community relations and governance in various ways, including: a) imposing colonial band council structures that were the domain of men, b) instituting a racist heteropatriarchal familial order wherein children's and women's status (as Indians under the *Indian Act*) was determined by the biological father's status<sup>5</sup>, as well as c) introducing provisions to privatize and individualize ownership of property on reserve (which comprise only a small portion of Indigenous peoples' traditional territories) (Bourassa et al., 2004; Cannon, 1998; Lawrence, 2001). These colonial interventions into Indigenous governance and family relations were intended to a) disempower First Nations people and b) enforce a patriarchal familial, governance and property model in order to assimilate First Nations people into the EuroWestern Canadian body politic.

Colonial policies, medical writing and other discursive practices in the late nineteenth and twentieth century employed colonial imagery denigrating Indigenous women's motherhood in order to justify the relocation of Indigenous children from their families and communities into residential schools (S. Carter, 1997; Davin, 1879; Kelm, 1998, 2005). Although public and media narratives continue to justify and minimize colonial processes (past and present) (Henderson & Wakeham, 2009; Landertinger, 2011), in recent years the colonial nature and intergenerational impacts of residential schooling on Indigenous communities has entered into public discourse, particularly via Truth and Reconciliation Commission processes and publications (Regan, 2010; Truth and Reconciliation Commission of Canada, 2015). The instruction and daily practices at residential schools were heteropatriarchal. For instance, biological males and females were separated and even brothers and sisters were forbidden to speak with each other (Fiske, 1996; Kelm, 1998; Milloy, 1999). While government officials,

educators and media discourse framed residential schools as moving Indigenous children along the teleological line of progress for their own good, these environments and practices compromised children's health, well-being and livelihood in many ways. For instance, these schools were often overcrowded and unsafe and children were malnourished and overworked. Children were also subjected to physical, sexual, mental, spiritual and emotional violence while at the schools with many of them dying or being killed (Furniss, 1995; Kelm, 1998; Miller, 2003; Milloy, 1999; Truth and Reconciliation Commission of Canada, 2015). After the Second World War, the federal government took over administrative control of residential schools (which had previously been managed by the churches) and began to close some schools as part of their policy shift from segregation to integration. However, it would be several decades before the last federally-run residential school closed in 1996 (Castellano, Archibald, & DeGagné, 2008).

As more and more schools closed in the 60s and 70s, the removal of Indigenous children from their families and communities did not end. Rather, the extension of provincial child welfare services onto reserves by 1951 changes to the *Indian Act* coalesced with a number of other factors to create a mechanism for further colonial interventions into Indigenous families and homes. These factors included: a) the lack of funding for preventative services to support family wellness on-reserve; b) poor housing and sanitation conditions on many reserves (due again to federal underfunding and the restrictions placed on First Nations); and c) the intersection of Eurocentric practices around child welfare, child welfare workers' white-settler and middle-class assumptions about parenting and families, and d) colonial imagery of Indigenous mothers, families and communities (Fournier & Crey, 1997; Johnston, 1983; B. McKenzie & Hudson, 1985; H. A. McKenzie, Varcoe, Browne, & Day, 2016). Indeed, the child welfare system

increasingly apprehended children who a decade or two prior would have been taken from their families to residential schools (Fournier & Crey, 1997; Johnston, 1983; Sinclair, 2007).

At the same time as the residential schools and the child welfare system were apprehending Indigenous children from their families and communities, other policies had further compromised Indigenous women's reproductive self-determination. For instance, colonial interventions took aim at Indigenous women's birthing practices during this time. While Inuit and First Nations mothers had birthed in their communities with the help of midwives, family members, their husbands, or by themselves for centuries, as early as the late nineteenth century the federal government introduced new practices and policies to regulate and medicalize their childbirth (Anderson, 2011; Kaufert, 1990; Lawford & Giles, 2013; O'Neil & Kaufert, 1990). The culmination of these practices and policies was the evacuation policy through which pregnant First Nations women living in rural and remote communities were, and are, routinely evacuated to urban centres to give birth (Couchie & Sanderson, 2007; Lawford, 2016, 2017; Lawford & Giles, 2012, 2013). While biomedical discourses frame transporting First Nations and Inuit women to urban hospitals for birth to be less risky, the risks introduced by evacuating First Nations and Inuit women from their communities to cities, often where women do not have any family or community support or speak the language, have largely been unaccounted for (Kaufert, 1990; National Aboriginal Health Organization, 2004; O'Neil & Kaufert, 1990). Recent research has begun to document the impact of evacuation to urban centres on First Nations women (H. Brown, Varcoe, & Calam, 2011; Kornelsen & Grzybowski, 2004; Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2011; Lawford, 2017; Varcoe, Brown, Calam, Harvey, & Tallio, 2013). For instance, H. Brown et al. (2011) documented First Nations women's concerns

for 1) “the safety of the children who they had to leave behind” during this process and 2) the impact of this separation on their families (p. 109).

Lawford and Giles’ (2013) analysis demonstrated that the marginalization of First Nations knowledge and coercion of First Nations women to comply with EuroWestern biomedical maternal and child health practices emerged within and is part of the project to assimilate Indigenous people into the Canadian body politic. Indigenous women have also been subject to coercive practices related to sterilization, justified and enabled by colonial narratives (Grekul, Krahn, & Odynak, 2004; Park & Radford, 1998; Stote, 2012). For instance, under Alberta’s *Sexual Sterilization Act* active between 1929 and 1972, six percent of the people recommended for sterilization were Indigenous even though Indigenous people comprised between two and three percent of people living in Alberta at the time. While the Act’s medical terminology gave a sense that patients were assessed objectively, analysis of the case files suggested that “more ambiguous social, economic and cultural rationales” were at play, including white-settler assumptions about gender norms and sexual morality (Park & Radford, 1998, p. 325).

Alberta and British Columbia were the only two provinces with formal legislation enabling forced sterilization; however, there is evidence that Indigenous women in other provinces and territories have been subjected to coercive practices related to sterilization (Boyer, 2014; Cohen & Baskett, 1978; Stote, 2012, 2015). These coercive practices were justified and enabled by colonial narratives that frame Indigenous women as irresponsible mothers who have ‘too many’ children and are a burden to the Canadian state (Acoose, 1995; Anderson, 2000; Browne & Fiske, 2001; Cull, 2006; Kelm, 2005; Landertinger, 2011; Tait, 2008, 2009). Canadian government policies during the late nineteenth and into the mid-twentieth century

limited the reproductive and sexual self-determination of Indigenous women, two-spirit and trans\* people and disrupted Indigenous ways of relating within families, communities and governance. These politics of disruption aimed to undermine Indigenous people's and communities' strength and sovereignty, and remain interconnected with the colonial project to eliminate Indigenous people as culturally distinct groups in order to extinguish their claims to Indigenous lands (Thielen-Wilson, 2014).

### **2.3 Shifting from Overt Colonial Discourses to Medicalized Discourses About 'Inferior Health': Re-Framing Indigenous Women as Placing Their Children 'at Risk'**

During the latter half of the twentieth century, narratives about Indigenous peoples shifted. Overt colonial discourses were supplanted by neutralized and medicalized language “with a focus on ‘inferior’ health and social problems” among Indigenous people and their “identification, prevention and treatment/intervention” (Tait, 2009, p. 199). Since the 1990s, discourses of risk have expanded and multiplied (Douglas, 1992; Strega, 2009), coalescing with neutralized and medicalized categorizing of Indigenous people's comparatively greater (in relation to non-Indigenous people) health and social problems, decontextualized from the racist and colonial conditions that produced those issues. Overt colonial discourses ascribe certain qualities to Indigenous communities', men's and women's nature, which have been reframed through epidemiological, public health and media discourses as risk factors. These narratives position Indigenous women as placing themselves and their children at risk through lifestyle choices that induce disproportionately high rates of illness and social disorder. For instance, Indigenous women are cast as a homogenous group who are at higher risk than non-Indigenous women for a number health and social conditions (such as giving birth to alcohol or drug-affected children, HIV/AIDS, teen pregnancy and cervical cancer) (see for instance Guimond &

Robitaille, 2008; Mann, 2013; Public Health Agency of Canada, 2010a; Wenman, Joffres, Tataryn, & Edmonton Perinatal Infections Group, 2004) due to their sexual behaviours, alcohol and drug use, refusal to seek treatment or health services and victimization at the hands of their partners (Browne & Smye, 2002; Hunting & Browne, 2012; Jones, 2004; Tait, 2009).

Epidemiological, public health and media discourses also re-frame many of these health and social conditions as further risks to Indigenous women and children's health and well-being.

Mann (2013) stated

Statistically we know that teenaged parents are less likely to complete their education, more likely to experience isolation and homelessness, less likely to develop good parenting skills, and more likely to transfer their histories of childhood abuse and neglect to their child. The social cost of teenaged pregnancy also includes higher rates of lone parenting, incarceration, poverty, and children taken into state care. All of these factors have lifelong impacts. (p.24)

Mann's analysis does not deconstruct how colonial violence and other forms of structural violence undermine young Indigenous mothers access to education, employment, housing and supports. Instead, Mann frames these conditions and situations as the cost of (read: the inevitable result of) teenage pregnancy.

When researchers, health practitioners, policy makers and journalists accept and perpetuate narratives that position Indigenous women as placing themselves at risk, they lend support to invasive techniques of prevention [e.g. the rate of birth control use as an indication of a program's success (Tait, 2008)] and treatment [e.g. the coercive use of prescription drugs on children who are diagnosed with, or suspected of dealing with, Fetal Alcohol Spectrum Disorder (Oldani, 2009)] that regulate Indigenous people's bodies. Constructing Indigenous women and

their families as suffering from social and health problems due to Indigenous women's behaviours universalizes the health and social conditions some Indigenous women are facing as attributes of Indigenous women, and individualizes the effects of colonial heteropatriarchy. It also homogenizes EuroWestern Canadian women and communities as the measure of health and wellness and reproduces colonial anxiety within non-Indigenous communities about Indigenous women's reproduction, reframing Indigenous women as a risk to, and a burden on, the colonial state. These colonial discourses, masked by liberal, individualized language, continue to justify the regulation of Indigenous women's reproductive autonomy and state opposition to Indigenous struggles for self-determination (Tait, 2009; Thielen-Wilson, 2014).

#### **2.4 Resisting Discourses of Risk and Re-Envisioning Indigenous Reproductive Practices: Indigenous Feminist, Two-Spirit and Queer Theorists' Resurgence Work**

Narratives framing Indigenous women as placing themselves at risk are the narratives non-Indigenous Canadians most often hear. However, increasingly researchers and advocacy organizations are critically deconstructing these narratives, connecting the ongoing processes of colonialism and neoliberalism to the risks and conditions Indigenous people navigate (see for instance, Browne, 2005; Browne & Fiske, 2001; Browne, Smye, & Varcoe, 2005; Browne, Varcoe, & Fridkin, 2011; Clark, 2016; Danforth & Flicker, 2014; Flicker et al., 2014; Hunting & Browne, 2012; Kelm, 2005, 2010; Million, 2013; National Indigenous Youth Council on Sexual Health et al., 2017; Colleen Varcoe & Browne, 2015). As the National Indigenous Youth Council on Sexual Health et al. (2017) succinctly and cogently state:

Indigenous youth are not inherently 'at risk'. Risk is created by colonialism. The label 'at risk' naturalizes the idea that Indigenous youth live inherently risky lives, rather than

situating the source of risk within systems of power which devalue Indigenous lives, create intergenerational trauma and foster displacement, disconnection and illness.

These complex analyses offered by researchers and advocacy organizations disrupt the colonial myth that Indigenous women are simultaneously sick and dysfunctional *and are the cause of their own sickness and dysfunctionality*. While researchers and advocacy organizations are deconstructing this narrative, Indigenous people are also increasingly sharing, reclaiming and re-envisioning traditional practices related to gender relations, reproduction and sexuality they have protected and sustained in the face of colonial interference.

Indigenous feminist analyses of traditional practices and work to reclaim and revision traditions has been, and continues to be, crucial to this resurgence work. Indigenous feminism is a tradition of thought grounded in the “gender-focused and anti-sexist organizing that has always been a part of and has existed alongside social justice struggles of Native women and Native peoples in general” which foregrounds “the relationship between colonialism and intersecting oppressions including those produced through race, class, sexuality and gender” (Nason, 2010, pp. 8 & 2). When speaking particularly about reclaiming traditions, Indigenous feminist J. Green (2007) asserted that it is necessary to analyze how power, including colonial and patriarchal power, may flow through traditional practices, and the impact of these practices on Indigenous women, men and children. Indigenous feminists’ reclaiming and re-envisioning of traditions often explicitly and implicitly carries this analysis. McKenna et. al’ (2010) chapter “Voices from the Moon Lodge” related the experiences within, and teachings of, the moon lodge as told by the chapter’s lead author (an Anishinaabe Elder and Knowledge Keeper) with a focus on how the moon lodge prepares young Anishinaabe women for childbirth and motherhood and informs relations among women, men and two-spirit people.

In *Life Stages and Native women: Memory, Teaching and Story*, Anderson, a Métis feminist, (2011) shared Métis, Nêhiyaw and Anishinaabe women and men's oral histories, which discussed diverse reproductive, pregnancy, maternal and child-rearing practices of the mid-twentieth century and analyzed how colonial forces have influenced these practices. In addition to highlighting the important roles of midwives in supporting women's reproductive health and decision-making, Anderson also described the crucial supports men offer their partners during pregnancy traditionally. Similarly, L. B. Simpson's text *Dancing on Our Turtle's back: Stories of Nishnaabeg Re-creation, Resurgence and a New Emergence* (2011), explored how her experiences of pregnancy, childbirth and mothering had transformed her understandings of treaties, Nishnaabeg Creation Stories and ways of relating while resisting the essentializing and totalizing discourse that homogenizes Indigenous female-woman-motherhood. She further built on this work in *As We Have Always Done: Indigenous Freedom Through Radical Resistance* (2017), in which L. B. Simpson articulates kwe<sup>6</sup> as a method of generating knowledge. At the core of kwe as method is refusal: "refusing colonial domination, refusing heteropatriarchy, and refusing to be tamed by whiteness or the academy...within this context [of Nishnaabewin and Michi Saagiig grounded normativity] it is always generative" (p. 33).

Closely connected to the work of Indigenous women and feminists is the work of Indigenous queer theorists and other trans\* and two-spirit people, in that their work also a) highlights how colonial forces have undermined gender relations and b) aims to re-create the conditions for more self-determining futures. As discussed earlier, Wilson's (2009) qualitative study grounded in Indigenous methodologies shared stories of Indigenous two-spirit people "coming in' to an empowered identity that integrates their sexuality, culture, gender and all other aspects of who they understand and know themselves to be" (p. 89). Similarly, Indigenous

queer theorists focus their analytic lens towards heteronormativity (and homonormativity) as produced through and as part of colonial projects. Driskill et. al.'s (2011) collection, *Queer Indigenous Studies: Interventions in Theory, Politics and Literature* offered queer and two-spirit analyses, which “invite critiquing heteronormativity as a colonial project, and decolonizing Indigenous knowledges of gender and sexuality as one result of that critique” (p. 3).

Much discussion about reclaiming traditions related to reproductive health centers on Indigenous midwifery (Carroll & Benoit, 2001; Gonzales, 2007; National Aboriginal Health Organization, 2004, 2008; Neufeld & Cidro, 2017; L. B. Simpson, 2006; Skye, 2010; Tabobondung, Wolfe, Smylie, Senese, & Blais, 2014). For instance, the National Aboriginal Council of Midwives’ mission statement reads, “We advocate for the restoration of midwifery education, the provision of midwifery services, and choice of birthplace for all Aboriginal communities, consistent with the U.N. Declaration on the Rights of Indigenous People” (n.d., para 1). Similarly, Indigenous doula initiatives and organizations have emerged in the last several years, growing the tradition of birthwork Indigenous women have always-already engaged (Gilpin, 2017; University of Winnipeg Communications, 2017). The resurgence of Indigenous midwifery and birthwork is one aspect of reproductive justice (NYSHN & The National Aboriginal Council of Midwives, 2014, May 28; Shaw, 2013; Silliman et al., 2004), which is the focus of the next section.

## **2.5 Reproductive Choice and Reproductive Justice Movements: Contested Terrain**

Poststructuralist feminists, Indigenous feminists and women of colour have long problematized the reproductive choice framework and reproductive rights movement (Poovey, 1992; Ruhl, 2002; Ralstin-Lewis, 2005; Silliman et al., 2004). As Luna (2011) pointed out, “The language of the reproductive rights [or reproductive choice] has cultural resonance with many

women who have evidence that, but for their gender, they could participate fully in society” (p. 234). Indigenous women and women of colour have pointed out that reproductive choice renders invisible the economic, social and discursive conditions that shape what choices are more (or less) possible, as well as the influence of pharmaceutical companies on the choices available (and what we know about the side effects of said choices) (Silliman et al., 2004). Similarly, women’s rights to mother their children has not been a focal point within reproductive choice discourse or activism, largely because white, middle-class, heterosexual women are encouraged to mother within EuroWestern Canadian society (within the right contexts); therefore the majority of reproductive choice activists and service providers take this right for granted.<sup>7</sup> However, Indigenous women continue to fight for their rights to mother in the face of a punitive, underfunded child welfare system, which blames Indigenous mothers for the effects of colonial processes and discourses, such as poor housing conditions and lower-incomes (Cull, 2006; Landertinger, 2011; Sinha & Kozlowki, 2013; Tait et al., 2013). The fact that more Indigenous children are in state care today than during the height of residential schools (Blackstock, 2007; Mandell, Carlson, Fine, & Blackstock, 2007; Sinha, Trocmé, Blackstock, MacLaurin, & Fallon, 2011; Sinha, Trocmé, Fallon, & MacLaurin, 2013) may be concerning to those working within the reproductive choice movement. However, reproductive choice organizations and advocacy groups very rarely, if ever, address these concerns in their activist work or service provision.<sup>8</sup>

Problematizing the liberal discourse on reproductive rights and choice, Ruhl (2002) analyzed how contemporary liberalism does not conceptualize pregnant women as legitimate subjects “in that the liberal paradigm of the individual is inherently unable to accommodate pregnancy” both philosophically and practically (pp. 37-38). Liberal ideologies depend on binaries such as social/natural and public/private, binaries that pregnancy transgresses (and

makes visible the failure of). Further, subjectivity within liberalism comes with a set of rights and responsibilities. Since a fetus cannot fulfill these obligations, unborn children are not-yet subjects. Simultaneously, the “natural laws” (reinforced through social and legal regulation) require pregnant women to forgo their own rights in order to care for their unborn children. They exist simultaneously as “*one* liberal subject in two bodies” (p. 39). In other words, the fetus has all of the rights of the liberal subject while the pregnant woman is responsible for all necessary obligations.

Poovey (1992) argued for a reconceptualization of rights as relational, “in which the heterogeneity of the individual could be accommodated” (p. 252). Addressing reproductive rights and choice in particular, Poovey went on to state that:

[F]or a concept like ‘choice’ to make sense, it will have to be conceptualized as a social issue and in a social arena: that is, a variety of options will have to be made available and supported with equal social resources. In the case of reproductive choice, these options would include not only access to safe and legal abortions but also pre- and post-natal care and day-care facilities (p. 253).

Poovey’s description above pointed to the limitations of much reproductive choice theorizing and activism as well as shared affinities with reproductive justice scholarship and work. Ross (2006a) explained that reproductive justice organizing in the United States was influenced by the global work of feminists from Third World countries, which is grounded in a human rights framework and takes into account colonization and globalization. As such, reproductive justice advocates conceptualize human rights as relational and contextually-bound, and move beyond the individualistic ideology underpinning reproductive ‘choice.’

The roots of the reproductive justice movement in North America can be traced to Indigenous women's and women of colour organizing and community work in the 1970s and 1980s.<sup>9</sup> In 1979, Mohawk midwife Katsi Cook initiated the Women's Dance Health Program in Minneapolis-St. Paul.<sup>10</sup> The Women's Dance Health Program involved teaching community members midwifery practices and researching sterilization practices, as well as developing and providing culturally relevant and appropriate health care. Cook brought the Women's Health Dance Program to the Akwesasne Reservation in 1980 where she initiated the Mother's Milk Project in 1985. This project investigated how toxic chemicals produced by local industry, such as polychlorinated biphenyls (PCBs), affect Mohawk people's food sources including Mohawk women's breast milk (Silliman et al., 2004).<sup>11</sup> Similarly, in 1987, the first Women of Color and Reproductive Rights conference was held in the United States and dealt with issues such as "racism in the pro-choice movement, Medicaid funding for poor women, genetic technology and men's roles in the movement" (Luna, 2011, p. 227).

Various networks of women of colour emerged among the conference attendees and in November 1994, a Black women's caucus at the Illinois Pro-Choice Alliance conference coined the term reproductive justice. This caucus became Women of African Descent for Reproductive Justice (Asian Communities for Reproductive Justice, 2005). In 1997, SisterSong: Women of Color Reproductive Health Collective representing 16 organizations of African American/Black, Asian/Pacific Islander, Latina and Native American women was formed (Luna, 2011). Luna reported in 2011 that the collective, now known as SisterSong: Women of Color Reproductive Justice Collective, had over 80 member organizations (led by women of colour) and ally organizations (serving women of colour, but not led by or solely focused on women of colour).

Reproductive justice emerged from, and continues to be situated within, an intersectionality framework, first articulated by black feminists and other women of colour. Intersectionality considers how oppressive forces intersect (such as racism, heterosexism, classism and colonialism) to shape women's, men's, two-spirit and trans\* peoples' experiences (Bourassa et al., 2004; Cho, Crenshaw, & McCall, 2013; Clark, 2012; Crenshaw, 1991; Hankivsky, 2011, 2012; Hankivsky et al., 2014; Hill Collins & Bilge, 2016; May, 2015; Moraga & Anzaldúa, 1983). Intersectionality renders visible *why* pro-choice discourses and material strategies do not reflect many of the pressing concerns of women of colour. Asian Communities for Reproductive Justice's (now Forward Together) description of reproductive oppression demonstrate both the limitations of pro-choice movements and the analytical power of reproductive justice frameworks:

The control and exploitation of women and girls through our bodies, sexuality, and reproduction is a strategic pathway to regulating entire populations that is implemented by families, communities, institutions, and society. Thus, the regulation of reproduction and exploitation of women's bodies and labor is both a tool and a result of systems of oppression based on race, class, gender, sexuality, ability, age and immigration status. (2005)

Similarly, SisterSong considered the three principles of reproductive justice to be, women's rights to:

Decide if and when she will have a baby and the conditions under which she will give birth.

Decide if she will not have a baby and her options for preventing or ending a pregnancy.

Parent the children she already has with the necessary social supports in safe environments and healthy communities, and without fear of violence from individuals or the government (Ross, 2006b, p. 3)

There are ongoing dialogues about what reproductive justice organizing and activist work is and can be. Activists working under the label of reproductive justice in Canada are focused on the ongoing struggle for the right to, and access to, abortion services (Shaw, 2013), even as those such as Shaw (2013) and Yee (2011b) have argued for a more complex, intersectional movement. Shaw argued that birth activists, working to end the medicalization of birth and activists working to ensure women's right to, and access to, abortion services (along with activists working to support families caring for their children in a myriad of ways) working collectively "under a full-spectrum reproductive justice framework" can further the project of re-creating a reproductive just society (p. 144).<sup>12</sup>

Luna (2011) highlighted concerns over the co-option of the term reproductive justice by reproductive choice organizations. Indeed, reproductive justice it is not a synonym for reproductive rights or sexual rights (Ross, 2006b). However, there is a risk that reproductive choice organizations, by using the term reproductive justice without changing to their material practices will effectively resignify the phrase as such within popular discourse.<sup>13</sup> Ross (2017) explained that with growing popularity of reproductive justice, theorists' and activists' raised concerns about people co-opting the framework. To address these concerns, a group of women of colour came together in order to establish parameters to guide reproductive justice praxis:

- Intersectionality-issues must be inter-connected
- Connects the local to the global
- Based in a human rights framework

- Makes the link between the individual and community
- Addresses government and corporate responsibility
- Fights all forms of population control (eugenics)
- Commits to individual/community leadership development that results in power shifts
- Puts marginalized communities at the center of the analysis
- Understands that political power, participation of those impacted, and policy changes are necessary to achieve reproductive justice
- Has its own intersectionality of involving theory, strategy, and practice, and
- Applies to everyone (p. 301)

Ross (2017) stated that these criteria were not meant to define the ‘correct’ way to engage reproductive justice praxis, rather they “delineate the most common incorrect ways to under-realize its dynamic potential” (p. 301). Organizations activate these criteria in various ways to address diverse, interconnected concerns. For instance, NYSHN, organized by and for Indigenous youth across North America, stated on their website (n.d.):

Sexual and reproductive health, rights, and justice contain a wide range of issues. Some of our key areas of work include:

- Culturally safe sex education
- Reclaiming rites of passage, coming of age ceremonies and traditional knowledge
- Healthy relationships and violence prevention
- Pregnancy options, youth parenting and families
- Environmental justice and environmental violence
- Harm reduction

- Two-Spirited and LGBTTIQQA advocacy and awareness
- Sexually Transmitted and Blood Borne Infections (STBBIs) and HIV/AIDS awareness and prevention
- Youth in custody, jail, prison and the child welfare system
- Sex trade, sex industries and street economies
- Indigenous feminisms and masculinities
- Sexual self-esteem and empowerment
- Media literacy
- Youth activism and human rights

Indeed, NYSHN recently worked with the Women’s Earth Alliance (WEA) on an initiative documenting how Indigenous women’s and young people’s safety and health “are impacted by extractive industries across North America” (2016, p. 2). The report discussed various impacts of environmental violence, violations of Indigenous peoples’ rights to free, informed and prior consent over decisions related to Indigenous lands and Indigenous peoples’ bodies, and foregrounded young people’s resistance work. As Silliman et. al. state, among Indigenous women activists “reproductive rights struggles are part of the struggles for sovereignty and land” (2004, p. 123), clearly articulating the already existing relationship between individual, family and community-level self-determination.<sup>14</sup> NYSHN’s work illustrates this relationship, as does the scholarship of Indigenous feminists, such as Kuokkanen (2014) and L. B. Simpson (2011, 2017).

Recent activist, institutional and community work Indigenous women have engaged across North America also demonstrates this integral relationship. In the Canadian court system, Aboriginal Legal Services of Toronto’s successful section 15 Charter challenge on Lynn Gehl’s

behalf, supported by the intervener Women’s Legal Education and Action Fund (LEAF), protested the continuing sex discrimination of the *Indian Act* as implemented by Indigenous and Northern Affairs Canada’s (INAC) Proof of Paternity Policy (Gehl, 2013). This is both a legal issue and a reproductive justice concern. When determining whether or not children have First Nations status, INAC has long used a Proof of Paternity Policy, which assumes a children’s father is non-status if he is not listed on the birth certificate. While a First Nations woman may not list her child’s father on the birth certificate for a number of reasons (for instance, to ensure the safety of her child from a violent ex-partner), her child may be denied land rights and community membership as a result (Gehl, 2006; Mann, 2009). The Court of Appeal for Ontario’s decision in *Gehl v. Canada* [2017 ONCA 319] determined that Gehl is entitled to status under the *Indian Act*. However, the court did not strike down the status provisions of the *Indian Act* or declare that the Proof of Paternity Policy violates section 15 of *Canadian Charter of Rights and Freedoms*.<sup>15</sup> Therefore, the Government of Canada can continue to use this Proof of Paternity Policy. Some First Nations mothers, in protecting their rights and their child(ren)’s rights to live violence free lives, may be put in a position that compromises their child(ren)’s right to community membership.

In reproductive and sexual health policy, Jessica Yee (now Danforth), founder of NYSHN led the Society of Gynecologists Joint Policy Statement “Sexual and Reproductive Health, Rights, and Realities and Access to Services for First Nations, Inuit, and Métis in Canada.” This policy statement recommends several actions that, if taken, would foster respect for Indigenous people’s individual reproductive and sexual rights, as well as the rights of communities and Nations. These actions would also promote more culturally safe and relevant reproductive and sexual health care. Similarly, NYSHN collaborated with the National

Aboriginal Council of Midwives to create an interactive, online Aboriginal Midwifery Toolkit that shares information and tools with communities who are “looking to bring birth and midwifery closer to home” (NYSHN & The National Aboriginal Council of Midwives, 2014, May 28, p. 1). This toolkit fosters Indigenous women, family and community wellness and respects individual and community self-determination.

This review of the field suggests that reproductive justice as a framework has potential to a) meaningfully account for the systematic reproductive violence to which Indigenous women continue to be subjected, and b) foster Indigenous women’s reproductive just futures. Indigenous women have been subject to reproductive coercion in various forms over time, including coercive sterilization, state apprehension of Indigenous children and forced evacuation from rural and remote communities to give birth in urban hospitals. To date, much of the Indigenous reproductive justice theorizing, research and activism is concentrated in Ontario, Alberta, and the United States, along with some national and international projects (see, for instance, Flicker et. al., 2014; Gurr, 2015; Mochalin, Lesperance, Flicker, Logie & NYSHN; NYSHN, n.d.; Silliman et. al, 2004). The research available does not highlight local definitions and articulations of reproductive justice. Regina, Saskatoon and Winnipeg are sites of intense colonial violence and surveillance (*In Re: Brian Lloyd Sinclair Inquest*, 2014, Dec. 12; Razack, 2002, 2015) as well as Indigenous community-building and resurgence (Kino-nda-niimi Collective, 2014). Therefore, this study’s exploration of 1) how urban Indigenous women defined reproductive justice in these three cities, and 2) analysis of what factors undermine and foster their reproductive sovereignty not only generated local knowledge that collaborators and I are mobilizing to foster change, it produced a complex analysis of reproductive justice that will contribute to theory and practice across disciplines.

## 2.6 Summary

This chapter began with a discussion of diverse views of traditional Indigenous gender-relations, mothering and reproduction. I explored how colonial heteropatriarchal policies and practices have rendered invisible Indigenous histories of gender-diverse people, undermined Indigenous gender relations as well as family and community relations. I also discussed some recent work by Indigenous people to reclaim and re-envision traditional relations and practices. This chapter then shifted to focus specifically on reproductive choice and reproductive justice frameworks and movements. I grounded this discussion in the limitations of reproductive choice movements and then explored how reproductive justice work is theorized and practiced. Informed by the potential of reproductive justice as a framework to analyze reproductive violence and foster reproductive justice among Indigenous women, and the community building and resurgence work taking place in Winnipeg, Saskatoon and Regina, I collaborated with Indigenous women and allies/accomplices in these urban centres to build a complex understanding of how they understand and activate reproductive justice. Next, I describe the methodologies and methods I utilized to do so.

### **Chapter 3: Research Approach and Methodology**

In this chapter, I outline my approach to this project. I first describe the project's research objectives. Then, I provide an overview of the three-phase process and approach. Next, I articulate the collaborative action-oriented approach that I took informed by Kovach's (2009) Indigenous Storytelling Approach, Lather's (2007) post-critical ethnographic approach, Hankivsky's (2012) Intersectionality-Based Policy Analysis Framework (IBPA) and Clark's (2012) Indigenous Intersectional-Based Policy Analysis Framework (IIPA). Finally, I describe this project's methods and research design. The collaborative intention and emphasis on generating knowledge relevant to local contexts means that the process changed throughout in response to emerging conditions and priorities. For instance, the research objectives were revised during a Phase One meeting with collaborators. Throughout this chapter, I share examples of how my methodological decisions were informed by poststructuralist, decolonial and Indigenous philosophers and theorists, particularly feminist theorists. These theorists have long been in conversation with each other, problematizing dominant EuroWestern notions of objective knowledge and Truth, as well as producing complex, localized, historically-situated knowledges and truths. I conclude by sharing my reflections about the project's process, how relationality flowed through this project and study 'impacts.' As discussed in the introduction, my understanding of relationality is informed by critical feminist and Indigenous scholars (Absolon & Willett, 2005; Doane & Varcoe, 2015; McLeod & Sherwin, 2000; Sherwin & Stockdale, 2017; S. Wilson, 2008). In particular, I understand humans as developing and existing within a web of relations. These relations include kin, animal, land and spiritual relations, are structured by political and social understandings and integrate what EuroWestern ideology has separated into the natural and social worlds.

### **3.1 Research Objectives**

*Objectives:* The purpose of this project was to explore: How do Indigenous women living in three prairie cities (Winnipeg, Saskatoon and Regina) define and understand reproductive justice and reproductive sovereignty? 2) How do urban Indigenous women claim and exercise their rights to reproductive justice? 3) What changes to social and health services will respect and support urban Indigenous women's rights to reproductive justice? 4) What political, economic and community changes will respect and support urban Indigenous women's rights to reproductive justice?

### **3.2 Introducing Project Processes and Collaborators**

This project took place in three phases, all driven by relational sampling, in that: a) people with an interest in, and experience with, Indigenous women's reproductive and sexual (in)justice(s) have become involved this research project in various ways at different times; and b) my relational networks also shaped who became involved in this project. When describing Phase One and Two collaborators, I treat professional, community and personal experiences as discrete even though this does not align with my conceptualization of relationality. During study recruitment, we utilized those terms in order to involve women with diverse experiential knowledge. Phase One focused on building a foundational understanding of how Indigenous women living in these study sites understand and relate to reproductive justice, as well as some of the factors that constrain and foster Indigenous women's reproductive justice. During Phase One, the project privileged<sup>16</sup> professional and community experience related to Indigenous women's reproductive (in)justices, and involved interviews and collaborative meetings with 12 Indigenous women and allies/accomplices with related experiences, knowledge and interests. I also analyzed policy documents that we determined were the most relevant to Indigenous

women's reproductive justice. After we met for our interviews, I completed an initial analysis, we came together for another meeting where I shared the analysis, and they provided me with feedback and further analytic insights. Then, at our next collaborator meeting, I presented Phase One collaborators with a draft of my Phase Two plan and they provided me with feedback on how to strengthen it. We also discussed possible knowledge sharing activities. After our Phase One collaborator meetings, we shared Phase One study findings in various settings with the intention of prompting action and change (Phase Three).

Phase Two focused on building further understanding of how Indigenous women living in these study sites from diverse Nations with varied life experiences understand and relate to reproductive and sexual justice as well as what conditions constrain and foster their reproductive and sexual justice. Phase Two privileged Indigenous women's personal experience related to reproductive and sexual (in)justice(s) and involved a) study conversations (research circles, interviews and meetings) with 20 Indigenous women with related experiences, knowledge and interests, b) continued conversations (meetings) with Phase One collaborators who wanted to continue to be involved in the project, c) an environmental scan of related services in all three cities, d) an analysis of policy documents and secondary sources focused on relevant policies and policy questions; as well as e) interviews with people who negotiate policy contexts in order to understand how these policy documents play out materially along with the relevant norms and 'unwritten rules' that structure practice (Colebatch, Hoppe, & Noordegraaf, 2010). After we had met for initial study conversations and I had completed my initial data analysis, collaborators and I came together for two collaborator meetings where I shared my initial analysis and they provided feedback and further analytical insight. We also identified potential knowledge sharing activities based on this study's findings, and what activities we should focus on first. Phase

Three is ongoing and involves mobilizing knowledge produced through this study in order to prompt action and change to foster Indigenous women's reproductive and sexual justice. Phase Three knowledge sharing activities that have been completed to date include: Phase One community forums, a policy briefing note and academic conferences. Future Phase Three activities include: Phase Two community forums, fact sheets, YouTube video, popular media article/blog as well as academic conferences and articles.

Below, I introduce the Indigenous women, two-spirit people and accomplices/allies who collaborated with me on this study in order to acknowledge collaborators' contributions and situate the knowledge shared within the dissertation and other study products. Many collaborators asked to be identified using their name, while others chose to be identified with a pseudonym. One collaborator asked not to have their bio shared. In our conversations, many collaborators located themselves in relation to their Nations and communities as well as the territories they grew up on and live on now; 29 of the 32 collaborators identified as Indigenous. Some collaborators focused our conversations on the interview questions and chose not to share much about their personal and professional background. These introductions reflect what was shared with me. Collaborators have had a chance to review these introductions and provide me with feedback or revisions, except for three collaborators who I have been unable to contact at the email address and/or phone number they provided. Collaborators are introduced by Phase and in alphabetical order.

### **3.2.1 Phase One Collaborators**

**Chris** is a daughter of a Mexican immigrant mother who was raised in residential school in Mexico. Chris grew up in Regina. Chris was a young mother. She was a sexual health educator for ten years and has also worked as an educator at an alternative school and a doula. She is

pursuing a Master's Degree in Educational Psychology at the University of Regina and she completed a Bachelor's Degree in Indigenous Education at First Nations University of Canada.

**Christine Smith** is an immigrant from Britain who works as an Executive Director of Planned Parenthood Regina and previously worked as the Executive Director at AIDS Program South Saskatchewan. Christine has a background in nursing and harm reduction.

**Denise McGillivary** is Cree from northern Manitoba and lives in Winnipeg. Denise is a single mother to three children and an outreach worker with Manito Ikwe Kajiikwe/Mothering Project.

**Jannica Hoskins** is a Métis two-spirit woman who grew up in Vancouver and has Indigenous and newcomer roots. Jannica moved to Saskatoon a few years ago and lives here with her young daughter. She is a single mother, an independent filmmaker, educator and a former foster mother. She sits on various non-profit Boards of Directors and is a Patient and Family Advisor for Maternal Services in the Saskatoon Health Region.

