How experiences affect decision-making: Exploring the phenomenon of access to healthcare through the stories of Indigenous women in British Columbia

by

Paige Smith
Bachelor of Arts (Honours), Wilfrid Laurier University, 2019

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We acknowledge and respect the lək̓ʷəŋən peoples on whose traditional territory the university stands and the Songhees, Esquimalt and W̱SÁNEĆ peoples whose historical relationships with the land continue to this day.

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Abstract

This thesis explores how Indigenous women experience barriers to accessing healthcare in British Columbia (B.C.) and how their experiences influence their health-related decisions. The intention was to explore how lived experiences with the provincially funded healthcare system affect if at all, Indigenous women's decision to access healthcare and consider the potential future implications. The phenomenon of access to healthcare for Indigenous women was explored by analyzing pre-existing literature and conducting in-depth qualitative interviews with Indigenous women. The data collected from the interviews were analyzed through Interpretative Phenomenological Analysis. By listening to and amplifying the realities of Indigenous women's experiences, this research is contributing toward reconciliation. As a non-Indigenous researcher conducting research with Indigenous Peoples, applying and honouring Indigenous research methods and principles of data governance was equally important. Indigenous Researchers at the University of Victoria guided this work along with the CARE principle for Indigenous Data Governance and the Four R's of Indigenous Research. The analysis indicated the significance of relationality and connection with providers and the system through which Indigenous women access care. It established that these were critical factors affecting their decision-making. Further, this study demonstrates the need for increased understanding and appreciation of Indigeneity within the healthcare systems and the unwavering perseverance that Indigenous women embody to advocate for their and others' equitable care. This thesis could enrich the development and application of services supporting Indigenous communities and strengthen current healthcare practices and policies by accepting alternative forms of care outside Western healthcare.

Keywords: Indigenous; women; healthcare; experiences, voices; self-determination; connection.

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I acknowledge with respect the Lekwungen-speaking peoples on whose traditional territory the University of Victoria stands and the Songhees, Esquimalt and WSÁNEĆ peoples whose historical relationships with the land continue to this day.

I would like to personally acknowledge my position as a settler on this land and my unique position as a non-Indigenous researcher conducting research with and for Indigenous Peoples. I recognize my responsibility towards the participants, their families, and communities. With that, I view my position as a humble helper in Indigenous People’s collective journey toward healing and self-determination.

Finally, I would like to acknowledge all my life's fiercely strong, independent, driven, compassionate, and loving women. You are the voice in my head, the conviction of my courage, and the hope in my heart.

Dedication

This work is dedicated to each remarkable woman who contributed to its creation. Without them, their knowledge, and their willingness to share their stories, this research and its potential impacts would not be possible. I am deeply grateful for their contribution and acknowledge the value of the wisdom they have shared with me.

Throughout this report, the term "we" is used. This term was used intentionally to demonstrate that while I authored this research, I did not view this research as an individual pursuit of knowledge but as a communal and relational approach to knowledge creation, shared between myself, my supervisor, and most importantly, the participants of this study who contributed their experiences for its creation.

"Indigenous women's perspectives and experiences must be included in all discussions about the future of our country." – Dr. Val Napoleon (Law Foundation Chair in Aboriginal Justice and Governance at the University of Victoria).

"Indigenous women have been leaders in our communities for generations, and it is important to continue to support and uplift their voices." – Sarah McIvor (Assistant Professor of Indigenous Studies at Lakehead University.

Chapter 1: Introduction

The research topic of this thesis is Indigenous women's access to health care in British Columbia (B.C.). Currently, the lack of access to healthcare is creating a barrier for many British Columbians (Xu, 2022); however, research on this issue illustrates that this problem is drastically amplified for Indigenous Peoples due to compounding obstacles including, but not limited to, widespread systemic racism that is perpetuated throughout B.C.'s healthcare system and settler colonialism's lasting impact on the health determinants of Indigenous Peoples (Loppie-Reading & Wien, 2009 & Turpel-Lafond, 2020). Various papers and investigations have highlighted this issue's gravity and urgency (Loppie et al., 2014; Loppie-Reading & Wien, 2009 & Turpel-Lafond, 2020). The *Indigenous Peoples Survey*, conducted by Statistics Canada, determined that of the 2,780 individuals surveyed, "1 in 5 described having experienced a form of Indigenous-specific racism" while accessing healthcare in B.C. (Turpel-Lafond, 2020, p. 36). Investigations into the widespread issue of Indigenous-specific racism in B.C.'s healthcare system indicate that Indigenous women and girls are disproportionately impacted by multiple barriers when accessing healthcare compared to their male counterparts (Loppie et al., 2014 & Turpel-Lafond, 2020). With that knowledge, this study intends to explore how experiences with B.C.'s healthcare system affect specifically Indigenous women's decision to access healthcare services.

Defining the Issue

Classification of Problem

The problem of access to healthcare for Indigenous Peoples, namely women, has been an issue since the first contact with colonial settlers, classifying this problem as historical yet ongoing (FNHA, n.d.a). This problem is nuanced and has multiple intersecting causes and outcomes, making it complex and challenging to define and solve.

Who is Affected by this Problem?

As this study focuses on the issue of access to healthcare for Indigenous women in B.C., Indigenous women are directly affected. With that, it is understood in many Indigenous cultures and communities that women's health is deeply connected to and indicates their families' and communities' health and wellness (Indian Residential School History and Dialogue Centre [IRSHDC], 2021). Therefore, the disproportionate barriers to accessing healthcare experienced by Indigenous women in B.C. indirectly affect Indigenous families and communities (IRSHDC, 2021 & Kurtz et al., 2013).

Indigenous Peoples have long-established systems about various social determinants of health. While these systems still exist, they have been heavily disrupted and devalued by settler colonialism and today's mainstream social, economic, and political systems (FHNA, 2021b). Consequently, Indigenous women's "health and wellness continue to be shaped by their social, economic, cultural, and political marginalization” in B.C. and throughout Canada (FHNA, 2021b, p. 74).

Main Issues and Causes

The marginalization of Indigenous Peoples is compounded by various interlocking systemic barriers, which historically and continue to complicate and limit their ability to access healthcare services. The literature suggests that multiple conceptual issues explain the problem of the disproportionate barriers experienced by Indigenous Peoples when accessing healthcare. (Burnett et al., 2020; Loppie et al., 2014; Loppie & Wien, 2009; Muller, 2022; Turpel-Lafond, 2020; Wylie & McConkey, 2018 & Wylie et al., 2020). The issues noted by the literature include but are not limited to experiences of racialized discrimination, the lasting impacts of settler colonialism, structural exclusion and geographical limitations, and exclusionary practices and inflexible systems which devalue the traditional methods of Indigenous Peoples (Burnett et al., 2020; Loppie et al., 2014; IRSHDC, 2021; Kurtz et al., 2013; Muller, 2022; Nelson et al., 2018; Turpel-Lafond, 2020; Wylie & McConkey, 2018 & Wylie et al., 2020).

The inadequacy of B.C.’s primary care system is a complex problem. Indigenous Peoples in B.C. have comparatively lower attachment rates, the rate at which individuals are connected to a family physician, general practitioner or nurse practitioner, than non-Indigenous folk. This unequal rate of attachment leaves Indigenous Peoples 75% more likely to visit and rely on emergency rooms for healthcare services, often when they are already experiencing a health crisis due to their reluctance or inability to access preventative care (Turpel-Lafond, 2020). The literature understands that in these circumstances, few of the previously mentioned conceptual issues present themselves and impede Indigenous Peoples from accessing equitable, culturally safe, and respectful care (Turpel-Lafond, 2020).

What Might Happen if the Problem Goes Unaddressed?

While the issue of access to healthcare for Indigenous Peoples continues to be explored, there is still ample room for inquiry and improvement, specifically regarding Indigenous women’s experiences. Should this issue continue to receive less than its necessary attention and genuine interest from the public and all the involved parties, Indigenous women and their families and communities will continue to experience disproportionate barriers when accessing healthcare.

Significance of Study

According to the 2021 census, Indigenous populations in Canada are growing twice that of non-Indigenous folks (Zimonjic, 2022). As the entire population of Indigenous Peoples continues to grow, so will their need to access safe and equitable healthcare services. As the literature points out, this has not been the experience for many Indigenous Peoples, especially women and girls, when accessing healthcare in B.C.

Aside from the growing rate at which Indigenous Peoples will be accessing care, this study is additionally significant because of its methodological approach. By utilizing a phenomenological approach, this study allows for the stories and experiences of Indigenous women to be illuminated and, therefore, has the potential to contribute a deeper understanding of how Indigenous women living in various communities across B.C. experience the mainstream healthcare system and how their experiences affect their decision to access care and potentially provide insight into why they continue or discontinue to access care.

This study can communicate a more human-centred understanding of Indigenous women's healthcare access. The significance of this study rests in its ability to humanize the issue. By doing so, readers will gain a deeper understanding of the issue and develop a genuine empathy for those experiencing it. This level of consideration is often lost when a study, report, or commission is riddled with statistics, creating distance between the reader and the research subjects. It is this distance that the design of this study also wished to address.

Further, by exploring this issue, the aim is to produce findings that will contribute to the field of public administration by revealing the impeding strengths and weaknesses of the current healthcare system when interacting with Indigenous women. This research will present wise practices and ways forward for healthcare institutions and individual providers to advance the current administration of health services for Indigenous women to improve their experiences when accessing care and their overall health outcomes.

This work has been guided by the CARE principle for Indigenous Data Governance established by the Global Indigenous Data Alliance and the Four R’s of Indigenous Research coined by Kirkness and Barnhardt. The CARE principles are a collective benefit, authority to control, responsibility, and ethics. As such, establishing a collective benefit derived from this research has been paramount to its significance and alignment with Indigenous values and data principles. This research and the data used to create it could enrich the “planning, implementation, and evaluation processes that support the service and policy needs of Indigenous communities” and strengthen the current healthcare system when serving and interacting with Indigenous women in culturally safe and respectful ways (Global Indigenous Data Alliance, 2022). Further, respect for Indigenous cultural integrity was of the utmost importance throughout this research, along with creating a final piece of work that is relevant to the values and purposes of Indigenous Peoples, building reciprocal relationships and holding myself accountable and responsible to honour and respect those relationships.

Finally, this study attempts to decolonize academic research by taking a two-eyed approach to multiple aspects of its contents. In particular, the methods and methodologies that support this study demonstrate the equally important role that Indigenous and Western knowledge systems play in academic research. Settler colonialism has severely impacted Indigenous research and knowledge acquisition approaches. Those impacts have lasting effects today within colonial-based institutions, causing the incorporation of Indigenous methodologies to be often viewed as illegitimate and unreliable. This research will demonstrate the incredible value and credibility that Indigenous approaches bring to academic research.

Purpose, Scope, and Research Question

This study explores how experiences with the B.C. healthcare system affect Indigenous women’s decision to access healthcare services, thus creating potential barriers to healthcare access. It should be noted that for this study, access to healthcare through a supply lens, meaning the limited number of healthcare providers, was not being explored.

The scope of this study included 6-10 self-identifying Indigenous women who live in various areas in B.C. and have accessed healthcare services from B.C.’s provincially funded system(s). Limiting this research's scope and recruitment of participants to B.C. was an intentional and pragmatic decision. This study aimed to contribute to Indigenous sovereignty and self-determination by honouring and incorporating Indigenous research approaches and cultural values. Relational connection is a cornerstone principle that must be adhered to and deeply considered when conducting research with and for Indigenous Peoples and their communities. As such, it was vital to the authenticity and credibility of this research to ensure that a relational connection between the research team and the participants either previously existed or was fostered throughout the research process. As the researcher and her supervisor and their relationships were predominately in B.C., limiting the recruitment of participants to B.C. was prudent.

In addition, due to the division of power in Canada, the healthcare administration was bestowed upon each province. Therefore, examining how Indigenous women in B.C. experience accessing healthcare elicits a unique research opportunity compared to other provinces, as each administration differs in theory and execution.

For example, B.C. delivers distinct healthcare systems and organizations specific to Indigenous people, unlike other provinces across Canada, like the First Nation Health Authority (FNHA). The FNHA is Canada's first and only provincial First Nation health authority responsible for delivering programs and services previously provided by the federal government (FNHA, n.d.c). FNHA, along with other governance agreements regarding the administration of healthcare for Indigenous Peoples, was developed to “improve First Nations’ health and access to quality care by increasing First Nations' control over decisions relating to health policies, programs and services and increasing First Nations' influence in addressing key health issues with federal and provincial partners” (First Nations Health Council, 2011, p. 33). Exploring this issue in a province with distinct governance structures for the administration of Indigenous health programs and services offers a unique examination and illustration of how Indigenous people, namely women, make sense of their experiences accessing healthcare services.

This snapshot study explores themes and lessons that can be transferred to similar situations or settings from this phenomenological study. The purpose is not to make generalizations from the sample of participants. Generalizing based on the findings of this research would not only misalign with the Western methods of data collection and analysis but would be in blatant opposition to the principles of Indigenous data governance and this research’s effort toward decolonization. To paint the experiences of all Indigenous women with the same brush would contribute to the harmful history of generalizing and stereotyping that continues to perpetuate ignorant and dangerous narratives that are then applied to all Indigenous Peoples.

As mentioned in the section above, by exploring this issue, this study's findings aim to illuminate the strengths and weaknesses of the current healthcare system when interacting with Indigenous women. We also want it to benefit the communities in which each participant is from by recommending transferrable solutions to this issue.

It should be noted that an intersectional perspective is not included in this study. This study did not explore how the intersecting identities of each participant affected how they experienced barriers to accessing healthcare or the effect that their identity factors had on how their experiences influenced their future health-related decisions. The research team decided that including an intersectional perspective may take away from the strength-based approach that this study was aiming to achieve. However, the research team recognizes how applying an intersectional perspective could add a supplementary understanding of the issue by potentially unearthing additional findings.

The research question being explored is: How do Indigenous women in B.C. experience barriers to accessing healthcare services, and how do their experiences influence their future decisions regarding continuing to access care from mainstream systems?

Important Terms:

Indigenous-specific gendered racism: Unique forms of racism and discrimination explicitly experienced by Indigenous women, girls, and 2SLGBTQQIA+ people (IRSHDC, 2021 & Turpel-Lafond, 2020).