**Jaqueline Anaquod** is a Nêhiyaw woman from Plains Cree and Treaty Four territory. Jaqueline is pursuing her Master of Arts in the Social Dimensions of Health Program and an Indigenous Nationhood certificate in the Indigenous Governance Program at the University of Victoria and lives in Regina, SK with her daughter, her daughter's partner and her granddaughter. Jaqueline has also worked at non-profit and grassroots organizations with Indigenous women and families.

**Jillian Arkles Schwandt** is a white-settler who grew up in Treaty Four territory and completed a Master of Arts degree at the University of Toronto in Women's and Gender Studies. Jillian is the former Executive Director of Saskatoon Sexual Health and currently lives in Vancouver where she is the Public Health Manager for STI/HIV Services at the BC Centre for Disease Control.

**Laverne Gervais** is an Anishinaabe (Dakota/French colonial settler) woman and grew up in Winnipeg and Montreal. Laverne completed a Master of Arts in First Nations Studies at the

University of Northern British Columbia. Laverne now lives and works in Winnipeg. She has worked in various roles related to sexual exploitation of youth, sexual health education and reproductive justice.

**Leona Quewezance** is Saulteaux from Keeseekoose First Nation. Leona lives in Regina and she is a single mother to four children. She is the Program Director with All Nations Hope Network and works in education related to Indigenous people and HIV/AIDS.

**Melissa Brown** is Anishinaabe and Diné from the Sagkeeng First Nation and the Navajo Nation. She lives in Winnipeg with her partner and two daughters. Melissa completed her Bachelor of Science in Midwifery at the University College of the North and she is a midwife and Co-Chair of the National Aboriginal Council of Midwives. Melissa is a co-founder of the Manitoba Indigenous Doula Initiative, which provides Indigenous women and families with doula support grounded in Indigenous teachings and cultural practices.

**Sharon Acoose** is a Saulteaux woman and a member of Sakimay First Nation. Sharon lives on Whitecap Dakota First Nation with her grandchildren and she is a Professor of Indigenous Social Work at First Nations University of Canada (Saskatoon Campus). Sharon engages Nêhiyaw and Saulteaux cultural practices within her teaching and research. She has worked with women and girls involved in sex work and other violent situations related to poverty and housing insecurity.

**Tanya** is Métis and grew up in rural Manitoba. She lives and works in Winnipeg. She has a Bachelor of Arts in International Development and Women's and Gender Studies from the University of Winnipeg. Her community-based work with youth has focused on sexual health, mental health as well as anti-oppressive approaches and social justice.

**Tori-Lynn Wanotch** is a Mohawk and German woman. Tori-Lynn lives in Saskatoon and is a foster mother to Nêhiyaw children. She engages Mohawk, Nêhiyaw and Christian cultural

practices and teachings in her work and life. Tori-Lynn is the Executive Director of the Core Neighbourhood Co-op, as well as a fashion designer with Her4Directions. She designs First Nations intimate apparel with the aim of disrupting the colonial narratives that shame Indigenous women for their sexuality.

### **3.2.2 Phase Two Collaborators**

**Autumn Sanderson-Taniskishayinew** is a Treaty Four woman living with HIV. Autumn lives in Regina with her two children and partner.

**Cassandra J. Opikokew Wajuntah** is a Cree woman from Canoe Lake Cree First Nation. She lives in Regina, Saskatchewan with her husband, two boys and five dogs. She is the Associate Director of the Indigenous Peoples Health Research Centre and a PhD candidate at the Johnson-Shoyama Graduate School of Public Policy studying Indigenous health and education policy. She sits on Planned Parenthood Regina's Board of Directors as well as other non-profit boards.

**Chasity Delorme** is a Nêhiyaw woman from Cowessess First Nation. Chasity was a young mother and lives in Regina with her two teenage daughters and an adopted son. Chasity completed a Bachelor of Health Studies with a focus on Indigenous Health and now works as a First Nations, Métis and Inuit student advisor with the Regina School Board. She has engaged various paid and volunteer community roles, from teaching First Nations traditional and jingle dancing to working as a family support worker.

**Danielle** is a Cree woman who grew up in Calgary and spent some of her teenage years living on her First Nation. She now lives in Saskatoon with her partner and two children. Danielle is pursuing her Bachelor of Science in Nursing.

**Jasmond Murdock** is a Cree woman. Jasmond is a member of Fisher River Cree Nation

and lives in Winnipeg with her son. She is a single mother. Jasmond studied Urban and Inner City Studies at the University of Winnipeg and has worked in employment and training as well as Indigenous child welfare.

**Jennifer Brockman** is a two-spirit Nêhiyaw who lives in Prince Albert, Saskatchewan with their father and adopted daughter. Jennifer worked in community-based organizations and now works in Indigenization at a post-secondary institution. They also do much unpaid work to support and build Indigenous and two-spirit community in Prince Albert and Saskatchewan.

**Jenny** is an Indigenous woman who lives in Winnipeg with her partner.

**Jenelle McArthur** is an Assiniboine woman and a member of Ocean Man First Nation. Jenelle lives in Regina with her children and dog. Jenelle was a young mother and is a single mother to two boys and two girls. She recently completed her Bachelor of Indigenous Social Work at First Nations University of Canada. She has worked at various community-based organizations in different roles, such as sexual health educator and parent aide.

**Julianne Herney** is a two-spirit Mi'kmaq, Nêhiyaw, Métis and Anishinaabe woman. Julianne is a single mother. She is also a multi-disciplinary artist who studied at First Nations University of Canada. Her art explores societal issues and envisions Indigenous futurities.

**Katryna Smith** is a Nêhiyaw woman and a member of Onion Lake Cree Nation where she grew up. She engages Nêhiyaw cultural teachings and practices in various ways in her life. Katryna has a Bachelor of Arts in Indigenous Studies and a Diploma in Theology, along with a Bachelor of Arts in Women's and Gender Studies. She has worked as a Continuing Care Aid, a research assistant and in various roles with youth. She is finishing her Honours Certificate in Indigenous Studies at First Nations University of Canada.

**Mary Shorting** lives in Saskatoon with her children and grandchildren. She is the primary caregiver (and foster parent) to three of her grandchildren. Mary works at a community library and engages Indigenous and Christian teachings and practices.

**Michelle** is a Inineu woman who is a member of a First Nation in northern Manitoba. She now lives in Saskatoon. She has her Business Administration Diploma and is a mother of three children.

**Mo Mike** is a two-spirit Nêhiyaw who lived in Saskatoon during study conversations and moved to Minnesota shortly afterwards. They have worked in community-based harm-reduction and two-spirit support services as well as studied Nursing.

**Matilda Young** is an Indigenous woman who lives in Regina.

**Morningsong Butterfly Woman-Jaynelle Kennedy** is an Oji-Cree and Dene woman from Sandy Lake First Nation who lives in Winnipeg with her sons. She is also a grandmother. She has attended university and is a beadwork artist. She advocates for families dealing with the child welfare system.

**Paulete Poitras** is a Dakota-Sioux and Nêhiyaw two-spirit female who grew up on Muscowpetung First Nation. Paulete lives in Regina where she is studying Human Justice at First Nations University of Canada. She has worked with youth who have been involved in the justice system and in community-based research with Indigenous women and two-spirit people as well as other community members.

**Rebecca Murdock** is a Cree woman. Rebecca is a member of Fisher River Cree Nation and lives in Winnipeg. Rebecca has been involved various Indigenous women's groups.

**Shannon Swiftwolfe** is an Indigenous mother and grandmother who engages Christian practices and teachings. Shannon lives in Saskatoon, where she is pursuing her Bachelor of Indigenous

Social Work at First Nations University of Canada. She also has worked in Early Childhood Education in Saskatoon and on First Nations.

**Tatanka Ska Win-Nadine M.** is a Dakota-Sioux woman who grew up in Regina and now lives in Winnipeg with her sons. She is an advocate for families involved in the child welfare system. She is working to reclaim Dakota-Sioux teachings and practices and to share these teachings with other Indigenous people.

This project was shaped by the stories, ideas and insights of a diverse group of Indigenous women and non-Indigenous accomplices and allies. There was a strong presence of Cree women within the study, which is unsurprising. In 2016, among people who reported Indigenous ancestry in Saskatchewan, most identified they they have Cree ancestors (Stastics Canada, n.d.b). Other collaborators identified with various Nations including Mohawk, Anishinaabe (Oji-Cree, Saulteaux, Ojibway), Assiniboine, Dakota-Sioux, Dene, Diné, Mi'kmaq and Métis. At times in our study conversations, collaborators spoke to specific Nations' and communities' cultural practices and the diversity of practices among Nations. Many times collaborators also spoke broadly about Indigenous cultural practices and teachings. Collaborators brought a diversity of educational, professional and lived/living experiences to study conversations. Many of the collaborators are mothers and parents and many have lived/living experiences with the child welfare system, experiences which shaped study conversations and were considered within my analysis.

### **3.3 Decolonizing Interventions**

As discussed earlier, the aim of this project was to: a) honour Indigenous women's community work, b) contribute to this ongoing work, and c) mobilize the knowledge gathered and generated in order to foster Indigenous women's reproductive sovereignty. As I designed

and facilitated this project, I was acutely aware that my ability to realize this aim was constrained by university standards and processes, which are grounded in colonial relations and ideologies (L. T. Smith, 2012) and my own positionality as a white-settler, queer, feminist, accomplice researcher. I engaged in various decolonizing interventions within this project in order to disrupt these processes and material relations as well as to foster decolonial moments. Tuck and Yang (2012) cogently argue that decolonization “specifically requires the repatriation of Indigenous land and life” (p. 21). It is crucial for Indigenous people and accomplices to engage decolonizing actions and processes embedded with this intention through their research and life. In “Everyday Decolonization: Living a Decolonizing Queer Politics,” Hunt and Holmes (2015) explore everyday decolonizing and queering processes they engage within the “intimate spaces of daily life,” which are interrelated with their actions for social change within “more ‘public’ spaces” (p. 156). Similarly, in *Dancing on Our Turtle’s Back*, Simpson explores biskaabiiyang, a Nishnaabemowin word that refers to the process of deconstructing colonialism within individuals and communities. Biskaabiiyang is not solely tied to research itself; rather, it is an ongoing process that one engages in throughout one’s life and research.

Working within the constraints of university standards and processes, I engaged various efforts to 1) foster decolonial moments among collaborators, Kookums and other community members as well as 2) disrupt the colonial relations of academic research. I engaged Indigenous methods, processes, protocols and principles throughout this project with Kookum Betty’s guidance and in dialogue with collaborators. I worked to disrupt the politics of academic knowledge production and benefits through co-authoring academic and community products with collaborators, Kookum Betty, another community member as well as academic colleagues, and recognizing Kookum Betty, collaborators and other community members with cash

honoraria for their contributions to the project. These decolonizing interventions into project processes are interrelated with this project's knowledge mobilization efforts (that aim to reduce the harm of colonial ideologies, norms and practices) and actions I engage in solidarity with Indigenous people beyond this research context.

### **3.4 Collaborative Action-Oriented Research Methodology**

This project's aim along with my intention to disrupt colonial relations and foster decolonial moments guided my decision that a collaborative action-oriented research methodology informed by Indigenous storytelling (Kovach, 2009; S. Wilson, 2008), post-critical ethnography (Lather, 2007) along with poststructuralist (Ahmed, 2012; Deleuze & Guattari, 1987; Weedon, 2004), decolonial and Indigenous theories (Hunt & Holmes, 2015; Tuck & Yang, 2012; L. T. Smith, 2012; A. Simpson, 2007, 2014; L. B. Simpson, 2011, 2014) was the most suitable methodological and theoretical framework. Collaborative, action-oriented approaches problematize the Enlightenment notion of objective knowledge (embedded within positivist research), which posits a Truth that is observable by the researcher (knower) and treats knowledge as extractable from politics. Instead, participatory and action-based research methodologies are based on understanding knowledge to be socially constructed and emphasize the need to engage in participatory and collaborative processes that gather and produce local knowledges about social inequities and take action "addressing immediate social issues or problems" (Lykes & Hershberg, 2011, p. 333). Action-based methodologies often include multiple collaborative processes of planning, acting and reflecting with the goal of prompting social change (Kemmis & McTaggart, 2005; Lykes & Hershberg, 2011). Reid, Tom and Frisby (2006) argue for a broader understanding of action among action-oriented researchers, arguing that action-oriented processes foster change within and among individuals as well as collectively.

Following from Reid et. al.'s (2006) argument for broader understanding of 'action,' this project diverged from predominant action-based processes, focusing on collaboratively gathering and generating knowledge about Indigenous women's reproductive justice and on mobilizing this knowledge in order to prompt individual and collective actions.

Participatory and action research have multiple origin stories, and many, particularly those researchers working in Latin America, Africa and Asia situate Freire's (1970) work about conscientização or critical consciousness as the origin (Lykes & Hershberg, 2011). Indigenous researchers have identified that Indigenous methods of gathering, analyzing and sharing knowledge both predates the origins of, and resonates with, participatory research approaches (Absolon, 2011; L. T. Smith, 2012; S. Wilson, 2008). Not only do participatory approaches share similarities with Indigenous approaches to knowledge-generation, participatory and community-based approaches are now accepted as 'best practices' when working with Indigenous communities (Canadian Institutes of Health Research, National Sciences and Engineering Research Council, & Social Sciences and Humanities Research Council of Canada, 2010). Indigenous and accomplice/ally researchers such as Baydala, Placsko, Hampton, Bourassa and McKay-McNabb (2006); Dell, Fillmore and Kilty (2014); and Walters et al. (2009) have adapted or revised community-based approaches through Indigenous frameworks. For instance, Walters et. al. articulated eight principles for decolonizing and Indigenizing community-based research: reflection, respect, relevance, resilience, reciprocity, responsibility, retraditionalization and revolution. Drawing on these researchers and others, we developed and defined ethical principles in relation to this project's aims and intentions: collaboration, inclusion, respect, relevance, reciprocity, responsibility and reflexivity.

Simultaneously, many researchers employing critical methodologies including participatory, collaborative and action-oriented research approaches still take for granted the “Enlightenment equation of knowing, naming, and emancipation” (Lather, 2007, p. 6). Drawing on Lather’s post-critical ethnography as well as poststructuralist, decolonial and Indigenous theorists facilitated my problematization of the assumptions many collaborative and action-oriented researchers continue to hold. These assumptions reproduce the researcher as the ‘knower’ even as they are trying to deconstruct knower/known binary produced through academic research, through the assumption that the researcher is the necessary facilitator for truly critical, consciousness-raising work. Four assumptions were particularly relevant: a) community members are clouded by false consciousness prior to the researchers’ ‘arrival,’ b) binaries such as insiders/outside, researchers/community members adequately capture peoples’ roles and relationships, c) reaching consensus among co-researchers about the project’s interpretation of the research results, and therefore the nature of the real material inequities and actions to address them is ideal, and d) actions are only those collectively-taken, systematic interventions that promote social change. Problematizing these assumptions in the context of this project has meant many things, including: a) understanding this project as one of many strands of a conversation about reproductive and sexual justice that Indigenous women and their allies/accomplices are already having, b) understanding collaborators’ knowledge and research roles to be varied and dependent on their training, experiences and interests, c) meaningfully involving a diversity of Indigenous women and representing multiplicity and diversity in opinion, analysis and interpretation of events and narratives, d) conceptualizing actions as multiple and varied, occurring within and among individuals as well as institutions and broader

society, and e) considering how our actions could contribute to reinforcing or producing exclusionary effects before (and even as) we take them.

### **3.5 Indigenous Storytelling and Post-Critical Ethnographic Approaches**

This project centers Indigenous women's theorizing and narratives. During study conversations (research circles, interviews and collaborator meetings), we explored the concept of reproductive justice and sovereignty, how Indigenous women relate to or define this concept, as well as related frameworks and concerns with which Indigenous women identify and work with. I resisted the academic tradition Cruz criticizes below:

Graciela Ramírez is a Mexican woman, a light-skinned woman, a wife, a mother of three, an undocumented worker in the United States with a sixth grade education. We met as we were both trying to do something about the worse than mediocre education her children and other Latin American kids were experiencing in an allegedly multicultural school district. From her I learned stuff that is not in the literature review I was expected to write. And yet I didn't feel free to simply cite her. She was to be talked about, not talked from. She was data (Cruz, 2008, p. 651).

Indeed, I viewed our conversations as collaborative sharing and theorizing rather than the production of research data from which I later produced theory. Simultaneously, I acknowledge our time in this co-theorizing space was limited and so this dissertation presents my analysis and interpretation of study conversations, informed by collaborators' analytical insights shared in interviews, meetings, phone calls and emails. Theorizing often comes through storytelling and collaborators shared many stories: stories filled with humour, violence, trauma, love, sadness, joy and strength, stories that filled up the room and left their imprint on the listeners. Storytelling is an accepted method of sharing knowledge and teachings in Indigenous communities, and one

of the Indigenous methodologies that has been most referenced and theorized about in academic literature (Archibald, 2008; Episkenew, 2009; Kovach, 2009). Indigenous methodologies are complex, wholistic approaches that consider both inward and outward knowing, the importance of relationships, language, place and Indigenous/white-settler relations. As such, when understanding stories through an Indigenous framework, they must be related to their context (Kovach, 2009; S. Wilson, 2008).

Post-critical ethnographic approaches engage poststructuralist thinking in order to disrupt taken-for-granted critical ethnographic practices and norms while drawing on tools of ethnographic research. My methodological approach is inspired and draws on Lather's (2007) engagement with post-critical ethnography in *Getting Lost: Feminist Efforts Toward a Double(d) Science*. Within this project, I activated post-critical ethnography by: a) questioning and disrupting Enlightenment norms embedded within critical ethnography (discussed above); b) treating knowledge generated within this project as produced through, and in, relation with collaborators and other participants, and therefore, engaging a process of relational sampling rather than standard ethnographic approaches to sampling (Schensul & LeCompte, 2013); c) drawing on ethnographic tools, including: open-ended exploratory interviews, semi-structured interviews, fieldnotes and (adapted) thematic analysis; d) recognizing that possible interpretations of study conversations are multiple, and informed by this recognition, engaging Lather's (2007) concept of rhizomatic validity (Lather, 2007); and e) presenting my analysis, along with collaborators' analytical insights, stories and other excerpts from study conversations in a coherent narrative organized by theme. Drawing on Weedon (2004), I made theoretical, methodological and representational decisions based on the potential explanatory potential of

particular theoretical and methodological tools, as well as the social and political implications of the knowledge generated and represented.

Informed by both Indigenous approaches to storytelling and Lather's post-critical ethnography (2007), I understand study conversations (research circles, interviews and meetings) and stories as co-constructed by participant/listener and storyteller, shaped not only by the research relationships, but the material and discursive contexts that precede and fold forward into particular interview contexts. In particular, the colonialism and racism that permeate Canadian society shaped these interview encounters and my identity as white-settler queer feminist informed what collaborators and participants said about 'race,' racism, Indigenous femininity and two-spirit identities, gender relations within Indigenous communities and reproductive (in)justices. My identity also informed *how* it was said. My efforts to deconstruct my colonial consciousness, to learn about colonial histories and present and the knowledge Indigenous women have shared with me also shaped how I *interpreted* what is said. For instance, in study conversations when collaborators discussed the silence surrounding sexual violence, I interpreted collaborators' analytical insights and stories as acts of resistance and within the context of the larger movement led by Indigenous women and two-spirit and trans\* people to name and fight back against violence. Simultaneously, working to decolonize my research processes and practices also shaped what Indigenous collaborators shared with me, particularly about racism, gender relations, cultural practices and community knowledge. Within Chapter Six, I share further reflections about how my positionality and decolonizing interventions shaped study conversations.

### **3.6 Indigenous Intersectionality Policy Analysis**

The focus of this policy analysis was how policies shape the material context of Indigenous women and their children's lives. Various scholars had demonstrated that intersecting policies continue to undermine Indigenous women's rights to reproductive justice and sovereignty in Canada (see for instance: de Leeuw, Greenwood, & Cameron, 2010; Greenwood & de Leeuw, 2006; Hunting & Browne, 2012; Lawford & Giles, 2012, 2013; H. A. McKenzie et al., 2016; Native Women's Association of Canada, January 2007; Salmon, 2011; Tait, 2003, 2008). Therefore, it was necessary to engage a policy analysis within this project. I analyzed institutional, health region and provincial policies that I identified as most relevant using Hankivsky's (2012) IBPF and Clark's (2012) IIPF. The IBPF is grounded in eight principles: intersecting categories, multi-level analyses, power, reflexivity, time and space, diverse knowledges, social justice and equity. It offers a framework of questions to guide the analytic process, which I will discuss in 3.4.4 along with other practical aspects of this policy analysis. Engaging Clark's IIPF foregrounds the relationship between intersectionality and Indigenous thought as well as centers decolonization and Indigenous self-determination. Clark offered the following elements as integral to engaging IIPF, "(1) analysis of policy and policy intersections as colonial violence; (2) anti-colonial gender analysis; (3) contextualization of individuals within community and family history; (4) positioning of agency as central... alongside of (5) acknowledgment of resistance" (p. 14). I consider these elements throughout my policy analysis.

In order to build a complex understanding of the discursive-material effects of these policies, I followed from Salmon (2005) who emphasizes the importance of engaging "with actual people whose everyday lives and experiences are organized through and mediated by the texts under question" (p. 100). Research circles, interview and meetings with collaborators

informed the policy analysis in two ways. First, when I noted the mark of policy discourses on women's stories and opinions, I sought them out. Second, in research circles, interviews and meetings, we directly discussed what policies carry the most force on urban Indigenous women's reproductive and sexual lives. The policy analysis included a review of: policy documents, related secondary sources (print and broadcast media coverage, along with reports and resources from government and advocacy organizations) and interviews with people who had experience negotiating contexts shaped by these policies. The aim of the latter interviews was to understand how written policies play out in practice, as well as relevant 'unwritten rules' that bridge between policy and practice and otherwise structure practice.

### **3.7 Ethics**

As discussed above, the concept of *biskaabiiyang*, a Nishnaabemowin word, refers to the process of deconstructing colonialism within individuals and communities. An ongoing process that one engages in throughout one's life and research (L. B. Simpson, 2011). Similarly, ethics is not something one considers only in relation to research, but in relation to how one lives one's life. Our (research) work is a part of living an ethical life and an important aspect of my ethics is decolonizing relations and processes (Chilisa, 2012; Cruz, 2008; Hunt & Holmes, 2015; Kinonnda-niimi Collective, 2014; L. B. Simpson, 2006; L. T. Smith, 2012;).

Indeed, the guidelines that we now have for conducting research with humans (i.e. the *Tri-Council Policy Statement for Ethical Research Involving Humans 2<sup>nd</sup> Edition [TCPS 2]*) and Indigenous communities (e.g. Ownership Control Access Possession [OCAP] and Chapter 9 within *TCPS 2*) have emerged in response to exploitative and violent research practices. These practices were enabled and facilitated by Social Darwinist ideologies that constructed (and continue to construct) certain bodies and lives as disposable and universalized EuroWestern

conceptualizations of individuals and societies. Following OCAP, TCPS 2 and Indigenous communities' ethical guidelines is a movement towards conducting ethical research with Indigenous communities and can mitigate the risk of researchers repeating these mistakes. As a group, we (collaborators and I) determined how to express our ethical guidelines within this project. In doing so, we sought to activate these principles so that they guided both a) this project's overall approach, and b) how we responded to emerging conditions and situations. During Phase One, we identified specific Indigenous and social justice principles that are integral to this work, and I drafted a document articulating these principles within the context of this project. Then, at both Phase One and Phase Two collaborator meetings we reviewed, revised, and further defined these principles and definitions, which are described below.

- a) *Collaboration*: working together to ensure that the research itself (process) and the research products (articles, blog posts, public talks, etc.) contribute to conversations and work about Indigenous women's (including two-spirit, trans\* and lesbian, bisexual, queer and other gender- and sexually-diverse [LBQ+] women's) reproductive justice.
- b) *Inclusion*: working to meaningfully involve Indigenous women (including two-spirit, trans\* and LBQ+ women) with diverse opinions and life experiences and to create an open, non-judgmental, welcoming, comfortable, accessible space for collaborator meetings and events that takes into account how power and privilege shapes spaces and our relations (H. A. McKenzie et al., 2018).
- c) *Respect*: Respect for each other, our diverse perspectives and experiences and particularly Indigenous cultures, knowledges and approaches. Specifically, within this project the lead researcher [myself], Knowledge Keeper, supervisory committee and collaborators will discuss and determine a) whether general or particular information about community teachings and

practices should be shared in community and academic products and if so, b) how to situate this particular knowledge as community knowledge within these products.

- d) *Relevance*: The research process and the study products (articles, blog posts, editorials and public talks) must be relevant to Indigenous women (including transgender, two-spirit and LBQ+ women) dealing with reproductive injustices and working to create more just futures.
- e) *Reciprocity*: Sharing gifts, including our knowledge, among people involved in the project and valuing multiple approaches, opinions and knowledges, in particular, privileging Indigenous knowledge and perspectives within conversations and processes is critical because institutions and society continue to privilege Western and colonial modes of knowledge (Fornssler, McKenzie, Dell, Laliberte, & Hopkins, 2014; Hall, Dell, Fornssler, Hopkins, & Mushquash, 2015).
- f) *Responsibility*: Responsibility to everyone involved in the project, particularly to collaborators and all Indigenous women (including two-spirit, trans\* and LBQ+ women) within the Métis homelands and Treaty One (Winnipeg), Treaty Four (Regina) and Treaty Six (Saskatoon) territories. Practically, this means working so that a) the results shared reflect collaborators' diverse perspectives, and b) the actions taken that foster Indigenous women's reproductive justice.
- g) *Reflexivity*: Recognizing how our complex identities, life experiences, values and cultural beliefs shape our understandings of the world and other people and considering this when working together (Absolon & Willett, 2005; herising, 2005).

Relationality flows through these ethical principles. Relationality also shaped my process and methods and analysis.

### 3.8 Research Process and Methods

The collaborative project engaged multiple methods, with an emphasis on ethnographic and Indigenous approaches to storytelling and conversations (research circles, interviews and meetings) throughout Phases One and Two, with a focus on sharing knowledge to foster action in Phase Three, which are summarized in Table 1 below.

<b>Table 1</b>		
<i>Summary of Project Phases and Processes</i>		
Phase	Participants	Methods
Phase 1: March 2015- May 2016	<b>12 collaborators</b> with professional experience related to reproductive justice Winnipeg: 4 Regina: 4 Saskatoon: 4	<ul style="list-style-type: none"> <li>• Open-ended interviews</li> <li>• Policy analysis</li> <li>• Meetings with collaborators</li> </ul>
Phase 2: September 2016-June 2017	<b>5 collaborators</b> with personal experience related to reproductive justice Winnipeg: 2 Regina: 1 Saskatoon: 2	<ul style="list-style-type: none"> <li>• Research circles</li> </ul>
	<b>20 collaborators</b> with personal experience related to reproductive justice Winnipeg: 5 Regina: 7 Saskatoon: 8	<ul style="list-style-type: none"> <li>• Open-ended interviews</li> <li>• Policy analysis</li> <li>• Meetings with collaborators</li> </ul>
	<b>Other Interview participants</b> Policy Navigators: 5 Organization Representatives: 34	<ul style="list-style-type: none"> <li>• Semi-structured interviews</li> <li>• Environmental scan semi-structured interviews</li> </ul>
Phase 3: April 2016-ongoing	<b>32 collaborators</b> with professional and personal experiences related to reproductive justice Winnipeg: 9 Regina: 11 Saskatoon: 12	<ul style="list-style-type: none"> <li>• Study updates</li> <li>• Community forums</li> <li>• Individual and group meetings about knowledge sharing activities</li> </ul>

#### 3.8.1 Kookum Betty's Role as Guiding Knowledge Keeper

At the beginning of this project, I approached Kookum Betty with tobacco and cloth, shared the aims and intentions of this project and asked her if she would become the project's Guiding Knowledge Keeper.<sup>17</sup> Kookum Betty agreed to guide this project and throughout this

process she has held ceremonies at different stages of the research project, shared teachings with me and instructed me on how to approach this work. Kookum Betty put out offerings during the different seasons to keep the project on track and held a sweat lodge before I started the writing process. She also hung a cloth print in the trees on a medicine wheel for the women involved in the research. We met to discuss project processes and plans, my initial analysis and when I was unsure of a how to address or deal with a conflict or concern. Kookum Betty also opened our Phase One Community Forum as well as led a sharing circle and a research circle. During the community forum, sharing circle and research circle she shared her own analysis and insights related to reproductive and sexual justice. She also co-authored an academic presentation with collaborators and I and reviewed an earlier draft of this dissertation.

Throughout this project whenever we met, or she contributed to a gathering, or I asked her to review a document, I recognized her contribution by presenting her with tobacco and cloth as well as a cash honoraria. Kookum Betty's teachings, instructions and participation in project activities shaped relations among collaborators, other participants and myself. Her involvement infused these relations with respect for Indigenous knowledge, protocol and ethics. How Kookum Betty's role materialized within this project was shaped by our already existing relationship and experience collaborating, as well as the reality that we lived in two different cities during this study (Saskatoon and Regina). The roles of Guiding Knowledge Keepers or Guiding Elders depend on the people involved and the study context.

### **3.8.2 Phase One Conversations and Collaboration**

Phase One involved conversations and collaboration with 12 collaborators who had professional and community experience related to Indigenous women's reproductive (in)justice(s) and sovereignty in Regina, Saskatoon and Winnipeg. These collaborators have

experiences and knowledges related to: sexual and reproductive health services, HIV/AIDS education and support services, midwifery and doula care, education, social services and social work, collaborative/participatory research with Indigenous women, policy analysis, advocacy and activism. Building on my experiential knowledge and relations developed over five years of community-based research with Indigenous people on these territories and through consulting with researchers and Indigenous community members, I developed a list of possible collaborators based on what I knew of their knowledge and experience related to reproductive justice. I approached them individually by email, describing the project and asking them to contact me if they were interested in participating.

During interviews with Phase One collaborators, I also asked whether collaborators could recommend other Indigenous women and allies/accomplices we should involve. When I met with one collaborator in Saskatoon, Tori-Lynn Wanotch, we decided I should work with a fashion collective of which she is a member (Her4Directions) to facilitate a workshop and sharing circle about Indigenous women's reproductive justice. At that time, Her4Directions was hosting workshops to share information about various topics and connect Indigenous women to opportunities for community involvement and entrepreneurship. I worked with Her4Directions coordinator, Jannica Hoskins, Kookum Betty and two other community-based researchers to organize a specific research workshop and sharing circle. Kookum Betty facilitated the sharing circle with 13 women participants who had professional and community experience related to Indigenous women's reproductive (in)justice(s), including a counsellor (who was available to support other participants). A few of the sharing circle participants became involved in the project as collaborators or in other ways (for instance, connecting me to individuals and organizations who were doing work related to reproductive justice). Through this process, 13

Phase One collaborators (5 in Saskatoon, 4 in Regina and 4 in Winnipeg) initially became involved with the project. One Phase One collaborator later left the study and withdrew the information she shared during interviews and meetings.

### **3.8.3 Interviews/Conversations**

I completed audio-recorded interviews with these 12 collaborators. Before beginning the interview, we discussed the research process and the collaborator determined whether they consented to be interviewed (and become involved in the project) using both Indigenous and university cultural protocols. We first went through the UBC Behavioural Ethics consent form and collaborators consented to university protocols by providing their oral or written consent. Then, I presented research participants with tobacco and tea and asked them to become involved in the project. In Kovach's research, "several researchers of Cree ancestry referenced as protocol the use of tobacco as a gift that signifies respect and reciprocity" (2009, p. 127). Some Métis people prefer the gift of tea when they are asked to share their stories, knowledge or teachings (Bourassa, personal communication, Oct. 16, 2007). According to cultural protocols, when a participant accepts one or both of these gifts, they have agreed to share their knowledge and I have agreed to respect the knowledge they share with me during our study conversations.

Our conversations were guided by an open-ended interview guide (Schensul & LeCompte, 2013) (Appendix A). Open-ended exploratory interviews aim to explore important topics, areas and concepts and to identify other areas for investigation. Through these interviews, we explored:

- a) The collaborator's interest in and relationship to reproductive justice (i.e., what brings this person to the conversation about reproductive justice?);

- b) The relevance of reproductive justice frameworks as discussed above for Indigenous women's experiences and realities;
- c) How to define reproductive justice in order to reflect the experiences, interests and needs of Indigenous women; and
- d) The conditions that foster and constrain Indigenous women's access to reproductive justice.

The interviews were dialogical. When we sat down for our initial conversations, I explained the purpose of the research, my interest and pathway coming to this project and started with questions from the interview guide. In order to sustain and prompt further conversation, I also asked follow-up prompting questions and engaged in conversation about the ideas collaborators shared. At times, I asked collaborators for clarification and summarized what I thought were the main ideas or themes of our conversation in order to reduce the chances of misunderstanding and subsequent misrepresentation.

#### **3.8.4 Thematic Analysis and Rhizomatic Validity**

I initially analyzed conversations (interviews) using an adapted thematic analysis approach in order to further understand the ideas and theories collaborators shared and their relationship with each other. I share concerns of Indigenous researchers such as Kovach (2009) about the extractive nature of analysis and coding. Thus, I used both inductive and deductive techniques to relate the ideas and theories shared with each other, as well as the wider contexts of Regina, Saskatoon and Winnipeg. My approach was adapted from Braun and Clarke's work (2006), with one significant divergence. I do not consider the interview transcripts to be raw data, but an (incomplete) archive of time spent co-generating analytical insights with collaborators and participants.<sup>18</sup>

First, these interviews were transcribed verbatim by myself and a transcriptionist and I reviewed the transcripts and interview fieldnotes while listening to the interviews. I identified various ideas and concepts that were co-generated within the interviews in relation to the research questions and particular quotes that illustrated these ideas and concepts. Next, I related these various ideas and concepts to each other, producing a narrative about their relationship and a redeveloped plan for Phase Two and Three of the research process, including rearticulated study aims and research questions. I shared this narrative and Phase Two research plan with collaborators through follow-up phone and in-person meetings, and discussed this narrative and research plan with Kookum Betty as well as my supervisory committee and colleagues (while protecting collaborators' confidentiality). Chilisa (2012) emphasizes the importance of discussing with participants the ideas, concepts and theories emerging from qualitative interviews. This need is particularly pressing when conducting research with and about Indigenous women, due to the continuing harmful and misrepresentative research about Indigenous women (L. T. Smith, 2012; Tait, 2008, 2009).

Following from Lather's (2007) articulation of rhizomatic validity these discussions fostered complexity and multiple openings and generated local, context-specific theories and actions. Lather frames rhizomatics as "a journey among intersections, nodes, and regionalizations" (p. 124). Indeed, within my analysis, I explored how I could interpret collaborators' stories and quotes in various ways and discussed some of these interpretations with colleagues, collaborators, my supervisory committee and Kookum Betty. Further, disagreement about how to interpret data among collaborators/participants, and myself as the lead researcher, were recorded, discussed and included in the analysis where appropriate. I

worked to honour collaborators’ diversity, voice and knowledge as well as recognize how dominant and counter narratives shape all of our opinions and views.

### 3.8.5 Policy Analysis

Based on the interviews I conducted with collaborators and participants, I identified and analyzed relevant policy documents. My analysis drew on secondary sources from media outlets (*Saskatoon Star-Phoenix, Regina Leader Post, Winnipeg Free Press, CBC and APTN*), reports produced by the Saskatchewan and Manitoba Ministry of Social Services as well as the Saskatchewan and Manitoba’s Advocates for Children and Youth available through each respective organization’s website. I gathered print media articles and transcripts of *CBC – The National* through the *Canadian Newsstream* database and I gathered other broadcast video and audio pieces through *APTN’s* and *CBC’s* websites. Outlined in Table 2 below are the policy analysis questions I used based on an adaptation of Hankivsky’s (2012) IBPF. Principles of IBPF and IIPF guided my analysis through the descriptive and transformative questions below (Clark, 2012; Hankivsky, 2012).

<b>Table 2</b>
<i>Policy Analysis Questions</i>
Descriptive:
<ul style="list-style-type: none"> <li>• What is the policy ‘problem’ under consideration?</li> <li>• What are the current policy responses to the ‘problem’?               <ul style="list-style-type: none"> <li>○ How do these policy responses shape Indigenous women’s access to reproductive justice?</li> <li>○ How does this policy discursively-materially interact with other policies (federally, provincially and local community)?</li> </ul> </li> </ul>
Transformative:
<ul style="list-style-type: none"> <li>• What inequalities actually exist in relation to the problem?</li> <li>• Where and how can interventions be made to improve the problem?</li> <li>• What are some possible reasons these interventions have not yet been taken?</li> <li>• What are the feasible short, medium and long-term solutions?</li> <li>• How will proposed policy responses reduce inequities?</li> <li>• What are some possible regulating and exclusionary effects?</li> </ul>

### **3.8.6 Collaborative Processes**

I asked Phase One (and later, Phase Two) collaborators if they would like to a) receive updates about the study every few months by phone and/or email about the study's progress (e.g. interviews completed to date and emerging results) in order to facilitate further feedback and discussion about the study process, b) participate in in-person collaborator meetings after interviews were complete to provide feedback about my analysis, and planned knowledge sharing activities, c) work with other collaborators and me on particular community and academic products, and d) other possibilities. For instance, some collaborators preferred to meet more frequently with me individually, while other collaborators chose to receive updates and provide feedback by phone or email. Collaboration was most concentrated during Phases One and Two, but continues throughout Phase Three and is ongoing as of 2020. Collaborators held different roles in this study than environmental scan and policy navigator participants, as they had opportunities to a) provide feedback about my initial analysis and share their own interpretations; b) discuss how to approach Phase Two; c) discuss what knowledge sharing activities we should focus on; and d) contribute to knowledge sharing activities as co-authors and/or co-presenters.

### **3.8.7 Phase Two: Continuing Conversations Through Research Circles, Interviews and Meetings**

The approach in Phase Two was informed by a) the themes and absences in Phase One as well as literature about reproductive justice and Indigenous women's mothering and reproduction, and b) discussions with collaborators during interviews, group and individual meetings, as well as phone calls and emails. For instance, at a Phase One collaborator meeting, we discussed the importance of meaningfully involving a diversity of two-spirit, trans\* and

LBQ+ women within this study and our failure to do so in Phase One. In order to ensure that the information about this study was reaching a diversity of potential Indigenous women participants we engaged in relational sampling (involving collaborators who have a relationship to Phase One collaborators and/or study aims and have diverse lived experiences and identities) through four processes: a) I facilitated community forums where we shared our Phase One community reports and explained Phase Two of the study with attendees as well as had conversations with interested individuals after these community forums; b) Phase One collaborators shared information about the study (a poster about the study, a one-page summary of the Phase One community report and a letter of invitation; the latter of which included study contact information) with Indigenous women whom they thought might be interested; c) I approached representatives from community organizations who work with Indigenous women who are often marginalized in research related to reproductive justice as well as research related to Indigenous women, mothering and reproduction (for instance women living with HIV/AIDS)<sup>19</sup> and asked them to i) share these same study materials with Indigenous women they thought might be interested and/or ii) hang a study poster at their organization; I also asked representatives of these community organizations if they were interested in a presentation about the study; and d) I asked representatives of community organizations who attended presentations, participated in the environmental scan or expressed interest in the study if they would be willing to i) share these same study materials with Indigenous women they thought might be interested in the study and/or ii) put up a poster at their organization.

If potential collaborators determined they would like to participate in the study, they contacted me and we discussed the study further. During this initial meeting, I asked if they would like to participate in a research circle or interview, or both and made arrangements to meet

them at a community-based organization where local Kookums<sup>20</sup> led the research circles and I facilitated the interviews. In Winnipeg, a Kookum led the research circle at Ka Ni Kanichihk and I facilitated interviews at Nine Circles Community Health Centre, in Regina a Kookum led the research circle and I facilitated interviews at All Nations Hope and in Saskatoon a Kookum led the research circle and I facilitated interviews at Station 20 West.

### **3.8.8 Environmental Scan**

In order to develop a resource list for Phase Two collaborators/participants and to further understand these three urban contexts, I conducted an environmental scan of services and supports related to reproductive and sexual (in)justice(s). I reviewed organizational websites and facilitated individual email and phone semi-structured interviews (Appendix B) with 34 people who work with these organizations in Regina (10), Saskatoon (14) and Winnipeg (10).

### **3.8.9 Research Circles**

In each city, a local Kookum facilitated a research circle a few days after the local community forum. Before beginning the research circles, we went through the plan for the research process and collaborators determined whether they consented to participating in the research circle and becoming involved in the project following Indigenous and university consent procedures. There were five research circle collaborator participants: one in Regina, two in Saskatoon and two in Winnipeg. In addition to collaborators, a Knowledge Keeper, counsellor and myself participated in each research circle. The research circle focused on collaborators' interests related to reproductive justice, what they thought was working well and what they thought could change to support and respect Indigenous women's rights to reproductive justice (Appendix C). In order to mitigate the possible harm of talking about and listening to other collaborators talking about, reproductive violence, there were a number of practical supports,

including a) availability of a counsellor if participants became distressed during or after the circles, b) a resource list was offered so they could connect to supports if they became distressed after the circle, c) taxi transportation (and in Winnipeg a local Indigenous women's volunteer ride service, Ikwe Safe Rides for Everyone), which was covered by study funds as well as d) food and refreshments. All of the research circles were audio recorded, transcribed verbatim and analyzed using thematic analysis as discussed above. Participants' stories were also reviewed within their context and summarized into what Kovach referred to as "condensed stories" (2009, pp. 52, 130-131). Condensed stories retain stories' contexts, "staying as true to each story, to the voice, as possible" (Kovach, 2009, p. 52).

### **3.8.10 Collaborator Interviews**

I conducted open-ended, exploratory interviews with 20 Indigenous women living in Regina (7) Saskatoon (8) and Winnipeg (5) which were audio recorded. All of the research circle participants (5) also completed individual interviews. We followed Indigenous and university consent procedures. During these open-ended interviews (Appendix D), we explored:

- a) Collaborator's interest in and relationship to reproductive justice (i.e., what brought this person to the conversation about reproductive justice); and
- b) The conditions that foster and constrain Indigenous women's access to reproductive justice.

This open-ended approach facilitated participants' sharing their ideas and theorizing (and co-generating theories and ideas) about these questions, as well as generated a space for participants to share related stories. The interviews were dialogical.

### **3.8.11 Thematic Analysis, Rhizomatic Validity and Condensed Stories**

I analyzed these interviews using the adapted thematic analysis approach and rhizomatic validity process. I related stories women share in study conversations to ideas, concepts and theories shared and co-generated as well as summarized them into condensed stories. I asked collaborators to review any quotes and condensed stories I planned to share in publications and other materials and revised them based on their feedback.

### **3.8.12 Policy Analysis**

Based on the interviews with collaborators, I identified and analyzed relevant policy documents and secondary sources using the approach outlined above in Phase One. Over Phase One and Phase Two, my policy analysis focused on: *The Child and Family Services Act* (Saskatchewan and Manitoba) and policies related to abortion services and tubal ligations, including informed consent policies (Saskatoon Health Region, Regina-Qu'Appelle Health Region and Winnipeg Regional Health Authority). In order to further understand how these policies materially shape Indigenous women's access to reproductive justice, as well as related normative practices and unwritten rules that structure practice, I interviewed five people whose work involves navigating these policies. I interviewed three people working in various child welfare contexts and two people working in abortion services about the key policies and practices and what changes to these policies and practices would further respect and support Indigenous women's rights to reproductive and sexual justice (Appendix E).

### **3.8.13 Phase Three: Sharing Knowledge to Prompt Action**

Based on my analysis of research circles, interviews and policy documents, during collaborative meetings we determined how to share the study's results and recommendations in order to foster Indigenous women's reproductive self-determination. Ideas for knowledge

sharing were co-generated through initial analysis or conversations with colleagues and community members. Collaborators also suggested various knowledge mobilization activities during individual interviews, group meetings, phone calls and email conversations. Phase Three overlapped with Phase Two and will continue after this project is officially complete. Since discussions about knowledge mobilization took place primarily during collaborator meetings, I prioritized or ‘ranked’ possible knowledge sharing activities based on the number of collaborators who attended and expressed interest in them or thought they were a useful way to share knowledge and prompt action. As a result of this process, we identified and completed the following community knowledge mobilization efforts a) Phase One and Two community reports and four Phase One community forums and b) a policy briefing note addressing the coercive sterilization of Indigenous women at the Royal University Hospital in Saskatoon (Appendix F). Next, we will focus on the following knowledge sharing activities: a) Phase Two Community Forums; b) a short (approximately 5-10 minutes) YouTube video about the project from footage of our community forums; and c) fact sheets focused on reproductive and sexual rights, patients’ rights to free, full and informed consent and parents’ rights when negotiating the child welfare system in each province.

### **3.9 Reflections on the Research Process: Relationality and Study Impacts**

Many have emphasized the importance of relationships when conducting research with Indigenous people, particularly when considering the relational nature of Indigenous worldviews (Kovach, 2009; Wilson, 2008) and relationality was integral to this project process. Enduring colonial relations shaped our study contexts and collaborator and my relations in various ways. First, historical and ongoing exploitative practices by white-settler and non-Indigenous health researchers reinforces many Indigenous people’s understandable apprehension about all non-

Indigenous researchers working in Indigenous communities. Knowing that most Indigenous people have experienced or heard about these exploitative practices, I started every meeting by explaining who I am and what my intentions were with this project. People expressed concern about and hostility towards me and this project at various points, which must be understood within the context of these exploitative relations well as the strong presence of anti-choice ideologies in both two provinces (C. MacDonald, 2018; Saskatchewan Pro-Life Association, n.d.). However, at a few points, I did question whether leading this project was my role. Maybe there were just too many gaps in my knowledge since I am a white-settler with very different experiences of walking in these three cities than the Indigenous women who collaborated with me? Maybe my limited traditional knowledge would lead me to misinterpret what collaborators shared? Then, I thought about how our collaborative processes mitigate the potential harms of the limits of my knowledge. I thought about the project's Guiding Knowledge Keeper telling me "Yes, you are doing your doctorate, but don't disregard that there is going to be a woman going through something in 10 years and, because of the work you did, she is going to have some support or understanding." I remembered Cassandra telling me at a collaborator meeting that "I was their [the collaborators'] library." I continued.

There are many other ways relationality shaped this project. For instance, my already existing relationships with Indigenous women and accomplices/allies were important to this project in various ways. First, a number of the women involved either had relationships with me before the study began or with someone who I knew, which fostered the development and growth of these relationships. Many women involved in the study had relationships with each other, some are ex-partners, some are cousins, some are friends. These relationships have shifted, grown and changed over the course of this project and will continue to do so.

Often literature about community-based research homogenizes relationships as positive forces within research, however, pre-existing relations can come with tensions and challenges, and power relations operate within and through research relationships (H. A. McKenzie et al., 2018; Varcoe, 2006). For instance, during this project, a conflict related to, but not explicitly involving, the project developed between two of the collaborators. I offered to facilitate a discussion with the two collaborators about how to work together with/in this conflict or to facilitate an appointment with a mediator; however, one collaborator declined to participate in this meeting. A few months after this conflict began, this same collaborator chose to leave the project and withdraw the information she shared in her interview and group meetings she attended. We arranged to meet shortly afterwards and at this meeting I provided her with a copy of her interview and the study products with which she had been involved. I also asked if she would be willing to participate in a follow-up meeting to share her insights about the project process so I could strengthen my approach in this and future projects. She declined and stated that she had decided to leave the study because of her relationship breakdown with the collaborator, not because of my actions as the lead researcher. While this situation is not what I would deem a 'success,' it highlights the complexity of relationships within research (and other) contexts. This experience also pushed us as a group to determine the group guidelines for dealing with conflict and fostering collaboration with/in conflict. As well, we engaged in different strategies to foster working relationships among all the collaborators and myself.

The critical role of relationality in research with Indigenous people, and within this project, raises the question: how one is accountable to these relations (S. Wilson, 2008)? While Wilson is writing from his position as Néhinaw, how I considered and enacted relational accountability is shaped by my positionality and experiences as a white-settler who has been

involved in various community-based projects. I have reflected on the processes through which I have been, and will be, accountable. Some of my attempts earlier in the project involved me denying my other relations and priorities to answer collaborators' phone calls, meet them at a moment's notice and/or to support them in some other way. While initially these actions felt fitting because of the enduring colonial privileges I have inherited, they undermined my wellbeing and my relations, were unsustainable and had no effect on mitigating the structural violence to which collaborators were subjected. My inability to meet with collaborators at various points prompted self-doubt about whether I should be doing community-based research at all. Determining what accountability looks like is dependent on context and an ongoing process, embodied now through sending out updates to collaborators, having conversations about the study and prioritizing community over academic products whenever possible. Mainstream processes continue to emphasize responsibilities to institutions over community (Fornssler et al., 2014). Therefore, it is necessary for those of us doing community-engaged scholarship to privilege community interests and responsibilities to communities as much as possible over institutional responsibilities and to challenge the primacy of institutional responsibilities and 'markers of success.'

I also reflected on how study impacts and knowledge translation efforts are measured and documented (Fornssler et al., 2014). There is increasing academic discussion about methods of knowledge translation when facilitating community-based research with Indigenous people (Estey, Kmetc, & Reading, 2008; Fornssler et al., 2014; Smylie et al., 2004; Smylie, Olding, & Ziegler, 2014; Varcoe, Brown, Calam, Buchanan, & Newman, 2011), with many researchers engaging multi-faceted, complex approaches, such as integrated or embedded knowledge translation. These practices begin before the grant application is submitted and continues after

the project has come to an official 'close.' Partnerships and interdisciplinary relations are valued within these approaches and they are more congruent with Indigenous community-based approaches to knowledge generation than end-of-grant knowledge translation approaches (Estey et al., 2008). Indeed, Smylie et al. (2004) states, "Methods of Indigenous knowledge generation and application are participatory, communal and experiential, and reflective of local geography" (p. 141).

When facilitating community-engaged research, study teams have a responsibility to create and share community-relevant products (such as those produced during Phase Three), and increasingly researchers are using methods to 'measure' the impact of these products. There are some significant impacts of this project that are difficult to measure quantitatively and there are risks that trying to do so will flatten their complexity. However, qualitatively it is possible to capture them to an extent. For instance, a number of collaborators spoke with me about how the most meaningful aspect of the project was the opportunities to come together to discuss reproductive justice and injustices with other women. Phase One collaborator Jillian shared that collaborator meetings and events have been unique opportunities where diverse women came together to learn from each other and grow as community leaders. She said that she personally has been incredibly inspired and motivated by all the participants she has interacted with who have made her think critically about the work that she does and apply a new lens to her organization's programs and services. Although differing viewpoints and opinions were presented at meetings, Jillian said that the other collaborators have always been really open, honest and real about their ideas, perspectives and experiences.

Collaborators also spoke about the impact of the study conversations on their conversations with families and friends. For instance, Jaqueline said that she hadn't really

thought much about reproductive justice and reproductive sovereignty before she became involved in this project and through our interview and meetings, she began thinking more about it, and having conversations with her daughter about her rights. Jaqueline's reflections resonates with the words of a knowledge ambassador cited in Fornssler et al. (2014), who indicated that "community members may see the conversation itself as the 'product,' and thus emerges the question of how can one really measure the impact of a conversation?"

### **3.10 Summary**

This project's collaborative action-oriented project was informed by post-critical ethnography, Indigenous storytelling, as well as IBPF and IIPF approaches. This approach shifted during the project through collaborative processes, for instance, at the end of Phase One we revisited the study aims and redesigned Phase Two. I also reflected on relational tensions and challenges that emerged during the study. Grounded in collaborators' reflections about important relational impacts of participating in this project, I represented these impacts qualitatively as well as reflected on the difficulty of trying to measure them quantitatively.

## **Chapter 4: Indigenous Women's Definitions of Reproductive and Sexual Justice**

This chapter offers a conceptualization of Indigenous women's reproductive and sexual justice developed through the collaborative, action-oriented methodology described in Chapter Three. While focusing on Indigenous women's reproductive and sexual justice, which is grounded in Indigenous histories and cultures that center self-determination, the analysis contributes to broader conversations about sexual and reproductive justice. This chapter's findings draw on a) conversations with collaborators during research circles, interviews and meetings; b) interviews with participants who have experience working within health and social service organizations to understand how their work is shaped by policy; c) environmental scan interviews; and d) a review of regional policies regarding abortion procedures and provincial-level policies about child welfare.

I begin this chapter by tracing my process of sharing and gathering information with collaborators to co-generate a definition of reproductive justice that is relevant and meaningful to collaborators, then I share how this definition of reproductive and sexual justice was further expanded (section 4.1). Next, I focus on the crux of reproductive and sexual justice: self-determination; in particular, the relational and intergenerational aspects of self-determination (section 4.2). Then, I offer an analysis of the context in which Indigenous women determine their sexual and reproductive futures; particularly how colonial policies, institutional processes and sociocultural relations effectively undermine Indigenous women's self-determination (section 4.3). Following this analysis of colonial disruptions, I discuss collaborators' experiences with responsive and inclusive services and care providers (section 4.4) then address Indigenous

survivance: the cultivation of self-determining pathways through refusal, negotiation, resurgence and re-envisioning (section 4.5). Reproductive and sexual justice is an expression of self-determination for Indigenous women. In contrast to EuroWestern individualist views of autonomy, choice and freedom, collaborators identified that collective wellbeing fosters individual freedom.

#### **4.1 Reproductive and Sexual Justice: Frameworks Troubled and Expanded**

Conversations with study participants challenged certain assumptions embedded in scholarly and activist definitions of reproductive justice and conceptualized Indigenous women's self-determination as the crux of reproductive and sexual justice. I started our conversations about reproductive justice in research circles and individual interviews by sharing commonly accepted principles of reproductive justice from Ross (2006b), co-founder and former National Coordinator of Sistersong: Women of Color Reproductive Justice Collective. Since these common principles emerged within a community-engaged context, they provided a good basis for initiating the discussion within this project. I summarized that reproductive justice is often talked about as women being able to decide and control four distinct elements, including: 1) whether or not to have children, 2) whether or not to continue or end pregnancies, 3) how and where they give birth, and 4) the ability to raise the children they do have in safe and healthy ways, free from violence (Appendices A, C & D). Grounded in this initial definition, the study conversations then explored four specific areas of inquiry:

- a) The collaborator's interest in and relationship to reproductive justice (i.e., What brings this person to the conversation about reproductive justice?);
- b) The relevance of reproductive justice frameworks as discussed above for Indigenous women's experiences and realities;

c) How to define reproductive justice in order to reflect the experiences, interests and needs of Indigenous women; and

d) The conditions that foster and constrain Indigenous women's access to reproductive justice.

The resulting conversations challenged certain assumptions underlying scholarly and activist definitions of reproductive justice, institutions that deliver health and social services and policy mechanisms that govern these institutions and processes.

In study conversations, collaborators emphasized the interconnections between reproductive and sexual justice, highlighted self-determination as central to reproductive and sexual justice and interrogated specific assumptions embedded within reproductive justice work. Collaborators asserted that to discuss reproductive justice, but not sexual justice within this project would limit its scope and possible impact. Sexual justice within this context includes: a) freedom from sexual violence and coercion; b) freedom of gender and sexual identity and expression; and c) having the resources, information and supports to materially assert these rights. While Ross stated that sexual freedom and bodily autonomy are part of reproductive justice (2017), much of the reproductive justice literature does not foreground sexual freedom (see for instance Luna, 2011; Luna & Luker, 2013; Ross, 2006b; Shaw, 2013). The tenuous relationship between reproductive and sexual justice found in the literature reflects (and is likely inherited from) the separation of reproductive and sexual health within EuroWestern biomedical systems. This separation is informed by Christian ideologies that disconnect reproduction from sexuality for non-reproductive purposes and historically framed sex for non-reproductive purposes as sinful and deviant (Goodwin, 2011).

Many collaborators referred to an affinity between reproductive and sexual justice and Indigenous conceptualizations of health and wellness, noting the usefulness of reproductive and sexual justice for understanding and articulating the interconnections among different aspects of their lives. Jannica reflected that during her involvement in this project:

I started to really dwell on many personal stories that I have had exposure to through fostering, through advocating for different sorts of issues on sexual health or wellness or addictions and then thinking about how different they were from my own experience with domestic violence and having to very carefully seek support services in a way that wasn't going to threaten my situation any more. So, it was really compelling to think very cognizantly about how each of those topics are so closely related and the influence of our history on the way that we address wellness or health and our social issues versus crime issues...

In the quote above Jannica not only highlights the connections that reproductive justice fosters, she alludes to the harms of colonial ideologies and institutions that disconnect these issues and experiences. Collaborators' framing suggested that reproductive and sexual justice must include the right to determine five aspects;

- 1) Gender and sexual identity and experiences,
- 2) The terms of reproduction (including the right to prevent pregnancy or become pregnant and to terminate or continue pregnancies),
- 3) The selection of birthing conditions (including whether to have a midwife-attended or physician-attended birth or not),
- 4) The selection of where one lives with one's family (including geographic location and housing conditions), and

5) The engagement of relationships (including community, cultural practices and the land).

These aspects center Indigenous women's self-determination in their reproductive and sexual lives, because they encompass important relationships across various aspects of Indigenous women's lives. Put in another way, these qualities center Indigenous women and their relationships with kin, animals, communities, ancestors, cosmos and the land as the primary influences governing their experiences. Indigenous women exist within a web of relations; foregrounding connections among elements that are often seen as separate or distinct in a EuroWestern framework. For instance, within a EuroWestern framework, women's relationship to, and knowledge of, the land is viewed as separate from reproductive decision-making. However, collaborators shared that women's knowledge of the land and medicines can foster their reproductive options. For instance, Tanya stated, "There are some awesome grandmothers out there who have a lot of knowledge around traditional medicines and plants that can help you regulate your moon time or control pregnancy, that kind of stuff." Collaborators also discussed how determining one's birthing conditions is directly related to access to cultural teachings, ceremony and land. By attending to these connections, collaborators are defining the meaning and impact of their relationships. In this approach to understanding reproductive and sexual justice, women's decisions are honoured, respected and supported by those around them and their self-determination is fostered through connections that are intergenerational and relational. This conceptualization of self-determination resonates with Indigenous feminists' work, such as that of Kuokkanen (2014, 2019) and L. B. Simpson (2011, 2017).

Our study conversations centering Indigenous women's experiences further prompted questions about and problematized study language, particularly regarding the meaning and

usefulness of the word ‘justice’ and the phrase ‘safe and healthy’ environments. For instance, during discussions about how to approach Phase Two of this study Laverne posited,

Are we ready to talk justice when we’ve yet to have the injustices acknowledged...I know many people are JUST learning or opening up about forced sterilization, for example and we just started talking about racism in the healthcare system.

There are also growing public and academic dialogues about whether (and how) Canadian colonial processes should be understood as genocide (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019; Stote, 2015; Woolford, 2015; Woolford, Benvenuto & Hinton, 2014). These necessary conversations must continue. Framing this project and other conversations through ‘justice’ or other strength-based terminology may run a risk of rendering complex, structural violence invisible and simplifying, or otherwise undermining, ongoing conversations about reproductive coercion and other genocidal acts. This approach may unintentionally, but problematically, facilitate proximal responses to injustices that require complex, distal and structural change (Reading, 2015). For example, emphasizing the strengths of an organization (such as their harm-reduction approach) that also holds enduring colonial norms, values and practices, may contribute to organizational leadership underestimating the impact of these critical concerns. As a result, leadership may implement a proximal response, such as a half-day of cultural sensitivity training, rather than a complex intervention (such as working with a consultant transform their organization’s culture, norms, values, staff and board representation, as well as services) that would be more effective for enacting meaningful change.

This question of achieving or understanding ‘justice’ without first addressing historical and continuing injustices, exemplifies how definitions of reproductive and sexual justice are part of broader sociocultural relationships. These broader relationships are characterized by

reproductive and sexual violence against Indigenous women, two-spirit and trans\* people and is part of the colonial project of disrupting Indigenous sexual and family relations, and settler-colonial political relations. In other words, the question of justice for Indigenous women is necessarily situated within the colonial governance mechanisms that undermine the autonomy and wellbeing of Indigenous peoples. As Jannica succinctly stated, “When you think about reproductive justice, you have to draw that direct link to the government’s use of Indigenous people as a commodity to control the land.” Importantly, the strengths-based framing in this study did not shut down discussion or critical conversation about the notion of justice, but rather prompted discussions about encounters, practices and moments of (in)justice, indicating that strengths-based frameworks can also facilitate critical analyses of (in)justice(s).

Embedded within many published definitions of reproductive justice are notions of ‘safe and healthy’ environments. To challenge the idea that safe and healthy environments are universally understood, applied and available, this terminology required destabilization and re-articulation in this study. As Denise stated, ‘safe and healthy’ means different things to different people, as it is “shaped by your background and the environment that you are raised.” Prompted by this recognition, collaborators discussed the various factors that contribute to Indigenous women’s and families’ safety and health including: access to safe housing (where women, their partners and children can determine who has access to the home); access to safe and healthy food, culturally relevant and culturally safe supports, information and services (including a range of childcare options); and relationships with family, friends and other community members. Indigenous women’s and families’ safety and health are compromised by colonial disruptions to housing and land use; material wealth and resource-sharing practices; household, family and community relations and self-determination; and intergenerational networks of support and

knowledge sharing. Achieving a ‘safe and healthy’ environment relies on a social foundation that prioritizes Indigenous women’s self-determination.

#### **4.2 Self-Determination: The Crux of Indigenous Women’s Reproductive and Sexual Justice**

In this study, self-determination was identified as the central tenet of Indigenous women’s sexual and reproductive justice. Reproductive and sexual self-determination was conceptualized as being able to articulate and exercise reproductive and sexual decisions within a context of intergenerational and relational support. Collaborators utilized concepts such as choice, autonomy, bodily autonomy, self-determination and sovereignty when discussing reproductive and sexual decisions or experiences. However, rather than individualizing these qualities, as often happens with neoliberal framings, autonomy and choice were instead discussed in ways that emphasized their relational and social nature. Self-determination and sovereignty were also articulated as relational concepts in study conversations, with collaborators discussing the intimate connection between individual and community self-determination.

Self-determination was discussed both as an emancipatory future and as activated in everyday practices. That is, collaborators discussed a) what intergenerational and relational supports they identified as necessary for urban Indigenous women to be able to fully determine their reproductive and sexual futures, as well as b) how they make and exercise decisions within their current constraining contexts. During study conversations, women discussed specific factors that support reproductive and sexual self-determination including: a) culturally-relevant information, resources and supports that facilitate women’s decision-making, b) people, organizations and governments that respect, honour and support women’s reproductive and

sexual decisions, and c) people, organizations and governments that respect familial and community rights to self-determination.

Due to the pervasiveness of EuroWestern ideologies that frame autonomy as abstracted from the individual's context (Poovey, 1992; Ruhl, 2002), some may misinterpret articulations of Indigenous women's self-determination as relational and intergenerational as also compromising an individual woman's right to make decisions that conflict with the opinions of partners, friends, family or other community members. However, relational and intergenerational self-determination does not undermine women's rights to make decisions. Rather, it brings into view the contexts within which decision-making occurs and how individual women's self-determination can be supported or undermined by families, communities and institutions. Highlighting how contextual factors influence decision-making suggests changes to policies and practices that would foster sexual and reproductive self-determination.

#### **4.2.1 Indigenous Women's Self-Determination is Intergenerational: "For Me a Lot of the Reproductive Justice Talk Begins with Our History"**

The intergenerational nature of Indigenous women's, two-spirit and trans\* people's<sup>21</sup> self-determination manifests in how individual, familial and community histories along with intergenerational practices of support and mentorship determine what reproductive and sexual decisions are more (or less) possible. Indigenous histories, practices and teachings can support women's self-determination and resistance to colonial interference. Jaqueline explained her interest and relationship to reproductive justice:

We're Cree and my mother was birthed by my chapam [Great-Grandmother], so when we talk about reproductive justice for me as an Indigenous woman it is all rooted in that history and yes, there are other conversations today about access to this and access to

that...for me a lot of the reproductive justice talk begins with our history. I come from a matriarchal society and hearing the stories of my Kookums, my Chapans [Great-Grandmothers] who were medicine women, who were midwives in the community and hearing stories about how that was interrupted by the residential school system, those values and teachings and all of that spiritual side of being pregnant and birthing and having children is just gone. It's not gone, it was stolen.

Jaqueline's statement highlights that while reproductive justice is a concept that has emerged within North American activist circles during the late 20<sup>th</sup> century, Indigenous midwives<sup>22</sup> and medicine women have long held knowledge and teachings that foster Indigenous women's reproductive and sexual self-determination. Further, she foregrounds the role of residential school practices in disrupting the intergenerational transmission of this knowledge. The imposition of EuroWestern biomedical systems through residential school practices and other colonial mechanisms (Kelm, 1998, 2005; Milloy, 1999), such as the criminalization of Indigenous ceremonies from the late nineteenth century until 1951 (CANADA, 1884, 1895, 1951) and the medicalization of childbirth (Lawford & Giles, 2013) undermined knowledge sharing practices and pushed the midwives who sustained them underground.

Collaborators highlighted the role of kinship systems in sharing reproductive knowledge and support. For instance, Katryna stated, "Through our [Néhiyaw] kinship system is how we learned our reproductive health and herbs and teas...and in our ceremonies and all of that comes through the kinship system." Katryna asserted that Christian churches purposefully undermined their kinship system. Indeed, the strength of intergenerational knowledge sharing practices was discussed alongside historical and ongoing forces that disrupt these practices.

Methods of intergenerational knowledge sharing, such as the berry fast,<sup>23</sup> full moon ceremonies,<sup>24</sup> teachings about two-spirit people's and women's roles (including pregnancy and parenting, and kinship and community support with childrearing) can foster Indigenous women's and two-spirit people's reproductive and sexual self-determination. Collaborators spoke about people who have protected and sustained these teachings and practices as well as those who are revitalizing and re-envisioning them. Collaborators described various intergenerational mentorship and knowledge sharing practices that foster Indigenous girls, women, two-spirit and trans\* people's self-determination. These supportive practices are embedded within everyday relations as well as ceremonies marking life transitions. For instance, related to gender and sexual identity, expression and experiences, Katryna shared how Nêhiyaw Knowledge Keepers in her community observe and mentor children in community and ceremonial roles:

The Elders started to closely watch you from five years old until you were twelve years old, but not in the sense of trying to make you be who you needed to be. It was more to train you in how to be in ceremony, so if you happened to be two-spirit that you could fulfill that role and be a gift to the community. That's all it was about. It was nothing about forcing that child to become something that they're not.

Katryna's quote highlights one of the everyday processes that support Indigenous youth to understand and express their identity, gesturing towards the depth and complexity of cultural practices and processes.

During study conversations about protecting and sustaining traditional practices, many collaborators discussed interrogating teachings and practices for the influence of colonial processes, as well as re-envisioning teachings and practices so that they are more inclusive of women, two-spirit people and other people who do not fit strict gender binaries. For instance,

Paulete described how she plans to share her Dakota-Sioux teachings with her future children in ways that will support her children's gender and sexual identities.

I want my child to feel that they are in a safe space to grow the way that they are intended to be, because I grew up with someone telling me exactly how I was supposed to be and I ended up not being any of them, but very active and traditional in my role. I understood that these were done with good intentions but that is not something that I am going to enforce in my own family with my own children.

Collaborators' conceptualizations of reproductive and sexual justice as intergenerational were embedded in how they spoke about their mothers', aunties', grandmothers' and prior generations' experiences and practices as well as in how they spoke about fostering self-determination among their children and future children. For instance, Jannica succinctly stated,

The more my reproductive justice is facilitated, the more access my daughter will have to reproductive justice as she grows. If we talk about intergenerational trauma, we also need to talk about intergenerational healing, and we should also talk about reproductive justice as intergenerational.

Many collaborators situated their understandings, experiences and decisions related to gender, sexuality and reproduction in relation to their families', communities' and wider histories of colonial disruption and reproductive and sexual injustices. Michelle shared such reflections about her family's history, noting that her grandmother lost her status under the *Indian Act* because she married a man of Hungarian ancestry. Michelle's grandmother was then subject to intense racist hostility focused on her interracial marriage and family, which ultimately undermined her right to parent her son. Michelle also stated that her mother spent much of her childhood at a residential school where healthcare providers subjected Michelle's mother to an

abortion procedure without her or parental consent. Michelle understands this pattern of colonial violence to have contributed to her mother's harmful substance use later in life and the child welfare system's apprehension of Michelle and her siblings. Michelle shared that her family history and experiences, along with other factors, influenced Michelle's decision to have a tubal ligation. Michelle reflected that her story "is the story for many people and this is just the way it is. I am trying to find this collective interconnectedness rather than feeling angry and unresolved about it, because it is not going to help." Michelle's reflections and analytic insights resonate with Indigenous people's and accomplices/allies' work about intergenerational trauma and the impacts of colonial violence on Indigenous communities', families' and individuals' lives today.

Since the 1990s, research has increasingly documented the relationship between historical colonial harms (residential school practices being the most documented) and some present-day health and social concerns within Indigenous communities (Brave Heart & DeBruyn, 1998; Cedar Project et al., 2008; Kirmayer, Gone, & Moses, 2014; Mehrabadi et al., 2008; Spittal et al., 2007). Narratives about historical and intergenerational trauma offer many Indigenous people a framework that reflects their family histories and experiences. At times collaborators took up these narratives in ways that flattened colonial violence and contexts. For instance, by referring solely to residential schools when discussing colonial violence. This focus on residential schools as the primary or sole cause of intergenerational trauma is understandable due to 1) the magnitude and varied types of violence to which residential school principals, teachers, priests and nuns subjected Indigenous children (Milloy, 1999; Truth and Reconciliation Commission of Canada, 2015), and 2) the breadth of scholarly and public documentation of the intergenerational impacts of residential schools (see for instance Cedar Project et al., 2008;

Chansonneuve, 2005; Mehrabadi et al., 2008; Spittal et al., 2007; Truth and Reconciliation Commission of Canada, 2015). Collaborators also took up these narratives in ways that demonstrate the interconnections among various colonial processes and how families or community members have resisted this violence, illustrating that these acts of resistance shape reproductive and sexual self-determination today. For instance, some collaborators shared that their family members protected traditional practices despite pressure and threats from the Christian churches and colonial government to abandon them. Their family members continue to practice and share this knowledge through their kinship networks today.

The intergenerational nature of reproductive justice was also highlighted in collaborators' discussions about fostering their children and future children's reproductive and sexual self-determination. Jaqueline shared that through her involvement in this study, she had reflected on and had conversations with her daughter about reproductive and sexual justice. For instance, Jaqueline reported that she has said to her daughter "You know that is part of our sovereignty, that is part of what we can do for ourselves, is we can say how we want to have our children." Similarly, Jenelle stated that when she thinks of reproductive and sexual justice, she thinks of her journey with her oldest daughter.

I think of my 12-year old, for sure, because this is the journey that I have been taken on with her, but when I was growing up, even since she's been a kid, I've been very protective of her and I've tried to be very conscious of her safety, just because of the abuse that I went through...And then also realizing and understanding the different ceremonies that take place while growing up. So, she's been able to have her naming ceremony<sup>25</sup> and I know what her spirit name is, so with me knowing that, I'm able to help guide her to who she is supposed to be, and she is able to get a better understanding of

who she is authentically. And when I was growing up and I transitioned to a woman, my experience with that was negative. My mom wasn't able to support me with that and that was really traumatic for me, so with my daughter when she had her moontime, I immediately embraced it and my baby girl and I cried and then we celebrated, we just went and got our nails done, and then when I was able to connect with the Elder that I've seen, we were able to have a ceremony for her where we formally said goodbye to her as a little girl and embraced her as a woman and she was able to cry for that, too, because now her roles are going to change and for her to understand what it means to be a woman and what that cleansing is all about. I'm hoping that that will help her feel in control of her body and feel like she's a powerful being and with her knowing her authentic identity.

Jenelle's story highlights some of the ways Indigenous women engage various techniques to disrupt intergenerational patterns of violence and trauma, which complicates flattened narratives that imply trauma is transmitted through a transgenerational linear process (Maxwell, 2014; Million, 2013). Jenelle discussed engaging EuroWestern and Indigenous cultural practices (getting a manicure and participating in ceremony) to disrupt harmful intergenerational patterns and support her daughter through this life transition. In this excerpt, Jenelle also highlighted a specific technique Indigenous women engage in to build intergenerational reproductive justice: seeking out supportive Knowledge Keepers to share teachings and practices with them and their children.

Conceptualizing reproductive and sexual justice as intergenerational brings into focus kin, community and institutional practices that both support and undermine Indigenous women, trans\* and two-spirit people's reproductive and sexual justice. Intergenerational engagement

highlights family and community knowledge sharing, mentorship practices and demonstrates the impacts of colonial processes on intergenerational networks. Protecting, sustaining and re-envisioning intergenerational support and knowledge sharing is integral to fostering reproductive and sexual justice among girls, women, two-spirit and trans\* people. Collaborators' work to disrupt intergenerational patterns and reinterpret cultural practices so they are inclusive highlights the complexity of building self-determining futures for present and future generations. Collaborators utilized Indigenous and EuroWestern practices, tools and knowledge to further understand intergenerational patterns and foster health and wellness. Study conversation excerpts and analytical insights shared above illustrate the interdependence of intergenerational and relational aspects of reproductive and sexual justice for Indigenous women, two-spirit and trans\* people.

#### **4.2.2 Indigenous Women's Self-Determination as Relational: "Access to Choice' Can Mean So Many Things"**

This section further expands on how Indigenous women's self-determination is conceptualized as relational. Indigenous women, two-spirit and trans\* people determine their reproductive and sexual futures in a web of family, community and spiritual relations that are influenced by sociopolitical forces. Tanya shared her insights about various relational factors that shape Indigenous women and girls' decision-making:

'Access to choice' can mean so many things, like what teachings have you grown up with? Have you grown up with grandmothers or mothers that have been taught ways of taking care of yourself or even of coming of age ceremonies that help you to appreciate your body processes? Also, have you been taught that you are a life giver and it is not okay to choose abortion (if that is what you want to choose)? So, you have a lot of guilt

about that. Or have you been taught that we had ways of choosing abortion through medicines and stuff and we had different reproductive choices, you know, before colonialization? Yes, I think that it can depend on what teachings you have been taught in terms of values and belief systems and sometimes you don't have either of those and you just get the lack of reproductive education which often happens in European school systems, or you do get sexual health education and you learn all about the different choices. Then it also comes down to physical barriers like in a lot of communities in Manitoba you have to fly to Winnipeg in order to access abortion and there is a lot of shame around that, or if your auntie works at the nursing center...So, there are a lot of barriers you know for adult women, but especially for young women in those communities to access birth control even, or even to have education around that.