Patient-provider attachment: Patient-provider attachment is achieved by fostering a safe and welcoming environment where trust and respect can be built between patient and provider to ensure the respectful articulation of health issues, the completion of treatment, the attendance of follow-up and referral appointments while valuing alternative medicines and healing practices within the conventional health care system (Wylie et al., 2020).

*Standard of Care: "*The appropriate care one should expect from their healthcare provider when they exercise reasonable care and skill in their practice" (Marin, 2019, para. 3).

Women: For this research, the term women will be defined as all Indigenous people living in B.C. who identify as or express themselves as women, including cisgender females, trans women, non-binary people, and those who identify as Two-Spirit or Indigiqueer" (FNHA, 2021b, p. 1).
The binary term "women" is used throughout this study. However, please note that this term may not accurately reflect the gender identification of each participant unless specifically articulated otherwise by the participant (FHNA, 2021b, p. 1)*. Participants were not asked to disclose how they identify.*

Body sovereignty: Body sovereignty means the right to have control over one's own body (Steen, 2023). Given the nature of this research, understanding body sovereignty through an Indigenous lens is essential. Many Indigenous Peoples honour the sovereignty of their own body and acknowledge and respect others. It is critical to recognize that currently, there is inequality regarding how bodies are valued in society. Unfortunately, Indigenous women and girls have their body sovereignty threatened and devalued much more than non-Indigenous folks (Steen, 2023). Body sovereignty also means acquiring the knowledge necessary to care for yourself and others.

Positive stereotyping: Contradictory to negative stereotyping, "a positive stereotype refers to a subjectively favourable belief about a social group within a society" (Encyclopedia of Knowledge, n.d.).

Settler colonialism: As a structure, settler colonialism differs from colonialism. "Settler colonialism is enacted through practices like the creation of reserves, residential schools, and abduction of Indigenous children into state custody, as well as the extraction of natural resources. In settler colonialism, colonizers impose their cultural values, religions, and laws and make policies that do not favour the Indigenous Peoples of the colonized land. They seize Indigenous land and control access to resources and trade for their advancement. The goal of settler colonialism is the genocide of the Indigenous peoples (Shah, n.d., para. 1-4).

Indigeneity: This term was used by various participants of this study throughout the interviews. A specific definition of what Indigeneity meant to each participant was not provided. For this report, Indigeneity was used to describe the "state of being Indigenous or related to Indigenous-ness. Indigenous Peoples recognize their Indigeneity, Indigenous-ness, and identity. Indigenous-ness for many can relate to one's territory, culture, community, and traditions" (Queen's University Office of Indigenous Initiatives, 2023, para. 8).

Positionality Statement

I am a master's student living, working, and learning on the territorial lands of the Lekwungen and Songhees families. I recognize that I am an uninvited outsider on these lands. I am a white, middle-class, cis-gender, second-generation Canadian woman of European descent. I realize that some of my identity factors may symbolize the traumatic history of settler colonialism for many Indigenous Peoples. Settler colonialism has placed white settlers like me in a position of power and privilege, which has the potential to foster unequal power dynamics between myself and the participants of this study. Participants may perceive me as the power holder within the relationship, thus creating a power-over dynamic. Recognizing this, I intend to build trust and respect-based relationships with the participants to mitigate potential power imbalances and ethically investigate and appreciate the perspectives and priorities of Indigenous Peoples.

I am not an expert in Indigenous practices or studies, nor do I have lived experiences with the issues I wish to explore through this research. However, the nature of this research is a step along the path to reconciliation. For reconciliation, there must first be truth, and it is through amplifying the voices of Indigenous women and their experiences that I wish to highlight and understand these truths. I want to inform other non-Indigenous people like me about these women's realities regarding accessing healthcare in B.C.

Discrimination or mistreatment based on my race or ethnicity is something I have never personally experienced. I have also never experienced how this form of discrimination can impact my access to my fundamental right to healthcare. Due to this, my understanding of this research topic is limited to the literature I have read and analyzed. I will need to be aware of how my own experiences and positionality can affect my ability to fully understand and accurately represent the experiences of those participating in this study. To do so, I must be self-reflective regarding my potential biases based on my experiences. Most importantly, I need to understand the essence of the stories this research will tell based on the knowledge and data from the participants. This will only be possible through in-depth and open conversations.

I have completed the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2: CORE-2022) course and know the additional steps and precautions involved when conducting research with Indigenous participants as a non-Indigenous researcher. I will use my knowledge from this course as my guiding principles and the guidance my supervisor, Dr. Susanne Thiessen, will provide me. I have also completed training on the concept and practice of a trauma-informed approach. My professional work outside of academia requires that I communicate with members of the public about their administrative unfairness issues with public authorities. Many of these conversations contain sensitive and highly personal information. I have handled these conversations with compassion, patience, and self-awareness using trauma-informed strategies. Ultimately, my life values are aligned to recognize and support individuals who experience the impact of settler colonialism across government programs and services.

I also acknowledge that because of potential cultural and epistemological differences, there is a possibility of misrepresentation or misinterpretation of the topic and participants, even with the effort to remain unbiased. Therefore, collaboration with Indigenous scholars and participants is necessary to ensure the integrity and validity of this study and ensure that Indigenous values of research, governance, and ways of knowing are present throughout the paper.

Though I am not Indigenous, I have committed myself to learning and conducting this study in a way that respects and is relevant, reciprocal, and relational to the Indigenous women who contributed to its creation. As a settler Canadian, this is how I am positioned in the research.

Importance of the Study

The significant health disparities and negative experiences faced by many Indigenous Peoples within the healthcare system demonstrate the urgent need to act on this problem (Wylie et al., 2020). The *Truth and Reconciliation Commission* (TRC) illuminated the colonial roots of health disparities faced by Indigenous Peoples in Canada. Conducting this research would contribute to fulfilling one of the TRC's calls to action to "prioritize the need to enhance cultural competency in health care and health education" to address these ongoing inequalities (TRC, 2015, p. 3). By specifically researching the experiences of Indigenous women, the findings and recommendations for healthcare providers and institutions from this work can contribute to the fulfillment of the Calls to Justice for All Governments regarding the health and wellness of Indigenous women and girls set out in the *Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls.*

It should be noted that while the recommendations from this research are primarily intended for individual healthcare providers and institutions, their application would benefit the development and implementation of policy and legislation within B.C. Therefore, wise practices and ways forward could be considered by decision-makers and leaders throughout the Ministry of Health.

Indigenous women's voices have historically been silenced (Kurtz et al., 2013 & IRSHDC, 2021). By engaging with, listening to, and collecting knowledge from Indigenous women, this research can raise Indigenous women's voices and experiences with the mainstream healthcare system while teaching settler individuals and communities the value and role that Indigenous traditional knowledge and practices have in healthcare.

This research has the potential to create an opportunity to understand the value of cultural differences within the province. By doing so, this research could enhance health outcomes and experiences within B.C.'s healthcare system for many individuals (Kurtz et al., 2013, p. 59). Additionally, this study hopes to contribute to the current field of knowledge through its ability to increase the retention of Indigenous women as patients within the mainstream healthcare system by improving relational connections between Indigenous patients and providers. Doing so will increase overall access to the fundamental right of healthcare and achieve better health outcomes.

Dr. Evan Adams, the former Deputy Provincial Health Officer responsible for Aboriginal health, spoke to the dangers of generalizing the health and wellness of Indigenous Peoples in B.C. and how harmful the "populist notion of the Indian problem, the Aboriginal person who is in terrible health and has few resources" is to the health and wellness of Indigenous Peoples (Adams, 2013, min. 14:04). Suppose the majority of what is reported about the health and wellness of the Indigenous population stigmatizes the entire population. Those reports and studies are a disservice to Indigenous Peoples (Adams, 2013). Generalizing a population dilutes the gravity of an individual's unique experiences and effectively places individuals into rigid boxes they cannot escape. Pathologizing or generalizing folks inferring to the rest of the world that they are all "sick or stuck, or ill-behaved" hinders the advancement of Indigenous Peoples (Adams, 2013, min. 14:45).

This study will not contribute to the field of knowledge by continuing to generalize the problem of access to healthcare for Indigenous women. The approach of a phenomenological study aims to inform readers of the individual experiences of Indigenous women when accessing healthcare rather than generalizing an entire population and reducing a problem to a statistic to be cited. We hope this study will benefit Indigenous women, and indirectly their families and communities, by facilitating the opportunity to learn from and listen to the authentic and raw experiences of accessing healthcare in B.C. as an Indigenous woman.

Chapter 2: Background

History

Before colonization, “Indigenous Peoples throughout what is now called Canada had their own distinct health and wellness systems which were rooted in culturally specific worldviews, knowledge and beliefs, as well as social roles, processes and structures” (IRSHDC, 2021, p. 4). While there was a sense of distinctiveness within the communities that formed, the literature indicates a common belief shared amongst them. The idea that “women’s health is [deeply connected] to family, community, nation, and cultural health” (IRSHDC, 2021, p. 4). After the invasion of colonial and patriarchal based systems, the notion that the “health of women and girls was an indication of the health and wellness of the society” was lost along with much of the traditional knowledge and leadership that Indigenous women inherently possessed (IRSHDC, 2021, p. 8).

Settler colonialism and the imposition of patriarchal systems not only undermined the role and value of Indigenous women in society but silenced these women’s voices through the “suppression of their languages and disintegration of their culture and social structures, resulting in ongoing oppression and disempowerment,” especially within the realm of healthcare and body sovereignty (Kurtz et al., 2013, p. 55). The silencing of Indigenous women continues and is depicted in the literature as a form of structural violence resulting from settler colonial practices. This form of violence towards Indigenous women is endorsed “through political, economic and social structures that are ignorant of, or that disregard, certain values and beliefs” (Kurtz et al., 2013, p. 55).

Consequently, Indigenous women are at a greater risk of encountering “limited access to basic services due to discriminatory policies, limited economic resources, and the rural or remote geographic locations in which they live” (Kurtz et al., 2013, p. 55). Participatory research on this topic has highlighted that silencing Indigenous women’s voices often contributes to women setting aside their health concerns and delaying or avoiding seeking services altogether (Kurtz et al., 2013). These colonial practices influence decisions that endanger Indigenous women’s health and the health of their families and communities (IRSHDC, 2021 & Loppie et al., 2014). Indigenous women tend to be the household decision-makers for their families. Therefore, their decision to access or not to access healthcare services has the possibility of impacting the health and wellness of their family and community at large (IRSHDC, 2021).

Connection between Body Sovereignty and Land Sovereignty

Relevant literature points to the deeply rooted connection between sovereign lands and sovereign bodies. Dr. Alex Wilson of the Opaskwayak Cree Nation speaks to this connection and its implications on Indigenous women, girls, and Two-Spirit people. Decades of settler colonialism have made successful efforts to assimilate Indigenous Peoples by forcibly removing them from their traditional lands, cultures, and ways of being (Wilson, 2015). These efforts resulted in the bodies, genders, and sexualities of Indigenous Peoples being “regulated in a continuum of violence” (Wilson, 2015, p. 2). Indigenous Peoples’ connection, respect, and responsibility towards land is essential to their way of being. Therefore, "to understand the violence seen against Indigenous lands is to understand the threat of violence towards Indigenous women" (Moore, n.d., para. 2). Research supported by the lived experiences of Indigenous women demonstrates that the pervasive violence against Indigenous lands introduced by settler colonialism is entangled with the epidemic of violence against Indigenous women, girls, and Two-Spirit peoples (de Finney, 2017; Moore, n.d., & Wilson, 2015).

Further, forcibly displacing Indigenous Peoples from their land and knowledge systems has contributed to the cultural genocide that Indigenous Peoples have continued to experience since first contact with settlers. This has caused, among many other consequences, vast disconnection from meaningful relationships with people, land, and water (Wilson, 2015). Finally, the violence and cultural genocide committed against Indigenous Peoples leads to what Dr. Wilson calls "dogma," which she explains as another way of saying, "It is what it is." The methods of being and knowledge systems of Indigenous Peoples have been around since time immemorial, while Western ways of being are comparatively relatively new. How Indigenous Peoples, specifically women, girls, and Two-Spirit people, have been and continue to be treated since the invasion of settler colonialism is often justified because of this incorrect and ignorant dogma. Therefore, the mistreatment and abuse of Indigenous land and the ill-treatment of Indigenous women and girls are intrinsically intertwined. Dr. Wilson eloquently says, "Indigenous sovereignty over our lands is inseparable from sovereignty over our bodies" (Wilson, 2015, p. 4).

Institutional/Legislative Background

Given the scope of this research, it is critical to understand and appreciate the legal rights of Indigenous Peoples and the commitments made by the provincial and federal governments to honour and uphold those rights.

In November 2019, the British Columbia government passed the *Declaration on the Rights of Indigenous Peoples Act* (*Declaration Act*) into law. According to the provincial government, the goal of the *Declaration Act* is "to create a path forward that respects the human rights of Indigenous People while introducing better transparency and predictability in the work we do together" (2019).

For the reader's understanding, cited below are the articles of the *Declaration Act* which are particularly relevant to this research. They are,

Article 22,

> *"1. Particular attention shall be paid to the rights and unique needs of Indigenous elders, women, youth, children, and persons with disabilities in the implementation of this Declaration.*
>
> *2. States shall take measures, in conjunction with Indigenous peoples, to ensure that Indigenous women and children enjoy the full protection and guarantees against all forms of violence and discrimination" (2019).*

Article 23,

> *“Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, Indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions” (2019).*

Article 24,

> *“1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals, and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.”*
>
> *2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right” (2019).*

These articles demonstrate the legal obligation and commitment to protecting Indigenous women from discrimination and violence. Additionally, they show Indigenous People’s legal right to be involved in developing health programs that affect them. Most importantly, the *Declaration Act* codifies into law Indigenous People’s right to access healthcare services free from discrimination. The readers of this thesis need to understand that there are legal obligations that the provincial government is to fulfill when it comes to the safety, respect, prosperity, and inclusion of Indigenous Peoples, with specific attention given to women, girls, and Two-Spirit folks, within the realm of healthcare.

In addition to the *Declaration Act*, in 2015, the *Truth and Reconciliation Commission of Canada (TRC)* published its final report. The *TRC* report illustrated the impacts of the residential school system and created a historical record of colonization’s legacy and its ongoing consequences. From this report came the 94 calls to action. The calls to action cover an extensive scope, including child welfare, education, justice, language, culture, and, most significant to this research, health. The calls to action about health focus on, among others, closing the gap in health outcomes for Indigenous and non-Indigenous communities, assessing the availability of appropriate health services for Indigenous folk, recognizing the value of Indigenous healing practices, and using them in the treatment of Indigenous parties, and increasing the cultural competence of all health-care providers (TRC, 2015). Particularly relevant to this research and vital for the reader's comprehension and appreciation of this study is Call to Action 22, which reads,

> *“22. We call upon those who can effect change within the Canadian healthcare system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.”*

While the *TRC* report is not codified into Canadian law, it calls upon all levels of government to "fully adopt and implement the Declaration as the [guiding] framework for reconciliation" (TRC, 2015, p. 5). The readers of this research need to understand that all levels of government are being called upon to uphold all 94 calls to action in the name of reconciliation.

Finally, perhaps most importantly, is the National Inquiry into Missing and Murdered Indigenous Women, *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls.* This report illuminates how pervasive and intentional human and Indigenous rights violations are the foundation for Canada's hauntingly high rates of violence against Indigenous women, girls, and 2SLGBTQQIA+ people (National Inquiry into Missing and Murdered Indigenous Women and Girls [NIMMIWG], 2019). Further, the report presents findings on social determinants of Indigenous Peoples' prosperity and healthcare needs.

The findings of this report demonstrate,

- How the current healthcare system has failed to meet the needs of Indigenous women, girls, and 2SLGBTQQIA+ people for them to access safe and secure care.
- How the current system and its practices are primarily designed and delivered by non-Indigenous folks.
- Due to systemic barriers within educational institutions and challenges in delivering culturally appropriate services, "efforts to train, hire, and retain Indigenous health and wellness services providers have been inadequate. As a result, there is a lack of language speakers and cultural knowledge in some locations" (NIMMIWG, 2019, p. 498).
- How "health and wellness services are most effective when they are designed and delivered by the Indigenous Peoples they are intended to serve, in a manner consistent with and grounded in the practices, world views, cultures, languages, and values of the specific communities they serve" (NIMMIWG, 2019, p. 499).
- There is currently a deficiency of culturally relevant treatment and healing options for Indigenous Peoples.
  "Gaps in social and physical health and wellness infrastructure and services within [Indigenous] communities often require women, girls, and 2SLGBTQQIA+ people needing health and wellness services to leave their communities to obtain these essential services. In many Inuit and northern communities, women must leave their communities to give birth. These forced and coerced relocations to access services contribute to heightened exposure to harm and risk. This relocation removes women, girls, and 2SLGBTQQIA+ people from the safety net of their communities and families, separating women from their children" (NIMMIWG, 2019, p. 499).

Ultimately, this report, and others similar, demonstrate that Indigenous people have the "solutions and knowledge to care for and heal themselves, but their strengths and knowledge are undervalued by the current system of health and wellness services" (NIMMIWG, 2019, p. 499).

Indigenous Sovereignty and Indigenous Data Governance Principles

It is only possible to conduct, analyze, and discuss research involving Indigenous Peoples by discussing the concept of Indigenous data sovereignty.

Indigenous sovereignty is multifaceted and might hold different meanings to each individual, community, nation, and government. An aspect of Indigenous sovereignty is the traditional knowledge that belongs to each Indigenous individual, family, community, and nation (Indigenous Environmental Network, n.d.). This knowledge consists of spiritual and cultural teachings, language, social and legal systems, and the intrinsic relationships that Indigenous Peoples have with the lands and waters. Indigenous sovereignty persists regardless of what the nation-state does or does not recognize (Indigenous Environmental Network, n.d.).

The idea of Indigenous sovereignty is nuanced and complex, therefore making it difficult to define and digest. In his research paper for the National Centre for First Nations Governance, Richard Missen explained that Indigenous sovereignty is not absolute or static. Instead, “Indigenous sovereignty" is used to promote the interests of First Nations people. [It is their] sovereignty that grants First Nations the jurisdiction over their lives without interference by other governments” (Missen, 2008, p. 2).

This aspect of Indigenous sovereignty, which grants Indigenous Peoples, including First Nations Peoples, the authority to structure their governance and social systems without the interference of other governments, speaks to the principle of non-interference. Non-interference is an essential component of Indigenous sovereignty. Dr. Jennifer Walker explains throughout her work on Indigenous governance and research ethics that one way of understanding the principle of non-interference is through a wampum[1] that articulates and demonstrates the Two-Row Treaty of 1613 (Walker, 2022). This treaty was made between the Haudenosaunee peoples and settlers when treaties were established for peace and friendship building (Walker, 2022). This treaty represents the idea of two distinct groups being able to travel alongside one another, allowing all systems of knowledge, governance, languages, and family structures to exist freely and equally without interfering (Walker, 2022).

Travelling alongside one another and learning from each other without interfering is incredibly unfamiliar to settlers and colonial-based institutions and organizations. The history of colonization for assimilation has made this concept of non-interference quite challenging to comprehend and practice, especially in academia. However, orienting ourselves and working through this non-interference framework is essential to decolonize research. We all have a collective responsibility toward reconciliation to decolonize our world. To do this, we must work in ways that do not impose or interfere but rather position ourselves to work alongside

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[1] A wampum is a belt bound by strings and beads traditionally made from shells often used to communicate history, traditions, and laws. For some Indigenous groups, wampums hold various sacred meanings and usages. Wampums have been used for ceremonial purposes and to bind agreements (Haudenosaunee Confederacy, 2023).

one another. This shift in approach will be difficult for institutions and organizations because colonial ideologies and assimilatory practices are deeply entrenched in the policies and laws that govern them (Walker, 2022).

For the scope of this research, the notion of Indigenous sovereignty and non-interference is deeply connected to my relational accountability as a researcher. I am responsible for honouring and understanding Indigenous People's sense of responsibility over their knowledge and data and orienting this research to support the self-determination and sovereignty of Indigenous Peoples, their communities, and nations.

A component of Indigenous sovereignty profoundly connected to this research is the notion of Indigenous data sovereignty and the broad principles of Indigenous data governance. The OCAP principles, for example, were developed by the First Nations Information Governance Centre to ensure that First Nations' data and knowledge are being appropriately governed, used, and honoured (2014). There is a long history of colonized research in Canada, and there continue to be instances of Indigenous data needing to be governed by Indigenous data governance principles (Walker, 2022). Due to this history, it is vital to ensure that the work we do as researchers and the stories we tell with the data we collect will not perpetuate further harm to Indigenous Peoples. To do this, the broad principles of Indigenous data governance need to be not only considered when shaping the design of the research but applied when conducting it as well. Indigenous People's inherent right to own, control, access, and possess their data allows them to be the stewards of their knowledge (First Nations Information Governance Centre [FNIGC], 2014). The ability of Indigenous Peoples and their communities to own, control, access, and possess their data is "fundamentally tied to self-determination and the preservations and development of their culture" (FNIGC, 2014).

The OCAP principles were established and developed by and for First Nations communities and governments. These principles are, therefore, specific to First Nations communities and governments. So, while they are essential to the governance and use of First Nations data, we cannot assume that they apply and are relevant to all Indigenous Peoples and how they wish their data, information, and knowledge to be governed. As this research is striving to move away from generalizing and blanketing all Indigenous Peoples and their needs to be the same, it is imperative to consider that the OCAP principles, while incredibly important to remain mindful of, are not going to apply equally and have the same impact on all Indigenous Peoples, communities, and governments.

In addition to considering the broad principles of OCAP, this research felt it was necessary to consider the CARE principles developed by the Global Indigenous Data Alliance (2022). The CARE principles were established as an international effort to develop guiding principles for Indigenous data governance. As such, to follow the CARE principles, "data must be treated in a way where there is a collective benefit, there is clear authority of Indigenous individuals or nations to control it, there is a shared responsibility for the data, and there is Indigenous ethics" practiced throughout the entire research process (Walker, 2022, min. 31). The CARE principles of Indigenous data governance sometimes oppose the FAIR principles of open data governance.

The FAIR principles are a mainstream view of data governance and are being pushed globally to strive for data to be Findable, Accessible, Interoperable, and Reusable. The additional layer of the CARE principles is necessary for the governance of Indigenous data because it protects against the potential harms that can be perpetuated from data only governed by the FAIR principles (Walker, 2022).

Following Indigenous data governance principles contributes to the advancement of Indigenous sovereignty. One of Indigenous People’s most sacred resources is the information and knowledge they have gathered and passed on to each generation (FNIGC, 2014). Many Indigenous Peoples and communities believe data encapsulates much more than quantifiable information. Instead, there is a shared belief that knowledge is about understanding culture, identity, and traditions and advancing self-determination (FNIGC, 2014).

These concepts must be discussed in the background section of this study because understanding the diverse aspects of Indigenous sovereignty is vital to understanding the study's objective and how it was designed and conducted. More importantly, if Indigenous data continues to be governed and utilized without Indigenous data governance principles, then we will continue to tell Indigenous stories without the involvement of Indigenous Peoples. Indigenous data governance ensures that the stories told are from Indigenous perspectives and that the data is not used to perpetuate further harm to Indigenous Peoples and their communities (Walker, 2022). The principles of OCAP and CARE are essential to ensuring that Indigenous data is used to advance Indigenous self-determination and sovereignty. In summation, nothing should be told of Indigenous People’s stories without their direct participation and involvement.

Chapter 3: Literature Review

This chapter presents a conceptual literature review used to develop the conceptual framework that informs data collection and analysis. Findings from this literature review were also used to refine the research question.

Mapping the Process: Literature Searched and Selected

It should be noted that this is not an extensive literature review but was deemed sufficient by the supervisory committee as a foundation for understanding this issue, refining the research question, and informing the conceptual framework.

This research understands and acknowledges the current body of literature that centres on anti-Indigenous racism within healthcare systems. This includes but is not limited to, the valued work of Margo Greenwood (2021) on addressing anti-Indigenous racism in healthcare, Samantha Loppie, Charlotte Reading, and Sarah de Leeuw's (2014) work on Indigenous experiences with racism and its impacts, and Amanda Gebhard, Sheelah McLean, and Verna St. Denis's (2022) work, *White Benevolence*, which centers on exposing and mitigating racism in helping-professions, including healthcare. The collective work of these scholars is vital to addressing anti-Indigenous racism within healthcare systems. However, this research sought to explore more deeply and personally the phenomenon of access to healthcare for Indigenous women in B.C. specific to relational interactions and future health-related decisions potentially impacting retention.

Compiling literature was initiated by generating search streams using Boolean operators to search for specific terms. Such terms included “Indigenous,” “Canada,” “healthcare,” and “access.” The UNDRIP-approved term “Indigenous” was preferred as it has the least colonial origins in Canada's context, but for future research, the search streams were revisited to include more words. For a preliminary review, interest was given to researching general trends in Canada regarding access to health care for all Indigenous folk. Filters like peer-reviewed scholarly articles published after 2015 were chosen as search parameters. The preliminary search was intended to consist primarily of empirical studies and the most current academic research. This search was facilitated through the University of Victoria's library database. Materials were selected for review based on their alignment with and relevance to the research goals of exploring Indigenous Peoples' experiences when accessing health care in Canada. A complementary piece of literature was selected through the reference list in one of the previously chosen materials written by the same authors. This article met the stipulations once set as search parameters and was therefore added to the materials for review.

A supplementary search was conducted where the search streams “Indigenous,” “Aboriginal,” “women,” “voices,” “healthcare,” and “Canada” were utilized while using Google as the database. The motivation behind including the term Aboriginal was potentially generating more literature on Indigenous women's experiences with access to mainstream health care services. While a scholarly database was not used, this was justified as grey literature was equally important to review as empirical and academic research. This search selected additional literature that aligned with and was relevant to my research goals.

It is worth considering that the term “anti-Indigenous racism” was not specifically selected as a search stream because the researcher was not solely focused on exploring anti-Indigenous racism as the only barrier experienced by Indigenous women when accessing healthcare but was attempting to explore barriers regarding relational interactions and issues of retention, including but not limited to instances of anti-Indigenous racism. Without including this search stream, the concept of anti-Indigenous racism was still explored in the literature review as reports and studies selected spoke to this concept as an access barrier for many Indigenous peoples.

As the research continued, it was realized that a more profound comprehension of Indigenous perspectives on health and wellness was necessary to understand some of the themes emerging from the participants’ data. As such, an additional search was initiated to unearth what the historical and current literature conveys about Indigenous perspectives on health and wellness. This search was facilitated through the University of Victoria’s library database using Boolean operators to search for specific terms. These terms included “holism,” “connection,” “Indigenous,” and “health.” These terms were selected due to their presence throughout the previously reviewed literature and the conversations had with the participants. An additional search was conducted using Google, searching the terms “Indigenous,” “perspective,” “connection,” and “holism.” Again, not using a scholarly database was reasonable because of equal interest in grey literature as academic research on this topic. Only a few pieces were selected from these searches as there was not much relevant literature on the subject.

Further, research was conducted on Indigenous research methods. As these concepts did not inform the creation of the research question or conceptual framework, they will be thoroughly discussed in the subsequent chapter on methods and methodology.

Quality of Materials

When assessing the quality of the selected materials, prompts from Dixon-Woods et al. (2004) were applied. The pieces selected for each stage of the literature review all relied upon well-defined research questions well-suited for qualitative inquiry into the topic (Dixon-Woods et al., 2004). The selected studies discussed concepts of racialized discrimination, settler colonialism, structural inequalities, Indigenous health and wellness practices use, and patient-provider attachment in terms of people’s lived experiences. Some were primarily focused on Indigenous women’s experiences. How each study looked at these concepts regarding concrete experiences made them relevant to the research topic, as this analysis process aligns with the research goals. For these reasons, the materials chosen for review from the preliminary and supplementary searches were of good quality.