Tanya's quote explicitly states and gestures towards some of the ways in which this web of relations and sociocultural forces make certain decisions more (or less) possible. For instance, whether women view having an abortion or using birth control as possible reproductive decisions is shaped by their engagement with Indigenous and EuroWestern teachings about reproductive decision-making.

The Indigenous teachings and practices girls and two-spirit people are raised with are influenced by various factors including their Nation, community and ceremonial family as well as broader sociocultural forces, including the imposition of Christian anti-choice teachings on communities, or familial and community histories of protecting and sustaining Indigenous teachings. Similarly, many Indigenous people were raised within various Christian denominations and residential schools where they received anti-choice teachings. The strong presence of Christian anti-choice organizations and ideologies in Manitoba and Saskatchewan

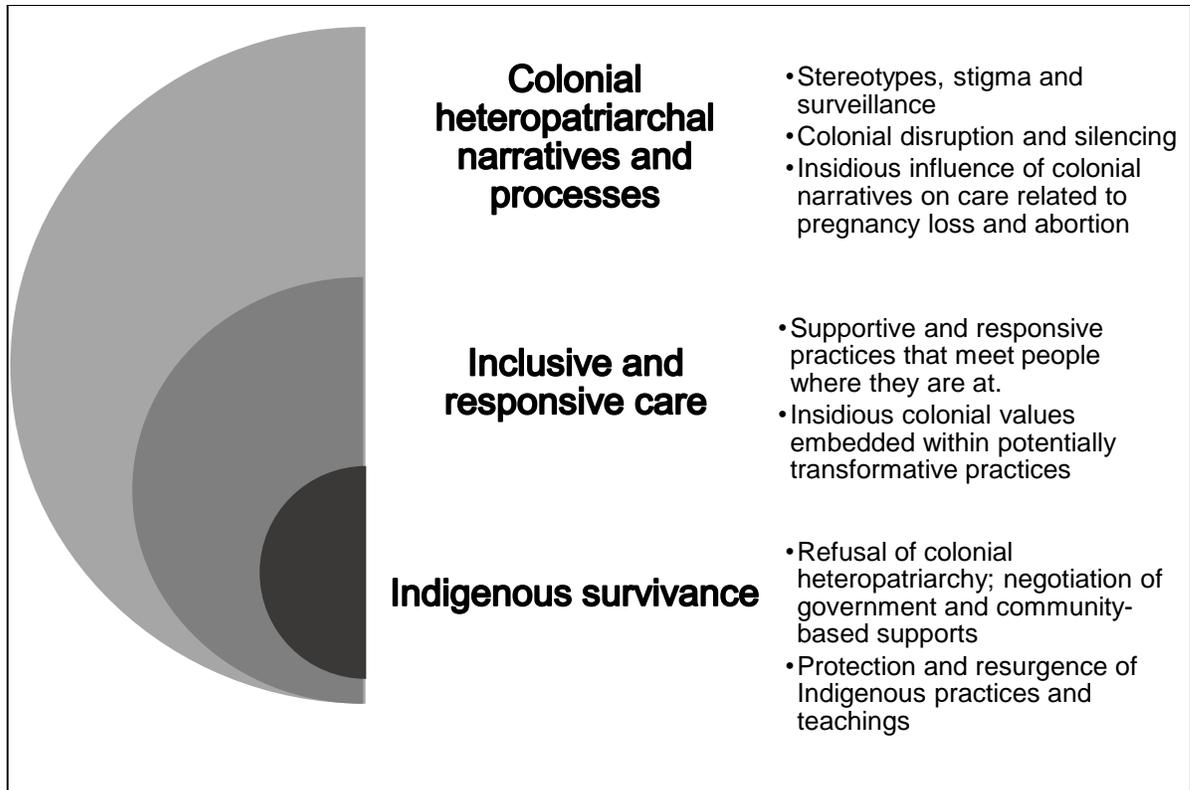
has contributed to many Catholic and public schools providing no or limited sexual health education. Further, within small communities, particularly rural and remote communities, accessing reproductive health care often means accessing care from a relative or close family friend. Depending on these healthcare providers' (and other family members' and friends') values and beliefs, women, girls, trans\* and two-spirit people may delay or avoid care in order to protect themselves from judgement, isolation, or violence.

How this web of relationships and sociocultural forces shapes what decisions are more (or less) possible depends on multiple factors. Jenelle discussed various factors that influenced her decision to become a mother:

Yep, well I started looking and Erik Erikson and his psycho-social model of development and at the age when I got pregnant I was kind of in an identity crisis where I didn't know where I belonged. You know how you try on all of these different identities when you are a teenager? I couldn't find one that fit me that I felt comfortable with, but I did know that if I found an identity in being a mother or a wife that I would have some sense of belonging or love. So, that's the identity I went with... no one was there to tell me that I was going through this identity crisis and helping me find an identity I felt authentic in, rather than creating this one where I am bringing another life into. So, I mean, that is stuff that I've learned. Also, looking back at my childhood and how my dad wasn't there and my mom tried to be there as best as she could, but the grief and the loss that we had in our family and how that played into the abandonment that I had as I was growing up and how this little person was hopefully going to fill that abandonment, but never could. I've been able to go through those places in my own healing and to figure out how can this stop or why did this happen, because I grew up not feeling empowered by my decision to

be a mother, but feeling like I was a victim of my decision. Like it wasn't my choice and now I have this person who sometimes I almost felt resentful towards, because I have to look after you when really I want you to look after me, but that's not going to happen.

Jenelle also described how her b) training and work as a service provider, b) group of women friends, and b) participation in Indigenous spiritual practices and teachings foster her and her children's wellness. While in the excerpt above Jenelle emphasizes the absence of intergenerational mentorship and positive relations in her early experiences of family, meaningful relationships with her community and learning various Indigenous and EuroWestern theories and practical skills have fostered her understanding of her family history and reproductive decisions as well as her resilience in the face of challenges. Her experiences challenge binaries that frame Indigenous and EuroWestern ways of knowing as incompatible and highlight the complexity of the multiple material, ideological and historical relations that shape her and other Indigenous women's reproductive and sexual decision-making, prompting me to further analyze the broader relational context in which collaborators determine their reproductive and sexual futures. The following section focuses on the broader socio-political context through three interrelated themes; 1) colonial policies, processes and narratives; 2) inclusive and responsive care; and 3) Indigenous survivance (see Figure 1 below).



*Figure 1. Socio-Political Context of Indigenous Women’s Reproductive and Sexual Self-Determination*

### **4.3 Colonial Heteropatriarchal Narratives and Processes That Disrupt Intergenerational and Relational Quality of Life: “All of the Ideologies Were Transported Here and Have Had Such a Negative Impact”**

Analyzing how Indigenous women’s relational contexts shape what decisions are more (or less) possible highlighted that certain conditions carry so much force in women’s lives that they often experience them as a single driving factor in decision-making. At times, these conditions are so constraining that Indigenous women expressed feeling that they had no viable options or alternatives. For instance, collaborators discussed that for women involved with the child welfare system, maintaining or regaining custody of their children and distancing themselves from this system are often their only concerns. Therefore, most of their decision-making is driven by these goals. As Denise explained, “The way to get the system off your back

is to do what you are mandated, what they require of you to do.” In recognition of the force that colonial heteropatriarchal narratives, policies and practices have on Indigenous women’s lives, this subsection focuses on one aspect of the context that Indigenous women negotiate: the colonial disruption of Indigenous intergenerational and relational quality of life.

Colonial heteropatriarchal narratives, policies and practices play out within Indigenous women’s lives in various ways including: stereotypes about Indigenous women, two-spirit and trans\* people; the imposition of heteropatriarchal norms through the *Indian Act* and residential schools; regulation of Indigenous women’s bodies and femininity; erasure of Indigenous histories of gender- and sexually-diverse people and roles; and colonial disruption of Indigenous relations and processes. For instance, Leslie, a Cree woman, advocate and Executive Director of Ka Ni Kanichihk discussed the pervasiveness of what she described as Christian, white-supremacist and capitalist ideologies. She stated, “All of the ideologies were transported here and have had such a negative impact on even traditional knowledge as we know it today...[these ideologies] have been insidious, endemic in many institutions and also endemic in [Indigenous] culture now” in terms of how they are evoked to regulate and control women’s bodies. Embedded within these narratives, policies and processes is the genocidal disposition to eliminate Indigenous people as a distinct group and assert Canadian sovereignty over Indigenous lands (Woolford, 2015; Woolford et. al., 2014).

Colonial forces shape Indigenous women’s lives in various ways, including enduring colonial ideologies that operate through EuroWestern systems today. For instance, collaborators spoke frequently about ways in which the child welfare systems perpetuate colonial relations.

Leona stated,

Our children today don't have residential school. What they are facing is child protection from social services. The word protection is completely inappropriate. They are breaking up homes. If you have a Caucasian woman and an Indigenous woman in the hospital both giving birth, both suffering with the same problem, they are going to be treated differently, because of the racism that is alive here in Canada today. It is alive and well, but if the system understood what that Indigenous woman was going through and what happened to her in her past and had a little bit more empathy and compassion you can help families heal and keep them whole by keeping them together.

Leona's quote highlights the relationship between residential schools and the child welfare system. This is an intimate relationship with both systems playing significant roles in disrupting Indigenous familial and community relations.

The residential school system was established in Canada as a joint government-church initiative in the late nineteenth century with the explicit intention of assimilating Indigenous people into the Canadian body politic (Milloy, 1999). Multiple generations of children were subjected to physical, sexual, emotional and spiritual violence at these schools and the impacts of this violence are well-documented (Bombay et. al., 2011; Furniss, 1995; Ing, 1991; Kelm, 1998; Milloy, 1999; D. Smith et. al., 2005). After the Second World War, the federal government took over the administration of residential schools, which they utilized primarily for child welfare purposes (Fournier & Crey, 1997; Milloy, 1999). Simultaneously social service organizations grew over the second half of the 20<sup>th</sup> century with provincial child welfare systems increasingly taking First Nations and Métis children into their 'care' (Fournier & Crey, 1997; Johnston, 1983).

As discussed in Chapter Two, multiple factors coalesced to naturalize EuroWestern ideologies in child welfare legislation and practice. For instance, colonial norms and values were (and continue to be) embedded within provincial child welfare legislation (de Leeuw et al., 2010; H. A. McKenzie et al., 2016), which contributes to the high proportion of Indigenous children in the ‘care’ of the state today. Both Saskatchewan and Manitoba’s child welfare legislation continue to center the ‘best interest of the child,’ which is framed in relation to various factors including children’s emotional, cultural, mental and physical needs (Manitoba, 2015, 2017a; Saskatchewan, 2014, 2016). Collaborators and other interview participants discussed how this legislation, particularly the concept of the ‘best interest of the child,’ reflects and perpetuates EuroWestern ideologies. This ideology situates children’s ‘best interest’ as separate from children’s communities, families and Nations and, as Leslie explained, this concept is activated through colonial ideologies that frame the apprehension of Indigenous children as an ‘understandable response’ to Indigenous people’s individual and collective deficits.

Study conversations discussed the endurance of colonial values and norms within the child welfare legislation and system at length. Collaborators highlighted that these values inform child welfare workers’ actions towards Indigenous families. Collaborators emphasized that once child welfare workers became involved in their families’ lives, they were subject to scrutiny and paternalistic treatment, and felt like they were being watched and had to ‘jump through hoops’ in order to maintain or regain custody of their children. Collaborators’ framing of these experiences echoes how Indigenous mothers from Winnipeg and The Pas, Manitoba described interacting with child and family service workers in 2007 (Bennett, 2009), which further demonstrates the enduring pattern of the child welfare system’s involvement in Indigenous families’ lives on the Prairies.

Collaborators also discussed the multiple interconnecting ways that colonial disruption manifests in Indigenous women's lives. Collaborators highlighted the interconnections among colonial disruption, harmful substance use<sup>26</sup>, child welfare involvement, erosion of family and community resources and inadequate culturally relevant harm-reduction services and treatment options. However, most social and health services are grounded in EuroWestern ideologies that isolate health and social concerns from each other and do not robustly account for sociocultural, historical and community contexts (Gerlach, Browne, & Suto, 2014; Swift & Callahan, 2009; Winder, 2014; Yee, 2011b). Therefore, available services do not have the mechanisms to effectively address these concerns as interconnected. For instance, collaborators discussed how colonial disruption of Indigenous relations has contributed to harmful substance use by themselves, their family members and partners as well as other Indigenous people. Study conversations highlighted that when Indigenous people use substances to deal with violence, pain and loss, they are often punished by the child welfare system for this use, because a) colonial stereotypes continue to compromise child welfare workers' judgement, and b) colonial disruption has eroded many Indigenous people's, families' and communities' resources to mitigate the harms of substance use. This punishment often takes the form of child apprehension, producing further pain and loss for Indigenous parents and their children.

Collaborators also identified that the lack of accessible, local, culturally relevant harm-reduction services and treatment options serve as significant barriers for Indigenous people accessing services to address the harms of substance use. This gap in services illustrates that supporting Indigenous people to address harmful substance use is not a funding priority for provincial and federal governments, since government representatives along with media sources and legal systems continue to employ narratives that position Indigenous people as somehow

naturally prone to addictions, dysfunctional and irresponsibility (see for instance Giesbrecht, 2015, Dec 19; Lavallee, 2014, Dec 20; Mandryk, 2015, June 26; Rabson, 2016, Feb 6). These narratives thereby further undermine Indigenous claims for self-determination (Tait, 2009; Thielen-Wilson, 2014) and the rationalization for continued underfunding is borne out in the continued use of these narratives, which ultimately operate to reinforce claims of Canadian sovereignty over Indigenous lands.

#### **4.3.1 Relational Influences of Surveillance, Stigma and Stereotyping of Indigenous Women: “Whatever Decision You Make as an Aboriginal Woman, You Are Judged Already”**

Individual and systemic surveillance, stereotyping and stigma are pervasive forces that constrain Indigenous women’s reproductive and sexual self-determination. Collaborators shared their analytical insights about these factors and illustrated multiple ways these forces impact Indigenous women’s lives. As Denise said of these relational influences: “Whatever decision you make as an Aboriginal woman, you are judged already.” In the broader socio-political context (excluding the health system), Indigenous women reported being subject to stigma, stereotyping and surveillance in various contexts including in shopping centres, when riding buses, during family gatherings and when accessing community and social services. Collaborators shared various techniques for intervening in non-Indigenous people’s stereotyping and stigmatizing statements and behaviour, such as questioning or challenging stereotypes and meeting stigmatizing behaviour with generosity and kindness. For instance, Danielle shared,

I just feel with First Nations people...in the hierarchy of society, we are at the bottom, we are non-existent almost and you can feel that. I can feel it within my own First Nations people that cannot look people into the eyes or hold their head up. I can feel it walking

into some places. I like to say that energy is what gets me and I can walk into a building and you don't even have to say anything to me, but I can tell the way that you look at me that you are not accepting of me as First Nations and I always make it a point... to face that stereotype, that labelling with a smile and say, "I hope you have a good day" and then I get a smile...and I know I can't change the world, but just showing that respect that I am not judging you back that I want to acknowledge you and hope you have a good day today, just hopefully one day they will just wake up and think, "I shouldn't have looked at First Nations people like that." It just really irritates me the ignorance towards it. It is sad, it is really sad and they don't know how mentally and emotionally it drains a First Nations person.

Collaborators shared stories about themselves and other Indigenous women they know facing intense scrutiny, judgement and stigma because of intersecting aspects of their identities and lived/living experiences as Indigenous women and Indigenous two-spirit and trans\* people. For instance, Paulete stated, "In small-town racist Saskatchewan, it is hard to walk in this world. Already people see that I am an Indigenous woman and the moment I tell them I am gay, things change." Collaborators particularly reported experiencing scrutiny, judgement and stigma while negotiating: young and single parenthood; situations of low-income; harmful substance use; living with HIV; and/or services and society as a two-spirit and/or trans\* person. Jaqueline related,

There is just so much stigma. The work that I do is in HIV, so a lot of the women are living with HIV and are addicted to drugs. They get pregnant and they do not access services at all whatsoever because of the stigma, because of the treatment.

Above, Jaqueline described one of the ways Indigenous women dealing with harmful substance use and living with HIV protect themselves from stigma and judgement: avoiding services.

While EuroWestern biomedical care often problematizes Indigenous women who do not engage with services, Jaqueline's quote situates 'the problem' as colonial relations operating within healthcare settings and beyond. Similarly, Autumn reflected that,

There is a lot of racism, there is a lot of looking down on woman that are HIV positive or Hep C positive, or living in poverty and I think that a lot of people feel that women that are suffering with those [conditions and situations] shouldn't have kids because they are not capable.

Above, Autumn's quote illustrates the pervasiveness of stereotypes that position Indigenous women as 'unfit mothers' who are to blame for the conditions of structural violence they negotiate.

Colonial narratives that frame Indigenous women as inherently hypersexual, prone to substance use, irresponsible and unable to care for their children intersect with other heteropatriarchal and capitalist narratives to produce conditions of intense scrutiny. These narratives are intimately linked to the historical and ongoing colonial project of appropriating Indigenous lands for white-settlement on the Prairie provinces (S. Carter, 1997; Million, 2013; Woolford et. al., 2014), which contributes to the pervasiveness of these colonial narratives despite Indigenous women's and allies'/accomplices' interventions. This surveillance, stigma and stereotyping violates Indigenous women's dignity in and of itself and compromises Indigenous women's self-determination.

This analysis highlights that collaborators often experienced institutional actors and other individuals evoking stereotypes when threatening or enacting violence against them. This

violence takes various forms and operates across contexts including: physical and sexual assaults, coercive practices related to tubal ligations and long-term contraceptives, and the child welfare system. For instance, collaborators discussed child and family service workers reframing individual and family histories of intergenerational colonial disruption so that they fit into (and reproduce) colonial narratives, which are then used to justify the system's intrusion into these families' lives. Melissa shared that she has heard stories about Child and Family Services [CFS] subjecting pregnant women and their partners who were raised in CFS to intense scrutiny, "their CFS worker who was evaluating them had said 'Well, you were raised in the system and your parents didn't parent, so how do you know how to be a parent?'" This pattern of reinterpreting colonial disruption of Indigenous families as 'evidence' of individual Indigenous women's and families' compromised parenting capacity, is a prime example of how overt colonial discourses have been reinterpreted through neutralized and medicalized language to position Indigenous individuals and peoples as suffering from "'inferior' health and social problems" (Tait, 2009, p. 199). It also demonstrates the enduring nature of stereotypes that frame Indigenous women as unable to care for their children, and suggests that these stereotypes continue to contribute to the unconscionably high rate of Indigenous children apprehended by the state in Manitoba and Saskatchewan.<sup>27</sup> This analysis resonates with Jacob's (2014) argument that that the child welfare system's historical and ongoing pattern of removing Indigenous children from their families in North America has become ingrained as a "habit of elimination," that is "difficult to identify, let alone break" (p. 190).<sup>28</sup> Instead, this genocidal practice is accepted by many working at these institutions and members of settler society as necessary or even benefiting the children, families and communities involved.

### **4.3.2 ‘Justice’ and Holding Perpetrators of Sexual Violence Accountable: “It Is a Story That Needs to Be Heard”**

Colonial heteropatriarchal violence takes many forms including sexual violence against Indigenous women, girls, two-spirit and trans\* people. Increasingly over the past 30 years Indigenous women, two-spirit and trans\* people along with other community members have been hosting protests, memorials, as well as sharing testimonials and community-based analyses challenging Euro-Western institutions, Indigenous communities and the broader society to respond (Amnesty International, 2004; Culhane, 2003; Hunt, 2014; H. A. McKenzie, 2012; Native Women's Association of Canada, 2010; National Inquiry). Collaborators are resisting intergenerational silencing about sexual violence and using the mechanisms of accountability to which they have access in order to hold perpetrators accountable and claim their rights to safety and justice. Indeed, collaborators spoke about how widespread sexual, physical, emotional and spiritual violence within residential schools, as well as adoptive and foster homes have contributed to pervasive sexual violence in many Indigenous families and communities. Collaborators also discussed that white-settler societal disregard for Indigenous women, girls, two-spirit people and trans\* people along with inadequate response from the justice system places Indigenous women at risk of sexual violence at the hands of partners, family members, strangers and acquaintances.

These intergenerational patterns of normalizing sexual violence interact with other colonial mechanisms to silence Indigenous women, girls and two-spirit and trans\* people. Laverne highlighted the role of residential school practices in producing a culture of silence among Indigenous women. “Residential schools have taught us how to not just be silent, right? To shut up and not say nothing... we have so many strong, powerful woman in this community,

but there is such silence.” Laverne also related a pattern of perpetrators and others retaliating against Indigenous women who do speak out about violence, which further entrenches this culture of silence. Collaborators addressed the difficulty in disrupting intergenerational patterns of silence about sexual violence. For instance, Jannica shared:

Reproductive justice has to encompass what those children that are being born are born into. What are the predispositions that exist? Like, we know with the intergenerational impacts of residential schools there is predisposition towards children having to deal with trauma that their parents experienced so, I think about that for my daughter and I think, because issues like sexual abuse that are so seldom talked about...because it is such a personal thing and it is so difficult to talk about, it is difficult for people to admit, because I think you know when you are trying to heal and be strong through something that you have suffered you don't want to appear to be weak and by being someone that voices that, you become vulnerable.

Jannica's quote illustrates how heteropatriarchal notions that sex and sexuality are inherently private and victimization is a sign of weakness reinforce the intergenerational silencing of sexual violence. The imposition of these values on Indigenous communities is interconnected with the normalization of sexual violence against Indigenous women, girls and two-spirit people, which emerged as part of colonial processes of the late nineteenth century on the Prairies and continues to compromise Indigenous women, girls, two-spirit and trans\* people's safety (Amnesty International, 2004; S. Carter, 1997; H. A. McKenzie, 2012; Native Women's Association of Canada, 2010).

There are various colonial mechanisms that contribute to the normalization of sexual violence against Indigenous women, girls, two-spirit and trans\* people. For instance, narratives

positioning a) Indigenous women and girls as inherently hypersexual, b) Indigenous men as prone to violence, c) Indigenous gender- and sexually-diverse people as deviant and unnatural (Amnesty International, 2004; S. Carter, 1997; Driskill, Finley, Gilley and Morgensen, 2011; H. A. McKenzie, 2012; Million, 2013; Native Women's Association of Canada, 2010), and d) Indigenous communities as spaces of dysfunction and violence (Tait, 2009; Waldram, 2004). Since white-settler society and colonial institutions often misinterpret Indigenous people holding Indigenous perpetrators accountable through the EuroWestern justice system as ‘evidence’ of these colonial narratives validity, these narratives can further perpetuate patterns of intergenerational silencing.

Collaborators spoke about resisting intergenerational silencing and sexual violence through critical conversations, activism and using mechanisms of accountability that are available to them. For instance, Julianne whose art has dealt directly with sexual violence against Indigenous women, discussed a new project she is working on: a book of poetry that shares her story about experiencing sexual violence and holding her stepfather accountable through the EuroWestern justice system. She reflected on the importance of sharing her story, saying “It is a story that needs to be heard, because these older people don’t want to talk about it...Even people my age they don’t want to talk about [it].” Collaborators’ acts of resistance are indicative of further work Indigenous women and communities are engaging in to disrupt intergenerational silencing and violence in order to claim Indigenous women, girls and two-spirit and trans\* people’s rights to safety and violence-free lives (Hunt, 2014; Native Women's Association of Canada, 2010; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019).

Indigenous communities had methods for dealing with community or family conflict and violence. However, colonial intrusion has eroded these mechanisms and practices in many

communities (Borrows, 2002; Deer, 2009; Hunt, 2014; LaDuke, 1997). Within this context, Indigenous women often turn to EuroWestern legal systems to hold perpetrators accountable, but some collaborators experienced (further) victimization through this system and process. For instance, collaborators spoke about facing intense judgement and violence for holding family and community members accountable. Two collaborators, one who reported an assault to the police and another who supported her daughter in reporting an assault, spoke about other family members regulating, isolating and threatening them with violence, and experiencing other forms of victim-blaming during the legal process. Danielle said that despite judgement and being personally attacked by her family members:

We continued on with court, we won our case and I had nothing bad to say to them, nothing, because I don't have anything to say, I just wish them well and I hope they can get the help that they need so that they are not so angry and ugly on the inside. When we won our case, I told my daughter you know it is a new start and pretty much celebrated the new beginning. We had family over, had a barbeque and my cousin was there and now everybody showed their love to [the girls who reported this perpetrator] and congratulated them on being so strong. I told my daughter I stood up for her and from this day forward that we are going to move forward and we are not going to be victims, we are going to be survivors and there will be some good things to come out of this horrible situation.

Danielle's quote described how in the face of colonial disruption, she and her family held their perpetrator accountable and refused victim-blaming narratives. Indeed, Indigenous women are disrupting patterns of intergenerational silencing, breathing life into their stories and claiming their right to safe and violence-free lives. Our discussion only briefly touched upon revitalizing

Indigenous systems of justice and accountability, however, this analysis also gestures towards this work.

### **4.3.3 Intergenerational Influence of Colonial Ideologies on Indigenous Teachings and Practices About Reproductive Decisions and Gender: “[These Ideologies] Have Been Insidious, Endemic in Many Institutions and Also Endemic in Culture Now”**

Collaborators spoke about various understandings of traditional beliefs and practices related to abortion, reproductive decisions and gender with many collaborators identifying that colonial processes have influenced these teachings and practices. Collaborators also demonstrated various techniques of refusing and negotiating these colonial influences. This analysis is grounded in an understanding that Indigenous cultures, practices and experiences across Saskatchewan and Manitoba are varied and that collaborators involved in this study identified with diverse Nations, familial and geographical histories as well as spiritual and religious teachings. Within this study, collaborators shared Nation-specific teachings about reproductive health practices and gender relations as well as referring to Indigenous practices and teachings more broadly.<sup>29</sup>

Collaborators’ discussion of Nation-specific and Indigenous practices emphasized the complexity and diversity within and among communities. This analysis highlights that the teachings women follow and how they interpret those teachings impact what possible decisions they will consider and how they feel about difficult reproductive decisions. As Melissa explained,

There’s stigma in general in society, but there is also, as far as traditional teachings go, I’ve had women say, “Oh, I’m not a murderer,” or “Creator gave me this gift and I can’t give that gift back” and so depending on which Elder that they talk to, and which

ceremonial family that they have, those beliefs are different and lots of women feel very strongly. If their grandma tells them, “You can’t do that, you can’t have an abortion” or “You can’t give your baby up for adoption” that woman will listen to their grandma even if that woman is really struggling. So, that’s a really tough subject, some women won’t even talk about it.

Across women’s diverse beliefs, many expressed that colonial ideologies have influenced Indigenous practices and teachings. For instance, Tanya shared that while at least some Indigenous communities had techniques to control pregnancy and reproduction, the imposition of colonial ideals of femininity and reproduction “definitely played a huge role in the loss of teachings around Indigenous women’s moontime and medicines and things like that, as well as Indigenous midwives and the medicalization of childbirth.” Colonial ideals were imposed through intersecting colonial forces, including the *Indian Act* (CANADA, 1884, 1895, 1951), residential schools (Milloy, 1999) and EuroWestern biomedicine (Kelm, 2005; Lawford & Giles, 2013). It is likely that many Indigenous people engage and espouse pronatalist beliefs as part of their resistance to ongoing colonial genocide, including coerced and forced sterilization of Indigenous women (Dyck & Lux, 2016; Gurr, 2015; Allen qtd in Perry, 1993). Recognizing the influence of colonial processes can foster critical conversations about how teachings can further support and respect Indigenous women’s reproductive and sexual justice. Similarly, collaborators discussed the impact of cultural practices and teachings that reproduce strict gender binaries on girls, women, two-spirit and trans\* people. As Mo expressed,

It is like okay they say go back to your roots, go back to this but then they bring the patriarchy into it. I know that there are teachings for when you go through puberty as young men and women, but where does the two-spirit fit in there? I know back in the day

it was different. I don't know how it was different. People say. "Oh well it was this way, it was that way," but how do I know that is real especially when it is not practiced? So, I have difficulty with that. I just take the basic core teachings and claim those because I know that praying with tobacco is something I can do that has nothing to do with anybody else, when you start going to ceremonies that involve gender roles, I have difficulty with that.

Mo's quote addresses the harmful effects of reinforcing strict gender binaries and the contested nature of tradition. There are many who point to traditional practices and teachings that embrace gender- and sexually-diverse people and languages that do not have gendered pronouns as evidence that two-spirit and trans\* people were valued members of their communities prior to colonial interference (Jacobs et. al., 1997; S. Lang, 1997; A. Wilson, 2009). Similarly, research has documented how colonial mechanisms have imposed strict gender binaries on Indigenous communities (Cannon, 1998; Fiske, 1996). However, as Mo alludes to, there are others who share teachings and lead ceremonies in ways that reinforce heterosexist norms. Mo's quote also illustrates one of the strategies Indigenous women, two-spirit and trans\* people use in the face of colonial heteropatriarchal practices: refusal of colonial influences (A. Simpson, 2014; L. B. Simpson, 2017).

Collaborators discussed other strategies of negotiating and refusing colonial influences on traditional teachings and practices, such as: foregrounding teachings that recognize diverse femininities and community roles and re-envisioning teachings and practices so that they are inclusive of girls, women, two-spirit and trans\* people. For instance, Tori-Lynn related a story about how her daughter was subjected to heteropatriarchal gender norms within a conversation about traditional roles and her response.

So, it came up that she was having some sort of a traditional conversation with someone and it came out that she doesn't have a period because she is on Depo. So, they were talking about, "Well, are you even a woman?" Because in traditional roles women who never got their periods, you would have a hard time conceiving children, you would be less of a desirable partner like I am talking about traditional women's roles something like 500 years ago. Someone who can't have children would be a medicine person, the people that you would go to when you are sick and when you need help. So, I talked to my daughter and I told her about that role, and I said, "Maybe your responsibilities are more medicinal, maybe because you can pick up my sweet grass and go and smudge with your friends and if you don't have a period there is more time when your community or circle of women can come to you and ask you to share that, so you can start the smudge for them or you can do certain things that women who have their regular time can't do." So, I think she soul-searched a little bit and it just so happens after that conversation that she was the one that says, "Okay, can you smudge today?" and she will initiate smudging ceremonies at the center or she will maybe do the medicine wheel, so she has always got that on her mind and it seems to have resonated with her.

Conversations exploring the influence of Christianity and other colonial ideologies on Indigenous views and practices, and how these practices affect Indigenous women are crucial in recovering traditional practices and teachings and resurgence. As this analysis gestures toward, this is critical work with impacts beyond reproductive decision-making; indeed, it may foster safety and justice for Indigenous girls, women and two-spirit people in various ways.

#### **4.3.4 Relational Influence of Colonial Narratives and Practices within Abortion and Pregnancy Loss Care: “In Saskatchewan We Are Quite Conservative”**

Colonial heteropatriarchy is insidious, taking various formations within EuroWestern institutions, organizations and practices. One formation is the influence of Christian heteropatriarchal narratives on abortion policy and services and the limitations of the pro-choice/anti-choice binary. Another problematic formation is the dominance of EuroWestern biomedical practices in care related to pregnancy loss.

In study conversations, collaborators discussed the dissonance between their experiences with pregnancy terminations and narratives about abortion commonly circulated by reproductive choice activists, reproductive health organizations and anti-choice activists, which are framed through pro-choice/anti-choice binaries, a discursive disruption with very real material impacts. Due to the large anti-choice contingent in Saskatchewan and Manitoba (see for instance, Catholic Civil Rights League, 2015; C. MacDonald, 2018; Saskatchewan Pro-Life Association, n.d.; Stachiw, 2006), abortion is a common and polarizing discussion within the study locations. Collaborators in Saskatchewan particularly emphasized the prevalence of anti-choice ideologies. As Chris stated, “In Saskatchewan we are quite conservative and unwilling to openly support reproductive health and sexual health agencies.” The prevalence of anti-choice Christian ideologies continues to influence healthcare policy and practice.

There is a stand-alone clinic providing abortion services in Winnipeg, Manitoba where terminations are performed up to 16 weeks.<sup>30</sup> Terminations are also performed at the Winnipeg Health Sciences Centre’s Women’s Hospital up to 19 weeks and 6 days. However, due to policy barriers<sup>31</sup>, there are no stand-alone clinics in Saskatchewan; rather, there are two Women’s Health Clinics: one at Regina General Hospital and one at Saskatoon City Hospital. Saskatoon is

considered one of the most difficult urban locations in Canada to access an abortion (French & Radford, 2015, June 5). In order to access a surgical termination in Saskatoon, a patient must undertake a three-step process: 1) make an initial appointment with the one of the doctors who provides pregnancy terminations, 2) access timely bloodwork and ultrasound tests, and 3) access a surgical termination at City Hospital's Women's Health Centre, where abortions are performed up to 12 weeks. If patients are unable to navigate this process before 12 weeks gestational age, they must travel to Regina (up to 18 weeks and 6 days), Edmonton (up to 20 weeks) or Calgary (up to 20 weeks), travel that presents additional financial and practical challenges.<sup>32</sup> Study conversations suggest that there is not the political will to improve access to abortion services in Saskatoon.

Similarly, when I completed this study's fieldwork (June 2017), coverage for the cost of Mifegymiso medication in Manitoba and Saskatchewan was limited. Mifegymiso, which can be used to induce a medical termination up to 9 weeks gestation, was approved by Health Canada in July of 2015 and healthcare providers started prescribing the drug in January 2017 (Action Canada for Sexual Health & Rights, n. d.). Six other provinces (British Columbia, Alberta, Ontario, Quebec, New Brunswick and Nova Scotia) had already implemented universal cost coverage of Mifegymiso. In Saskatchewan, Mifegymiso was covered under the Saskatchewan drug plan, so people with low incomes and high drug costs could access it for free or at a reduced cost, but other people had to pay approximately 360 dollars in order to access the medication (Taylor, 2018, May 7). In Manitoba, Mifegymiso was offered for free at the Women's Health Clinic and Health Sciences Centre in Winnipeg and the Brandon Regional Health Centre, which means universal coverage was available in southern urban Manitoba centers. It was also covered by Manitoba's Pharmacare plan (which requires people to pay a 100-dollar deductible for access)

and provided for people participating in the Employment and Income Assistance Program (Hoye, 2019, Jan 4). First Nations people with status under the *Indian Act* also could also access Mifegymiso coverage through the Non-Insured Health Benefits (NIHB) program (Action Canada for Sexual Health and Rights, n.d.). Together, these policies provided full coverage for some people, some coverage for many people, but left others with a hefty out-of-pocket expense they must cover within a limited timeframe or a medical termination was no longer an option.

When accessing surgical and medical terminations, patients often drive or walk through anti-choice protesters and face judgement and criticism from healthcare providers, family and friends. Despite well-known high levels of violence, sexual coercion and assault against Indigenous women (Amnesty International, 2004; Brennon, 2011; Brownridge, 2003, 2008; Conroy & Cotter, 2017; Johnson, Statistics Canada, & Federal/Provincial/Territorial Ministers Responsible for the Status of Women (Canada), 2006; National Inquiry into Missing Indigenous Women and Girls, 2019; Royal Canadian Mounted Police, 2014) heteropatriarchal narratives that women and girls seeking abortions are hypersexual, irresponsible and unnatural coalesce with colonial stereotypes placing Indigenous women at risk of verbal judgement, harassment and other forms of violence. For instance, when a Nêhiyaw woman was waiting to be admitted for a surgical termination at City Hospital she overheard a nurse say, “Here comes another one.” Similarly, collaborators shared that in Saskatchewan patients continue to report anti-choice doctors who refuse to provide patients with birth control or information about how to access an abortion.

Recently, the Saskatchewan College of Physicians and Surgeons introduced a policy that aims to reduce and mitigate these harmful practices. Their policy on Conscientious Objection came into effect in 2015. The policy clarifies physicians’ responsibilities in providing care that

respects patients' rights when physicians conscientiously object to the care or service patients are seeking. In these situations, physicians are required to provide a patient with the information necessary to access the service or procedure with another provider (College of Physicians and Surgeons of Saskatchewan, 2015). The introduction of this policy is likely to influence the culture of physician care on the prairies.

In Manitoba and Saskatchewan, public narratives about reproductive rights focus predominantly on abortion and anti-choice/pro-choice arguments, which shapes where most conversations about reproductive health and rights begin. For instance, many collaborators and interview participants shared their opinion and experiences related to abortion near the beginning of our interviews. While we started the conversation there, many collaborators also emphasized that reproductive and sexual justice encompassed more than legal and accessible abortion services. One of the limitations of the pro-choice/anti-choice binary is that patients seeking supports and more nuanced understanding often find themselves patching together services and supports, or worse, faced with gaps in service and silence or judgement from family members and friends. For instance, in our interview, Jannica spoke about her own experience making a difficult reproductive decision to terminate a pregnancy while leaving a violent relationship. She also offered her analysis of the services (or lack thereof),

There is very little to no counselling or healing that is a support service that is provided after having had the abortion and when you think about that-anytime you are dispirited by sexual abuse or domestic violence, for sure respirit yourself, rehabilitate, but if you are dispirited because a life has come out of the life that you have, that support doesn't exist. Her experiences and other study conversations pointed to the limited counselling or support services for people who have complex or difficult abortion and pregnancy experiences.

Most sliding-scale and publically-funded counselling services have long wait lists and there are few counselling services specifically grounded in a reproductive justice framework. Indeed, during this study's environmental scan, I identified only four possible counselling options that provide explicitly supportive, non-judgemental and/or pro-choice counselling with a focus on reproductive decisions and experiences available to collaborators in Saskatoon, Regina and Winnipeg. Two of these counselling options are telephone based and available across North America (Backline and Exhale). There is one clinic in Saskatoon, Saskatoon Community Clinic (for patients accessing a termination through a doctor at this clinic or who are otherwise patients at this clinic), and one in Winnipeg, Women's Health Clinic. As in other parts of North America, abortion rights and access in Saskatchewan and Manitoba are operating under threat from anti-choice activists and politicians. Organizations and activists must focus a significant amount of resources on protecting these services and legal rights, which undermines their capacity to provide counselling and related supports that meet the complex needs of people who are making difficult reproductive decisions. As well, if these sexual and reproductive health organizations increase their provision of services that acknowledge patients' complex and difficult experiences with abortions, these services may be misrepresented by anti-choice organizations and advocates as 'evidence' of the harms of abortion. However, not providing robust, non-judgemental supports that address people's complex and varied experiences with abortion and reproductive decision-making puts patients at risk. There is a significant need to further develop services that provide support to people during this reproductive decision-making process and afterwards.

Study conversations emphasized the limits of individualistic, biomedically-driven care when women are dealing with pregnancy loss. This model of care is embedded in policy and practice as if it meets everyone's needs, however, it is grounded in a particular worldview and

limited in what it can provide and whose needs it can meet. When Indigenous women's needs and expectations of care are not met by this model, collaborators reported that healthcare practitioners often problematized Indigenous women rather than the model of care. For instance, while working as a practicing midwife, Melissa witnessed how multiple biomedically-driven, time-constrained physicians responded to Indigenous women's complex descriptions of pain and (ill)health

I have read and I have seen things in my job where it says [in a patient's chart] "poor historian" or "doesn't want to look me in the eye" and that kind of a thing. So, when a woman comes in she will say "Oh I don't feel good." and we will say "Okay, how come you don't feel good?" and she will say, "Well you know I feel nauseous or something" and she won't just talk about why she is nauseous or why she is hurt or something like that. She will talk about how it affects how she is caring for her kids, how it affects her relationships or the people around her she doesn't just talk about the physical aspect of it. That is very common. So, when someone comes in and practitioners are looking at a checklist and they are checking off things in the boxes and all the other things that they are saying doesn't necessarily fit into those boxes, a lot of times they are labelled as "poor historians," so I feel like when we have this gift of an hour to spend with each client, it helps us look at all aspects of this woman and to get to know her and establish that trust.

In this interview excerpt, Melissa spoke about healthcare relations and interactions broadly. Within individualistic, biomedically-driven models of care, the relational aspects of Indigenous women's health and wellness can be misinterpreted as irrelevant, contributing to time-constrained physicians' problematizing Indigenous women.

Many collaborators who spoke about their pregnancy loss in interviews and meetings identified a dissonance between the options many healthcare providers presented (e.g. a surgical termination of a pregnancy they would not be able to carry to term), comments healthcare providers made, and their experiences and understandings. For instance, Cassandra shared that when she miscarried her doctor informed her, “So, based on the extent of the bleeding, this fetus isn’t viable.” Cassandra reported that her doctor’s very technical use of language felt dismissive of her deeply intimate and traumatic experience of pregnancy loss. While the biomedical system trains practitioners to use specific medical language to avoid moralizing statements, the disconnection from the emotional state of the patient is also harmful and underlies the absence of emotional and spiritual aspects of care. A number of collaborators spoke about experiencing biomedically-driven comments or advice from healthcare providers as isolating rather than comforting.

The limits of biomedical narratives and practice are further illustrated by how emergency care practitioners often interpret and respond to patients dealing with pregnancy complications or pregnancy loss. Cassandra spoke about how when she was experiencing pregnancy complications and loss she waited for five or six hours in the Emergency Department at Regina General Hospital on several different occasions with numerous other patients. She was not seen as an urgent case because other patients had more physically critical conditions. However, it was emotionally and mentally difficult for her to wait in the Emergency Department with other people in crisis around her, including children. She explained that when she was waiting in the Emergency Department “[W]hat I really wanted was a private space, what I really wanted was someone to also be treating me for the emotional and mental trauma that I am going through in the moment.” In 2016 the Regina General Hospital responded to concerns about emergency care

treatment of patients dealing with pregnancy loss and opened the first Saskatchewan center for early pregnancy assessments for patients dealing with medical complications (CBC News, Nov 24, 2016), which provides a private space and different supports than the Emergency Department. My review of online information for this project's environmental scan did not identify similar services in the Winnipeg Regional Health Authority or Saskatoon Health Region.

While providing supportive and meaningful acute care during pregnancy complications and loss is crucial, this analysis also emphasized the importance of supports beyond acute care settings, including individual counselling, support groups, talking with friends and family, meeting with Knowledge Keepers and participating in ceremonies. The dissonance between Indigenous women's experiences and the predominant models of care indicate that the imposition of biomedically-driven reproductive health care on Indigenous women (Lawford & Giles, 2013) continues to interfere with their wellbeing. It also highlights the reproductive choice movement's failure to account for Indigenous women's experiences and needs (Silliman et al., 2004; Stote, 2017; Yee, 2011a, 2011b). Examining both the limits of EuroWestern narratives and practices surrounding pregnancy loss and abortion illustrates the need for more responsive, wholistic, culturally relevant supports.

#### **4.4 Responsive and Inclusive Care: “I Was Home and Asleep in My Own Bed by Nine, Because of the Care of This Midwife”**

Services and supports that meet people where they are at and are patient-driven were identified as inclusive and responsive through study conversations and analysis. Some individual healthcare practitioners and organizations are working in ways that make possible responsive, inclusive care. Understanding how enduring colonial values and practices coexist within potentially transformative practices or organizations is also an important aspect of these findings,

as this analysis can prompt the deep work required to transform organizations and practices to become welcoming, inclusive and representative of all community members.

Responsive and inclusive care can be mobilized in various ways. D. Smith et al. (2006) conceptualizes responsive care as care that “seeks to understand, respect and respond to those [worldviews, values and priorities] of communities and clients” (E37), within this analysis, responsive and inclusive care refers to collaborators’ experiences with service providers who meet them where they are at, respond to their needs, and respect their identities and lived experiences. This analysis includes participants’ experiences within organizations a) led by Indigenous people with Indigenous governance structures, and b) led by non-Indigenous people with EuroWestern governance structures, which collaborators identified as Indigenous or non-Indigenous respectively during study conversations. While this framing may be reductive, it was what guided and situated collaborators’ understanding of service provision.

Collaborators emphasized the importance of individual healthcare practitioners who provide supportive, responsive care. In our interview, Paulete shared her story about navigating her surgical experience with a responsive, supportive physician:

Going into a procedure where it is very invasive, and it had to be invasive in order for the procedure to go well, freaked me right out and I ended up being severely triggered because of sexual violence in a prior relationship and sexual violence when I was a child. I went through the procedure and that was the most drugs that they had given someone and I did not fall asleep, I fought the whole way and I felt everything regardless of the numbing. The doctor understood why I was reacting that way and he said, “I understand.” He was the first person that said, “Do you need your partner? She needs to be there” and

the whole time he kept saying, “You are safe, we are just going to quickly do this so that you are safe and healthy.” He kept assuring me through the whole process...

We go from there and the doctor tells me about the procedure, how it went, everything and I go for a follow-up with him and then he says, “Okay, so what is your next step?” I say, “My next step, like I thought I had a clean bill of health?” and he said, “Are you guys planning on having a baby?” Just opened up the conversation. We have been planning it since we met each other and I said, “Kind of, yes” and he said, “You are now safe to have a baby, you are a fertile person and everything is going to go good for you.” With all of the trauma and bullshit that I have been through, I have been told that I wasn’t good enough, and by including me in that demographic the doctor told me you can be a mom with your partner and it is acceptable.

Through opening up this conversation, this doctor validated Paulete and her partner as partners and future parents, which illustrates the impact an individual inclusive and responsive healthcare provider can have. This validation was particularly meaningful to Paulete, because of the sexual violence and homophobia with which she has dealt. She related that members of white-settler society and colonial institutions in Saskatchewan often do not “make space available” for conversations about two-spirit people’s parenting. For instance, when same-sex female couples facilitate a pregnancy with donated sperm, the Saskatchewan’s *Children’s Law Act, 1997* does not consider the birth parent’s female partner a parent since “the presumptions of paternity are explicitly limited to males” (Law Reform Commission of Saskatchewan, 2018, p. 18; Saskatchewan, 1997).<sup>33</sup>

In discussions about responsive and inclusive supports that meet women where they are at and are patient-led, collaborators primarily discussed Indigenous liaisons and advocates,

midwifery and doula care, community-based organizations and services grounded in trauma-informed and harm-reduction frameworks. Collaborators identified the importance of Indigenous liaisons, midwives and doulas advocacy and support in negotiating biomedical healthcare interactions. Increasing these positions and services grounded in trauma-informed and harm-reduction frameworks could foster care that more effectively meets Indigenous women's needs. However, significant investments from provincial governments in this type of care are unlikely considering the neoliberal climate and conservative leadership. Within this type of climate, inclusive and responsive services are generally seen by governments as peripheral or supplementary rather than essential, even when they reduce healthcare costs (for instance, midwifery-attended home births cost the healthcare system significantly less than physician-attended hospital births (Janssen, Mitton, & Aghajanian, 2015)).

Collaborators identified specific aspects of midwifery and doula care as relevant and responsive to their reproductive health care needs including: a) alignment with Indigenous practices related to pregnancy and childbirth, particularly Indigenous midwifery; and b) holistic approach that foregrounds informed consent and continuity of care as well as takes into consideration pregnant people's extended support network. A number of collaborators spoke about wanting to access doula and midwifery care during their pregnancy and childbirth and the barriers to doing so, including the scarcity of midwives (and midwifery positions) in both provinces and their own lack of awareness about doula or midwifery care options when pregnant.<sup>34</sup> Collaborators' discussions of their experiences with midwifery care, as a midwife, doula or patient, highlighted the relationship among midwifery practices and trauma- and violence-informed and harm-reduction frameworks. For instance, Cassandra shared her story

about accessing midwifery care during her difficult pregnancies (she dealt with Hyperemesis Gravidarum [HG]):

[T]he midwife would take at least an hour with me in appointments, she would check in with me mood-wise at every appointment knowing that I was struggling with my condition. Although she maybe wasn't an expert in treating a high-risk condition like HG she had done lots of research and always came back to each appointment having kind of gone the extra mile with "What if we tried this?" She also included my husband in the appointments; she always welcomed him into the room; he was always there for the full hour which was also great because he had to be really involved in my care during my pregnancy because of my condition.

When I actually went into labor at the hospital with both my boys, she respected the way I wanted my room set up and the environment I wanted to create for my delivery. When I gave birth to my first son, there was jazz music playing in the room and I was sipping on tea and she was talking to me. She said, "Hon, I think it is time to start pushing." That was the environment after this horrible pregnancy that she was able to create for me and I delivered my first son, no problem. The second little guy, same thing, I gave birth in the hospital and I think he was out in maybe one push. The midwife was literally just coming to check and see how dilated I was and I said, "No, he is coming out now." I just pushed that kid out and she was like, "Okay, this is done." And the same thing, she had established a wonderful environment and I think that time I had whales playing in the room and I was sipping tea.

When I gave birth to my second son and I was recovering right after, maybe within 20 minutes of him being born she asked, "So, when would you like to go home,

because I will start arranging and doing all that stuff for you.” I really don’t like being in hospitals and I had such a negative experience being in hospitals from all the ER visits and I have an acquired brain injury that I got when I was a teenager and I spent time in hospital then so it does not feel like a positive place. I had no desire to be there any more than I had to. So I joked to the midwife, “Can I leave tonight?” She asked, “Is that what you want to do?” and I said “Is that an option?” She said, “Yes.” I said, “Yes, I want to be out of here as soon as I can, I have a one-year-old at home and I have come here and done what I needed to do. I have had a baby and he is healthy and I want to go home.” She was willing to actually fight with the hospital because it is not their standard policy to let a mom go home, and I said, “Is this going to be okay? Is this too much work?” and she said, “You don’t even worry about that, I will handle it all” and she did and so I think I had my son by 6:00 pm and I was walking around Shoppers Drug Mart like at 8:00 pm buying some stuff that we needed to take home for the baby and I was home and asleep in my own bed by 9:00 pm, because of the care of this midwife.

Cassandra’s story highlights the impact a responsive midwife providing care from a trauma- and violence informed framework can have on an individual’s and family’s wellness. Cassandra, like many collaborators, identified that she had had harmful experiences in hospital settings, making her midwife facilitating her early release from the hospital all the more meaningful. Within the wider context where First Nations women from northern rural and remote communities continue to be forcefully evacuated to hospitals in Saskatoon and Winnipeg for childbirth, Cassandra’s experience of being home with her children the same day she gave birth gestures towards a possible future where it is the norm for First Nations women to choose whether to stay in their

community to give birth with a midwife, or to travel to an urban center to do so with the assistance of a healthcare provider

Trauma- and violence-informed care was highlighted as a framework that facilitates inclusive and responsive care. Collaborators shared stories of supportive care they received grounded in a trauma- and violence-informed framework. Some collaborators used the term trauma-informed to refer to this care, which continues to be the more commonly used term.<sup>35</sup> While collaborators discussed care that was trauma- and violence-informed in all three locations, collaborators in Winnipeg used the term trauma-informed care more frequently. Melissa shared a definition of trauma-informed care stating that this model of care takes into consideration: 1) patients may have experienced trauma, 2) healthcare provider/client power relations, and 3) the healthcare system may subject the client to (further) trauma. Melissa's definition reflected how trauma-informed care was discussed by multiple collaborators, alluding to the violence many people experience when negotiating health services. Indeed, present institutions and health and social services have inherited histories of violence, hierarchical power relations and paternalism, which require recognition and disruption through frameworks such as trauma- and violence-informed care.

Trauma- and violence-informed care aligns with harm-reduction approaches, another framework of care that some collaborators identified as inclusive and responsive. Within this study, harm-reduction was discussed most commonly as services and supports that aim to reduce the harm of substance use and sexual contact through the provision of non-judgemental care, which includes, but is not limited to, providing supplies that facilitate safer drug use and sexual relations. Denise described harm reduction as "learning to do stuff in a safer way...Because we can't tell people not to do what works for them, but we can teach them and help them learn how

to do what works for them in a safer and healthy way.” Her description gestures towards the women-led nature of harm-reduction practices she engages in as a practitioner.

This study’s analysis highlighted tensions related to harm-reduction services on the prairies.<sup>36</sup> Some collaborators understood harm-reduction services as crucial services that treat people who use drugs and engage in sex work respect and dignity. Others were frustrated with harm-reduction services because they viewed them as band-aid solutions and/or practices that enabled people to continue harmful behaviours instead of addressing the root causes of these behaviours. This tension is not unique to this study, rather it is present in public discourse and embodied in institutional practices. For instance, Denise expressed that many people working in government services do not have a sufficient understanding about trauma and harm reduction and that this lack of understanding contributes to government’s punitive policies towards people who use substances. When talking about harm-reduction practice, collaborators who work as service providers identified that building trusting relationships where women are confident that service providers would not judge them or punish them for using substances remains challenging. Women’s expectations that even service providers who espouse harm-reduction values are unsafe is an understandable protective practice within systems and a society where dominant narratives continue to blame people dealing with the harms of substance use for their continued use. These barriers and challenges demonstrate the need to further transform the cultures of care and service provision.

While collaborators emphasized the strengths of responsive and inclusive care, they also highlighted a tension: enduring colonial values that are embedded within potentially inclusive and responsive practices, for instance the erasure of Indigenous influences on these practices. Laverne explained that a lot of Indigenous ceremonies respond to people in what would be

considered trauma-informed ways. Further, she discussed her experience at a trauma-informed conference, where “they were talking about this greatness, like it was a new concept and theory of trauma-informed care...I realized that I get frustrated when I hear these ‘new theories’ and Indigenous people have been saying this for years.” The erasure of Indigenous thought and practices and reframing of EuroWestern thought and practice as the ‘origin’ of a framework or theory reproduces (and further naturalizes) the dominance of EuroWestern thought and healthcare systems.

Another way insidious colonial values creep into discussions about trauma- and violence-informed care is through the disregard or marginalization of Indigenous peoples’ experiences of colonial violence and trauma. For instance, Melissa related that when she talks about colonial violence and trauma and concerns specific to Indigenous women within the healthcare system:

The responses I have gotten are, “Well, there are other people, too, and there are newcomers, and there are all of these other things,” which I totally respect...but when I try to talk specifically about Indigenous women and Indigenous issues, the response has been, “Well, we have to represent everyone.”

These responses are examples of how inclusivity is discursively mobilized to undermine conversations and initiatives that focus on Indigenous women’s needs and experiences. These findings indicate that further work is required to ‘dig up’ insidious colonial values, norms and practices that undermine the potential of these potentially transformative frameworks of care.

Digging up insidious colonial values and transforming practice to meaningfully involve Indigenous women requires what an environmental scan interview participant, Rachel Loewen Walker, OUTSaskatoon Executive Director, referred to as “deep work.” While both Indigenous organizations and non-Indigenous organizations are influenced by colonial heteropatriarchal

values, below I relate relevant analysis from environmental scan interviews with non-Indigenous and EuroWestern-governed organizations, because a) the majority of environmental scan respondents worked at organizations that were non-Indigenous and EuroWestern-governed, and b) collaborators and policy expert participants emphasized the pervasiveness of colonial values and practices within non-Indigenous and EuroWestern-governed organizations. Significantly, many of the environmental scan participants discussed their organizations' services as grounded in male/female gender/sex binaries, which can be mobilized in ways that isolate and regulate two-spirit and trans\* people. Indeed, a respondent from a Saskatoon agency reported that when trans\* people access their short-term emergency housing for women, staff place them in an individual room rather than a shared room for what staff perceive to be "their own safety." However, two-spirit, trans\* and LGBTQ+ youth have identified that isolation and being 'marked' as different is harmful (Robinson, 2018).

Environmental scan participants discussed various efforts their organizations have taken to meet the needs of Indigenous women including two-spirit and trans\* women. Some organizational representatives' responses stated that staff at their organizations serve everyone and clients are treated equally. Often, every client being treated equally translates into every client receiving the same treatment, which is grounded in dominant, taken-for-granted values, in this context, EuroWestern individualistic values. When clients' needs are not met by equal treatment these organizations often problematize these clients, rather than the services or framework, as illustrated by collaborators' discussions about how healthcare practitioners respond to them and other Indigenous women when their needs are not met by biomedically-driven individualistic care. Other environmental scan participants spoke about hiring Indigenous staff, involving Indigenous people on their Board of Directors, and engaging cultural awareness,

cultural competency or cultural safety training in order to promote staff members' knowledge and understanding of Indigenous people's cultures, histories and contexts. In addition, a few organizational representatives spoke about recognizing their programs, policies and practices were grounded in a colonial worldview and revising them to better align with decolonizing or Indigenous values. For instance, Rachel Loewen Walker discussed some of the processes they have been engaging in in order to "Indigenize" their queer work at OUTSaskatoon:

Part of this work of making the space more welcoming to [Indigenous two-spirit, trans and queer people] is revisiting our basic philosophy and having numerous conversations around hospitality and cultural humility...I did not think it would be this difficult or this much work but [the Elder we are working with] pushed us to look at our guiding principles and to reshape them to make them more open and flexible, more consistent with Indigenous worldviews. It is process. We are not there.

Colonial narratives and processes continue to operate insidiously in community-based and government contexts, making this deep work that confronts and disrupts enduring colonial narratives, practices and policies crucial, as is reshaping values, norms and processes so they are truly inclusive, welcoming and representative. Non-Indigenous organizations must work in partnership with Indigenous communities, organizations and people in order to transform their values, norms and practices, which will reduce the harm Indigenous women are subject to within non-Indigenous government and community-based organizations.<sup>37</sup>

#### **4.5 Indigenous Survivance: Refusal, Negotiation and Resurgent Practices: "We Have Always Been Historically Political Leaders and Speakers"**

Indigenous survivance was enacted in this study through the refusal of colonial limitations, negotiation with and survival in the face of colonial conditions and breathing life into

pathways that foster self-determination through resurgent practices. While collaborators did not utilize the term Indigenous survivance or Indigenous refusal, their stories and analytical insights resonate with these terms articulated and activated by Indigenous scholars. Vizenor (1994) defined survivance as moving beyond survival within the context of ongoing cultural genocide to engage in acts of cultural recovery and renewal. Vizenor (1999) later expanded the definition of survivance as “a native sense of presence, the motion of sovereignty and the will to resist dominance” (p. 93). Tuck’s (2009) work indicated that in order to foster survivance, it is necessary to engage with complexity, contradiction and “the self-determination of lived lives” (p. 416). This work on Indigenous survivance aligns closely with Indigenous refusal (A. Simpson, 2014; L. B. Simpson, 2017), which L. B. Simpson articulated as refusing colonial heteropatriarchy and generating alternative lifeways. Discussions about acts of Indigenous survivance and refusal emerged in conversations focused on colonial narratives, policies and practices; inclusive and responsive care; and sustaining and re-envisioning Indigenous teachings and practices. How collaborators discussed acts of refusal and resurgence held significant similarities across all three cities, which is likely related to their similar sociopolitical contexts and shared histories as discussed in Chapter One.

#### **4.5.1 Refusal and Negotiation of Colonial Heteropatriarchal Narratives and Processes:**

##### **“For Me to Have a Safe Home, I Am Going to Do What I Feel Is Right”**

Collaborators described acts of refusal that push back against colonial and heteropatriarchal systems and narratives, in particular, recognizing and eliminating colonial influences on their decision-making. Collaborators also reflected on their past decisions and ways they could mitigate the impact of colonial intrusion in the future. In our interview, Laverne shared that by the time she had finished her Master’s thesis, which analyzed the impacts of the

*Indian Act*, “I said, ‘One of the most revolutionary acts as a woman is just to have a baby and to hell with laws, policies and legal crap.’” Refusing colonial influences on Indigenous women’s reproductive decisions was not equated with Indigenous women making the decision to become pregnant or continue a pregnancy, indeed, this is only one expression that may take. Another expression is refusing rigid definitions of motherhood. For instance, Autumn stated, “For me to have a safe home [for me and my children], I am going to do what I feel is right whether the public or the community says, ‘This is how it should be.’” Autumn’s quote resonated with study conversations in which collaborators discussed facing pressure to comply with colonial ideals of motherhood and womanhood from family and community members as well as institutions and how they negotiated and refused these pressures. These acts of refusal are acts of following and forming pathways of building and raising self-determining families. While the power of pushing back against these narratives and institutions and building alternative lifeways was emphasized, collaborators also spoke about individuals fearing retaliation if and/or when they did so. For instance, Laverne explained that people working in government services often punish women who refuse to engage systems and services the ‘right way,’ denying them access to other supports unless they fully comply with the system.

Along with stories and theories about refusing colonial heteropatriarchal narratives and policies, collaborators also spoke about negotiating government supports and systems as well as community-based supports. For instance, Tatanka Ska Win, spoke about herself and other Indigenous mothers becoming “super moms, super advocates” to protect themselves against the threat of child welfare and justice system involvement, which entailed learning their laws and rights within different systems in order to advocate for themselves and their family members. These acts of refusal and negotiation generated alternative pathways for her, her children and

other families. At different points in history, Indigenous women on the prairies have utilized government organizations, services and settler economies in order to meet their needs and advance their sociopolitical aims (Anderson, 2011; Nickel, 2018).<sup>38</sup> Negotiating community-based services and supports was also discussed as a pathway to accessing resources eroded by colonial forces. Jaqueline explained, “Community-based organizations and the grassroots have been really vital to providing these services that we need for access to culture, access to food, access to rides and transportation, Elders and family/children centres.” Indeed, negotiating these government and community services provides a pathway for Indigenous women to mitigate the harms of colonial erosion of knowledge sharing and resource sharing practices, as well as insufficient wages, social assistance and disability allowances and high cost of living.<sup>39</sup>

Negotiating and refusing colonial influences and systems carries a heavy mental and emotional burden, one that may be mitigated by building and growing community relations. As Chris stated,

There is a lot of isolation and then eventually, and not all people, but women accessing the community as a sisterhood, the women, the aunties, you know and really reaching out and that is powerful and real and happening, you know, and it is done outside of policy and government and funding. I have seen young women learn how to navigate health benefits through INAC... I have seen young women get pregnant so that they can start the life that they want and leave a way they were raised that isn't what they want and, because they have educated themselves, they have become empowered and they want to change a cycle that has been set on them. So, that is one avenue that they will access to become independent and start their own life. I have seen young women, and again back to the community—it is going back to the teachings that they know are inherent and they

have been taught, but maybe not have opportunity to practice so they start accessing and asking for what they need.

While epidemiological and other health research often frames young pregnancy and parenting through deficit-based narratives, Chris positioned young pregnancy and parenthood as a possible pathway through which Indigenous young women disrupt harmful intergenerational patterns and build self-determination. Chris' quote highlights the limits of colonial epidemiological narratives in understanding Indigenous women's experiences and the strength of building and growing community relations. Building and growing community relations fosters knowledge sharing among Indigenous women and families about colonial conditions and strategies of refusal and negotiation, knowledge sharing that can illuminate and co-generate possible pathways.

#### **4.5.2 Sustaining and Re-Envisioning Indigenous Practices and Teachings: “It Was Beautiful Because I Felt Really Connected to Her”**

Collaborators spoke about a resurgence of Indigenous knowledge and practices as emanating from specific Nation-based traditions and shared understandings, values and experiences across Nations. Collaborators from various Nations discussed utilizing similar services, organizing together and attending ceremonies together. They also expressed that spending time with Indigenous women from various Nations who had shared experiences negotiating colonial systems and participating in cultural practices was powerful. Collaborators' framing of Indigenous teachings suggests that most collaborators found more similarities across First Nations teachings than between First Nations and EuroWestern beliefs and values. Further, there were insufficient resources and support for Indigenous-specific programming in the three centres; therefore, the programming available was often designed to meet the needs of Indigenous women from diverse Nations with varied life experiences. These factors contributed

to Indigenous women in the three cities coming together across Nations for ceremonies and organizing. As Laverne related to me, “We never get a chance to actually sit around and negotiate [our differences in values and beliefs] amongst ourselves, because we are so busy trying to just have a place so that there is assistance” for Indigenous women in Winnipeg. Increasing resources and support for Indigenous-led organizations and networks will foster these critical conversations.

Indigenous teachings and practices can support Indigenous women’s self-determination. Collaborators spoke about engaging in practices and teachings in multiple ways within their reproductive lives as part of their approach to life, which reflects how dynamic, relational and complex cultures are. Jennifer shared some of the ways they prepared for the arrival of their adoptive daughter, prior to and shortly after their daughter was born.

I took a traditional parenting program and I remember asking the Elder, “What can I do to help with that bonding since I am not carrying?” and she told me about going as soon as I was able to after she was born to have a blanket and wrap that over us and sort of simulate being in the womb and hold her. Then, just send her as much love or talk with her about whatever I wanted to in order to make that connection and so I did that. I brought one of my ceremonial blankets and when we were in the hospital I did that. I talked with her and told her about her birth mom and her birth dad and about all of this love that was waiting for her. It was beautiful because I felt really connected to her. I prayed lots before she was born and went to ceremony in sweat lodges and felt that was my way to connect with her as well.

Jennifer’s remarks illustrate that cultural practices are engaged and activated in various, everyday practices and relations. Tanya shared her reflections about how engaging cultural

practices promotes further growth within and across communities, “I think that the more that there is space made for people to come together and talk about these things, it becomes less isolating and there are more opportunities to...share the knowledge or teach the knowledge.”

This knowledge sharing takes place in multiple sites, including community-based organizations and various community and family settings. A number of collaborators specifically spoke about the NYSHN, particularly NYSHN’s work on consent, violence on Indigenous lands and violence on Indigenous bodies, and in collaboration with the National Aboriginal Council of Midwives.

Collaborators also emphasized the role of local community-based services and programming in sharing this knowledge, for instance: organizations involving Knowledge Keepers, Elders, Elder Helpers and/or Indigenous cultural liaisons; and programs that engage Indigenous cultural teachings. For instance, Jenelle discussed a Planned Parenthood Regina program she co-led named “Respect Self,” which engaged traditional teachings in order to foster youth’s reproductive and sexual self-determination through building their understanding that: “We are all purposeful beings and the only way we will get to reach our purpose is if we stay balanced and take care of ourselves.” This analysis also highlighted the crucial role that Indigenous-led and Indigenous-governed organizations play in knowledge sharing activities.

Collaborators discussed the diversity of teachings among families, ceremonial families, communities and Nations about gender and reproductive decision-making and how these teachings can frame what decisions are more (or less) possible. Collaborators also spoke about seeking teachings and experiencing difficulties finding the right teacher. This was identified as a particular barrier by: a) two-spirit and trans\* collaborators who are seeking teachers who respect their gender and sexual identity and expression; and b) collaborators who currently live a significant distance from their Nation’s traditional territory and are seeking Nation-specific

teachings. Denise shared, “I don’t have an Elder for myself yet, because I live in a city that is predominantly Ojibway [Winnipeg] and I am Cree, so I feel like in some ways those teachings are going to be different.” Melissa also discussed this challenge and her own work to recover knowledge about pregnancy, labour and birth:

Yes, there are a lot of women’s ceremonies and family ceremonies and things like that, but when it comes to cultural knowledge around pregnancy, labor and birth and things like that, that is kind of lacking in general. I have a lot of people e-mailing me or messaging me and saying, “Who can I talk to about this?” and “Have you heard about this teaching and that?” I have a little bit of knowledge; it feels like a tiny bit compared to what an Elder would have...My dad’s side is from Arizona and I connected with a really good friend who is a midwife down there, so I have been learning a lot about that side of me.

She further explained that this knowledge has been eroded through the forced removal of births from communities, sexual violence at residential and boarding schools and related intergenerational patterns of violence. Indeed, colonial processes have purposefully disrupted this intergenerational transmission of knowledge in order to undermine Indigenous women’s and communities’ self-determination.

Indigenous women, two-spirit and trans\* people respond to these constraining conditions by purposefully seeking supportive and life-affirming teachers, recovering and revitalizing relations and knowledge, as well as bringing the influence of colonial processes on Indigenous teachings into conversations about tradition. Collaborators framed the latter critiques in relation to people who present teachings as grounded in Indigenous philosophies and histories rather than

people who explicitly bring together Indigenous and Christian teachings in their practices.

Jennifer explained how they approach these conversations:

Often, I will question, when I am told, “This is a traditional teaching,” I will ask, “Where did that come from? Is that really a traditional teaching or is that based on a Christian teaching that has been mixed into it? Is that a colonized teaching? So, are those cultural teachings actually there to help women? Or, sometimes those cultural teachings can actually be more harmful.

Another Nêhiyaw collaborator agreed that these teachings can be “more patriarchal and hierarchal in nature. They say they’re tradition, but really they are colonized.” There are varied ways that colonial influences manifest in how traditional constructs and practices are articulated and activated. For instance, Leslie reflected on how narratives framing Indigenous women as sacred life-givers are often taken up:

I hear this over and over again in the traditional community around how women are sacred as life-givers and then it stops. To me that is also socially constructing women in a particular way, without our full humanity...as if it stops with our ability to reproduce children.

Indeed, as Leslie alluded to, limiting the value of women to their reproductive capacity and related qualities reflects, and likely has been produced through, heteropatriarchal narratives.

Laverne similarly critiqued the homogenization of Indigenous women’s roles within many Indigenous communities: “There is way more around women’s roles. Women are not just mothers, they are aunties and those different roles we played in the community-they can accept us as mothers, but they can’t accept the other roles we played.” Laverne spoke further about the constraints of homogenized, essentialized notions of culture and Indigenous gender relations and

how these notions play into funding organization's expectations about culturally-relevant programming.

I've been worried a little about what is considered cultural, because our funders, they are all focused on culture...so we're not doing the beading class...but what we are focusing on is responding, so if our women become politically outspoken, that's who we are, that's our culture. We have always been historically political leaders and speakers, because we did care for our community. That is our culture. So, how am I going to frame that to the funder to understand that yes, we are responding and we are responding in a cultural way, because this is who we are?

Indeed, EuroWestern organizations who are responding to the need to support Indigenous-specific programming often put out funding calls that frame Indigenous cultures as homogenous and static, embodied in specific practices rather than dynamic and flowing through everyday relations. Collaborators questioning how culture and tradition are framed and evoked by Indigenous community members and EuroWestern organizations are resurgent acts that reflect diverse historical and present pathways. This work involves Indigenous women, two-spirit and trans\* people claiming their historical roles as political leaders, midwives and medicine people, and the everyday practices of engaging these and various other community roles. Through cultivating conversations about what is traditional, collaborators are asserting their power and place in recovering and re-envisioning Indigenous teachings and practices, which emphasizes the relationship between individual and community self-determination as well as how creating and following self-determining pathways fosters reproductive and sexual justice for Indigenous women, their families and other community members.

## 4.6 Summary

This chapter offered an analysis of Indigenous women's reproductive and sexual justice as relational and intergenerational, with Indigenous women's self-determination at the center of reproductive and sexual justice. I explored the relational context in which Indigenous women, two-spirit and trans\* people determine their reproductive and sexual futures. In particular, I discussed how enduring colonial narratives, policies and practices undermine Indigenous women's self-determination through a) stigma, stereotyping and surveillance; b) intergenerational patterns of normalizing and silencing sexual violence; c) colonial disruption of Indigenous relations and practices; and d) the dominance of Christian heteropatriarchal narratives, pro-choice/anti-choice frameworks of reproductive rights, and biomedical, individually-driven approaches to health care. Then, I explored how responsive, inclusive practices can support and respect Indigenous women's rights to reproductive justice, as well as the pattern of individuals and organizations reproducing colonial values even as they aim to provide inclusive and responsive supports. Lastly, this chapter discussed Indigenous women's survivance, particularly Indigenous women's refusal and negotiation of colonial narratives, practices and services, as well as the recovery and resurgence of Indigenous practices related to gender, sexuality, reproduction, birthwork and parenting. Reproductive and sexual justice is an expression of self-determination for Indigenous women, who have identified that collective wellbeing fosters their potential to determine their reproductive futures.

## **Chapter 5: Reproductive Coercion: Colonial Narratives and Practices, and Indigenous Women's Resistance**

This chapter presents the study's findings regarding how colonial narratives inform and are reproduced through institutional processes and practitioners' actions to deny and regulate Indigenous women's reproduction.<sup>40</sup> My analysis focused on coercive practices related to sterilization, long-term contraceptives (i.e. intrauterine device [IUD]) and abortion procedures. There are two reasons for this direction, first, study conversations brought into focus recent acts of reproductive coercion related to these technologies and procedures. My initial analysis highlighted that Indigenous women have recently experienced coercion from healthcare and social service providers who have pressured and forced them to prevent or end their pregnancies by using long-term contraceptives or undergoing tubal ligation or abortion procedures. Second, there is a lack of existing academic research analyzing reproductive coercion. The research that exists analyzes historical patterns of reproductive coercion, mainly coercive sterilization (see for instance Dyck, 2013; Dyck & Lux, 2016; Stote, 2012, 2015).

I present my analysis of study conversations, policy documents and related media coverage to highlight various techniques Indigenous women use to build self-determining pathways within a context of reproductive coercion, including acts of refusal, negotiation and sharing community knowledge. The following analysis resonates with key findings from Chapter Four, demonstrating that colonial narratives about Indigenous women undermine their rights to reproductive self-determination despite written policies, law and international agreements that assert these rights. Due to the robust and multiple sources of data along with the significance of these findings, it was necessary to focus this chapter on representing this analysis, rather than

integrating it into Chapter Four. By doing so, I provide a nuanced analysis of media and study conversations as well as institutional policy responses.

My focus on coercive practices related to long-term contraceptives, tubal ligations and abortion procedures began with study conversations with collaborators during research circles, interviews and meetings where they shared related community knowledge and experiences. In response to these study conversations and media coverage of women's stories about coerced and forced sterilization, I analyzed regional and institutional policies focused on tubal ligation procedures and informed consent, drawing on media coverage about problematic practices related to these policies as a secondary source (*Saskatoon Star-Phoenix, Regina Leader Post, CBC and APTN*), as well as the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). First, I provide an overview of the media coverage about coercive practices related to tubal ligations in Saskatchewan and across Canada (5.1). I then focus on Indigenous women's stories about problematic practices related to tubal ligation consent procedures at Royal University Hospital (RUH) in Saskatoon and connect these narratives to study conversations focused on coercive practices including tubal ligations, long-term contraceptives and abortion procedures (5.2). Lastly, I describe Saskatoon Health Region's (SHR) response to women's stories about coerced and forced sterilization at RUH with a focus on RUH's changes to its postpartum tubal ligation policy (5.3).