Concepts

Settler Colonialism

The concept of settler colonialism was rampant throughout the literature, and the analysis of its effects on Indigenous Peoples' ability to access health care was consistent. It was interpreted as a barrier within the literature because of the lack of trust that Indigenous Peoples commonly have in colonial institutions due to historical and personal experiences (Burnett et al., 2020; Loppie et al., 2014; Loppie-Reading & Wien, 2009; Muller, 2022; Turpel-Lafond, 2020 & Wylie & McConkey, 2018). Similarly, the power imbalances that the legacy of settler colonialism creates between Indigenous and non-Indigenous individuals was understood to be an additional barrier as it makes it challenging to foster trustworthy relationships between patients and providers, further impeding access to care for Indigenous patients (BC Women's Health Foundation and Reciprocal Consulting [BCWHFRC], 2021; Burnett et al., 2020 & Nelson et al., 2018).

Congruently, colonial practices are often "unwelcoming and inflexible to Indigenous forms of healing" (BCWHFRC, 2021; IRSHDC, 2021; Turpel-Lafond, 2020, p. 36 & Wylie & McConkey, 2018), which creates a barrier for Indigenous Peoples attempting to access the care they need and aligns with their beliefs and approaches to health and wellness. Similarly, the literature illuminated how Indigenous medicines and healing practices are often devalued or disrespected in the mainstream healthcare system (IRSHDC, 2021; Kurtz et al., 2013; Loppie et al., 2014; Turpel-Lafond, 2020; Wylie & McConkey, 2018 & Wylie et al., 2020).

Racialized Discrimination

The concept of racialized discrimination as a barrier to healthcare access figures prominently in the existing literature. This concept was evident in each piece of literature reviewed. Similar patterns of how racialized discrimination acted as a significant barrier to accessing health care were recognized throughout the literature; however, interpretations of this barrier were not always consistent or explicit. It was clear that racialized discrimination in the form of stereotyping tended to lead to sub-standard care administrated by providers and caused a lack of trust in Western institutions, therefore creating an access barrier for Indigenous Peoples (BCWHFRC, 2021; Burnett et al., 2020; Loppie et al., 2014; Nelson et al., 2018; Turpel-Lafond, 2020 & Wylie & McConkey, 2018). What was not explicitly clear or further interpreted by the literature was how, if at all, racialized discrimination experienced expressly by Indigenous women affected their decision to access care in the future or on a preventive basis.

Additionally, interpretations of structural racism and its use to justify the "exclusion of sub-groups to increase the vitality of larger populations" were inconsistent within the few pieces of literature that discussed it (Loppie et al., 2014; Loppie-Reading & Wien, 2009 & Muller, 2022, p. 363). While varying throughout the literature, structural racism and exclusionary practices experienced by Indigenous Peoples were analyzed as potential barriers to accessing healthcare and are relevant to the research topic.

Indigenous-specific Gendered Racism

Few of the literature reviewed spoke to Indigenous-specific gendered racism as a barrier to Indigenous women accessing healthcare services (BCWHFRC, 2021; IRSHDC, 2021; Kurtz et al., 2013 & Turpel-Lafond, 2020). Indigenous-specific gendered racism is racism explicitly experienced by Indigenous women and other women-identifying individuals. This concept was minimally addressed throughout the literature, which could demonstrate how the experiences of Indigenous women regarding gendered racism when accessing healthcare continue to be silenced and, therefore, underrepresented in academic and grey literature. While it was not prominent in most of the literature, there remained a shared notion that Indigenous women have historically and continue to bear the burden of anti-Indigenous racism disproportionately to Indigenous men (BCWHFRC, 2021; IRSHDC, 2021; Loppie et al., 2014 & Turpel-Lafond, 2020). Interpretations of how this concept acts as a barrier for Indigenous women were diverse throughout the few pieces of literature that discussed it.

One understanding of how Indigenous-specific gendered racism manifests as an obstacle for Indigenous women was the inherent ways in which women "need to interact with the healthcare system in more regularly intimate ways in comparison to Indigenous men" and how those situations can be a catalyst for experiences of racism and abuse explicitly endured by Indigenous women (Turpel-Lafond, 2020, p. 73).

The notion of patriarchal or "misogynistic stereotyping" of Indigenous women by healthcare professionals was an alternative interpretation of this concept (IRSHDC, 2021, p. 13; Kurtz al., 2013 & Turpel-Lafond, 2020). Misogynistic stereotyping was a commonly cited experience within the literature and presented itself as an additional barrier to access as a noted implication of this concept was a lower proportion of Indigenous women feeling safe in comparison to their male counterparts when accessing healthcare (Loppie et al., 2014 & Turpel-Lafond, 2020). This perceived lack of safety experienced by Indigenous women is said to be supported by "the disproportionate rate at which Indigenous women leave hospitals against medical advice" and before the completion of treatment (Turpel-Lafond, 2020, p. 74).

While this concept had varying interpretations of how it presents as a barrier to Indigenous women's ability to access healthcare, what was unanimous was how experiences of Indigenous-specific gendered racism left Indigenous women and other women identifying folks "feeling unsafe and facing inequitable health outcomes" (BCWHFRC, 2021; IRSHDC, 2021, p. 6 & Turpel-Lafond, 2020)

Geographical Limitations & Structural Exclusion

Notions of geographical limitations were considered barriers to accessing health care services for Indigenous Peoples (Burnett et al., 2020; Nelson et al., 2018 & Turpel-Lafond, 2020). Historically, one way that the perpetual health inequalities within Indigenous communities have been justified is as an inevitable consequence of living remotely rather than a condition of structural exclusion influenced by settler colonialism (Muller, 2022). Structural exclusion as a concept can be defined as a condition of settler colonial, structural racism, and neoliberal state structures which intentionally excludes sub-populations from economic, social, and political activities under the premise that the exclusion of the sub-population allows for increased vitality of the larger population (Information Science Reference, 2019 & Muller, 2022). While it received inconsistent consideration in the literature, the concepts of geographical limitations and structural exclusion as exclusionary practices of Indigenous Peoples are nonetheless barriers to accessing health care. They are, therefore, relevant to the research topic (Muller, 2022).

Throughout the literature, there were aspects of this concept that were overlooked. For example, one of the pieces reviewed mentioned needing to travel to a specific location to access a particular treatment, i.e., treatments related to female reproductive health (Muller, 2022). In addition, while the concept and implications of entrenched colonialism throughout the healthcare system were well identified throughout the literature, the notion of the intersection between colonialism and geographical limitations to access healthcare was once again under-observed. More simply put, the need to travel to alternate facilities because those within a reasonable distance do not feel physically or emotionally safe due to the historical and continued colonial ties were underexamined in the literature, and how these aspects of geographical limitations affect the overall access to healthcare for Indigenous women was widely unapproached by the literature. One piece of literature, however, spoke to Indigenous women in rural areas choosing to leave their communities and travel to “bigger health centres in an attempt to be prioritized by the doctors” (BCWHFRC, 2021, p. 21).

Indigenous Health and Wellness Practices

Among the literature reviewed, three pieces spoke to Indigenous women's traditional roles in health care. Shared notions of Indigenous women being the “social fabric of their communities,” the decision-makers for their families, and the indicators of health and wellness for their communities were widespread within all three pieces of literature (IRSHDC, 2021, p. 7; Kurtz et al., 2013 & Turpel-Lafond, 2020). The narratives within the literature highlighted that because Indigenous women traditionally embody a crucial role in facilitating and caring for the health and well-being of their families and communities, when access to health care for Indigenous women is limited or restricted, it can not only be detrimental for their health but for the health of their family and community (IRSHDC, 2021 & Kurtz et al., 2013).

As the current conventional healthcare system is profoundly rooted in patriarchal and colonial practices, it stands to reason why much of the literature reviewed would be consistent in its analysis that Indigenous Peoples feel that their traditional methods and approaches to health and wellness are unwelcome and unacknowledged (IRSHDC, 2021; Kurtz et al., 2013; Loppie et al., 2014; Turpel-Lafond, 2020; Wylie & McConkey, 2018 & Wylie, et al., 2020). The current healthcare system is completely misaligned with Indigenous beliefs of holistic health and wellness and the knowledge that women’s health is deeply connected to family, community, nation, and cultural health. Therefore, the literature demonstrates how this misalignment creates potential barriers to access regarding aspects of personal safety and feeling connected to and involved in the system that treats you (IRSHDC, 2021).

Patient-provider Attachment

The concept of patient-provider attachment and the low rates of it among Indigenous Peoples was understood throughout the literature as a consequence of the multiple barriers impeding access to health care for Indigenous Peoples; however, this concept was only briefly discussed in the literature (Turpel-Lafond, 2020). Wylie and McConkey's (2018) study mentioned how "Indigenous people have admitted their reluctance to continue accessing health services after their experiences with discrimination in the healthcare system," however, further interpretation of this phenomenon and the potential personal motivations behind it, were not provided within their study (p. 38). Additionally, the literature briefly discussed how many Indigenous people postpone accessing healthcare until it is necessary or experience a "diminished utilization of services critical to [Indigenous] Peoples' health (Loppie et al., 2014, p. 9; Turpel-Lafond, 2020 & Wylie & McConkey, 2018). This phenomenon often leads to more frequent visits to the emergency room rather than visiting a primary physician to whom they are attached (Turpel-Lafond, 2020).

Kurtz et al.'s (2013) participatory research highlighted how to mitigate negative encounters with the [mainstream] healthcare system; many women would first turn to family, friends, or Indigenous-run health services before seeking conventional care, while others would use home remedies to treat themselves (p. 58). Though the concept of alternative practices, procedures, and medicines used by Indigenous women to avoid negative experiences with the mainstream system received inconsistent consideration throughout the literature, it remains an essential concept to the overall research topic and is relevant and noteworthy.

Finally, it was noted that "Indigenous women are more likely to cease health care services before the completion of their treatment" due to negative experiences when interacting with the mainstream system (Turpel-Lafond, 2020 & Wylie et al., 2020, p. 10).

Balance and Interconnection

When reviewing the literature focused on Indigenous perspectives of health and wellness, the concepts of interconnectivity and health as a balance between the physical, emotional, mental, and spiritual realities figured prominently (Auger et al., 2016; Katz et al., 2017; Hill, 2014; FNHA, n.d.d; Joseph, 2020 & Loppie-Reading & Wien, 2009).

Collectively, the literature cited holistic approaches to health and wellness, those concentrated on balancing the four realities of the self, emphasized better health outcomes for Indigenous Peoples, and increased cultural respect and feelings of safety (Auger et al., 2016; Katz et al., 2017 & Hill, 2014). It was understood that holistic approaches commonly intend to heal "root causes, rather than symptoms" because they address the whole self, an approach noted as lacking within Western medical systems (Auger et al., 2016; Katz et al., 2017; FNHA, n.d.d; Hill, 2014, p. 18 & Loppie-Reading & Wien, 2009). Similar patterns demonstrated that healing must be addressed holistically, with specific attention given to each aspect of the self to achieve holistic health balance (Auger et al., 2016; Katz et al., 2017; Hill, 2014; FNHA, n.d.d & Joseph, 2014). Additionally, it was understood that traditional healing requires a thorough understanding of and respect for the self and others. The literature also emphasized the essentiality of relationships to achieve meaningful and safe healthcare interactions (Katz et al., 2017; Hill, 2014 & Joseph, 2014).

Knowledge Gap

It was clear from the literature review that access to healthcare for Indigenous Peoples in B.C. and throughout Canada had been examined through various lenses. The literature demonstrated a strong understanding of how colonialism, racialized discrimination, Indigenous-specific gendered racism, and geographical limitations and structural exclusion are barriers for Indigenous Peoples needing healthcare access. Additionally, the concept of patient-provider attachment and its low rate among Indigenous Peoples was briefly discussed as a consequence of the previously mentioned concepts. The literature also provided a conceptual understanding of how Indigenous health and wellness practices are often undervalued and unwelcomed within the mainstream healthcare system, leading to a misalignment between Indigenous patients and the system through which they access care. Finally, the supplementary literature review revealed the importance of holistic approaches to health and wellness among many Indigenous Peoples and cultures as concepts of interconnectivity and balance figured prominently.

Multiple gaps in the current field of knowledge were discovered by conducting the literature review. Currently, the literature lacks studies focusing on Indigenous women and their experiences navigating barriers to accessing healthcare, specifically in B.C. More purposely, space remains for additional research which examines the motivations behind Indigenous People's reluctance to continue accessing healthcare services if they have experienced discrimination or other access barriers while receiving care from the mainstream healthcare system. In addition, less attention is given to understanding how this phenomenon affects specifically Indigenous women in B.C. The reluctance to access health care and its further implications on Indigenous women's health and the attachment rates of Indigenous women as patients within B.C. remains to be more deeply explored. This research recognizes and values the current literature's contribution to understanding Indigenous People's experiences accessing healthcare, i.e., *The In Plain Sight Report* (2020) and *The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (NIMMIW, 2019).* While the *In Plain Sight Report* included the experiences of Indigenous women, the report was predominantly concerned with experiences of anti-Indigenous racism, leaving other experiences to be observed. The *NIMMIW* was a nationally-based report and was not concentrated on the specific experiences of Indigenous women accessing healthcare solely in B.C., therefore making room for our research to contribute additional understandings to this issue by solely focusing on Indigenous women's experiences in B.C. and utilizing their stories as primary data.

Finally, much of the current literature focuses on what Maggie Walter calls the five D's of Indigenous research and data representation. The five D's are disparity, deprivation, disadvantage, dysfunction, and difference, each regularly cited in research involving Indigenous Peoples (Walter, 2016). While identifying the five D's may have its place in research, if the majority of what is written and presented on Indigenous Peoples is continuously painting this picture of despair and difference, then it will continue to feed the narrative and damaging stereotype that Indigenous Peoples cannot take care of themselves and do not know what is in the best interest of their families, communities, and nations (Walker, 2022). Presenting research findings that only speak to the "dire and longstanding socioeconomic and health inequalities that exist between Indigenous and non-Indigenous peoples" does not advance the goal of self-determination or the sovereignty of Indigenous Peoples and nations. Walter states, "The problem is that there is a plethora of easily accessible 5D data. Attempting to move outside this trope of the statistical Indigene is to find yourself in a data desert" (Walter, 2016, p. 81). With that in mind, this research wants to add to the present field of knowledge by ensuring that strength-based findings are presented based solely on the data collected from the Indigenous contributors involved. Notions of the five D's of Indigenous research and data representation will only be offered in this paper should the data speak to them and only be presented through recounting the Indigenous contributors' perspectives, knowledge, and stories.

While gaps in the literature were identified, this research will address how experiences endured by Indigenous women in B.C. can affect their ability to access healthcare by potentially influencing their decision to continue to access care from mainstream systems.

This gap in the contemporary literature allows this study to focus on the essence of a phenomenon, access to healthcare for Indigenous women, and how their experience with it affects their general healthcare decisions. This exploration focuses on amplifying the voices and experiences of Indigenous women, which contrasts with much of the current literature that focuses on quantifying the issue of access to healthcare for all Indigenous People.

Conceptual Framework

It has been stated that a "robust conceptual framework describes the different concepts one would need to know to understand the particular phenomenon, without pretending to create causal links across variables and outcomes" (Pacheco-Vega, 2018, para. 6). Further, as Regoniel (2015) states, a conceptual framework is the researcher's idea on how to explore the research problem (para. 4). With that understanding of what a conceptual framework is and what it means in Western academia, the initial conceptual framework was formulated based on the literature reviewed. From the preliminary and supplementary literature reviews, five prominent concepts emerged which were deemed necessary to understand the phenomenon of access to healthcare for Indigenous women in B.C. Each concept contained one or multiple sub-concepts, creating its unique relation to the studied phenomenon. This initial framework was then utilized to collect data which spoke to the concepts and sub-concepts by informing the interview questions. The concepts that are presented in the initial model were what was being observed and explored through the data collection process. This initial conceptual framework operated as the framework of ideas that informed and guided this study.

The conceptual framework represents what has been learned about this phenomenon throughout each research stage. As such, the framework has been responsive to additions and modifications needed to express the ideas guiding this study. When collecting and analyzing data, I remained open to the possibility that concepts from outside the initial framework may become prominent and require equal attention and consideration as the concepts within the initial framework.

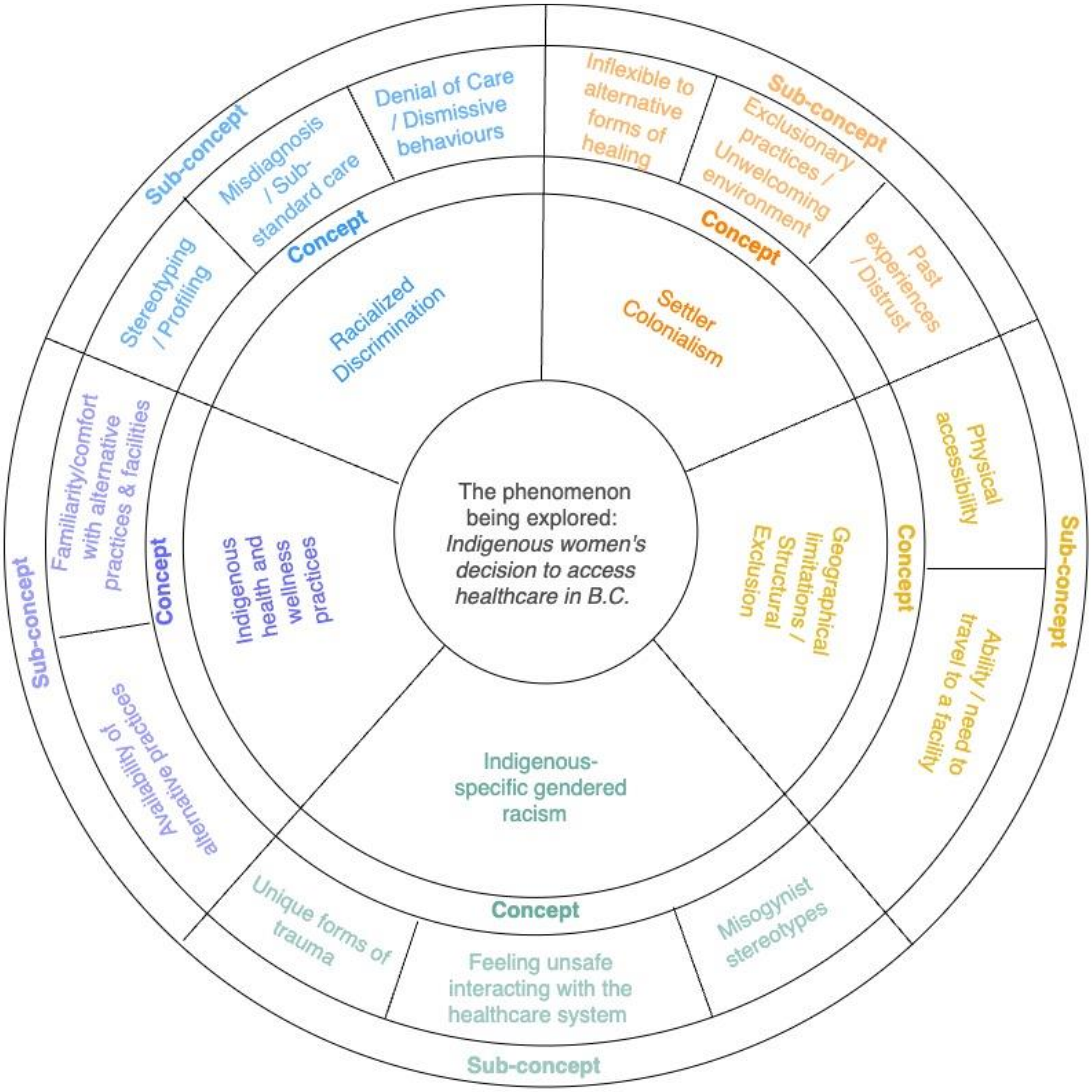
The initial conceptual framework model did not change; however, as previously stated, it was essential to remain open to the possibility that additional concepts would emerge from themes within the participants' data, and these concepts would aid in the explanation of the phenomenon being studied. As such, other emergent concepts were deeply considered during the data analysis stage and were researched to support the discussion chapter.

It is important to note that while these were the initial concepts and sub-concepts selected to focus on throughout this research, acknowledgment must be given that these are not the only concepts that help explain and make the argument for why this phenomenon occurs and should be studied. The concepts presented within the framework were solely the ones that became the most apparent throughout the preliminary and supplementary literature review and were relevant to the phenomenon of Indigenous women's experiences when accessing healthcare. Therefore, the framework informed the research team's idea of how to explore this research problem.

Ultimately, the concepts and sub-concepts presented in the framework were developed and legitimized by drawing from the predominantly Indigenous primary and secondary research and documented experiences. The teachings of the Medicine Wheel or the Sacred Circles inspired the conceptual framework model. To honour and incorporate Indigenous perspectives on health and wellness, embodying the concepts of connection and balance by creating a model that mirrored those values was important. Considering how this framework took shape was vital as it intended to symbolize and represent a two-eyed approach to research, honouring Indigenous and Western methods. Choosing to display the framework as a circle was intentional. While Medicine Wheels and Sacred Circles are interpreted uniquely among Indigenous Peoples, the shape and what that shape represents is often interpreted uniformly. The circle represents the "interconnectivity of all aspects of one's being" (Joseph, 2020, min. 1:08). In addition, Medicine Wheels and Sacred Circles broadly represent the "continuous interaction between the physical, emotional, mental, and spiritual realities (Joseph, 2020, min. 0:55). While this circle does not speak to the physical, emotional, mental, and spiritual realities, it was intended to demonstrate the essence of interconnectivity that exists between the concepts presented in the framework in a similar way to that of the continuous interactions of the various realities represented in Medicine Wheels and Sacred Circles. By doing so, the goal was to merge and honour the distinctiveness of Indigenous and Western approaches in one conceptual framework.

Figure 1

Initial Conceptual Framework



Initial Conceptual Framework Explanation

The model of the initial conceptual framework was developed from the five prominent concepts that emerged from the preliminary and supplementary literature reviews. The framework was made of these concepts as they were deemed necessary by the research team to understand the phenomenon of access to healthcare for Indigenous women in B.C.

As previously mentioned, choosing to display the conceptual framework as a circular model was deliberate, as the inspiration for the model's shape was derived from the lessons of the Medicine Wheel and Sacred Circles. The intention behind the design was to represent and communicate the interconnectivity between the concepts and how they all share a unique relation with the phenomenon being studied.

The model contains the five prominent concepts and their corresponding sub-concepts. Each concept and its sub-concepts were investigated through the interviews as the framework informed the interview questions.

This framework was then used to collect data about each concept and sub-concept. As specific interview questions were developed from the framework, participants' answers often directly spoke to the concepts contained within it. However, as mentioned, the researcher needed to remain open to ideas emerging from outside the framework becoming prominent and requiring equal attention as those within it throughout the data collection and analysis stages. During the analysis stage, the framework acted as a guide to identify gaps in the current literature's interpretation of the phenomenon. As the framework was developed from the preliminary and supplementary literature reviews, it was possible to determine where the data collected from this research contradicted or supported the literature's interpretation.

Chapter 4: Methodology and Methods

This chapter discusses the methodologies and methods utilized throughout this study. As this research sought to amplify the voices of Indigenous women while advancing the self-determination and sovereignty of Indigenous Peoples by decolonizing the healthcare system, it was vital that the design of this study honour Indigenous approaches to research. As such, this chapter will discuss Indigenous and Western research methodologies and methods that were employed with a conscious commitment to demonstrate their equal value and contribution to academic research.

Ethical and Research Review

This research required approval from UVic's ethical review board, HERB, as it wanted to explore human experiences. There was a low-medium level of risk that accompanied this research. Recalling experiences could trigger memories of traumatic incidents for the participants. To mitigate this risk, I consistently relied on the guidance of my supervisor, Dr. Susanne Thiessen, an Indigenous scholar. A trauma-informed approach was practiced when engaging with participants.

Certificate approval number 22-0647.

Methodology

Due to the nature of this research, the methodology and methods used were only partially rooted in Western science and colonial practices. There are deep colonial roots within Western academic institutions, and these roots often dictate how research is conducted. Therefore, it was imperative to the authenticity and credibility of this research that the methodology and the methods of data collection and analysis chosen not only incorporated and honoured Indigenous practices but were aligned with the goals of this research, that is, contributing to Indigenous sovereignty and self-determination by amplifying the voices of Indigenous women and advancing their inherent rights.

Western Methodologies

A qualitative approach was utilized for this research. The qualitative method of phenomenology was employed to explore the essence of the healthcare access phenomenon. The essence of a phenomenon is often described as the "universal commonality of the experience" being studied (Gates et al., 2018, min. 0:15). Others see "individuals as the vehicle through which the essential structure of the 'essence' of the phenomenon may be accessed and subsequently described" (Priest, 2002, p. 51).

According to Max van Manen, author of *Phenomenology of Practice,* phenomenology is a "sober reflection on the lived experience of human existence" (2007, p. 12). More than that, phenomenology is a methodology motivated by fascination, exploration, and the desire to discover deeper meaning (van Manen, 2007).

As a methodology, phenomenology can be particularly useful when examining multifaceted, ambiguous, or emotionally laden topics (Research Tube, 2021). As the research topic being explored is complex and, at times, emotionally demanding, phenomenology was deemed a well-suited methodological approach.

Since phenomenology does not attempt to test predetermined hypotheses but intends to explore an area of interest or concern, the data collected using phenomenological methods are described as emergent (Gates et al., 2018). As such, the data collected helped to develop a narrative of experiences that transitioned from the abstract to the conceptual (Research Tube, 2021). When principles of Indigenous research methodologies were considered, the conceptual transitioned to the relational (Wilson, 2001).

As the primary goal of phenomenology is to explore how the participants make sense of their personal and social world (Research Tube, 2021), this methodology helped explore how Indigenous women make sense of their experiences when accessing healthcare in B.C. and their experiences' influence on their health-related decisions.

Steps of a Phenomenological Methodology

To begin, the act and process of 'bracketing' was undertaken as it was essential to the validity and confirmability of the study. *Bracketing* "is setting aside personal experiences, biases, and preconceived notions about the research topic. It also involves setting aside previous theories and knowledge that the researcher might hold about the research topic" (Gates et al., 2018, min. 9:02). This process was also coined "epoche" by the philosopher Edmund Husserl. It is important to note that while this process of bracketing or epoche is what commenced the phenomenological approach to this research, it is not the "first step." As Husserl noted, "epoche is not a "step" that we do "first" to prepare ourselves for the later "step," instead, bracketing and the move whereby we drive the self back upon itself, [essentially reflection], occur together (Cogan, n.d., para. 18). While bracketing initiates the approach, it also occurs entirely throughout data collection and analysis.

To bracket, reflexivity was employed to reflect upon researcher biases, experiences, and preconceptions to understand how they might impact the interpretation and dissemination of the data collected. A practice often used to achieve bracketing of one's biases effectively is the employment of a 'bracketing journal.' A bracketing journal is a legend kept throughout the entire research process where the researcher notes each time a personal bias or preconceived notion surfaces. This legend is then presented in the final paper so that the readers know the researcher's preferences when reading the interpretation and presentation of the findings. To bracket personal biases and preconceptions throughout the research process, bracketing journaling was used throughout the data collection stage of this research. The final legend of this journal can be found in the appendix.

The next step in a phenomenological study is *intuiting*, which requires the researcher to remain open to the multiple meanings of different experiences during the data-gathering stage. Staying open to the various purposes or truths of each participant's experience with the phenomenon is imperative to intuiting. It is also essential to understanding Indigenous knowledge paradigms, which will be explained in the *Indigenous methodologies* section. This step was additionally important when analyzing data collected from individual participants.

Following intuiting was the *analysis* stage. After the data had been gathered from multiple sources, emergent patterns and themes were searched across the data. Interpretative Phenomenological Analysis, IPA, was used as the data analysis method.

The last step is *describing,* where the intention is to understand and define the phenomenon conceptually and present that understanding through the final dissemination of findings and discussion (Gates et al., 2018).

According to van Manen (2014), phenomenology has three methodological domains. They are the philosophical domain, where reduction and epoche occur; the linguistic domain, which is the use of language to describe meaning; and the social science domain, which is the use of interviews, observations, and reflective practices to attempt to understand themes and the importance of lived experiences through the stories obtained from interviews (YouTube, 2014). The philosophical and social science domains were necessary for this study to ensure minimal researcher interpretation bias while identifying and interpreting the meanings behind the emergent themes from the participants' stories.