### **5.1 Burgeoning Media Discussion About the Coercive Sterilization of Indigenous Women at Royal University Hospital (Saskatoon, SK)**

During this study's fieldwork (March 2015 to June 2017), there was increased media coverage regarding the coercive sterilization of Indigenous women in Saskatchewan and Canada. This increase was initially anecdotally identified during a Phase One collaborator meeting. In

order to determine patterns in media coverage about coercive sterilization, I searched the *Saskatoon Star-Phoenix*, *Regina Leader Post*, *Winnipeg Free Press* and *CBC's The National* coverage through the *Canadian Newsstream* database and *CBC* and *APTN's* websites for media coverage published between March 1, 2015 and June 30, 2017 (28 months). *CBC* does not publish all broadcast coverage on their website<sup>41</sup> and it is unlikely that *APTN* does; however, this search did provide a sample of their coverage and, importantly, coverage that was available nationally after broadcast. I searched the database and websites using the terms “sterilization” or “tubal ligation” or “abortion” or “birth control” or “long-term contraceptives” or “long term contraceptives” and “Indigenous” or “First Nations” or “Aboriginal” or “Métis” or “Native” or “Inuit” Through this search, I identified 27 items regarding coercive sterilization of Indigenous women, including news and opinion articles, a letter to the editor and broadcast coverage (see Table 3 for a summary of coverage by media outlet and Figure 2 for a summary of media coverage over time). The only media source with no related coverage during this time was the *Winnipeg Free Press*. Since the majority of the media coverage focused on problematic practices related to informed consent at RUH, it was unsurprising that *Saskatoon Star-Phoenix* published the most coverage (10 news and opinion articles and 1 letter to the editor). The search did not identify any media coverage focused on coercive practices related to long-term contraceptives, other types of birth control or abortion procedures.

In order to determine whether 27 media representations over 28 months was a significant increase in media coverage in comparison to previous months, I also searched the *Saskatoon Star-Phoenix*, *Regina Leader Post*, *Winnipeg Free Press* and *CBC's The National* through the *Canadian Newsstream* database for media coverage during the 28 months immediately preceding this study's fieldwork (November 1, 2012, to February 28, 2015).<sup>42</sup> This search identified one

article published in the *Winnipeg Free Press* on coercive sterilization and no articles on coercive practices related to long-term contraceptives, other birth control or abortion procedures. The *Winnipeg Free Press* article published during the timeframe, “‘Heinous’ Eugenic History Explored” reviewed Dyck’s (2013) book, *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice* (Horodyski, 2014, Mar 1).

Table 3					
<i>Media Coverage About the Coercive Sterilization of Indigenous Women During Fieldwork</i>					
Month(s) Years	Media source and number of media representations <sup>a</sup>				
	<u>Star-Phoenix</u>	<u>Leader Post</u>	<u>CBC</u>	<u>APTN</u>	<u>All Media</u>
Mar-May 2015	0	0	0	0	0
June-Aug 2015	0	0	1	0	1
Sept-Nov 2015	3	1	2	0	6
Dec 2015-Feb 2016	3	2	3	1	9
Mar-May 2016	0	0	0	0	0
Jun-Aug 2016	3	0	0	0	3
Sep-Nov 2016	0	0	1	0	1
Dec 2016-Feb 2017	2	2	1	1	6
Mar-May 2017	0	0	0	1	1
June 2017	0	0	0	0	0
Total	11	5	8	3	27
<sup>a</sup> Number of broadcast and current events coverage, news and opinion articles as well as a letter to the editor on coercive sterilization of Indigenous women.					

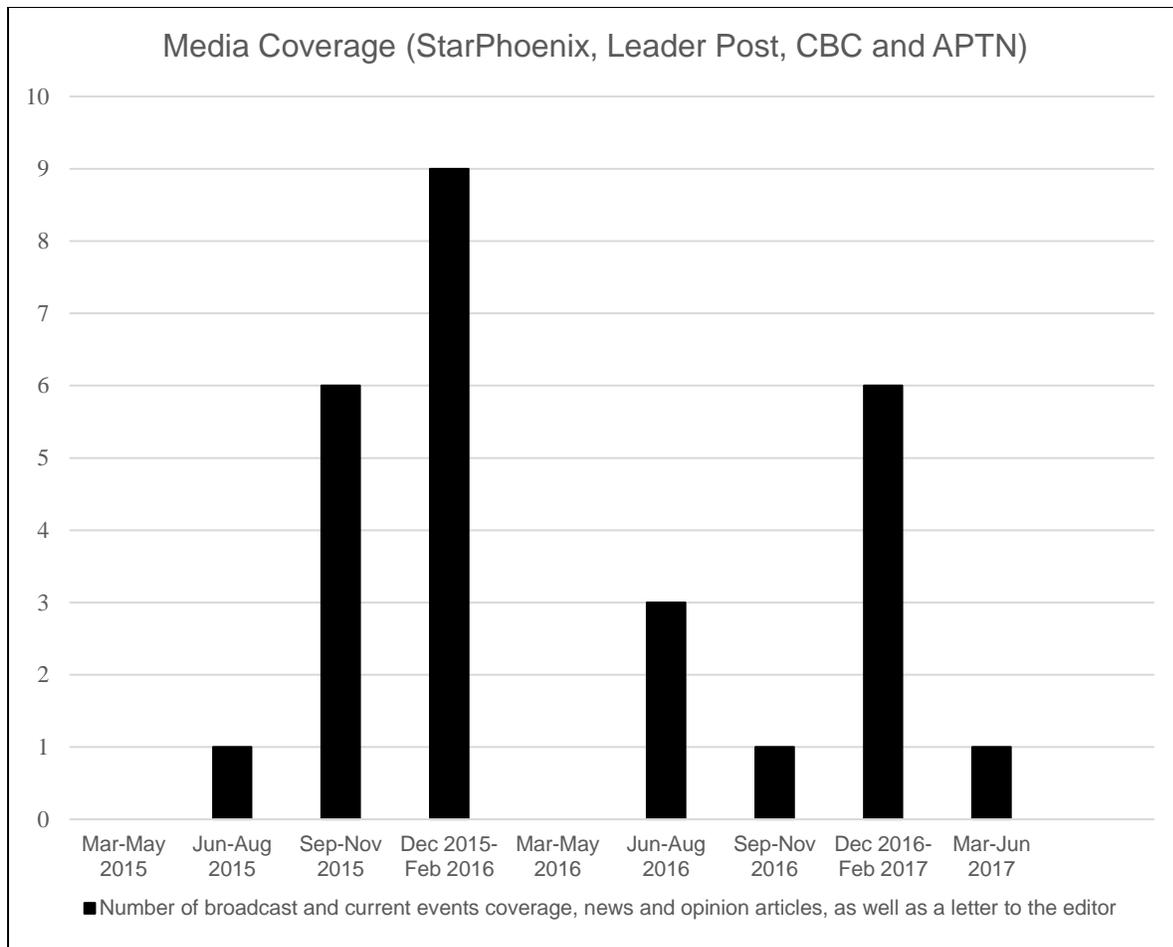


Figure 2. Total Media Coverage of Coercive Sterilization During Fieldwork (March 2015-June 2017)

During study conversations, collaborators spoke about this media coverage, the institutional response to women’s stories as well as the ways in which healthcare practitioners and service providers across various contexts have pressured them or forced them to undergo procedures that would limit their reproductive futures. As I addressed earlier, there is a ban on the publication of the representative plaintiffs’ names and information that could identify them. Recognizing this ban, but more importantly representative plaintiffs’ decision to remain anonymous, we briefly summarize our media analysis findings below without referencing information that could identify them. Much of this burgeoning media conversation about coercive sterilization of Indigenous women was prompted by or focused on: a) several

Indigenous women sharing their stories with journalists about healthcare and social service providers subjecting them to coercion or forcing them to have a tubal ligations at the SHR Royal University Hospital (RUH) in Saskatoon, SK, b) the SHR launching, quietly cancelling and re-launching (in response to media pressure) an external review “into concerns raised by Indigenous women who felt pressured to consent to tubal ligations after the birth of their child,” a procedure commonly referred to in hospital policy as a postpartum tubal ligation (Royal University Hospital, 2009, 2010, 2016; Saskatoon Health Region, 2017, Jan 20, para 1), and c) the publication of Karen Stote’s text, *An Act of Genocide: Colonialism and the Sterilization of Aboriginal Women in Canada* in April 2015. When speaking with journalists, Indigenous women framed the reproductive coercion they experienced in various ways, including: a racist practice, as well as a colonial practice that undermined their identity as women and compromised their Indigenous rights.

Stote’s book (2015) is the first book-length analysis of the coercive sterilization of Indigenous women in Canada. Drawing on historical records and policies, Stote examines coercive sterilization during the timeframe in which formal sexual sterilization legislation was in effect (roughly 1928 to 1973) in provinces where the legislation was enacted (British Columbia and Alberta) as well as in provinces where such acts were not passed but such practices occurred. Stote argued that the coercive sterilization of Indigenous women is a genocidal act, as it is “one policy among many imposed in an effort to separate Aboriginal peoples from their lands, and to reduce the number of those to whom the federal government has obligations” (p. 8). The publication of this text has influenced scholarly conversations (see for instance Conner, 2017; Dyck & Lux, 2016; Geddes, 2017) and received media attention (Porter, 2015, Aug 27). As well,

Stote was interviewed and cited in newspaper and broadcast coverage of coercive sterilization of Indigenous women at RUH (see, for instance, Adam, 2015, Nov 17)

It is evident that this increased media and related public discussion about coercive sterilization influenced our study conversations and the context in which they occurred. During our interviews, some collaborators and other interview participants referenced media reports about coercive sterilization and, when Phase One collaborators met in December 2015, we discussed stories women had shared with journalists about healthcare and social service provider coercion. Responding to this news, I led the publication of a policy briefing note to address the racist, sexist and colonial conditions that underlie coercive practices and the hospital policies that enabled them to be enacted (Appendix F). At the same time, collaborators discussed coercive practices related to tubal ligations and other reproductive technologies and procedures (e.g. abortion procedures and long-term contraceptives) during interviews and meetings indicating that Indigenous communities' and women's knowledge about coercive practices aimed at limiting their reproductive futures not only predates this media coverage but offers complex and historically-contextualized accounting of these harmful practices. Therefore, I integrate my analysis of Indigenous women's stories offered through media coverage and study conversations with my policy analysis in order to build a complex understanding of these harmful practices, what factors enable them and how Indigenous women resist them, including sharing these stories within community contexts and with journalists.

Indigenous women's stories as reported in media coverage indicate service providers' actions violated Canadian patients' rights to free, full and informed consent (Evans, 2006), as well as Indigenous people's rights to free, prior and informed consent (FPIC) (United Nations, 2008). Canadian patients' rights to free, full and informed consent are based on three

requirements (Evans, 2006): 1) patients must have voluntarily agreed to the procedure or treatment; 2) patients must have the capacity to consent to the procedure or treatment; and 3) patients must have all of the necessary information, including the risks and benefits of the procedure and alternatives. At the time of these reports (and previously) SHR had a region-level policy regarding patients' rights to informed consent (Saskatoon Health Region, 1995, 2007, 2015), which focused on the three requirements of free, full and informed consent described above.<sup>43</sup>

These news stories also suggest that healthcare providers' actions violated these Indigenous women's rights to FPIC as asserted in the UNDRIP. Canada endorsed UNDRIP in 2010 and announced its intention to fully implement the declaration at the United Nations Assembly in 2016 (Fontaine, 2016, May 10; Indigenous and Northern Affairs Canada, 2017; United Nations, 2008). UNDRIP recognizes Indigenous individual and community rights to self-determination and is grounded in principles of justice, human rights and non-discrimination. UNDRIP asserts Indigenous people's collective rights to FPIC in various articles. Article 19, for instance, states,

States shall consult and cooperate in good faith with the indigenous peoples concerned through their own representative institutions in order to obtain their free, prior and informed consent before adopting and implementing legislation or administrative measures that may affect them.

While the UNDRIP does not explicitly outline how FPIC should be interpreted within healthcare settings, Andrea Carmen, Executive Director of the International Indian Treaty Council, defined FPIC in the context of medical procedures as "the right to feel fully informed (while awake), to hear the pros and cons, the right to have a waiting period if you want it, and hear about other

options...” all without pressure or coercion (cited in Yee, 2011a, p. 15). These women’s stories and other experts’ interviews indicate that (at least at times) informal practices shaped by enduring eugenic and colonial narratives, as well as the wider context of colonial genocidal relations, may have more impact on Indigenous women’s reproductive self-determination than more recently introduced formal policies asserting human rights and Indigenous rights.

The eugenics movement has had a strong presence in Western Canada, particularly during the early and mid-twentieth century. Alberta and British Columbia passed laws that enabled eugenics programs, while Saskatchewan and Manitoba drafted sterilization acts, but this legislation was defeated (Dyck, 2013). During this timeframe, (roughly between 1928 and 1973) both in provinces with sterilization acts and in provinces without such legislation, Indigenous women were subject to reproductive coercion related to tubal ligations, birth control and abortion procedures, practices that were enabled by colonial narratives that framed Indigenous women as hypersexual, unfit mothers who were unable to make responsible decisions (Stote, 2015). These acts of reproductive coercion must be understood in relation to various colonial genocidal processes within Canadian society that seek to compromise Indigenous people as a distinct group and therefore, their claims to Indigenous land (Wolford, 2015; Woolford et. al., 2014). Indigenous women’s reflections and stories reported in the media coverage described above suggest that eugenic and colonial narratives continue to undermine Indigenous women’s reproductive and sexual self-determination within a context that naturalizes genocidal acts.

## **5.2 Coercive Practices Across Care Providers and Contexts: Coercion Related to Tubal Ligations, Long-Term Contraceptives and Abortion Procedures**

Study conversations resonated with women’s stories about coerced and forced sterilization as represented through media coverage. This resonance suggests that Indigenous

women experience patterns of reproductive coercion across contexts and engage various techniques of resistance and negotiation within these contexts. Within research circles, interviews and meetings, collaborators shared stories about healthcare practitioners and other service providers pressuring them and other Indigenous women to agree to tubal ligations, long-term contraceptives (particularly IUDs) or pregnancy terminations. Collaborators also discussed using various strategies of refusal and sharing of community knowledge in order to negotiate these coercive encounters. While there was growing media conversation about, and related institutional responses to, healthcare providers pressuring and forcing Indigenous women to have tubal ligations at RUH during this fieldwork (March 2015-June 2017), there was no media attention to coercive practices related to long-term contraceptives and abortion procedures in the *Saskatoon Star-Phoenix*, *Regina Leader Post*, *Winnipeg Free Press*, *CBC* and *APTN*.<sup>44</sup>

Indigenous women's stories represented through media coverage focused on coercive sterilizations strongly resonated with collaborators' reflections and stories. Indeed, this media coverage may have prompted some women to reflect on and share their stories of reproductive coercion in study conversations and/or offered a discursive frame that facilitated sharing their truth. Collaborators discussed coercive practices related to tubal ligations and other reproductive technologies and procedures across all three study sites. During research circles, interviews and meetings, some collaborators described their healthcare providers' or service providers' problematic practices in three distinct ways: a) as pressuring, rushing, or tricking them into making these decisions; b) as proceeding as if they had already consented to the procedure or treatment; and/or c) as overtly or covertly evoking racist and colonial stereotypes to justify or convince women to agree to a procedure or technology. Indeed, collaborators' description of

coercive practices also aligns with how women described service providers' coercion in media coverage.

During our research circle and interview, Jasmond spoke about multiple experiences of healthcare providers pressuring her to make certain reproductive decisions and proceeding as if she had agreed to a procedure or treatment when she did not consent. For instance, when Jasmond was 20 weeks pregnant, a doctor repeatedly asked her if she wanted to have an abortion and she explained she did not want to terminate her pregnancy. When the doctor kept asking this question, Jasmond accessed support from an Aboriginal Liaison Worker at the healthcare organization who advocated for Jasmond with the doctors. In Jasmond's words, the Aboriginal Liaison Worker "finally got them off my back." Then, when Jasmond gave birth to her son, Jasmond's doctor asked her if she wanted a tubal ligation. When Jasmond responded that she did not want the procedure, the doctor stated, "Well, we are going to do it." Jasmond and her sister both intervened and prevented the doctor from performing the procedure. Jasmond's story illustrates how formal and informal liaisons and advocates can support Indigenous women's reproductive self-determination. However, Jasmond soon had to negotiate another coercive encounter with a healthcare provider.

Shortly after she had her child, Jasmond's gynecologist gave her a prescription for Mirena after very little discussion. Mirena is an intra-uterine device (IUD), a long-term, reversible form of birth control that is inserted into the uterus to prevent pregnancy.

My gynecologist, he said, "Well because you are Aboriginal, because you are Native, you should be on birth control." He had a nursing student with him and the student looked at him and I was like, "Oh." I just wanted to get out of there because my baby was with me. She described her interaction with her physician further:

He didn't ask me anything, he just said, "So, I talked to your doctor and we decided that you are going to take Mirena." I was like, "I am going to take Mirena?" And he said, "It is like an IUD, it is plastic." He showed me it and he said, "Your doctor will show you more and you wear it for five years." I am like, "Okay," like he didn't ask me if I wanted to be on Depo-Provera or needles.

Jasmond explained that she does not plan to fill the prescription for the IUD and she did not engage in further dialogue with this doctor about the IUD, because:

I just didn't want to sit there and be lectured because I knew he was going to say, "Well"...I mean he already said "You are Native, you are Native, so..." you know. I knew he was being racist, but I was just trying to pretend like he wasn't.

Jasmond's explanation and reflections about healthcare providers subjecting her to reproductive coercion resonates with women's framing of service provider's treatment as 'race'-based or racist in the media coverage described above. It also highlights one of the techniques Indigenous women use within coercive contexts: refusal. Her refusal to engage with a provider whose care for her was guided by his colonial assumptions about Indigenous people through not filling her prescription and avoiding further dialogue with him was one of the ways she exercised her agency within this constraining context.

Similarly, Rebecca shared in our research circle that she feels that a doctor tricked her into having a tubal ligation after the birth of her second child at 23. Reflecting on her experiences with this doctor and other healthcare providers, Rebecca discussed how she would respond differently in a similar situation today.

Nowadays, if I was to go back in there and I was still able to have children I probably would like to know why they think I shouldn't have any kids. What is their reason?

Because I know for a fact that if I am going to have a baby then I am going to want to make sure that I am going to love this child and I am going to make the best life that I could that I never had. But to come and tell me, “I want you to get your tubes tied, you shouldn’t have any kids.” Well, first of all, who are you to tell me why I shouldn’t have kids? You know, it is my choice.

In this quote, Rebecca shares her vision of an alternative pathway where rather than a doctor misleading her, she claims her rights to free, full and informed consent and FPIC through challenging service providers’ opinions and coercive practices, and trusting her own capacity to raise her children.

Collaborators spoke about acts of coercion crossing contexts and taking place within community-based organizations, group homes, foster homes and healthcare settings. For instance, Jenny shared that a service provider told her she should be on Depo-Provera and threatened “If you get pregnant, I’m going to take you to have an abortion.” Jenny talked to someone else at the organization about this person’s actions and the service provider was reprimanded for her coercive behaviour. Similarly, various collaborators raised concerns about youth in group homes, foster homes and other contexts being pressured to terminate pregnancies and/or being prescribed long-term contraceptives without being meaningfully involved in the decision-making process. Laverne shared,

...we were talking about it and [a work colleague] had come across a girls’ group home and Depo was kind of what the girls are all being injected with and I think it is big on reserves. It is being pushed big for teenagers, right? You don’t want your kid to get pregnant, get your kid on Depo.

Similarly, Jannica reflected on how she has witnessed people working in social services respond to youth ‘in care’ planning to become pregnant or becoming pregnant:

It is normalized for people in social services you know to try to caution kids against having kids while they are in social services, instead of supporting that idea and maybe tailoring a plan towards healthy choices and carrying to term. Usually the first comment is about birth control or the first comment is, “Have you talked to your family doctor?”

[Implying that the youth should discuss an abortion procedure with their family doctor].

As Jannica’s quote implies, service providers often start (and focus) conversations about reproductive decision-making on preventing and/or ending the pregnancy. Jannica and Laverne’s quotes illustrate how insidious problematic practices related to birth control and long-term contraceptives can be. They can take the form of providing youth with long-term contraceptives, such as Depo-Provera, as a common practice without sharing the information necessary for free, full and informed consent and FPIC with youth. It can take the form of beginning and consistently returning the conversation to a youth’s birth control or abortion options and not discussing parenting as a feasible option (or available parenting supports).

This analysis demonstrates a pattern of paternalism towards Indigenous women and girls within reproductive healthcare and social service contexts and highlights the need to address coercive practices within healthcare contexts and beyond. Indeed, for reproductive and sexual self-determination to become the norm for Indigenous women, the wider context of colonial genocidal relations and structural violence must also be transformed. Michelle shared her reflections on how the coercive context she and other Indigenous women negotiate influenced her decision to undergo a tubal ligation procedure:

Involuntary sterilization and being pressured into sterilization, for myself, although I voluntary got sterilized, I did it because of the past experiences of watching other people suffer from having their children taken away or being sterilized themselves, I know a lot of women especially mid-30s to mid-50s, they were sterilized...you see it everywhere, [the attitude that] Indigenous women, First Nations people should stop having kids and it's so disrespectful.

While Michelle specifically noted that her healthcare provider's actions respected her rights to free, full and informed consent, she also indicated that colonial and other structural violence, particularly colonial interference in her grandmother's and mother's lives as well as her own life, shaped this decision. Her quote gestures towards the breadth and depth of intergenerational community knowledge about forced and coerced sterilization among Indigenous women. Collaborators shared community knowledge about reproductive coercion and how they utilize this knowledge in their work supporting other women to assert their self-determination. For instance, Rebecca shared,

My friend said to me, "Oh, I am pregnant" and I am like, "Really, congratulations! I am really happy for you because I want more kids but I can't have any kids and I wouldn't mind having a daughter because I don't have any daughters, I just have boys. Then she tells me, "Oh, this doctor wants me to have an abortion." and I said "Why? Don't listen to them," I said. "It is not their choice," I said. It is your body, you know." I told her, "How I see things, Creator gave me a life and I am going to carry through with it." Then I said, "What happened? Why are they trying to make you have an abortion?" She says, "Oh, they are saying that there is something wrong with my baby like it is not growing, there is no heartbeat or something like that."

Then I told her, “Don’t listen to them, like they are probably just trying to say that to you because right now there is a struggle with the government and Aboriginal people and they don’t want our people to be successful and strong and grow and they want to try and limit us so that they can control us and who we are. They look down at our people, because they want stuff that they can’t take from us and they want it for their own use” and I just told her “Just go through your pregnancy if you want this baby.” I said, “If it is going to be too much for you, just let me know and I will be there to help you.” Then I didn’t hear from her for a long time and then time had passed already like she had her baby and then she told me, “You know I am so happy that I listened to you.” I asked, “Why?” She said, “Because I have a beautiful daughter.”

Rebecca’s quote connects colonial anxieties about Canadian sovereignty over Indigenous lands with the doctor’s advice to her friend, which resonates with critiques that Indigenous people and allies’ have leveraged against colonial systems and actors for decades: that white-settler society and the colonial government are enacting genocide against Indigenous people. These genocidal practices include, but are not limited to, taking measures to limit the number of Indigenous children and other practices that seek to undermine Indigenous people as a distinct group (Dyck & Lux, 2016; Gurr, Stote, 2015; Wolford, 2015; Woolford et. al., 2014). Notably, in sharing community knowledge, Rebecca supported her friend to form her own self-determining pathway and refuse biomedical ‘expert’ advice informed by colonial relations. Her quote gestures towards the harm Indigenous women negotiate when accessing care within healthcare institutions.

Many collaborators reported that they and other Indigenous women feel they cannot trust many doctors’ and other healthcare practitioners’ care and information. For instance, Cassandra shared a story about her cousin experiencing delays and barriers when trying to access care

related to pregnancy complications and how her cousin and her cousin's partner experienced this (lack of) care. She explained,

They had a miscarriage and there are so many question marks and so much hurt and anger in their mind about could that have been prevented? And why was that response to our care? They really felt like they were put off because they were a young First Nations couple and this was going to be her fifth child, his first, but her fifth, and so they felt like they were like... we can't do anything for you and they didn't really feel supported or cared for.

Collaborators discuss ways that they negotiate and refuse colonial influences on healthcare interactions and relations, including reinterpreting the care provided through the context of colonial relations (as Rebecca discussed above) or refusing to engage with these providers (as mentioned by Jasmond). Similarly, Katryna shared,

After the experience of the first miscarriage, I just was done with talking to people from the health community, because of the way I got treated. I'm First Nations, I'm Aboriginal, why would I need to be treated with disrespect? When you ask something like that, they're gonna say "Oh, you're sleeping around are you?" or something like that and make you feel like you're a slut or something just because you want to find out about reproductive health in a way that's healthy and it's really frustrating, because I'm sorry, I'm 44 and I'm just now getting more real information and it took a Black doctor to help me sort through all of this. It just was a bit discouraging that it took this much to heal.

In response to providers subjecting her to judgement and stereotyping, Katryna avoided healthcare to protect herself from further harms. Then, she utilized another strategy that

collaborators discussed: engaging with a supportive and responsive healthcare provider in order to negotiate the healthcare system and access useful information.

EuroWestern biomedical care often problematizes Indigenous women's lack of engagement with healthcare services (see for instance Wang, Larke, Gabos, Hanrahan, & Schopflocher, 2005) without meaningfully considering the problem of colonial healthcare relations (Varcoe et. al., 2013). Collaborators' quotes and stories highlighted that refusal, reinterpretation and negotiation of care influenced by colonial narratives are integral to determining healthy pathways for themselves and their families. This analysis indicates that colonial narratives framing Indigenous women as hypersexual, irresponsible mothers and blaming them for their own victimization shapes healthcare and service providers' actions. These narratives undermine Indigenous women's rights to free, full and informed consent and FPIC in relation to various reproductive technologies and procedures. These acts of reproductive coercion coalesce with multiple other genocidal acts and processes in order to undermine Indigenous people as a collective and their relationship to land. Indigenous women negotiate these coercive contexts in various ways including: acts of refusal, reinterpretation and negotiation as well as by sharing community knowledge and personal stories.

### **5.3 The Health Region Responds to Women's Stories of Coerced and Forced Sterilization: Cultural Competency Training, Policy Changes and an External Review**

In response to women sharing their stories with journalists about problematic practices related to informed consent in late 2015 and early 2016, along with two women filing formal complaints and launched an external review. Media coverage indicated SHR had made policy changes after women first shared their stories with journalists in November 2015, however, these policy changes were inconsistently reported in media coverage between November 2015 and

June 2016. Based on my analysis, the policy changes implemented by June 2016 at RUH restricted tubal ligations after delivery to the following circumstances: a) only after caesarean deliveries; and b) only if a patient discussed having a post-delivery tubal ligation with their physician during their prenatal care and this discussion was documented. There is no written policy document that reflects these noted restrictions but, according to study conversations, they were in practice. For instance, Jillian shared concerns she had heard from healthcare providers whose patients were unable to access tubal ligation procedures because of these policy restrictions. Indeed, this revised policy presented specific challenges for patients who had vaginal births and lived in rural or remote areas, were single parents and/or had multiple children, because it requires a separate trip to the hospital. While on the surface it appears to be a fitting response to prevent coercive sterilizations, it also limits many women's reproductive freedom and does not address complex factors that contribute to reproductive coercion.

The external review process was not straightforward. SHR launched an external review in early 2016, which was cancelled by June 2016. In response to pressure media and public pressure, SHR re-opened the external review in January of 2017 led by Yvonne Boyer, Métis lawyer and Canada Research Chair at Brandon University and Judith Bartlett, Métis doctor and former professor at University of Manitoba (Saskatoon Health Region, 2017, Jan 20) and in July 2017, Boyer and Bartlett (2017) released their final report. As such, the review process was ongoing when this study's fieldwork came to an end. This external review used a community-based methodology and involved interviews with Indigenous women who experienced coercive practices related to postpartum tubal ligations, service providers as well as a review of women's medical charts and SHR policies. This review process was community-based and aligned with Indigenous research approaches. While SHR's decision to re-launch the review was shaped by

pressure from outside sources, the decision indicates that SHR may be willing to engage structural change to foster a more responsive and inclusive culture of care.

RUH also made significant revisions to their written Postpartum Tubal Ligation policy (Royal University Hospital, 2016), which embedded considerations about free, full and informed consent in policy and procedure. The media release that announced the re-launch of the external review (Saskatoon Health Region, 2017, Jan 20) provided a link to their revised written policy about tubal ligations at RUH that had been finalized October 2016.<sup>45</sup> This revised policy facilitates tubal ligations after vaginal *and* caesarean deliveries if healthcare providers have documented discussions of patients' free, full and informed consent before they are in the hospital for childbirth, unlike the earlier policy change that restricted postpartum tubal ligations to only after caesarean deliveries. This change aligns with 1) Indigenous women's rights to FPIC as articulated by Carmen (cited by Yee, 2011a) (although FPIC is never explicitly discussed in RUH's policy); and 2) guidelines from the World Health Organization to prevent coercive sterilization (2014). RUH also included a statement in the 2016 policy asserting individuals' rights to reproductive autonomy. The policy stated, "All individuals have the right to decide the number and spacing of children, regardless of their race, ethnicity, religion, health status, mental capacity, social circumstances and sexual orientation" (Royal University Hospital, 2016, 1.2, p. 1 of 6). RUH's 2016 written policy also contains a strengthened emphasis on free, full and informed consent embedded in the policy's purpose, principles and procedure. Its stated purpose is:

2.1 To provide safe, efficient and timely service for women requesting postpartum or cesarean section tubal ligations.

2.2 To ensure that consent for tubal ligation is free, full and informed (p. 2 of 6).

In comparison, previous versions of RUH's Tubal Ligation Policy (2009, 2010) focused primarily on facilitating postpartum tubal ligations. Both the April 2010 and September 2009 Tubal Ligation policies discussed consent briefly; for instance, they included statements about which unit (2009) and which practitioner (2010) are responsible for facilitating consultation and the consent process with patients. This strengthened written emphasis on informed consent within the 2016 policy brings healthcare providers' obligation to adhere to consent procedures to the foreground. However, Canadian law and the health region-level policy about free, full and informed consent (Evans, 2006; Saskatoon Health Region, 2015) applied to tubal ligation procedures prior to this policy change. If pre-existing Canadian law and region-level policies about free, full and informed consent were followed, overt violations such as those described by Indigenous women in media coverage would have been prevented. Therefore, further education, accountability processes and institutional changes remain necessary.

Some of the responses offered by RUH and SHR gesture towards a willingness to change institutional culture. For instance, SHR's implementation of an external review that uses community-based methodologies, and emphasis on reproductive autonomy and informed consent in the 2016 Postpartum Tubal Ligation policy. However, more work is required to transform the culture of care at RUH and SHR. An integral part of interrogating their institutional culture of care includes determining whether their policies, values and norms enable, justify or prevent reproductive coercion in various forms. As this analysis demonstrated, Indigenous women are subject to problematic practices related to informed consent across various reproductive technologies and procedures and in various locations. Therefore, it is also necessary for other institutions and organizations to interrogate and transform their cultures of care so Indigenous women can navigate their reproductive decision-making with safety and dignity.

## 5.4 Summary

This chapter began with an overview of media conversations about coercive sterilization in Saskatchewan and across Canada during this study's fieldwork. While media coverage of coercive sterilizations has grown, there is little discussion about reproductive coercion related to other technologies and procedures. Within study conversations, collaborators shared stories and knowledge about coercive practices related to tubal ligations, long-term contraceptives and abortion procedures across various contexts. Interestingly, my analysis suggests that media coverage relating Indigenous women's stories about coercive sterilization prompted some collaborators to reflect on and share related experiences and community knowledge.

Study conversations resonated with women's stories of coercive and forced sterilization as represented by various media sources. Building on Chapter Four, these findings indicate that colonial narratives about Indigenous women undermine their rights to reproductive self-determination, despite written policies and Canadian law on free, full and informed consent, and Indigenous people's rights to FPIC as asserted within UNDRIP. These acts of reproductive coercion must be understood in relation to other colonial genocidal acts that seek to undermine Indigenous people's collective identity and relationships to land. This analysis also demonstrates that Indigenous women use various techniques to build self-determining pathways through contexts of reproductive coercion, such as refusing healthcare providers' path of treatment and sharing community knowledge. In order to reduce the harms Indigenous women are subject to within healthcare institutions and to support Indigenous women to access safe biomedical care, it is necessary to transform the context in which healthcare is practiced as well as wider society, through processes grounded in the values of equity and responsive care with decolonizing aims.

## **Chapter 6: Discussion and Conclusion: Study Contributions to Academic, Public and Practice Contexts**

Overall, this study highlighted that, for urban Indigenous women in Regina, Saskatoon and Winnipeg, self-determination is the crux of reproductive and sexual justice. Among Indigenous women, self-determination was articulated and activated in ways that emphasized its relational and intergenerational qualities. These included refusing colonial narratives and processes, sharing community knowledge and recovering and re-envisioning traditional teachings and practices. Further, I identified changes that can foster Indigenous women's self-determination, particularly increasing and further developing inclusive and responsive supports and transforming organizations and institutions through processes grounded in decolonizing aims and values of equity and responsiveness. I begin this chapter by discussing how Indigenous women's conceptualization of reproductive and sexual justice as interdependent, relational and intergenerational can inform reproductive and sexual justice theory and practice, as well as related services and supports (6.1). Next, I bring collaborators' framing of self-determination as relational and intergenerational into conversation with Indigenous feminists' work about self-determination and Indigenous scholars' work focused on Indigenous survivance, refusal and resurgence (6.2). Then, I relate my findings that Indigenous women have recently experienced reproductive coercion from healthcare and service providers in various contexts to current media and public conversations, and historical research about similar practices (6.3). Next, I discuss this study's implications for policies, services and supports (6.4). I also reflect on how relationality contributed to the knowledge produced in this study (6.5) and recommend areas for future research (6.6). I conclude by reflecting on where Indigenous women and their accomplices

should put their/our energy in order to foster self-determination among current and future generations (6.7).

## **6.1 Expanding Reproductive Justice Theory and Practice**

Indigenous women's articulations of self-determination as relational, intergenerational and central to reproductive and sexual justice promotes further understanding within academic and practice contexts specific to Indigenous women's reproductive and sexual lives and beyond. Reproductive justice as a framework resonated with collaborators who emphasized a) the interdependence of reproductive and sexual justice; b) self-determination as the crux of reproductive and sexual justice and c) self-determination as relational and intergenerational. These findings provide a nuanced understanding of the importance of key relationships articulated elsewhere, including the interconnections among struggles for reproductive rights, sovereignty and land, particularly within work by the NYSHN (NYSHN & Action Canada for Sexual Health & Rights, 2016; NYSHN & The National Aboriginal Council of Midwives, 2014, May 28; Silliman et al., 2004; WEA & NYSHN, 2016). It also resonates with Indigenous philosophies that situate decision-making more widely within contexts of ancestral histories and care for future generations (Clark, 2018; Kuokkanen, 2019; McKenna, 2017; L. B. Simpson, 2011, 2017).

Foregrounding the relational aspects of Indigenous women's reproductive and sexual justice fosters complex analyses of sociopolitical and institutional forces and relations with kin, community members, animals, spiritual forces and land. Conceptualizing reproductive justice as intergenerational brings into focus how experiences emerge and decisions are made within a context of familial, community and institutional histories, relations and practices. For instance, many collaborators drew on narratives about intergenerational trauma to frame their experiences

and decision making within a context of colonial disruption, resistance and knowledge sharing (Brave Heart & DeBruyn, 1998; Cedar Project et al., 2008; Kirmayer et al., 2014; Mehrabadi et al., 2008; Spittal et al., 2007). This analysis also emphasized the varied practices through which Indigenous women activate reproductive and sexual justice as intergenerational, for instance engaging Indigenous and EuroWestern practices to disrupt harmful patterns and celebrate life transitions as well as re-envisioning traditional teachings so that they are inclusive of girls, women, two-spirit and trans\* people. How collaborators work to foster their own and their children's reproductive and sexual self-determination troubles narratives that imply intergenerational trauma is transmitted through a transgenerational linear process (Maxwell, 2014; Million, 2013).