Indigenous Methodologies

As mentioned at the outset of this chapter, it is vital to remain cognizant that Eurocentric methodologies fundamentally differ from Indigenous research approaches. While there are fundamental differences between each method, both held equal value and were necessary to the overall authenticity of this research.

Etuapmunk or Two-eyed Seeing

To begin this section, the Indigenous methodology of Etuapmunk or two-eyed seeing will be discussed. By utilizing Elder Albert Marshall’s metaphor of two-eyed seeing, a method for negotiating and navigating between two distinct cultures, the intention of this research and its methodologies was to be able to honour both the strengths of Western and Indigenous knowledge and ways of knowing to benefit all involved in this research (Bartlett et al., 2012). In doing so, it was recognized that commonly, in Western positivist knowledge systems, there is only one truth; however, within Indigenous knowledge systems and ways of knowing, there can be multiple truths (Indigenous Corporate Training Inc. (ICT), 2016). Acknowledging and considering this contrast between cultures, knowledge systems, and individual beliefs was necessary at all stages of this research and aided in relationship-building between myself and the participants.

Much of my understanding of Indigenous research methodologies and relational accountability has come from the teachings and knowledge of Shawn Wilson. Wilson explains that Western research paradigms hold the fundamental belief that knowledge is an individual entity, whereas Indigenous paradigms believe that knowledge is relational (Wilson, 2001).

Wilson (2001) further articulates the difference between the so-called dominant and Indigenous paradigms by illustrating how “knowledge is shared with all of creation” (p. 176-7). By doing so, one learns that knowledge is shared not only through interpersonal relationships with the research participants but also through the relationships that exist and extend to all of creation. “It is with the cosmos, with the animals, the plants, and with the earth that we share this knowledge” (Wilson, 2001, pp. 176-7). Again, the difference rests in moving beyond individual knowledge to relational knowledge (Wilson, 2001, pp. 176-7). Wilson (2001) emphasizes that this way of thinking extends to demonstrate that ideas are not as important as one's relationship to that idea. This way of thinking is incredibly foreign to other research paradigms; in this case, connections are deemed more important than reality (Wilson, 2001, p. 177). Wilson (2001) provides an example of this relational knowledge paradigm through his conversation with his father. His father once said how the word couch in Cree translates literally to “someplace where you sit.” Instead of calling it a couch and diluting it to a mere object, it was named through one's relationship to it (Wilson, 2001, p. 177). This simple example beautifully illustrates that “it is not the realities in and of themselves that are important; it is the relationship that we share with reality” (Wilson, 2001, p. 177).

Further, Indigenous knowledge systems are built upon relationships. Not simply the relationship between researcher and participant but the relationships that humanity has with everything that grounds and surrounds us (Wilson, 2001, p. 177). As a non-Indigenous researcher, I must continue intentionally considering my relationship with the ideas and concepts I attempted to explain through this research and understand that this knowledge was shared among myself and the participants. Wilson (2001) believes this effort is necessary because the relationship with knowledge is communal and mutual. Therefore, “ideas and knowledge cannot be owed or discovered” (Wilson, 2001, p. 177). Thus, the knowledge contributing to much of this research cannot be attributed to my research efforts alone. Throughout the research process, I was not simply gaining knowledge in an abstract or individual pursuit. Instead, I was gaining knowledge to fulfill my contribution to the research relationship shared among all involved (Wilson, 2001).

A critical element to the design of this research was approaching potential participants who had pre-existing relationships with my supervisor or me. This element was crucial as it aided in avoiding the appropriation of Indigenous culture and knowledge. Such appropriation occurs when proper relationships between researchers and participants have yet to be established, maintained, and honoured (Wilson, 2001, p. 177). To ensure this appropriation does not happen, Wilson states that “researchers must fulfill their role in the researcher relationship through their methodology” (Wilson, 2001, p. 177). At this moment, the concept of *relational accountability,* coined by Wilson, lends itself to the foundation of Indigenous methodologies. Relational accountability is a methodological aspect of Indigenous research paradigms that is at odds with Western research paradigms. According to Wilson, relational accountability is when a researcher answers to all their relations (2001, p. 177). Rather than answering questions about the validity or reliability of their research, they are fulfilling their relationships with the world around them (Wilson, 2001, p. 177). As such, relational accountability asks different questions than Western methodologies might. The researcher must ask themselves how they fulfill their role and obligations in this relationship. Further, Wilson emphasizes how "morals need to be an integral part of the methodology so, as previously mentioned, when the researcher gains knowledge, it is to fulfil their end of the research relationship" and not in an individual pursuit (Wilson, 2001, p. 177). As such, in my case, to honour and incorporate the values of Indigenous methodology, I must be accountable to all my relations.

Before moving on to the methods section of this chapter, my role and obligations in this relationship must be articulated. These obligations were fulfilled by holding myself accountable to the participants involved and, more than that, to their families and communities by ensuring that the findings and discussion of this research were entirely built from their personal and collective truths. When each participant shared their stories, they shared their wisdom and knowledge and opened a window into their personal lives, building a relational connection. By doing so, the accountability felt to uphold their truth and dignity was monumentally increased because of how I viewed my relationship with them and the impact this work may have on their lives.

Complementary to relational accountability are the principles which Cora Weber-Pillwax (1999) states underlie most Indigenous research. These principles are as follows:

1. The interconnectedness of all living things.
2. The impact of motives and intentions on person and community.
3. The foundation of research is lived Indigenous experience.
4. The groundedness of theories in Indigenous epistemology.
5. The transformative nature of research.
6. The sacredness and responsibility of maintaining personal community integrity.
7. The recognition of languages and cultures as living processes (Weber-Pillwax, 1999, p. 31).

Principles one through six were deeply considered throughout the creation of the research design and the data collection and analysis process. While the importance of principle seven was recognized, the concept of language was not touched on throughout the research. It was, therefore, considered less relevant to the objectives of this study.

Weber-Pillwax states that researchers who wish to utilize Indigenous methodologies "face formidable challenges when attempting to meet the standards of two knowledge systems" (1999, p. 40). Because of this, Weber-Pillwax states that how researchers choose to meet these challenges is "unquestionably a personal decision, and as is true for any other researcher, their decisions will be based on the significance and weightings that they assign to the particular factors that go into making them who they are as an individual and as parts of a community" (1999, p. 40).

My supervisor and Indigenous Researchers at the University of Victoria supported the decisions to meet these challenges. Through consultation with my supervisor, we decided how to meet some of the standards of Indigenous and Western knowledge systems. A tremendous effort was made to fulfill my researcher relationship by positioning myself as accountable to all those involved in this research. This was achieved by fostering respectful and reciprocal relationships, respecting Indigenous cultural integrity, creating a final research product relevant to Indigenous Peoples' perspectives and demonstrating my responsibility to ensure that this work would not perpetuate further harm to Indigenous Peoples. This way, I gained the participants' trust as they were assured that the objectives of this research were grounded in principles that aim to advance the inherent rights and sovereignty of Indigenous Peoples (Kirkness & Barnhardt, 2016). As Weber-Pillwax says, "A researcher who has realized that the benefit of research can and should be moved beyond mere good intention and into some form of actuality within the subject's world is ready to make appropriate and responsible choices about the purpose and form of their research." (2016, p. 37).

Methods

The ideal sample size for this study was between 6-10 self-identifying Indigenous women participants. Ultimately, seven participants were involved in this study. Participants were initially obtained through purposive sampling, with contact first facilitated by my supervisor or me to foster a preliminary relationship with participants. Purposive sampling was employed, and a small and primarily homogenous sample of participants was sought: Indigenous women who have had personal experiences with the healthcare system in B.C. It should be noted that while the classification of this sample of participants might be deemed as 'homogenous,' this research does not view the women or their experiences as homogenous and acknowledges the uniqueness of each participant and their lived experiences. Further, snowball sampling was also employed, as active participants were asked if they would be able to and feel comfortable referring other potential participants who met the eligibility criteria for this study. The selection criteria consisted of self-identifying Indigenous women aged 18-55 currently living and accessing, or have attempted to access, healthcare services in B.C.

Qualitative interviews were used to collect information about individuals' experiences with the phenomenon being studied. The discussions focused on the interviewee's narrative to foster a relationship between myself, the participants, and the data collected (Wilson, 2001). To acknowledge and respect personal preferences and boundaries, interviewees could conduct the interview in person or via Zoom. This method allowed each woman to elaborate on their experiences by telling stories. The interviews covered six questions focused on specific themes to identify the concepts and sub-concepts included in the conceptual framework. The structure of the interviews allowed for in-depth answers to be provided by the participants. While the conversations were led by asking open-ended questions, the goal for the interviews was for much of the discussion to be focused on the participants sharing and discussing their experiences with the phenomenon being studied while I listened.

Approaching these conversations, it was recognized that some participants may not have felt comfortable sharing their experiences with me. For this reason, the invitation to participate in this research explained that individuals had no responsibility to share anything they deemed too sensitive or personal during the interview. It was also explained that recording devices would only be used for audio and transcription purposes, not for visuals. Additionally, participants who wished to meet virtually had the option not to turn on their virtual cameras. This option offered the participants greater comfort and safety if they did not want to disclose their physical identity to me. Finally, the consent form explained that pseudonyms would be used in disseminating the findings to ensure that the identity of the participants is kept entirely confidential and always protected.

Additional efforts were made which contributed toward relationship-building with the participants outside of the scheduled interviews. These efforts included continued correspondence throughout the data collection and analysis stages and additional virtual meetings were offered to discuss participant enquiries along with my approach to and position within the research. For example, after one of the participants had expressed their interest in contributing to this research, we scheduled a virtual meeting and discussed their questions and any concerns they had about contributing to this research. As this meeting had answered the participant's questions and reconciled their trepidations, we scheduled our interview for the following week.

As discussed extensively in the background chapter, the broad principles of Indigenous data governance, including the OCAP principles, were considered during the design and execution of this research. Indigenous People's inherent right to own, control, access, and possess their data allows them to be the stewards of their knowledge and information. This right is "fundamentally tied to self-determination and the preservation and development of their culture" (FNIGC, 2014). As such, participants were provided with written summaries of the emergent themes from the individual interviews and were given the opportunity to receive copies of the original transcript and video recordings. It was also explained that the data collected would solely remain on my devices until the summation of this research and then be permanently destroyed. Only with the permission of each participant was their data utilized in this research. Participants could specify information shared in the interview that they did not want to use in this research as copies of the findings and discussion chapters were sent to each participant once drafted, to receive their edits and approval. This way, participants were able to oversee and have direct input regarding the final dissemination of the findings and discussion. The information obtained from the participants was only used and shared in a way that aligned with and could benefit the participant and their community while minimizing any possible harm (FNIGC, 2014).

In addition, the CARE principles were employed when conducting this research. The objective is for this research to have the collective benefit of amplifying Indigenous women's voices while advancing the self-determination of Indigenous Peoples and cultures. The additional layer of the CARE principles is necessary to govern Indigenous data. It protects against the potential harms perpetuating from data governed only by the previously mentioned FAIR (findable, accessible, interoperable, and reusable) principles.

With that, one of this research's main goals was to decolonize the healthcare systems and the academic institutions in which research like this is conducted. As Shawn Wilson states, “It is impossible to decolonize a research method without addressing its underlying beliefs” (Wilson, 2001, p. 177). However, some methods can be helpful and fit quite well within Indigenous paradigms. These methods often include interviews and focus groups because they focus on and “coincide with the Indigenous epistemological importance of relationships” (Wilson, 2001, p. 178). It was an intentional choice to conduct interviews that focused on personal narratives and storytelling because this way, more could be learned about each participant and a relationship could begin to build. As Wilson states, “When you look at the relationship that develops between the person telling the story and the person listening, you [witness the development of] a strong relationship (2001, p. 178).

It is important to note that there is a significant difference between exchanging words and exchanging meaning, as Cora Weber-Pillwax (1999) discusses in their work on Indigenous research methodologies. Weber-Pillwax (1999) further says that few researchers are motivated enough to move beyond the superficial exchange of words and “endure the suffering that is required to enter into the creation of shared meaning through conversation” (p. 33). While there is still much more that this research could have uncovered through the conversations throughout this research, I was motivated and fully committed to moving beyond merely exchanging words and working towards creating something of true meaning between myself and each participant.

The methods are centred around sharing and listening to one another’s dialogue and narratives. This practice has historical and current cultural significance for Indigenous Peoples and their ways of knowledge acquisition (IRSHDC, 2021). Indigenous Elder Doris Fox noted that sharing and learning from “dialogue itself is an exercise in decolonization” (IRSHDC, 2021, p. 10). Therefore, these data collection methods were chosen to build respectful and meaningful relationships between the participants and me and to decolonize data collection within a research project conducted by a non-Indigenous researcher within a colonial institution.

Data Analysis

The steps to Interpretative Phenomenological Analysis (IPA) were utilized for this phenomenological study. Ultimately, this approach searches for emergent themes across the data and is comparable to a thematic analysis. IPA is a contemporary yet reliable qualitative analysis method (Charlick et al., 2016). While it was developed in psychology, “IPA is now increasingly being used in the human, social, and health science fields” (Charlick et al., 2016, p. 206). IPA was utilized because it is beneficial when examining research topics that are nuanced and subjective, like individual experiences (Research Tube, 2022). IPA allows one to understand the “needs and concerns of individuals, what is important to them, and how they impose meaning on events in their lives” at a deeper level (Charlick et al., 2016, p. 206). “IPA is concerned with the detailed examination of individual lived experiences and how individuals make sense of that experience” (Charlick et al., 2016, p. 206).