Conceptualizing reproductive and sexual justice as intergenerational and relational highlights how proximal responses to reproductive injustices that abstract individual decisions from their context elide and even enable structural violence. These types of proximal responses have been taken up within much of the reproductive justice advocacy work in Canada, which continues to focus primarily on legal rights and access to abortion (Shaw, 2013); however, they are limited in their effectiveness to support many people's reproductive justice. These limits are highlighted by study conversations about Indigenous women's experiences of reproductive coercion and with difficult reproductive decisions, as well as historical and ongoing colonial practices that undermine Indigenous women's control of their reproduction and right to parent with dignity (Fournier and Crey, 1997; Johnston, 1983; Maxwell, 2014; H. A. McKenzie et. al., 2016; Milloy, 1999; Stote, 2015). If reproductive justice advocacy continues to focus predominantly on proximal responses, there is a significant risk of rendering invisible intermediate and distal conditions that undermine many women's, two-spirit and trans\* people's

reproductive and sexual self-determination. For instance, if reproductive justice activists in Saskatoon focus only on increasing the number of gestational weeks during which patients can undergo abortion procedures from 12 to 20 weeks, only one reproductive decision will become more accessible within Saskatoon. Possible reproductive and sexual futures for many will remain limited unless reproductive justice advocates prompt the Saskatchewan government to: increase social assistance and disability benefits, increase minimum wage, increase funded childcare options, increase safe and affordable housing, and address harmful colonial practices, policies and ideologies pervasive within government institutions.

Conceptualizing reproductive and sexual justice as interconnected, relational and intergenerational across various contexts could also strengthen theory and practice in various ways. When taking up this analysis grounded in Indigenous women collaborators' framing of reproductive and sexual justice it is integral to acknowledge their contributions. The interdependent nature of reproductive and sexual justice has been discussed within some literature (Cohen and Caxaj, 2018; Ross, 2017), particularly literature focused on reproductive justice work with Indigenous people (Gurr, 2015; WEA and NYSHN. For example, as discussed in Chapter Four, Ross (2017) framed bodily integrity and sexual freedom as aspects of reproductive justice. However, academic literature about reproductive justice within non-Indigenous communities rarely brings these important aspects into focus (see for instance Luna, 2011; Ross, 2006a; Shaw, 2013). I argue that this tenuous relationship was likely inherited from EuroWestern biomedical practices, which separate sexual and reproductive health, and Christian narratives separating reproduction from 'sex for non-reproductive purposes,' historically constructing the latter as sinful and deviant (Goodwin, 2011). This analysis emphasized the need for research to consider principles of reproductive and sexual justice together. Similarly,

analyzing relational and intergenerational aspects of reproductive and sexual justice across various communities can deepen theory and practice. Ross' (2017) description of the parameters of reproductive justice work explicitly addressed socio-political and community relations. Further insights can be established through foregrounding familial, interpersonal, intergenerational and environmental relations. Indeed, recent work with Indigenous communities has highlighted the relationship between reproductive and environmental justice (Hoover, 2018; Hoover et. al. 2012). Emphasizing the interdependence of reproductive and sexual justice, and bringing familial, interpersonal, environmental and intergenerational relations into focus aligns with intersectionality theory and reproductive justice theorists' focus on interconnectivity (Ross, 2017).

Through expanding reproductive and sexual justice analyses, more complex and creative solutions will be imagined and actualized, solutions that respect individual decision-making and foster support for women's, children's, two-spirit and trans\* people's intergenerational networks. For instance, if the provincial child welfare systems and legislation were re-envisioned through a reproductive and sexual justice framework that is relational and intergenerational, how might child welfare responses change to children and families in Saskatchewan and Manitoba dealing with situations of neglect or 'at risk' of maltreatment?<sup>46</sup> Available research (Blackstock, Trocmé & Bennett, 2004; Sinha, Ellenbogen & Trocmé, 2013; Sinha et al., 2011; Sinha, Trocmé, et al., 2013; Trocmé et al., 2010; Trocmé, Knoke, & Blackstock, 2004) established the substantial overrepresentation of First Nations children in the child welfare system and analyzed the relationship among child welfare involvement in Indigenous families' lives and structural inequities including unstable and unsafe housing, systemic discrimination and poverty. In particular, Sinha, Trocmé et. al.'s (2013) analysis of the 2008 Canadian Incidence Study of

Reported Child Abuse and Neglect demonstrated that First Nations families are most often investigated for neglect or risk of maltreatment. Their analysis also highlighted that in comparison to non-Indigenous families who were investigated, First Nations families were more likely to be dealing with conditions of low-income, harmful substance use, domestic violence and strain related to caregiving (Sinha, Ellenbogen, et al., 2013, p. 828).

Through adopting a reproductive and sexual justice framework, most of the child welfare system's focus would shift to ensuring families have the support and resources they need to create the safe and healthy environments they envision. This framework would align more closely with the Nation-specific and broad Indigenous teachings collaborators shared during this study than the existing legislation. Therefore, it is likely that re-envisioning this legislation through a reproductive and sexual justice lens would reduce the tension First Nations Child and Family Service workers have identified between workers', agencies' and community's expectations of culturally relevant services and the requirements of the provincial legislation (Mandell et al., 2007; Walmsley, 2005). Further, through bringing into focus families' resources to create safe and healthy environments, inequitable distribution of material resources through various colonial and capitalist practices would become more visible.

## **6.2 Contributions to Conversations About Indigenous Self-Determination**

In expanding definitions of reproductive and sexual justice, this study highlights collaborators' framing of self-determination as relational and intergenerational, which foregrounds the relationship between individual women's and their communities' self-determination and resonates with Indigenous feminists' work, such as that of LaRocque (2007), L. B. Simpson (2011, 2017) and Kuokkanen (2014, 2019). In this study, self-determination is conceptualized as being able to articulate and exercise reproductive and sexual decisions within a

context of intergenerational and relational support. Self-determination was articulated both as an emancipatory future and as activated in everyday practices. In particular, collaborators discussed a) the intergenerational and relational supports they envision that would facilitate Indigenous women, two-spirit and trans\* people to fully determine their reproductive and sexual futures; as well as b) how they assert their decisions within their current constraining contexts.

Much of the existing academic literature regarding self-determination is focused on state-centered definitions and processes (Kuokkanen, 2014; 2019). Indigenous women's assertions of individual self-determination have often been framed as compromising collective self-determination efforts (see, for instance, Trask, 1996; Russell, 2000; Wotherspoon and Satzewich, 2000). This tension is present within academic and political contexts. In the 1960s and 1970s, members of the National Indian Brotherhood, likely responding to concerns about coerced and forced sterilization of Indigenous women and the Canadian government and white-settler society's genocidal disposition, framed pronatalism as inherent to community self-determination (Dyck & Lux, 2016). Despite this tension, there are significant parallels between how the Canadian government responds to and manages Indigenous political movements for self-government and how the government responds to and manages Indigenous women's activations of reproductive and sexual self-determination.

The Canadian government has reframed political self-determination as neoliberal self-management, recognizing Indigenous chiefs' and councils' right to make decisions about small parcels of reserve lands and some aspects of people's lives, similar to municipal governments (Million, 2013).<sup>47</sup> However, when political self-determination efforts extend beyond settler-colonial approved structures, Indigenous organizations are subject to surveillance and sanctions (Proulx, 2014). Similarly, Indigenous women's reproductive and sexual self-determination is

managed through government institutions, such as child welfare, even if families manage themselves in such a way that they do not come in contact with to these systems. When the child welfare system determines that a family has not managed themselves in a way that aligns with their standards (which are informed by colonial and capitalist ideologies), families are subject to surveillance and regulation. Parents' decision-making becomes largely driven by what the system requires in order to maintain or regain custody of their children. I am reminded of Tatanka Ska Win's statement that Indigenous mothers have to be "supermoms, super advocates" in order to keep themselves and their children safe and out of the system, and Jacob's (2014) analysis that the child welfare system's ongoing pattern of removing Indigenous children from their families and communities in Canada and the United States has become ingrained as a "habit of elimination" (p. 190).

This study's findings contribute to the growing discussion about Indigenous self-determination that takes into account gender and various non-legislative contexts in which self-determination is exercised. Indigenous feminists such as LaRocque (2007), Kuokkanen (2019) and L. B. Simpson (2017) articulated definitions of self-determination that emphasize the interconnections between individual and collective sovereignty. For instance, Kuokkanen (2019) described self-determination "[a]s a future vision, Indigenous self-determination requires nondomination in all relations, ranging from state relations of dispossession and removal, oppressive relations of colonial policies and law, to the most intimate relationships" (p. 22). Central to Kuokkanen's conceptualization of self-determination "is the norm of integrity, with two of its main dimensions: integrity of the land and individual integrity" (p. 19)

This study highlights how Indigenous women articulate and activate self-determination within the context of their reproductive and sexual lives as one aspect of forming self-

determining pathways with their families and communities. Collaborators' framing indicate that five relational aspects are integral to Indigenous women's reproductive and sexual self-determination:

- 1) Gender and sexual identity and experiences,
- 2) Terms of reproduction (including the right to prevent pregnancy, become pregnant and to terminate or continue pregnancies),
- 3) Selection of birthing conditions (including whether to have a midwife- or physician-attended birth),
- 4) Selection of where one lives with one's family (including geographic location and housing conditions), and
- 5) Engagement of relationships (including community, cultural practices and the land).

These relational aspects center Indigenous women and their relationships as the primary influences governing their experiences. Conceptualizing reproductive and sexual self-determination as relational and intergenerational brings into focus familial, environmental, animal, community, spiritual and institutional relations and practices that both support and undermine Indigenous women's reproductive and sexual justice.

This study also identified relational supports that facilitate Indigenous women's reproductive and sexual self-determination, including: a) culturally-relevant information, resources and supports that facilitate women's decision-making, b) people, organizations and governments that respect, honour and support women's reproductive and sexual decisions, and c) people, organizations and governments that respect familial and community rights to self-determination. Together, these relational aspects of, and supports for, Indigenous women's reproductive and sexual self-determination can provide a useful foundation for analyzing

policies, services and community actions. In these analyses, it is essential that local Indigenous women are engaged to interpret, contextualize and build upon these relational aspects and supports so these analyses are relevant to local contexts and cultures. As many of Kuokkanen's (2019) interview participants agreed, self-determination “means different things for different people and different communities,” (p. 26).

This study demonstrates that Indigenous women engage various techniques to exercise their self-determination. These acts coalesce as one expression of Indigenous survivance and include: a) refusing the influence of colonial conditions and narratives on their lives, b) negotiating colonial systems and community-based supports to meet their needs, and c) engaging in resurgent practices. Indigenous scholars consider survivance to be the moving beyond bare survival to grow self-determining presents and futures (Grande, 2015; Tuck, 2009; Vizenor, 1994, 1998). I find Tuck's (2009) work that embraces the messiness of self-determination within constraining contexts particularly useful as collaborators everyday practices involved acts of refusal and negotiation of colonial systems in order to build alternative pathways for themselves and their children. Acts of refusal and negotiation exist alongside acts of resurgence (L. B. Simpson, 2011, 2017), including protecting and sustaining Indigenous teachings, seeking out life-affirming teachers, sharing knowledge, and re-envisioning teachings and practices so they are inclusive and supportive of girls, women, two-spirit and trans\* people. As Kuokkanen (2019) asserts, restructuring relations of domination is necessary to foster Indigenous women's self-determination and these everyday acts of refusal, negotiation and resurgence disrupt oppressive, hierarchical relations. Using creative techniques to contribute and share resources with Indigenous-led organizations, networks and communities doing this crucial work can accelerate the re-creation of alternative lifeways. Simultaneously, it is necessary to foster relations of non-

domination through transforming enduring colonial heteropatriarchal policies, institutions, norms, values and relations that continue to harm Indigenous women.

### **6.3 Expanding Academic and Public Conversations About Reproductive Coercion**

This is one of the first studies in Canada that gathered and shared Indigenous women's stories and community knowledge about experiencing reproductive coercion from healthcare and social service providers and their strategies to resist these coercive practices. This analysis indicated that colonial narratives framing Indigenous women as hypersexual and irresponsible mothers continues to compromise Indigenous women's reproductive and sexual self-determination. This study's findings that Indigenous women recently have been subjected to coercive practices to limit their reproductive futures resonates with feminist and queer scholarship that demonstrates colonial heteropatriarchal narratives, policies and practices have, and continue to, deny, regulate and degrade Indigenous motherhood and reproduction as well as erase caregiving roles of two-spirit and other gender- and sexually-diverse people (S. Carter, 1997; Driskill et al., 2011; Emberley, 2001; Evans-Campbell et al., 2007; Kelm, 1998, 2005; Lavell-Harvard & Lavell, 2006; Million, 2013; L. B. Simpson, 2017; Stote, 2015). In order to impose colonial heteropatriarchy within Canada, government officials, frontier media and members of white-settler society circulated narratives that denied and degraded gender- and sexually diverse people, and positioned Indigenous mothers as irresponsible, deviant and prone to addictions and violence, narratives that endure in settler-colonial society and institutions today (Browne, 2005; Browne & Fiske, 2001; Browne & Smye, 2002; S. Carter, 1997; Denison, Varcoe, & Browne, 2014; Driskill et al., 2011; Emberley, 2001; Hunting & Browne, 2012; Lavell-Harvard & Lavall, 2006; Million, 2013; Tait, 2008, 2009). Colonial forces continue to seek to erase and degrade as well as manage and regulate Indigenous women's reproduction as

part of the colonial genocidal disposition: to undermine and eliminate Indigenous people's governance systems and claims to their lands (Thielen-Wilson, 2014; Stote, 2015; Woolford, 2015; Woolford et. al., 2014).

Research has demonstrated that Indigenous women in Canada were subject to reproductive coercion while Alberta's and British Columbia's sexual sterilization legislation was in force (between roughly 1928 and 1973) within both provinces that enacted this legislation and provinces and territories that did not (Stote, 2012, 2015). There also are indications that physicians have problematically prescribed long-term contraceptives in Indigenous communities in northern Canada and the United States. (Canadian Women's Committee on Reproduction Population and Development, 1995; NYSHN & Action Canada for Sexual Health & Rights, 2016; Ralstin-Lewis, 2005).

There is growing media and public discussion about the forced and coerced sterilization of Indigenous women at the RUH in Saskatoon and other healthcare institutions in cities across Canada (see, for instance, Canada NewsWire, 2018, Dec. 7; Kirkup, 2018, Nov 12; Zingel, 2019, Apr 18). In July 2017, Boyer and Bartlett completed the external review for SHR into concerns that healthcare and other service providers had pressured and forced Indigenous women to undergo postpartum tubal ligations at RUH. Boyer and Bartlett's report emphasized the pervasiveness of systemic racism within SHR and offered several calls to action that promote institutional change. For instance, Boyer and Bartlett recommended restructuring the Saskatoon Health Region and the Saskatchewan Ministry of Health so Indigenous people are equal partners in health governance.<sup>48</sup>

In October 2017, Two Indigenous women launched a class-action lawsuit against the federal and provincial governments, Saskatchewan Health Regions and three doctors

“allegd[ing] their charter rights were breached and that they were subjected to institutional systemic racism” (Adam, 2017, Oct 14, p. A6). By July 2019, more than 100 Indigenous women in six provinces (including Manitoba) as well as Yukon and the Northwest Territories had joined this proposed class-action lawsuit (Kirkup, 2019, May 6; Sanders, 2019, Jul 10). The National Inquiry on Missing and Murdered Indigenous Women and Girls explicitly addressed this proposed lawsuit and forced sterilization more broadly in their final report referring to forced sterilization as “directed state violence against Indigenous women” (2019, p. 267). Burgeoning media and public conversations about these reproductive injustices have also drawn the attention, and concern, of the United Nations Committee Against Torture. This committee’s report released December 7, 2018 addressed the forced and coerced sterilization of Indigenous women in Canada, recommending that the Canadian government:

- (a) Ensure that all allegations of forced or coerced sterilization are impartially investigated, that the persons responsible are held accountable and adequate redress is provided to the victims;
- (b) Adopt legislative and policy measures to prevent and criminalize the forced or coerced involuntary sterilization of women, particularly by clearly defining the requirements of free, prior and informed consent with regard to sterilization and by raising awareness among Indigenous women and medical personnel of that requirement (p. 12).

The Assembly of First Nations (AFN) passed a resolution in early December 2018 “to support the class action claimants of forced sterilization in seeking redress and to advocate for changes to the *Criminal Code of Canada* to criminalize forced sterilization in Canada” (Canada NewsWire, 2018, Dec 7, para 6), however, these changes have not yet been made. Instead, federal

government representatives stated that forced sterilization is already criminalized through the existing Criminal Code provisions and asserted that they are taking a “public health approach to the issue” (Saskatoon StarPhoenix, 2018, Dec. 7, para 7).

This study contributes to other research, media and public conversations, demonstrating that Indigenous women experience reproductive coercion in relation to long-term contraceptives, tubal ligation and abortion procedures across various contexts. Specifically, reproductive coercion was discussed in study conversations in Winnipeg, Saskatoon and Regina as taking place at community-based organizations, group homes, foster homes and within healthcare settings. These findings emphasize the limits of written policies and Canadian law to ensure Indigenous women’s rights to reproductive and sexual self-determination since these providers’ actions (as reported by collaborators and in media coverage) violate Canadian law (Evans, 2006), health region policies about free, full and informed consent (Regina Health District, 2001; Saskatoon Health Region, 2015; Winnipeg Regional Health Authority, 2007) and Indigenous peoples’ rights to FPIC as asserted within UNDRIP and articulated by Indigenous women advocates (WEA and NYSHN, 2016; Carmen qtd by Yee, 2011a). Media and public conversations to date remain focused on reproductive coercion related to tubal ligations, with limited discussion about coercive practices related to abortion procedures (see, for instance, Saskatoon StarPhoenix, 2018, Nov 12; Kirkup, 2018, Nov 21). Importantly, women’s stories about coerced sterilization represented through various media and community sources may have contributed to women reflecting on and subsequently sharing their experiences of reproductive coercion more widely, illustrating the potential for media coverage and research to co-inform public awareness and advocacy. This study also highlighted various techniques that Indigenous women employ to build self-determining pathways through contexts of reproductive coercion,

such as refusing healthcare providers' recommended path of treatment informed by colonial stereotypes as well as sharing their stories and community knowledge. However, rather than relying on individual women's advocacy efforts, it is crucial to transform these cultures of care to foster Indigenous women's safety and dignity.

#### **6.4 Implications for Legislation, Policies, Services and Supports**

This study's findings suggest various interventions with potential to foster Indigenous women's reproductive and sexual self-determination, for instance, increasing a) safe and accessible food and housing, b) social assistance and disability benefit rates, c) funded childcare and culturally relevant early childhood education, d) minimum wage, as well as resources for Indigenous-led networks and organizations that support women. Increasing these supports and resources would reduce the harms of colonial erosion of resource sharing practices, extended family and community child-rearing practices, and the appropriation of Indigenous lands. Other interventions focus on a) criminalizing various acts of reproductive coercion and sharing knowledge about consent, b) increasing access to abortion services, c) further growing inclusive, responsive, wholistic, culturally relevant supports, e) reducing the harms of colonial institutions and organizations, as well as f) repatriating stolen Indigenous lands.

As discussed above, there are growing media and public conversations about coercive sterilization and organizations such as the United Nations Committee Against Torture and AFN have recommended that Canada criminalize forced sterilization. While coercive sterilization and coercive abortion are technically already criminal acts, I argue that the Act should be revised to explicitly criminalize forcing or coercing someone to 1) have a tubal ligation or abortion procedure and/or 2) to use contraceptives. While Indigenous women often experience revictimization when accessing the EuroWestern justice system (Balfour, 2008; Dylan, Regehr,

& Alaggia, 2008; Hunt, 2014), these changes to the Criminal Code would validate women's experiences of reproductive violence and open up another (albeit problematic) avenue through which women could hold their perpetrators accountable. Relatedly, there is growing media, scholarly and public conversations about FPIC and UNDRIP (see, for instance, Boyer and Bartlett, 2017; Kuokkanen, 2019; Last, 2019, Nov 2; Lightfoot, 2018; The Canadian Press, 2018, May 30), and while the federal government has not yet implemented UNDRIP, British Columbia recently introduced legislation to do just that (Bellrichard, 2019, Oct 24; Last, 2019, Nov 2). If provincial, territorial and federal governments fully implement UNDRIP, there will be further (albeit, again problematic) avenues for Indigenous people to assert their rights to collective and individual self-determination.<sup>49</sup> Alongside these Criminal Code and legislative changes, sharing knowledge with various groups about patients' rights to free, full and informed consent and Indigenous people's rights to FPIC can further people's understanding about consent and how to assert (and advocate for) these rights.

As demonstrated, Christian heteropatriarchal forces and the limiting pro-choice/anti-choice binary shape what services, technologies and procedures are available in Saskatchewan and Manitoba. Most significantly, Saskatoon remains one of the most difficult urban locations in Canada to access surgical terminations (French & Radford, 2015, June 5) as patients must attend multiple appointments within a short timeframe or travel elsewhere for the procedure. While these policy barriers have been in place for many years, recent actions in Saskatchewan hold promise for increasing access to abortion services. For instance, since the completion of this study's fieldwork, financial barriers to accessing Mifegymiso (medication that induces abortions up to 9 weeks) have been eliminated in Saskatchewan and Manitoba with both governments fully covering the cost (A. Hunter, 2019, Jun 7; The Canadian Press, 2019, Jun 01). In order to foster

reproductive justice, eliminating policy barriers to accessing surgical abortion procedures in Saskatchewan is crucial, which would include: a) increasing the number of gestational weeks during which patients can undergo abortion procedures from 12 to 20 weeks at City Hospital, b) revising City Hospital procedures so women can self-refer for surgical terminations and attend all of their related appointments in one day, as well as c) eliminating policy barriers to stand-alone abortion clinics in Saskatchewan. It is also important to further develop services related to reproductive decision-making so patients can access robust, non-judgemental support when considering a pregnancy termination, tubal ligation and/or long-term contraceptive. For instance, a formal or informal network of advocates who can support patients in navigating the reproductive decision-making process and accompany patients while they attend healthcare appointments and undergo procedures, such as full-spectrum doulas; as well as accessible counselling services grounded in a reproductive justice framework.<sup>50</sup>

This analysis emphasized the limits of another colonial heteropatriarchal formation, EuroWestern, biomedical, individualistic care, in meeting the needs of many Indigenous women who have experienced pregnancy loss. Biomedical, individualistic care has been problematized, particularly by women and couples experiencing pregnancy loss (A. Lang & Fleiszer, 2011) and Indigenous women (D. Smith et al., 2006). Many collaborators who spoke about their pregnancy loss highlighted the harms of this approach. In 2016, the Regina General Hospital responded to concerns about emergency care treatment for patients dealing with pregnancy loss and opened the first Saskatchewan center for early pregnancy assessments for women who are dealing with pregnancy complications (CBC News, Nov 24, 2016). While it is necessary to further expand acute care options, this analysis also highlighted the importance of supports beyond acute care

settings, including: individual counselling, support groups, talking with friends and family, meeting with Knowledge Keepers and participating in ceremonies.

This study's findings also emphasized the importance of inclusive and responsive care in fostering Indigenous women's reproductive and sexual health and wellness, as well as the need to critically interrogate these services and supports for insidious colonial values and practices. This analysis highlighted both a) the impact of individual responsive health and social service providers; and b) specific roles and models of care that are grounded in responsive and inclusive frameworks including: Indigenous liaisons and advocates, midwifery and doula care, community-based organizations and services grounded in trauma- and violence-informed and harm-reduction frameworks. These findings indicate the need for responsive and inclusive care to grow through: a) increasing funding for Indigenous liaison and advocate roles, b) increasing funding for midwifery positions and education, c) increasing funding for trauma- and violence-informed care and harm-reduction services and d) funding doula care. This analysis also indicates that allocating further resources to organizations and networks providing Indigenous models of trauma- and violence-informed care, and midwifery and doula care will foster Indigenous women's self-determination.

This analysis demonstrated that potentially transformative care, such as harm reduction and trauma- and violence-informed care are activated by some organizations and individuals in ways that perpetuate colonial values and norms. For instance, a) the erasure of interconnections between Indigenous practices and trauma- and violence-informed care; and b) the marginalization of Indigenous peoples' experiences of colonial violence despite research and toolkits explicitly foregrounding colonial violence and trauma (Ponic et al., 2016; Poole, Urquhart, Jasiura, Smylie, & Schmidt, 2013). These findings resonate with Indigenous and

ally/accomplice researchers' critiques that trauma narratives are being utilized to perpetuate colonial processes and interventions, such as health and social service interventions and the apprehension of children (Clark, 2016; Landertinger, 2011; Maxwell, 2014; Million, 2013). Simultaneously, researchers and advocacy organizations have demonstrated the need for more culturally relevant harm-reduction services that address structural violence in addition to reducing the harm of immediate risks associated with substance use and sexual encounters (NYSHN, 2014; Smye, Browne, Varcoe, & Josewski, 2011). Further, this study's findings that Indigenous women experience reproductive coercion despite written policies and laws about free, full and informed consent suggests transforming cultures of care and wider society is necessary to foster Indigenous women's safety and dignity. It is crucial for organizations and institutions to interrogate policies and practices for colonial values and norms in order to reduce the harms of colonial heteropatriarchal values and processes on Indigenous women's lives.

Colonial heteropatriarchal values and norms remain embedded in policies, organizations and institutions despite numerous reports and inquiries that recommend and advocate for Indigenous self-determination, decolonizing relations and services, and structural change to support and respect Indigenous women's bodily integrity (Amnesty International, 2004; Canada, 1996; National Inquiry into Missing Indigenous Women and Girls, 2019; Native Women's Association of Canada, 2010; Truth and Reconciliation Commission of Canada, 2015). While institutional and structural change is difficult and slow-moving, the colonial genocidal disposition embedded within white-settler society and government profoundly interferes with this work (National Inquiry into Missing Indigenous Women and Girls, 2019; Stote, 2015; Woolford, 2015; Woolford et. al., 2014). Indeed, Canada as a nation-state is invested in maintaining colonial processes and values and undermining Indigenous individual and collective

strengths in order to maintain jurisdiction over Indigenous lands (Emberley, 2001; Kuokkanen, 2019; Million, 2013; Thielen-Wilson, 2014). In light of these constraining factors and the harms of colonial norms, values and practices on Indigenous women's lives, as demonstrated not only by this study's findings, but also by previous research (Billie Allan & Smylie, 2015; Bennett, 2009; Browne, 2005, 2007; Browne & Fiske, 2001; Browne & Smye, 2002; Browne, Smye, et al., 2011; Browne, Varcoe, et al., 2011; Denison et al., 2014; K. MacDonald, 2002; Salmon, 2007; D. Smith et al., 2006; Tait, 2009; Tait et al., 2013; Tang & Browne, 2008; WEA and NYSHN, 2016), further action is needed.

It is imperative that Indigenous people and accomplices interrogate organizational and institutional policies and processes for colonial heteropatriarchal values. Collaborators' emphasis within study conversations on the colonial harms of the child welfare and healthcare systems indicate that these institutions are crucial sites for intervention. However, as Indigenous scholars assert (J. Green, 2007; Hunt, 2015; Kuokkanen, 2019) and this analysis supports, colonial heteropatriarchal values and norms have influenced both EuroWestern and Indigenous organizations; therefore, all organizations need to engage in this important work. It is integral for non-Indigenous organizations to work in partnership with Indigenous organizations, communities and individuals. Through doing so, organizations and institutions can transform policies, mission statements, mandates, practices, services, as well as staff representation and knowledge in order to become more welcoming and representative of all community members (H. A. McKenzie et al., 2018).<sup>51</sup> These processes will vary, and some useful strategies and actions may be found in: McKenzie et al.'s (2018) work focused on promoting meaningful inclusion, Browne, Varcoe, Ford-Gilboe and Wathen's (on behalf of the EQUIP research team) (2015) and Ford-Gilboe et al.'s (2018) work on equity-oriented care, Boyer and Bartlett's (2017)

calls to action, the Truth and Reconciliation Commission's (2015) calls to action, and the National Inquiry into Missing Indigenous Women and Girls' (2019) calls for justice. Simultaneously, institutions need to create safe and respectful processes through which people who have been subjected to reproductive coercion and other forms of violence by service providers working at their institutions can access reparations. As part of this transformation, non-Indigenous-led organizations can use creative strategies to share resources and power with Indigenous-led organizations and networks through which Indigenous women are building self-determining pathways.

All of the interventions that I have offered thus far focus on reducing the harm of colonial heteropatriarchy and fostering alternative lifeways. However, deconstructing colonial genocidal relations and respecting Indigenous individuals, families' and communities' rights to self-determination cannot be fully achieved if Canadian sovereignty over Indigenous lands remains primary. As Woolford et. al. wrote, "restitution for colonial genocide would thus entail returning stolen territories" (2014, p. 9). Similarly, Tuck and Yang (2012) assert that decolonization will be achieved through the repatriation of land to Indigenous people and the recognition that Indigenous and white-settler societies have different relationships with these lands. With the repatriation of stolen lands, Indigenous people, communities and Nations can continue creating contexts in which individual and collective self-determination is fully possible, as well as define what (if any) relationships they would like with the settler collective and other visitors.

## **6.5 How Relationality Shaped This Study**

This study was shaped by relationality, including: a) my existing human relationships, b) the relationships collaborators and myself have with the territories on which the study was facilitated, and c) colonizing and decolonizing relations. A number of collaborators who became

involved in the study had already existing relationships with me or someone who I knew, which facilitated the development and growth of these relationships. Indeed, these relationships were largely developed through my academic and community work related to Indigenous health and wellness, violence against Indigenous women, girls, two-spirit and trans\* people, and reproductive rights. As a result, my academic and community work and related relationships shaped who became involved in this study and the focus of study conversations. Further, this study was designed with the intention to create knowledge that is local and specific to these three urban centres. This study was conducted on Treaty One (Winnipeg), Treaty Four (Regina) and Treaty Six (Saskatoon) territories and therefore these findings are reflective of urban Indigenous women's analytical insights and experiences on these territories. While these findings will contribute to academic and community conversations about reproductive and sexual justice and Indigenous women's self-determination, some of the findings reflect localized realities (such as the limited access to abortion services in Saskatoon). In another example, study conversations did not foreground the impacts of resource extraction on Indigenous lands and Indigenous women's bodies, which is a critical reproductive and sexual injustice (WEA and NYSHN, 2016). The likely reason for this absence is this study's focus on urban contexts and the concentration of resource extraction in the rural and northern areas of these two provinces.

I facilitated this study through a strength-based critical framework, because I have witnessed the limitations of deficit-based approaches to understanding Indigenous women's reproduction and sexuality. Strength-based frameworks also align closely with Indigenous pedagogical approaches (Anderson, 2011; Battiste, 2013). However, using a strength-based framework raised concerns that study conversations could minimize complex, structural reproductive injustices, which would contribute to the implementation of proximal changes in

contexts where complex, distal interventions are needed. However, during study conversations and later when continuing my analysis, I was struck by how much study conversations focused on reproductive and sexual violence. It is likely that this focus on reproductive and sexual violence within study conversations was shaped by colonizing processes and relations. Collaborators may have focused more on reproductive and sexual violence, because they are subject to forms of colonial violence that I am not and knowledge about these reproductive and sexual violations is crucial to this work. It is also possible that collaborators focused our conversations more on reproductive and sexual violence, because colonial institutions privilege white-settler voices and perspectives and therefore, if I speak to these acts of violence, institutions may take me seriously and these urgent changes may be made. When I asked collaborators and other participants to share their visions of functioning, supportive systems or programs, some articulated their specific visions, but often these discussions focused more on abstract elements or proximal responses. Pervasive EuroWestern individualistic ideologies likely contributed to these tendencies in study conversations, since these ideologies undermine structural analyses and visioning of potential futures outside of EuroWestern frameworks and structures.

My intentions in engaging this work and how I facilitated this study were informed by my decolonizing politics. As Hunt and Holmes (2015) articulated, our daily relational practices are interconnected with our advocacy and activism for large social change. As discussed in Chapter Three, I engaged various efforts to foster decolonial moments among collaborators, Kookums and other community members, for instance, following Indigenous protocols throughout the project including: a) engaging Kookum Betty's guidance of the project, b) cooking feast food with my partner for the initial sharing circle during Phase One, and c) following Indigenous

protocols of consent and gifting. I also worked to disrupt colonial politics of knowledge production and the material benefits of research through a) co-presenting and co-authoring academic presentations and community products with collaborators and Kookum Betty; b) recognizing the contributions of collaborators, Kookum Betty as well as other Kookums and community members with cash honoraria; c) mobilizing knowledge gathered and co-generated in this study in ways that aim to foster social change (particularly through the policy briefing note, fact sheets and YouTube video); and d) fostering space within study conversations for collaborators to gather and share knowledge relevant to their concerns and interests so they could take action within their own lives and support others to do the same (Reid et. al., 2006). While I found avenues to creatively disrupt academic research practices and politics, I was constrained by the colonial standards and ideologies that continue to structure academic research. I was also constrained by own experiences, analytical lens and what collaborators shared with me, which was shaped by my positionality as a white-settler, queer, feminist, accomplice researcher. Further, I recognize that the settler-colonial privileges I have inherited contribute to my acceptance and ‘success’ in this PhD program, and therefore, my opportunity to facilitate this project. The de/colonial politics of my role in this project are messy: a product of a) the mentorship of, and relationships with, Indigenous Knowledge Keepers, researchers, thinkers and other community members, b) my accomplice work with Indigenous people, and b) settler-colonial privileges.

## **6.6 Areas for Future Inquiry**

This study is one strand of the burgeoning reproductive justice research movement and further research is needed to build deeper understandings of how Indigenous women from diverse Nations across various territories articulate and conceptualize reproductive and sexual

justice and to determine what local, provincial/state, national and global changes will foster Indigenous women's self-determination. It is integral to take account the diversity among Indigenous people and communities who have complex cultures and realities shaped by varied histories, relationships to land, living conditions and sociocultural forces. Within this study, collaborators consistently highlighted constraints Indigenous women in rural and remote areas negotiate related to their reproductive and sexual lives. Therefore, it is crucial that action-oriented projects are facilitated with Indigenous women living in rural and remote areas to gather and co-generate knowledge about their experiences and understandings related to reproductive and sexual justice. It is also critical that future research specifically explores how two-spirit, trans\* and LGBTQ+ people relate to and conceptualize reproductive and sexual justice and the factors that foster and constrain their reproductive and sexual self-determination. This study also identified the need for specific related areas of inquiry, including: a) further exploring Indigenous women's, two-spirit and trans\* people's experiences with abortion services and pregnancy loss; b) identifying how services and supports related to abortion services and pregnancy loss can change to foster Indigenous women's, two-spirit and trans\* people's self-determination; c) identifying how Indigenous midwifery and doula care can grow to further foster Indigenous women's, two-spirit and trans\* people's self-determination in urban, rural and northern communities; d) further research about Indigenous women's reproductive coercion across various contexts; and e) research exploring whether and how Indigenous two-spirit and trans\* people experience reproductive coercion. This future research will support Indigenous women's, two-spirit and trans\* people's work to build alternative self-determining pathways and reduce the harm of colonial heteropatriarchal institutions and processes.

## 6.7 Conclusion

This collaborative action-oriented study further expands understandings of reproductive and sexual justice and offers a conceptualization of Indigenous women's self-determination as relational and intergenerational. Based on collaborators' framing, I offer relational aspects and supports that foster Indigenous women's, two-spirit and trans\* people's reproductive and sexual self-determination, which can be used as a foundation for analyzing policies, services and community actions. This analysis also demonstrates that enduring colonial heteropatriarchal narratives and values limit Indigenous women's reproductive futures. Indigenous women experienced healthcare and social service providers pressuring and forcing them use long-term contraceptives and undergo tubal ligation and abortion procedures across various contexts. Based on this analysis and the endurance of colonial heteropatriarchal values, norms and practices, it is crucial for non-Indigenous organizations to work with Indigenous partners to interrogate their policies and practices for colonial norms and values and transform services and organizations so they are responsive, inclusive and safe for Indigenous women.

While writing this chapter on how this study's findings contribute to academic, public and practice conversations about reproductive and sexual justice, Indigenous self-determination and reproductive coercion, I repeatedly returned to the following questions: Which actions are most needed? Where should Indigenous women and their accomplices put their/our efforts first? I kept revisiting Kookum Betty's words as shared in the preface: "...there is going to be a woman going through something in 10 years and because of the work you did, she is going to have some support or understanding. Your work will affect future women's lives..." I determined that in order for this work to have the largest impact on future women's lives, it is crucial for Indigenous women and accomplices who are invested in this work to focus their/our energy on:

a) creating alternative lifeways through acts of refusal, negotiation and resurgence, and b) reducing the harms of colonial heteropatriarchy through transforming relations, services, organizations, institutions and communities.

## Endnotes

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<sup>1</sup> The pass system was introduced in 1885 and restricted movement outside reserve communities of First Nations people with status under the *Indian Act*. First Nations people were required to obtain a pass from the Indian Agent in order to travel outside their community and law enforcement often questioned them when doing so (Daschuk, 2013).

<sup>2</sup> The *Indian Act* is federal legislation first passed in 1876 that regulates First Nations people's lives, including who is recognized as 'Indian,' what forms of First Nations governance the federal government will recognize (and therefore negotiate with) and what First Nations people can and cannot do. The 1876 Act consolidated various pieces of legislation, such as the *Gradual Enfranchisement Act* that imposed restrictions and regulations on First Nations people. The *Indian Act* is informed by colonial and racist assumptions that Indigenous people are less civilized than EuroWestern Canadians and require regulation in order to assimilate into the Canadian body politic. From 1869 until 1985, the *Gradual Enfranchisement Act*, and then later the *Indian Act*, imposed patriarchal familial relations on First Nations people, defining as 'Indian' men with status, their wives and children. Therefore, women with status under the *Indian Act* were stripped of their status if they married men who did not have status under the *Indian Act*, including Métis men. While some of the overtly sexist provisions of the *Indian Act* have been eliminated, the legislation retains much of the paternalism and regulation of the original version (Lawrence, 2004).