Steps of Interpretative Phenomenological Analysis

It has been noted throughout the literature on IPA that “no single, definitive method is necessary to undertake IPA” (Charlick et al., 2016, p. 210); however, advocates of its process and other scholars have identified a seven-step data analysis process. A variation of this process was utilized to analyze the data collected for this research. It was as follows:

1. **Reading and rereading**: I immersed myself in the original data from individual interviews. This included rereading the transcripts multiple times and listening to the recorded audio of each interview.
2. **Initial noting:** This step involved free association and exploring the semantic content of the data. This step initially occurred during the interviews and was also conducted during step one. This step included horizontalization, a process of analysis which identifies similar statements made by participants to search for emerging themes.
3. **Developing emergent themes:** I focused on pieces of the individual transcripts and analysis of notes and created summaries of emerging themes which supported the conceptual understanding of the issue. The initial notes made during the interviews and step one of this process and the transcripts of each interview were used to inform the summary of initial emergent themes drafted for each interview and returned to each participant for their input and approval.
4. **Searching for connections across emergent themes and clustering meaning:** This step highlighted the themes through thematic analysis by focusing on similarities/differences and amplifications/contradictions across the emergent themes (Research Tube, 2022).
5. **Moving to the following interview:** Attempts were made to bracket previous themes and remain open-minded to honour the uniqueness and individuality of each new participant. This was accomplished by writing in a bracketing journal.
6. **Searching for patterns across cases:** This step involved finding repetitions of shared qualities across interviews and noting idiosyncratic instances. This step included searching for connections across the emergent themes in each interview and within the answers to each specific question.
7. **Taking interpretations to deeper levels:** This step included deepening the analysis by drawing from the literature to solidify its meaning and relation to the studied phenomenon. (Charlick et al., 2016, adapted from Smith et al., 2009). This step will be completed in the discussion chapter.

By following this rigorous process of analysis, the intention was to “illustrate, inform, and master the emergent themes [that support the conceptual understanding of this issue] by firmly anchoring findings with direct quotes from the participants” while mitigating the risk of demonstrating findings that are based on my own opinion or preconceptions (Charlick et al., 2016, p. 212).

As previously discussed, while there are differences within individual Indigenous cultures, in general terms, Indigenous knowledge systems believe there can be many truths and that the truth is dependent upon personal experiences (ICT, 2016). During the analysis stage of this research, it was vital to consider and value the multiple realities that exist among the participants' individual experiences without reverting to the Western tendency of only seeing and acknowledging one truth.

In Western methods of analysis, there is a concept called triangulation. “Triangulation refers to using multiple methods or data sources in qualitative research to develop a comprehensive understanding of phenomena” (Carter et al., 2014, p. 545). Initially, it was proposed to conduct a focus group with the same participants who partook in the individual interviews; however, as the data collection stage of this research unfolded, it became evident that an additional element of participation would not be realistic. The research team recognized how participation fatigue could factor into the ability to execute an extra part of participation and further considered the impacts of historical knowledge extraction from Indigenous Peoples. The research team recognized how the assumption that participants would be willing and able to commit not only the time but also the mental and emotional energy required to relive their experiences and share their stories and knowledge was ill-informed. The decision to no longer conduct a focus group was discussed with my supervisor, who approved this alteration to the research design and reinforced that it is another step towards decolonizing academia. The stories of seven women should be reliable enough to add to the current field of knowledge without imposing colonial and Western methods of analysis onto them so that colonial practices can continue to be upheld and their truths can be justified.

Coding

Both deductive and inductive coding methods were used to analyze the data. The analysis process opened by rereading each transcript and listening to the recorded audio of each participant's interview. The coding software NVivo, which allows one to create codes supported by aspects of the interview transcripts, was utilized in the initial stages of analysis. First, the focus was on creating codes that captured the essence of the concepts presented in the conceptual framework. This included “racialized discrimination,” “settler colonialism,” “geographical limitations/structural exclusion,” “Indigenous-specific gendered racism,” and “Indigenous approaches to health and wellness.” Within each of these codes, nodes were created for each one of their sub-concepts. For instance, for the concept of racialized discrimination, a node for “sub-standard care leading to misdiagnosis,” “denial of care,” and “stereotyping/profiling” were created. This was a deductive approach to coding, as the focus was on identifying the prominent themes within the data that supported the concepts already identified within the initial conceptual framework. The interview questions were developed to probe further into the concepts within the conceptual framework. As such, many participants spoke directly to the concepts within the framework. Therefore, themes that supported those concepts and that specific understanding of the problem being studied were identified.

As each step of the IPA process was conducted, excerpts from the interview transcripts that supported the initial concepts from the conceptual framework were identified. Steps one through six were followed, and similar patterns supporting the initial concepts were identified throughout the data. Further, once the supporting excerpts were identified, similarities/differences and amplifications/contradictions were identified across the data's themes and the pre-existing literature. This was achieved by creating a master Excel spreadsheet that organized each participant's response and how it related to each theme that supported the concepts from the framework and how the literature supported or contradicted these themes.

The IPA process was initiated a second time to conduct inductive coding. This step was essential as in Indigenous methodologies and phenomenological studies; it is crucial to remain open to emergent themes representing more than one truth or understanding of a problem. Steps one through six of the analysis approach were worked through; however, this time, the emergent themes were coded based strictly on what was found within the data. By rereading and summarizing the interview transcripts, emergent themes supported an additional conceptual understanding of the issue. These supplementary concepts were identified based on the frequency at which participants spoke to their supporting components throughout the interviews. NVivo was initially used to create codes that captured the essence of the emergent themes which supported the new concepts. Using NVivo confirmed the prominence of the emergent themes as the number of excerpts supporting them was tallied. This helped identify idiosyncratic instances across the data collected. For example, codes were created for “advocacy,” “connection,” and “self-determination and decision-making,” concepts not initially presented in the conceptual framework. Each additional emergent concept coded had sub-concepts within it. For example, under “advocacy” were the sub-concepts “advocating for care,” “advocating for truth,” and advocating for others.” Once again, similarities/differences and amplifications/contradictions were identified amongst the emergent themes within the data and the pre-existing literature. The emergent themes identified within the participants' responses that supported the new concepts were added to the same Excel spreadsheet to analyze and understand a more well-rounded and in-depth picture of what the data were saying about the phenomenon being studied. By doing this, themes within each question could be analyzed and, more broadly, across all the data collected.

Data Analysis Tools

Recording software within the Zoom application was utilized throughout each interview to transcribe participants’ responses later. This process only took place with the participant’s prior and informed consent. Zoom was used when participants wished to meet virtually. Microsoft Excel and NVivo software were utilized to organize, manage, and analyze the data collected. As participants shared their valuable and vulnerable experiences and stories with me, it was essential to consider the appropriate means of compensation that may be required in their chosen currency. Gifts were given to participants to thank them and to acknowledge their valued contribution to the study. After each interview, I requested that the participant inform me what gift card they would like to receive. Once notified, I would send this via email with a summary of the prominent themes from their interview.

Ensuring Data Quality: Establishing Credibility

According to McGregor (2018) and O’Leary (2017), when attempting to ensure high-quality qualitative research, the criteria differ from quantitative studies focusing on reliability and validity. For qualitative studies, trustworthiness, confirmability, credibility, transferability, dependability, and authenticity are primarily considered.

Trustworthiness

This research strove to collect, analyze, and present trustworthy data. Essentially, the data must be truly transparent and open to critical thinking and questioning by the reader. The findings were supported by pre-existing literature and member checking to achieve trustworthy data. Member checking is the active involvement of the participant(s) in reviewing and confirming the findings (McGregor, 2018 & O'Leary, 2017). Detailed descriptions were used to accompany the collected data to provide context to the findings when presented in the final research paper.

Trust must be fostered between all parties involved to collect trustworthy participant data. Trust is essential when a non-Indigenous researcher conducts research involving Indigenous participants. Relational trust is critical to the reliability and trustworthiness of the data. For the participants to feel comfortable speaking their whole truth, they must trust the researcher and the research. As participants for this study either had a pre-existing relationship with me or Dr. Thiessen, a sense of trust was established before the commencement of this research.

Confirmability

Confirmability involved reflexivity and profound discourse about what predispositions and prejudices I brought to the research. Discussion of my positionality within the study and with the participants was critical to confirmability. While values are central to the qualitative, post-positivist research process, the findings needed to be confirmed and corroborated by others to ensure confirmability. Therefore, member checking continued to be employed to achieve this criterion to ensure that my values and biases did not weaken the integrity of the data (O'Leary, 2017). Once the data analysis was completed, the findings were sent to each participant to receive their edits and approval. This was done to ensure that the conclusions presented in the final paper were genuine and authentic to the participants' lived experiences and only presented with their consent and approval.

Credibility

Achieving credibility relied on creating the "faithful accounting of people's lived experiences (i.e., an accurate representation of the participants' realities from their unique perspectives)" (McGregor, 2018, p. 20). Credibility was also achieved by recognizing and demonstrating that the participants' unique experiences are their authentic truths. By doing so, many voices who have been historically silenced were rightfully legitimized. Credibility was further achieved by solid connections between the pre-existing data and the participant's experiences to rule out alternative explanations of the phenomenon (McGregor, 2018). Additionally, the strategies used were member checking and detailed descriptions to provide context to the findings and demonstrate overall credibility (O'Leary, 2017).

Transferability

Transferability is specific to qualitative studies as the goal is for findings to be applied or transferred to other settings rather than generalized. As the researcher, I was responsible for providing accurate and complete descriptions of the context and the participants involved so that future researchers can utilize this study and determine if the findings, conclusions, and potential recommendations are transferable in their specific context (McGregor, 2018 & O'Leary, 2017). Detailed descriptions, researcher reflexivity, and explicitly stating the study's limitations were required throughout the research process.

The criterion of transferability, while associated with Western approaches to academia, does fit well when researching alongside Indigenous Peoples and, in a way, works towards undoing some of the past harms that Western-based research has done to Indigenous Peoples. By strictly focusing on transferability, the chance of generalizing the participants' experiences is lessened. Generalization can lead to harmful stereotypes and misconceptions about all Indigenous people. This research attempts to eliminate them from future academia by setting a purposeful example of conducting research with Indigenous Peoples that honours their uniqueness and advances their inherent rights.

Dependability

Dependability is related to the quantitative criterion of reliability; as the researcher, I was responsible for providing sufficient information so fellow researchers could repeat the research design in their context. This did not necessarily mean that the same findings would be produced, but merely that others could rely on or depend on this study due to the design's and findings' stability (McGregor, 2018). It should be noted that credibility ensures dependability, meaning similar strategies were utilized to achieve dependability as they were to gain credibility. In addition to rich documentation to provide context to the findings and the findings being supported by pre-existing literature on the topic, the approach and procedures were appropriate for exploring the specific phenomenon being studied and were documented.

Authenticity

To ensure authenticity, the participants' voices and agency were guaranteed, and all participants' views were represented (McGregor, 2018). It was vital to foster a collaborative relationship with the participants. This was achieved by having the participants review the emergent themes and findings and researcher reflexivity, which involved being self-critical and aware of my biases. O'Leary (2017) additionally acknowledges that authenticity within qualitative research is "concerned with the value of truth while recognizing that multiple truths may exist" (p. 74). To represent the multiple truths that existed, the analysis and representation of the data collected were concerned with describing the deep structure of the participant's experiences in a way that was truthful and authentic to their personal experiences (O'Leary, 2017).

Relational Accountability

I recognize that discussing these principles is essential to establishing the overall credibility of one's study through the lens of Western academia. However, a two-eyed approach must be applied when establishing credibility to decolonize the academic institutions conducting research such as this study and others.

When considering Indigenous perspectives on producing trustworthy research, we are reminded of Shawn Wilson's theory of relational accountability and how the respect and responsibility we hold for those we are accountable to establishes what Western-based academics would call reliable and valid data. By endlessly asking myself, "What is my responsibility to all of my relations?" and "How am I showing up for them and truly holding myself accountable," this research has demonstrated how to achieve trustworthy data outside the colonial realm of academia. I recognized that my responsibility is to amplify the voices and experiences of each participant accurately and honestly to invoke change within various colonial systems in our world. Robin Wall Kimmerer (2013) shares how "writing is an act of reciprocity with the world;" and is a way to give back everything that has been given to someone (p. 152). That is how I feel. Throughout this process, I have felt an immense responsibility to ensure that the final product of this research is worthy enough to reciprocate everything that each participant has given to me by contributing to this research so that it can reach its proposed objectives. I have committed myself to a journey of continuous learning so that I can conduct this study in a way that respects Indigenous People's integrity, is relevant to their perspectives and beliefs, is reciprocal and offers a collective benefit, and is relational both in design and execution by demonstrating my accountability to all involved.

Strengths and Limitations

Methodology and Methods

Strengths

This research presents strengths through its methodological approaches, data collection methods, and analysis. To begin, this study utilized both Western and Indigenous methodologies. By doing so, the methodologies contribute to the overall goal of working towards reconciliation between Indigenous and settler populations and demonstrate a clear and intentional effort to decolonize the systems through which research involving Indigenous Peoples is conducted.

More specifically, the methodology of phenomenology was chosen because it allows for the essence of participants' experiences to be brought closer to the reader. This methodology offered strength and value as this study was interested in understanding how Indigenous women's experiences accessing healthcare in B.C. affected their decision-making regarding future care. Data collected through interviews can highlight the authenticity and significance of this phenomenon and, once analyzed, illuminate the prominent themes among participants and communicate them to the readers. Additionally, but most importantly, by collecting data through in-depth interviews, the stories and voices of a historically silenced group, Indigenous women, can be amplified and given the rightful attention they deserve. Furthermore, as supported by Indigenous researcher Shawn Wilson and Elder Doris Fox, the exchange of dialogue between two people is not only a way to foster relational accountability but also an act of decolonization (IRSHDC, 2021 & Wilson, 2001).

Limitations

When designing this study, retention and involvement of participants were deeply considered as it was recognized and understood that participants might be reluctant to be involved in research primarily conducted by a non-Indigenous researcher. When the research team intentionally designed this study, a significant amount of time was allocated for participant recruitment and data collection. By doing so, there was ample time and effort to connect with potential participants in a way that made them feel comfortable participating in research conducted by a non-Indigenous person.

This was a strictly qualitative study that utilized in-depth interviews to generate data collection. This method may be viewed as a limitation as we were obtaining data from a relatively small sample size. While it is understood why readers might hold this perspective, the sample size and approach to data collection for the design of this study are justified from a Western methodological perspective. For phenomenological studies, sample sizes range from 3-15 participants, making a 7-person sample size well within the acceptable range (Research Tube, 2021).

Further, as the study did not conduct another method of data collection, i.e., a focus group or survey, some might view this as a lack of triangulation and deem it a weakness, making it difficult to confirm the conclusiveness of this study. However, this potential weakness was addressed as many of the findings confirmed the conclusions presented in pre-existing literature. The emergent knowledge this study uncovered was supported by the authentic truths of the women who shared their stories and supported and validated each other's realities by recounting similar experiences.