<sup>3</sup> As discussed in the introduction, when referring to traditions and traditional, I include knowledge shared through oral history and written accounts as well as recent articulations of reclaimed and resurgent relations.

<sup>4</sup> The narratives around Haudenosaunee women's power and their associated political and economic power strongly influenced early maternal feminists and, as Emberley (2001) states, since "their ideas on women's equality did not extend to the originators of this democratic tradition...the question of 'influence' must be seen as a form of appropriation that contributed to the oppression of First Nations" (p. 65). In other words, early EuroWestern maternal feminists drew on examples of Haudenosaunee women's traditional political roles in order to argue for their own equality (in relation EuroWestern men) but did not view Indigenous women, including Haudenosaunee women, as their own equals. This serves as an example of how EuroWestern forces have taken up, and continue to take up, Indigenous practices and narratives in ways that serve to further marginalize Indigenous peoples or compromise Indigenous struggles for self-determination. More recently, people working within academic, justice and health care institutions have mobilized discourses around historical trauma to pathologize Indigenous people and communities, and undermine Indigenous struggles for self-determination (Maxwell, 2014; Thielen-Wilson, 2014).

<sup>5</sup> This included 1956 changes to the *Indian Act*, which facilitated band members' challenges of so-called illegitimate children's status and band membership. Depending on the evidence that the child's father was or was not a status Indian, band councils could deny children status and band membership (CANADA, 1956; Cannon, 1998). As Cannon (1998) cogently argues, these changes to the *Indian Act* "privileged heterosexual unions by emphasizing the importance of paternity to the exclusion of non-male partners. In this way, the existence—even possibility—of same-sex relationships in First Nations communities went unacknowledged" (p. 11). Similarly, *Martin v. Chapman* [1983] 1 S.C.R. 365 determined that according to the pre-1985 *Indian Act*, illegitimate biological males who were descended from non-status mothers and status biological fathers had a right to Indian status. However, biological females did not.

<sup>6</sup> L. B. Simpson conceptualizes kwe as "woman within the spectrum of genders in Nishnaabemowin or the Nishnaabe language" (p. 29).

<sup>7</sup> As evidence of how certain women are 'encouraged' to reproduce and therefore take the right to mother for granted, the May 28, 2007 issue of Maclean's cover story "'The Baby Shortage: Hey Lady! What will it take to make you breed? Your government wants to know'" featured an image of a white woman who embodied heterosexual, middle-class norms along with an outline of a pregnant belly where one 'would' be. George and Gulli write in the cover story, "the fact that it's not so much about urging women to have babies as it is about urging the right women to have them -- and to preserve Western civilization in the process. As it happens, the group whose fertility rates are declining the fastest are those with the greatest social and financial prospects. That is, Western (well-assimilated, if not white) professionals with university degrees" (2007, p. 5 of 9)

<sup>8</sup> As Luna (2011) states, the exclusion of women of colour and their concerns from the reproductive choice movement "stems from the unintended consequences of strategic decisions made by mainstream women's organizations" (229).

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<sup>9</sup> This is one way of ‘tracing’ the movement: Silliman et al. (2004) situates today’s struggles for reproductive justice as arising “from a long history of oppression and resistance, beginning before the 20<sup>th</sup>-century battles to legalize contraception and abortion” (3).

<sup>10</sup> When Cook left the Minneapolis/St. Paul area, the Oneida Nation adopted the project.

<sup>11</sup> This research, conducted with scientists from the New York State Department of Health and the State University of New York School of Public Health, demonstrated that women who ate fish from the St. Lawrence River had 200 percent more PCBs in their breast milk than the general population. The project then worked to inform pregnant women and young mothers about how they could reduce their risk by not consuming fish from contaminated waters, such as the St. Lawrence River, and how to avoid intense weight loss during pregnancy or soon after birth. However, as fish is both a cheap source of protein and a traditional food among Mohawk people, this pollution has had a wide range of effects.

<sup>12</sup> It is important to acknowledge that many Indigenous societies and other societies were more equitable prior to the imposition of EuroWestern colonial values. Further, many Indigenous activists and scholars are reimagining and recreating Indigenous lifeworlds that foster individual and community self-determination (L. B. Simpson, 2011, 2017; WEA and NYSHN, 2016)

<sup>13</sup> When the term ‘reproductive justice’ is used to describe reproductive rights or reproductive choice organizing, pro-life organizations criticize reproductive justice with the same criticisms they have leveled at the reproductive choice movement for years, discursively reframing reproductive justice as reproductive choice. Luna (2011) draws on an example where Polak criticized the National Organization for Women’s “emphasis on abortion on the ‘reproductive justice’ page of its website” (p. 237)

<sup>14</sup> For instance, NYSHN and First Nations Child and Family Caring Society of Canada (2012) assert that “[t]he self-determined gender expression of Indigenous Peoples, for example, the freedom to identify as Two-Spirit, is something to be celebrated – not criminalized” (6). Similarly, L. B. Simpson (2012) asserts,

I see the expression of heteropatriarchy in our communities all the time – with the perpetuation of rigid (colonial) gender roles, pressuring women to wear certain articles of clothing to ceremonies, the exclusion of LGBQ2 individuals from communities and ceremonies, the dominance of male-centred narratives regarding Indigenous experience, the lack of recognition for women and LGBQ2’s voices, experiences, contributions and leadership, and narrow interpretations of tradition used to control the contributions of women in ceremony, politics and leadership, to name just a few.

This simply cannot be a part of our nation-building work. This is not resurgence. (para 7 & 8)

<sup>15</sup> Section 15 of the Canadian Charter of Rights and Freedoms secures the rights to “equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability” (Canada, 1982).

<sup>16</sup> Collaborators in both phases shared various experiences across contexts. Within the context of this study, privileging a) professional and community experience related to reproductive (in)justice(s) during Phase One and b) personal experience related to reproductive and sexual (in)justice(s) during Phase Two, was activated through a) the relational sampling process, b) the questions that shaped study conversations (in interview guides and collaborator meetings), and c) decisions about what to highlight in the study findings and products from each phase.

<sup>17</sup> During our earlier work together, Kookum Betty had instructed me to follow this protocol when asking for guidance. Protocols vary based on Knowledge Keeper’s territory, Nation and ceremonial family, and teachings.

<sup>18</sup> This archive is incomplete, because video and audio recording cannot adequately capture a moment in time-space (for instance, even if recording the visual and audio aspects of an interview, we cannot see what is beyond the visual frame nor can we revisit the tone of the room). My memory did not serve to accurately bridge the gaps since, as R. L. Walker (2014) articulates “the past is continually re-imagined in its present invocations” (p. 47). At the same time that I recognized the limits of this archive and my knowledge, I did not interpret this limit as a reason to abandon analysis, but rather I seek to follow Lather’s (2007) lead in undertaking analysis and simultaneously troubling it. As such, I took field notes following the interview and throughout the coding process in order to map this process.

<sup>19</sup> As part of this process, we also approached organizations who work with young women and two-spirit, trans\* and LBTQ+ people. Collaborators also worked to share information about the study with a) women who do not have children, and b) women who engage with Indigenous teachings and practices related to reproductive and sexual health.

<sup>20</sup> Kookum is a Cree and Saukteaux word that translates to grandmother in English.

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<sup>21</sup> As discussed in Chapter One, this study emphasized the openness of the category of women and involved a diverse group, including two-spirit and trans\* people who also identified (in some way) with the category women.

<sup>22</sup> As discussed in Chapter Two, midwives within many Nations held important roles as reproductive healthcare practitioners, which included, but was not limited to, supporting women during pregnancy, childbirth and postnatally (Anderson, 2011; Carroll & Benoit, 2001). Indigenous midwives provided care that accounted for spiritual, mental, emotional, physical and community aspects of pregnancy and childbirth (Anderson, 2011). Colonial forces undermined Indigenous midwifery practices through first encouraging, and then requiring, First Nations to give birth in nursing stations and then hospitals, even when this involves women's evacuation from their communities to urban hospitals (Couchie & Sanderson, 2007; Lawford & Giles, 2012; 2013).

<sup>23</sup> A berry fast is an Anishinaabe ceremony a girl participates in when she is close to her first moon time. Girls participating in the fast cannot eat berries for a year, through which girls learn the valued traditional skill of postponing gratification (McKenna, 2017).

<sup>24</sup> A full moon ceremony is an Anishinaabe ceremony in which people gather and celebrate the full moon through offering, singing and drumming (McKenna, 2017).

<sup>25</sup> I have been instructed by not to explain this ceremony in a publication.

<sup>26</sup> I use the term harmful substance use in recognition that substance use is common across various cultures and contexts in North America and is not inherently problematic, but that when substance use compromises individual and family wellness, it causes harms.

<sup>27</sup> As of March 31, 2017, 10,714 children aged 0-18 were in out-of-home care in Manitoba (89% of these children are Indigenous) and approximately 6,000 children were in out-of-home care in Saskatchewan (Manitoba, 2017b; Saskatchewan, 2017). While in 2017 the province of Saskatchewan did not report the proportion of children in out-of-home care who are Indigenous, statistics from past years suggest that Indigenous children comprise approximately 80% of children in out-of-home care (Saskatchewan Child Welfare Review Panel, 2010).

<sup>28</sup> Jacobs is building on Wolfe's (2001) "logic of elimination," which he argued regulates settler colonial societies' ideologies, policies and actions. In order to appropriate Indigenous lands, settler colonial societies seek to a) remove Indigenous people from their lands, b) eliminate Indigenous people as a distinct group, while simultaneously c) replacing them with a settler population.

<sup>29</sup> Collaborators instructed me that some of these Nation-specific practices and teachings should not be shared in this dissertation or other study products. Therefore, I have only shared Nation-specific practices and teachings that a) have been published about elsewhere, or b) the collaborator who shared this teaching or practice consented to my publication of it.

<sup>30</sup> This clinic was initially a Morgentaler clinic, then a Jane's clinic and is now the Women's Health Clinic and is fully-funded by the province. Henry Morgentaler established and opened the clinic in 1983. He along with other doctors provided terminations at this clinic that did not have a Therapeutic Abortion Committee (TAC) as was required by law at the time. The clinic was raided several times and Morgentaler and other healthcare providers were arrested. After a lengthy legal battle, the Supreme Court ruled that the law requiring that patients gain permission from a TAC violated the *Charter of Rights and Freedoms* and, as such, the abortion law was struck down and Drs. Morgentaler, Scott and Smoling were acquitted of these charges. The Morgentaler clinic reopened in 1988 and Morgentaler and the Manitoba government began to negotiate transferring ownership of the clinic to the government. Due to the breakdown of relations between the government and Morgentaler, Morgentaler sold the clinic to a group of local, pro-choice women in 2004. It was then renamed as the Jane Clinic and governed by a community-based board. Later that year, the Manitoba government started to provide full funding for terminations performed at the clinic (Stachiw, 2006). In 2007, the community-based Women's Health Clinic integrated Jane Clinic's abortion services into its medical services program (Women's Health Clinic, 2018).

<sup>31</sup> Abortions are included as one of the procedures that can be facilitated at non-hospital facilities. The College of Physicians & Surgeons of Saskatchewan (2018) sets out a number of conditions that must exist at these facilities in order for a physician to provide services there. These conditions go beyond what is medically necessary for safe surgical terminations as was noted in interviews with people who work in health policy, and therefore this policy acts as a barrier rather than a facilitator of safe abortion care.

<sup>32</sup> First Nations patients with status under the *Indian Act* may be able to access some funding for such travel costs through the Non-Insured Health Benefits (NIHB) program.

<sup>33</sup> In comparison, Manitoba's *The Family Law Reform Act (Putting Children First)* of Manitoba considers "a person who was married or in a marriage-like relationship with the mother when the child was conceived" to be a parent to this child (2015, 14(2)).

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<sup>34</sup> One of the factors contributing to the lack of awareness about midwifery in Saskatchewan and Manitoba is the imposition of biomedical reproductive healthcare in the early 20<sup>th</sup> century (Lawford & Giles, 2013). Midwife-attended births have only been provided as part of insured healthcare in Manitoba and Saskatchewan since 2000 and 2009 respectively (Haworth-Brockman, 2002; Midwives Association of Saskatchewan, 2018).

<sup>35</sup> Some researchers and practitioners have been shifting to the use of trauma- and violence-informed care, in order to “focus on acts of violence and their traumatic impact on victims” (Ponic, Varcoe, & Smutylo, 2016, para 8). Collaborators described both receiving and providing care that was trauma- and violence-informed, which is why I use this term even though they did not.

<sup>36</sup> Abstinence-based approaches to treating substance use continue to dominate public discussions about substance use on the prairies, which has a strong history of the temperance movement. For instance, Saskatoon was initially established as a temperance colony (R. Brown, 2012).

<sup>37</sup> I am drawing on Tuck and Yang’s work (2012) which considers “the curricular-pedagogical project of critical consciousness as *settler harm reduction*, crucial in the resuscitation of practices and intellectual life outside of settler ontologies” (p. 21).

<sup>38</sup> For instance, there is historical evidence that during the early 20<sup>th</sup> century First Nations women in western Canada similarly utilized government services and organizations, such as the Indian Homemakers’ Clubs, to meet their families’ needs and advance their sociopolitical aims (Nickel, 2018).

<sup>39</sup> Due to growth in the oil and gas industry beginning in 2007, housing prices increased substantially in Regina and Saskatoon. While work in the oil and gas industry has decreased significantly the rental market prices and other costs of living in Saskatoon and Regina remain higher than pre-2007 rates. Winnipeg did not have a similar growth in industry during this time; however, cost of living in these three centres is similar. For instance, in 2015 the average rent for a two-bedroom apartment was \$1,033 in Winnipeg, \$1,079 in Regina and \$1,091 in Saskatoon (Canada Mortgage and Housing Corporation, 2015a, 2015b).

<sup>40</sup> Study conversations and media coverage reviewed focused on reproductive coercion Indigenous women face. There was no information shared during study conversations and in media conversations about Indigenous two-spirit and trans\* people’s experiences of reproductive coercion during this study’s fieldwork. Further research is needed to explore whether and how Indigenous two-spirit and trans\* people are subject to reproductive coercion.

<sup>41</sup> For instance, I participated in an interview on *CBC’s Saskatoon Morning* about coercive sterilization on December 15, 2015 and this broadcast coverage was not published on the *CBC* website.

<sup>42</sup> *CBC* and *APTN* websites do not facilitate searching for coverage within specific timeframes. Therefore, I did not replicate my search on these websites during the 28 months preceding my fieldwork.

<sup>43</sup> The Regina Qu’Appelle Health Region and Winnipeg Regional Health Authority also had similar policies (Regina Health District, 2001; Winnipeg Regional Health Authority, 2007).

<sup>44</sup> SHR also shared statistics about the decrease in the number of tubal ligation procedures completed after vaginal births with journalists, from 94 in 2010-2011 to 24 in 2014-2015 in Saskatoon (Adam, 2015, Nov 18), with the implication that, because there are fewer procedures being performed, there is less likelihood that women are being coerced or forced to have the procedure. Leanne Smith, the Director of Maternal Services, framed this decrease in tubal ligations as the likely result of increased long-term contraceptive options (Adam, 2015, Nov 18). However, there is no acknowledgement of the possibility of coercive practices related to long-term contraceptives.

<sup>45</sup> Of the three health regions/authorities where this study was facilitated, SHR is the only health region with a policy specific to tubal ligation.

<sup>46</sup> While this transformation of child welfare systems may seem like an unrealistic vision, Manitoba’s 2018 amendment to *Child and Family Services Act* that prevents children from being removed “on the basis of the family’s financial status” (10) suggests that there are decision-makers who amenable to structural change.

<sup>47</sup> As Coulthard (2014) has cogently argued, the colonial government has only recognized Indigenous communities self-determination in ways that reaffirms colonial sovereignty.

<sup>48</sup> In 2017 Saskatchewan’s health governance was restructured from 12 health regions to 1 provincial health authority. Boyer and Bartlett (2017) recommended restructuring health governance so Indigenous people are equal partners during this provincial transition.

<sup>49</sup> Through British Columbia’s Bill 41, government departments can now “share decision-making with Indigenous governments,” however, FPIC is not robustly embodied in this legislation (British Columbia, 2019; Last, 2019, Nov 2, para 14).

<sup>50</sup> Senator Yvonne Boyer recently called on the federal government to fund a crisis line specifically for people who have experienced coerced and forced sterilizations (Kirkup, 2019, May 6). Based on this study’s findings, I

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recommend the development of counselling services grounded in a reproductive justice framework, through which people can access responsive support related to various reproductive experiences and decisions.

<sup>51</sup> Indeed, organizations may have a mission and mandate to serve a particular community or population (e.g. 2LGBTQ+ people) and this process would not change that mission or mandate.

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## Appendices

### Appendix A Phase One Collaborator Interview Guide/Script

Thank you so much for meeting with me today. I want to speak with you about Indigenous women's rights to reproductive justice and reproductive sovereignty, lots of times these rights are talked about as the rights of women to determine whether or not to have children, to terminate pregnancy, to choose how to give birth, and to raise the children they do have in safe and healthy environments. This can be anything from women and their families having safe housing they can afford to having good food to eat to being able to see doctors and other health care workers, including traditional medicine people when they want to. It can also include women and their families being able to take part in cultural, spiritual and religious practices and being able to live in communities they choose.

1. a) Are you familiar with reproductive justice and reproductive sovereignty?  
b) If so, how are people talking about reproductive justice and reproductive sovereignty?
2. a) Thinking about reproductive justice as, the rights of women to determine whether or not to have children, to terminate pregnancy, to choose how to give birth, and to raise the children they do have in safe and healthy environments, what are some related rights and issues?

\*Possible prompts\*

- Access to birth control and abortion services
- Other reproductive health and sexual health care including midwifery and doula care
- Access to other health care services
- Child welfare
- Being able to take part in cultural practices and ceremonies
- Indian Act status regulations

b) Can you tell me more about this?

3. a) What supports Indigenous women's rights to reproductive justice and sovereignty?  
b) What gets in the way of Indigenous women's rights to reproductive justice and sovereignty  
b) How do Indigenous women deal with this?  
c) What could change to better support Indigenous women's reproductive justice and sovereignty?

\*Possible Prompts\*

- In policies?

- Services?
- In media?
- In the local community?

4. a) I have a one-page summary of some of the different ways that health research and social justice literature are talking about Indigenous women's mothering and reproduction. Would you like to have a quick look at it and we can talk about it?

b) [If yes] What do you think about what you read?

\*Possible prompts\*

- Is it different from what you expected or what you know from your experiences?
- What is missing?

5. During the next phase of the research, the plan is to interview Indigenous women around the things we discussed today. Do you have a few minutes to look at the interview guide and one-page research plan?

[If yes] Do you have any feedback?

\*Possible prompts\*

- What do you think of the questions? Is there anything we should add? Is there anything we should take out? Is there anything we should reword?
- Do you think this research plan is practical?
- Do you think Indigenous women will be interested in participating?
- Is there anything we should change to make it more relevant to Indigenous women? To make it easier for Indigenous women to take part?
- Who should we invite to participate in this research? How should we invite Indigenous women to participate?

6. I am going to be looking at policies and how different policies affect Indigenous women's lives around what we have talked about today. What are some policies I should look at? Why?

7. Is there anything else you would like to add?

## Appendix B Phase Two Environmental Scan Interview Guide/Script

Hi, my name is Holly McKenzie and I am a researcher from the University of British Columbia and I am facilitating a research project with Indigenous women to explore Indigenous women's understandings and experiences around reproductive justice that is approved by UBC's Behavioural Research Ethics Board. **Reproductive justice** is often talked about as women being able to *decide and control whether or not to have children*, women being able to decide and control *whether or not to continue or end pregnancies*, women being able to control *how and where they give birth*, and women being able to *raise children we do have in safe and healthy ways, free from violence*.

As part of this research, I am trying to learn about related support services available in Saskatoon, Regina and Winnipeg. I am also making up a resource list for participants with various services, from counselling to parenting programs to transitional housing and we will also be including some of this information in our articles, blog posts, and presentations. I have emailed you today, because I think your services would be really useful to some of the women I will be speaking with and I would like to include some detailed information about your services in our resource list we are developing. It is also important information for this research.

If you are able and willing to participate, you can answer these questions by email or by phone. We can also set up a time to meet in person. Answering these eight questions in person or over the phone will take about 20 minutes. You can skip any questions you don't want to answer or stop answering the questions at any point.

- 1) What services do you provide?
- 2) Are there any costs for your services?
- 3) Are there any restrictions or requirements for accessing services?
- 4) Do you have any waitlists for these services? If so, how long?
- 5) Are there any efforts you have taken to meet Indigenous women's needs in your programming and services?
- 6) Are there any efforts you have taken to make your programming and services comfortable and welcoming for Indigenous women?
- 7) What organizations do you suggest we include in our resource list?
- 8) How would you like to be identified if we publish any information you shared with us today in a journal article, blog or presentation.
- 8) Would you like to receive any more information about the project? For instance, would you like to receive phone and email updates? Our Phase 1 report (that we recently completed)? our Phase 2 report? Or any other publications or reports we produce?

I have three more questions that I am asking because there is a network, the SK Pro-Choice Network who wants to provide volunteer support to women who are seeking abortion services. We want to understand how to screen and train volunteers to provide these services and since your organization also provides supportive services to women, we think we could learn a lot from the services you provide. Would you be able and willing to answer these questions?

- 7) Do you have volunteers or employees providing services?
- 8) Do your volunteers or employees receive specific training?
- 9) Do you use any specific screening procedures for volunteers or employees to ensure clients safety (ie. a Criminal Record Check)?

## Appendix C Phase Two Research Circle Guide/Script

Thank you so much for coming to the research circle today. We will be talking about Indigenous women's reproductive justice. This research project is trying to understand Indigenous women's experiences around reproductive justice and how things could change for the better.

**Reproductive justice is** often talked about as women being able to decide and control **whether or not to have children**, women being able to decide and control **whether or not to continue or end pregnancies**, women being able to control **how and where they give birth**, and women being able to **raise children we do have in safe and healthy ways**, free from violence. If you want, you can share your personal experiences, but you don't need to and can speak to these issues as you see them. Either way, we are interested in hearing your opinions about urban Indigenous women's experiences and what you think should change.

- 1) Can you tell me a little bit about what interests you about reproductive justice? Or why you have chosen to come to the circle today?
- 2) What do you think needs to change?
- 3) What do you think is working?

## Appendix D Phase Two Collaborator Interview Guide/Script

Thank you so much for meeting with me today. As you know, I am interested in hearing your thoughts about Indigenous women's reproductive justice. I am trying to understand Indigenous women's experiences around reproductive justice and how things could change for the better.

**Reproductive justice** is often talked about as women being able to decide and control *whether or not to have children*, women being able to decide and control *whether or not to continue or end pregnancies*, women being able to control *how and where they give birth*, and women being able to *raise the children they do have in safe and healthy ways, free from violence*. If you want, you can share your personal experiences, but you don't need to and can speak about these issues as you see them. Either way, I am interested in hearing your opinions about urban Indigenous women's experiences and what you think should change.

I have a few questions I am going to ask you to get started, and we will get as far through these questions as we can in 90 minutes if that is okay with you? We can also talk for a shorter time if you want. Let me know if you want to skip a question, or stop at any point to either end the interview or just take a break.

- 1) Can you tell me a little bit about what interests you about reproductive justice? Or why you have chosen to speak with me today?
- 2) a) Thinking about yourself, and other Indigenous women you have known, when Indigenous women **want to have children**, what makes this easier or a better experience? This could be when women are thinking about having children, when women are pregnant or going through the adoption process.
  - b) What makes it more difficult?
  - c) What do you think should change about this?
- 3) a) Thinking about yourself, and other Indigenous women you have known, when Indigenous women **want to prevent or end a pregnancy**, what makes this easier or a better experience?
  - b) What makes it more difficult?
  - c) What do you think should change about this?
- 4) a) Thinking about yourself, and other Indigenous women you have known, what makes it easier for Indigenous women to **raise their children in safe and healthy ways**, free from violence?
  - b) What makes it more difficult?
  - c) What does safe and healthy mean for you?
  - d) What do you think should change about this?
- 5) We have talked a lot about different things that make it more difficult for Indigenous women to have children, to prevent or end a pregnancy, and to raise their children. Can

you think of some different ways Indigenous women deal with or navigate these difficulties?

- 6) I am going to be looking at policies and how different policies affect Indigenous women's lives in relation to what we have talked about today, for instance the Non-Insured Health Benefits policy, or the Social Assistance Policy. Do you have any suggestions for policies I should look at? Why?
- 7)
  - a) Thinking about reproductive justice as what we have talked about today, the rights for women to decide whether or not to have children and to raise children in safe and healthy ways, free from violence, is there anything else that comes mind?
  - b) Is there anything that you like that's happening right now?
  - c) Is there anything that you would like to see being done differently?

## Appendix E Phase Two Policy Navigator Interview Guide/Script

As you know, I am facilitating a research project with Indigenous women to explore women's experiences and understanding about reproductive justice. **Reproductive justice** is often talked about as women being able to *decide and control whether or not to have children*, women being able to decide and control *whether or not to continue or end pregnancies*, women being able to control *how and where they give birth*, and women being able to *raise children we do have in safe and healthy ways, free from violence*. As part of this research, I am doing a policy analysis. I consider policies to include everything from federal and provincial legislation (such as the *Indian Act* and Saskatchewan and Manitoba's *Child and Family Services Act*) to the health regions' and organizations' policies and procedures, to the 'unwritten rules' about how things are usually done in an organization. I am going to ask you some questions about the policies and practices affecting Indigenous women's access to reproductive justice. One of the reasons I wanted to speak with you today is because of your experience working with \_\_\_\_\_ (i.e. sexual assault).

I have a few questions I am going to ask to get started, the interview will take between 30 and 60 minutes. We can also speak for a shorter time if you want. Let me know if you want to skip a question or stop at any point to either end the interview or just take a break.

- 1) What are the key things affecting Indigenous women's access to reproductive justice from your perspective?
  - a) Can you describe for me what you think are the most important policies and practices related to \_\_\_\_\_ (ie. sexual assault)?
  - b) How are these policies and practices working together?
  - c) How could these policies and practices be changed to better respect and support Indigenous women?
  - d) What are some of the barriers to making these changes?
  - e) Are there any strategies for changing these policies and practices that you would recommend?
- 2) Is there anything that you would like to add?

## **Appendix F Policy Brief**

**ISSUE:** Royal University Hospital Employees coercing and forcing Indigenous women to have tubal ligations.

**SUBMITTED TO:** Dan Florizone, President and Chief Executive Officer (Saskatoon Health Region), Jackie Mann, Vice President of Integrated Health Services (Saskatoon Health Region), Leanne Smith, Director of Maternal Services (Saskatoon Health Region), Gabe Lafond, Director of First Nations and Métis Health Services and Representative Workforce (Saskatoon Health Region), Honourable Jim Reiter, Minister of Health (Government of Saskatchewan), Honourable Jane Philpott, Minister of Health (Government of Canada), Honourable Donna Harpauer, Minister of Government Relations and Minister Responsible for First Nations, Métis and Northern Affairs (Government of Saskatchewan), Honourable Carolyn Bennett, Minister of Indigenous and Northern Affairs (Government of Canada), Honourable Tina Beaudry-Mellor, Minister of Social Services and Minister responsible for the Status of Women (Government of Saskatchewan), and Honourable Patty Hajdu, Minister of Status of Women (Government of Canada), Honourable Gordon Wyant, Minister of Justice and Attorney General (Government of Saskatchewan), Honourable Jody Wilson-Raybould (Government of Canada).

**DATE:** September 26, 2016

**SUBMITTED BY:** Holly A. McKenzie, PhD(c) (University of British Columbia), M. R. L. P., Jillian Arkles Schwandt (Sexual Health Centre Saskatoon), Karen Olsen Lawford, PhD(c) (University of Ottawa), and Colleen Varcoe PhD, RN, Professor (University of British Columbia).

### **KEY MESSAGES:**

- Since mid-November 2015, five Indigenous women have spoken with journalists about Royal University Hospital (RUH) employees pressuring them to have tubal ligations and other unethical practices.
- RUH policies regarding tubal ligation are not publically available.
- News stories report that RUH has changed their policy in response to public outcry. According to a hospital spokesperson Leanne Smith, the revised policy specifies that a) women who have vaginal births cannot have tubal ligations while in the hospital for delivery, and b) women who have caesarean births and discuss and consent to tubal ligations prior to coming to RUH for childbirth can have tubal ligations while in the operating room for delivery.
- While possibly intended to reduce coercion, the revised RUH policy unnecessarily diminishes the reproductive choices of women who have vaginal births.
- Reproductive justice necessarily includes respecting women's autonomy and choice to make decisions to have or not to have tubal ligations. RUH policies and practices currently constrain Indigenous women's rights to reproductive justice in numerous ways.

- There is no evidence that the revised policies address systemic racism, heterosexism, and classism, which are the root of coercive and forced sterilization. Without addressing these systemic issues, Saskatoon Health Region (SHR) and RUH will continue to put Indigenous women at risk of other coercive and harmful practices, such as being pressured to use long-term contraceptives or being flagged for child protection concerns without due cause.
- **Several recommendations are offered to foster culturally safe, trauma- and violence-informed care that respects and supports Indigenous women’s rights to reproductive autonomy.**

## **BACKGROUND:**

On November 18, 2015 the *Saskatoon Star Phoenix* first published two Indigenous women’s stories of RUH employees pressuring them to have tubal ligations and other unethical practices (1). In the months following at least three other Indigenous women spoke with reporters about similar experiences. The coercive sterilization of Indigenous women at RUH is tied to Canada’s history of denying Indigenous peoples’ reproductive futures, along with other people who have been deemed unfit to parent, such as people who identify beyond the gender binary of male/female, people who have sexual relations outside of heterosexual monogamy, people who are differently-abled, and people living in poverty, particularly women (2-6). Whether performed through legislation or through coercive practices, sterilization without informed consent violates Indigenous women’s rights to reproductive justice and the rights of Indigenous peoples. Reproductive justice is often defined as the rights of women to decide and control a) whether or not to have a child or children, b) how and where women give birth, c) and being able to raise their children in safe and healthy environments, free from violence (7). RUH policies and practices currently constrain Indigenous women’s rights to reproductive justice in numerous ways.

Coercive and forced sterilization has a long history in Canada. British Columbia and Alberta had sexual sterilization legislation in the 20<sup>th</sup> century. BC’s legislation was in effect from 1933 until 1979 and Alberta’s legislation was in effect from 1928 until 1972. Among the cases presented to the Alberta Eugenics Board, both Indigenous people and women were overrepresented (2). While Alberta’s legislation framed the acceptable conditions for sterilization in medical terms, Park and Radford’s (1998) analysis of case files makes clear that the board’s decisions were made based on racist, heterosexist, and classist assumptions about who is fit/unfit to parent and sterilizations were justified using social Darwinism (3). In her recent book, *An Act of Genocide: Colonialism and the Sterilization of Aboriginal Women* (2015), Karen Stote demonstrated that Indigenous women were coerced into sterilization in other provinces and territories without official legislation (4, 5). There is ample evidence that stereotypes and colonial, racist, and heterosexist views continue to influence healthcare providers’ treatment of Indigenous people with deleterious results (8-14).

It is disappointing that the RUH tubal ligation policies in place when Indigenous women were coercively sterilized are not available to the public despite requests for this information (15). In personal communication, Leanne Smith (Director of Maternal Services) stated the only policy in place during this timeframe was that all women who came to RUH for delivery until 2012 were

asked at intake whether they wanted to have a tubal ligation (16). In a media interview, Smith reported that their revised policies are: a) women who have vaginal births cannot have tubal ligations while in the hospital for delivery, and b) women who have caesarean births and discuss and consent to having tubal ligations prior to coming to RUH for childbirth can have tubal ligations while in the operating room for delivery. However, a written policy document to this effect is not available to the public (15). Further, if Smith's report is accurate, this revised policy unnecessarily diminishes the accessibility of tubal ligations for those who have vaginal births. There is also no indication that there is policy attention to the systematic colonialism, racism, and heterosexism underlying discriminatory health care practices including coercive and forced *sterilization* and limiting access to other reproductive health care. These revised policies continue to put Indigenous women at risk of other coercive practices, such as being pressured to use long-acting reversible contraceptives or being flagged by child welfare without due cause. The SHR is proceeding with an external review of these women's experiences at RUH. Additional policy changes are required to ensure Indigenous women's rights to reproductive autonomy and culturally safe care.

### **POLICY RECOMMENDATIONS:**

- 1) Proceed with a thorough external independent review of the coercive sterilizations of Indigenous women, which includes a) using mainstream and social media sources to publicize the external review and invite women who experienced coercion around tubal ligations at RUH to participate; b) privileging Indigenous candidates when choosing an external reviewer; c) ensuring the external reviewer has extensive knowledge of colonial relations and Indigenous perspectives in Canada; d) ensuring the review thoroughly addresses RUH's previous policies and practices with respect to informed consent around tubal ligations; and d) sharing the findings of the external review with the public, including information about RUH's previous policies and practices of informed consent and tubal ligations in order to rebuild relationships between Indigenous and non-Indigenous communities. Women who share their personal testimony in the external review must be given the opportunity to decide whether and how their stories are shared with the public. Particularly, women must be given the choice to a) share their personal testimony in a public record; or b) keep their testimony anonymous and confidential (17).
- 2) Formally apologize to Indigenous women who have experienced coercion related to tubal ligations and provide financial compensation including funds for a) counselling and support services; b) loss in quality of life; c) loss in worktime hours; and d) tubal ligation restoration, and/or in-vitro-fertilization and/or private adoption depending on the options pursued (17).
- 3) Increase cultural safety training in SHR. Ensure cultural safety training in SHR thoroughly addresses: a) racism, colonialism, and heterosexism within healthcare institutions and broader society; b) processes by which healthcare providers and social workers can recognize individual and institutional bias; and c) fostering and growth of culturally safe care (18-25).

- 4) Ensure that the Representative Workforce Strategy evaluations collect and analyze information about patients' experiences of discrimination and bias in SHR (17, 25).
- 5) Train healthcare providers and social workers to provide trauma- and violence-informed care including women-centered care for all women (25-27). Given the evidence of the particularly problematic care received by pregnant and parenting women who use substances (28-31), special attention should be paid to training providers in care for pregnant and parenting women who use substances and harm-reduction models.
- 6) Continue working towards a representative workforce by increasing Indigenous employees, women, employees of all genders and sexualities, and differently-abled employees within SHR at all levels.
- 7) Change SHR's tubal ligation policies and long-acting reversible contraceptives policies so that:
  - a) ***If*** women discuss the benefits, risks, and alternatives to long-acting reversible (LARC) and/or permanent contraceptives (including Depo-Provera, Intrauterine device, and tubal ligations) with their care providers ***before going into labour*** and consent to using a LARC or permanent contraceptive postpartum, *ensure women's timely access to LARCs or permanent contraceptives while in hospital. If women rescind their consent before or during the procedure, the procedure must be ceased.*
  - b) ***If women are in a situation where they are likely to feel pressured*** to agree to use any type of long-acting reversible or permanent contraceptives (including Depo-Provera, Intrauterine device, and tubal ligations), *do not seek consent for long-acting reversible or permanent contraceptives at this time.* These situations include i) while receiving a termination; ii) during labour; or iii) directly following delivery. If women express interest in these contraceptives in these situations, ensure timely follow-up appointments are scheduled and document the conversation (17).
- 8) Fund a full-time reproductive and maternal health advocate/liason position housed in RUH's Birthing Unit to provide information and connect women to services and supports in their community. The advocate/liason should work with any woman who is interested in information, services, and supports. The work should include, but not be limited to: a) one-to-one education and counselling about contraceptive options; b) scheduling follow-up appointments with women who are interested in long-acting and permanent contraceptives and did not consent to using these contraceptives before coming to the hospital for childbirth; c) breastfeeding support referrals; d) respite childcare referrals; e) housing support referrals; and f) foodbank and food security supports referrals.
- 9) Fund a full-time education consultant housed in Sexual Health Centre Saskatoon to provide:
  - a) Mandatory workshops to healthcare providers and social workers in SHR about contraceptive options and the principles of voluntary and informed consent, with an

- emphasis on the meanings of free, fully-informed consent and informed consent best practices. The benefits, risks, and alternatives of contraceptive options should be discussed and patient-centred written informative materials should be distributed to attendees. It is vital that such materials be appropriate for those with low-literacy and consent procedures include verbal and written consent (17, 32-34), and;
- b) Support to healthcare providers, social workers and patients' education by compiling, creating, and sharing useful and relevant resources.
- 10) To evaluate the effectiveness of recommendation #3 through #9, SHR should support research with women who are seeking or receive long-acting reversible or permanent contraceptive care in SHR. In particular, a) gather demographic and health information of women who are seeking or receiving long-acting reversible or permanent contraception; b) support external researchers to conduct quantitative and qualitative interviews with women about their experiences seeking or receiving contraceptive care in SHR, researchers must use unobtrusive recruitment strategies and ensure women's free, fully-informed consent; and c) support external researchers to explore trends of long-acting reversible or permanent contraception use through qualitative and quantitative research, particularly trends that suggest women's rights to free, fully-informed consent and reproductive autonomy are being compromised.

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