Data Analysis

Strengths

The intensive process of Interpretative Phenomenological Analysis (IPA) allows the researchers to analyze the data collected thoroughly and deeply from a small number of participants rather than merely collecting surface-level data from many participants. This aspect of the analysis approach is helpful for studies that center around the stories and experiences of individuals as it allows for deep and genuine understanding to occur.

Another strength of this analysis is that it can provide researchers with insights into the participants' lives. This is particularly useful when the participants may be those whose voices have been historically silenced or whose experiences have been ignored (Charlick et al., 2016). Further, this approach creates a relational connection between the participants and the researcher, allowing participants to share their truths comfortably.

This approach to analysis allowed this study to explore a specific phenomenon while focusing locally. As such, the findings can utilize the broad knowledge presented and understand them locally (Charlick et al., 2016). This is a strength because this research wanted to produce transferrable findings instead of generalizable ones. Further, because the findings tend to reflect a specific focus due to the participants' shared experiences, advocates for IPA say that this allows for claims to be made at a group level, strengthening the confirmability of the findings. (Charlick et al., 2016).

Finally, this approach to data analysis can be advantageous when conducting healthcare-oriented research. The depth behind this analysis has the potential to influence policy and practice within healthcare institutions as it can highlight the beliefs and expectations of individuals that may be outside the knowledge or expertise of those providing care.

Limitations

As a researcher, you bring your unique position into your research. As such, leaving your biases at the door and presenting an impartial interpretation of the data can be incredibly difficult. Similarly, moving on to the following interview with a blank slate to be open to the emergent themes that the next participant might speak to can be difficult. This potential weakness was addressed by keeping a bracketing journal to address my biases throughout the data collection stage. It is difficult to move on to the following interview while honouring the full story of the participant you are moving on from. “As Heidegger (1962) noted, people cannot help but look at any new stimulus in the light of their preconceptions. Therefore, researchers need to be aware of their own biases and be able to illustrate their steps in the data analysis process. This demonstrates that the findings are not based on opinion or preconceptions, but on a rigorous analytical transparent process” (Charlick et al., 2016, pp. 212-13).

Chapter 5: Findings

Introduction

The findings of this study demonstrate how Indigenous women make sense of their experiences accessing healthcare services in B.C. and how such experiences influence their healthcare-related decisions. The findings were derived from the stories of Indigenous women's experiences accessing health care in B.C. Through the presentation of these findings, this research aims to amplify Indigenous women's voices and their truth while illuminating the strengths and weaknesses of the healthcare system when interacting with and caring for Indigenous women. The depth of the findings chapter emphasizes the importance of voice and magnifying the truth of each woman's experience. By conducting this research and presenting these findings, the objective is to recommend action to decolonize the healthcare system and academia.

Structure of Findings

The findings are presented by interview questions organized by the prominent themes discussed among participants. This section also offers findings supporting less central themes; some were equally crucial to answering the research question and problem. Specific findings reinforce the understanding of the phenomenon being studied that the literature review previously demonstrated. Other conclusions provided new insight into the problem and will be discussed in more detail in the subsequent chapter.

Question One:

Can you share any of the experiences with the healthcare system that you have personally accessed in B.C.?

Connection

The theme of connection involves the relational link and attachment between patients and providers. This theme also speaks to the relationship between the patient and the system through which they seek care. The theme of connection includes both the Western and alternative healthcare systems and providers. This theme also speaks to a consistent relationship shared between a patient and both a provider and the system. Connection is significant within Indigenous epistemologies as there is a shared belief that everything in the universe is connected. Understanding the concept of Indigenous connectivity is essential to understanding what affects and motivates the decision-making process for many Indigenous individuals and communities (Joseph, 2020). This theme does not speak to its counterpart of disconnection as that theme stands on its own merits and will be subsequently presented.

Multiple participants shared experiences that supported the theme of connection and building relationships with healthcare providers. One participant shared their experience interviewing their family's potential physician and the strong relational connection built from this experience.

> *"I was able to interview the physician, and then [we decided] that we were all a good fit as a family… It's great; we went as a family and met with him. He asked questions. We asked him questions, and then he agreed to take us on as patients, which I believe is a new practice, and I think it should be the practice of all, regardless of whether you're Indigenous or not. I think it just allows people because not everyone clicks, right? So, I am grateful to have that [experience] because he has been wonderful."*

One participant spoke about their positive experiences accessing healthcare within the Western system and how having a longstanding connection with a family doctor has made her experiences affirmative.

> *"I think we have great healthcare in the province, and I have a family doctor, which not everyone has. I am very lucky to have been able to form that relationship many years ago when it was not so difficult. I am lucky because my two sons now have that family doctor."*

Another participant supported the theme of connection by demonstrating how their comfort level is much higher when accessing care within their community than outside because of the relational bonds fostered between her, her doctor, and other care providers.

> *"I know that I have a generally higher level of comfort when I can access healthcare services in my community. But if we go all the way back to the time when I was born. My family doctor knew me before I was born. He was a part of my gestation, and then he was my family doctor until I moved away, and then he retired. So, I found that I have had better care under my family doctor, who had known me my whole life."*

Another participant's experience supported the theme of consistent connection-building with healthcare providers. This participant explained how she had positive experiences of feeling safe and vulnerable with her care provider after the connection between them had been built and consistently cared for.

> *"I was with him for probably ten years, you know. So having that consistency was really important for me to be able to share some really vulnerable information."*

The findings that support the theme of connection were presented first because of the links between it and other themes. Without the connection findings, it would be difficult to recognize the association between connection, settler colonialism, and cultural competence by understanding Indigeneity. Connection, as a theme, was linked to settler colonialism through the inability to build trusting relationships with providers. It was also interconnected to cultural competence/understanding of Indigeneity due to the lack of understanding that can develop when connection is absent.

Cultural Competence and Understanding of Indigeneity

A common theme among participants was the apparent need for more cultural competence and understanding of Indigeneity among providers. This theme includes the interactions between patients and providers. Some participants recognized that healthcare providers in the mainstream system demonstrated a need for a more profound understanding of Indigeneity, Indigenous issues, culture, and Indigenous beliefs surrounding health and wellness. One participant shared how the lack of knowledge from providers affected the care she received as she felt her beliefs were not being supported or understood,

> *"I was scheduled for surgery, but it never worked out, thank goodness! Then, it was scheduled again, and it did not work out. But as an Indigenous woman, we believe that when you leave this world, you come in whole, and you leave whole. So, for me, I was grateful that the procedure was cancelled. But trying to share the why around that was difficult, right?"*

Several participants noted that from their experiences, healthcare providers demonstrated a lack of cultural competence by being unfamiliar with Indigenous patient's history and genetics. Participants expressed how these experiences often lead to assumptions being made, creating sub-standard experiences when accessing care. One participant specifically shared,

> *"I was having these tests done, and then [I received] a lecture about my fatty liver. I found this interesting because the person I saw as the expert, apparently, you know, asked the question about alcoholism… And if you look at the history and the studies in place, a lot of Indigenous people, in particular, the northern part of B.C. and North Vancouver Island, all have that. I do not know if it is a makeup or what it is, but Cowichan tribes have done some studies, I believe, related to that, so it was not even that…. But just trying to have that conversation, and then after that, I was really bothered by that and kind of felt a bit ashamed. Even though I really shouldn't have been, you know."*

In addition, participants noted how healthcare providers demonstrated a lack of cultural competence and understanding of Indigenous issues, expressly how providers framed and asked questions of Indigenous patients about their personal and home matters. One participant shared,

> *"The health care system has it set up so that everything I have ever talked to medical [professional] about is on my file. So, [the nurse] is bringing up everything. "So, I see I have head lice on here. Is that still a problem?" I was like, what are you talking to me about that for? I am here to talk about my breast surgery removal. I was so annoyed."*

Another participant provided a similar example of why she feels it is essential for physicians to have a deeper understanding of Indigeneity and demonstrate strong cultural competence to foster more trust and connection between the patient and provider. Specially she shared,

> *"[Physicians need to] explain when they go to ask personal questions, "This is why I am asking you these questions." I know they have to do that, but if I did not know why they were asking me those questions, I would be quite taken aback and find it very rude and intrusive. Like why? Why do you need to know about my home life? I am just here for this, okay."*

These examples demonstrate that the current level of cultural competence among healthcare providers in the mainstream healthcare system is deficient. Participants have expressed that a lack of cultural competence and understanding of Indigeneity hurts their overall experience when accessing care. There is a connection between this theme and the themes of colonialism and racialized discrimination. Without a thorough understanding of Indigeneity demonstrated through cultural competence, a trusting relationship between patient and provider can be incredibly difficult to foster, which is already difficult because of the history of settler colonialism within the system. Further, relying on generalizations and assumptions of Indigeneity and Indigenous history can lead to harmful assumptions being made by providers, as indicated by the findings.

Racialized Discrimination

When recounting their experiences of accessing healthcare within the mainstream system, a common theme shared among most of the participants was the experience of racialized discrimination. This theme includes provider denial of care and dismissive behaviours, receiving sub-standard care and misdiagnoses, stereotyping and profiling, and discrimination based on one's presented identity.

Participants supported the prominent theme of racialized discrimination by sharing their experiences of receiving sub-standard care and misdiagnoses when interacting with the mainstream healthcare system. Participants reflected that the sub-standard care and misdiagnoses often stemmed from assumptions about their Indigeneity. One participant shared their experiences with sub-standard care, eventually leading to long-term health issues. She also mentioned that her health issues were initially misdiagnosed because of the assumptions made by her care providers. Explicitly, she shared,

> *"Ultimately, what happened with my gallbladder issues was the treatment delay, which affected my pancreas. So, my pancreas shut down. And I ended up in the hospital for two weeks trying to get my pancreas back. And now I am diabetic because of that. I am the only person in my family to have diabetes directly resulting from that situation. Whereas they would tell me that I am having gallbladder and stomach issues due to alcoholism. I don't drink."*

The same participant shared that the delay in correctly diagnosing her symptoms caused her to develop diabetes today and had long-term effects on her health and life expectancy.

> *"Had he (the healthcare provider) done the surgery for my gallbladder in a timely manner. I might not be diabetic today, which sucks, because that also decreases my lifespan. Generally, diabetics [live] about 15 years less [compared to] non-diabetics."*

Participants spoke to instances where healthcare providers commonly relied on generalizations and assumptions informed by harmful stereotypes perpetuated in society and how this form of racialized discrimination often led to sub-standard care and misdiagnoses and negatively impacted the participants' experiences. One participant shared an example of when she was accessing care for a head injury, and providers assumed she had been physically abused. Specifically, she shared,

> *"I started to feel like they were creating a story that was different from the narrative I was telling them. I do understand that people in abusive situations are not going to come out directly when asked if they are experiencing abuse; there will be an alternate explanation. But in my case, that was not the same. I wasn't being abused, but I had a mountain bike accident. I felt like I was put under an umbrella of what any Indigenous woman who walks into a hospital would experience; they will automatically assume that I was abused because my face was bruised up, right."*

Another participant provided a similar example when she attempted to communicate her symptoms and concerns to healthcare providers in the past but was met with discriminatory and hurtful stereotyping about the social location of Indigenous women. She shared,

> *"It's been hard because even when I had my son, and I was telling them (the healthcare providers) how sick I was, this lady, the baby doctor, was telling everybody in my earshot that it's just me and my "social issues," you know. She said, "Oh, you know, it's just her and her social issues."*

Finally, few participants supported the denial of care and dismissive behaviours aspect within the racialized discrimination theme. By doing so, participants expressed a spectrum of experiences with healthcare providers, from outright denials of care to dismissive microaggressions. One participant shared her experience attempting to access care at a walk-in clinic, where she faced dismissive behaviours from care providers,

> *"I was having stomach issues because of it, and I did not have a family doctor, so I was going to walk in clinics and being completely dismissed for my issues, like nausea and an inability to eat certain things or to keep things in my stomach. Completely dismissed."*

Another participant shared a similar experience when accessing care from unfamiliar providers, like at specific walk-in clinics. This participant explained a nuanced element of dismissive behaviours as her experience captured the notion of care providers dismissing Indigenous belief systems. The participant reflected on how these interactions impacted her decision to access healthcare moving forward,

> *"I felt discriminated against. As soon as the doctors would find out that I was indigenous, their tone would change. They would just be a little less sensitive, a little less caring and become dismissive of my beliefs about what was happening with my body and what was true for me. So, you know, they weren't very validating at all. So, of course, I would avoid accessing healthcare."*

Similarly, another participant supported the theme of dismissive attitudes from providers and being denied care. When she told the care provider about her pain symptoms regarding her IUD placement, she was met with dismissive and invalidating attitudes and ultimately rejected the required care. Once again, this participant shared very intimate details of her experience accessing care, which triggered emotions within her. Specifically, she shared,

> *"I had to go to the doctor, and he was my doctor. He was my family doctor at the time, at a clinic where I was living, and I was saying something like, I said the IUD that was put inside me hurts. It hurts to have sex with my husband. It hurts. I don't think it's right. And he says, "I think you better go find another doctor, " and that was how he dealt with me. So, I left. I just left the place, and I left."*

She emphasized how she often feels that mainstream healthcare providers do not have her best interests in mind and that many will not listen to her or take her concerns seriously. She added that she has experienced a pattern of being dismissed and having her problems discredited throughout her life.

One finding that presented a unique distinction within the theme was discrimination based on one's identity. Meaning that a participant recognized how her experiences accessing care had been affected by how she outwardly presented her identity in society. This participant shared,

> *"So, I am white, passing as an Indigenous woman. I also aged out of the foster care system, which affects my identity, right? And like how I walked in the world when I was younger and accessed care."*

Another participant added to this distinction by reflecting on her positive experiences with the healthcare system and largely attributing them to how her identity presents physically. She shared,

> "*I think I have good experiences because of who I am, how I was raised, and what I look like."*

These examples demonstrate that the presence of racism experienced by Indigenous women within mainstream healthcare is significant and incredibly troubling. Participants expressed how sub-standard care and misdiagnosis, often informed by harmful stereotypes, have caused lasting impacts on their health and relationships. In addition, participants said how providers' dismissive behaviours and attitudes have caused them to retreat from the system and feel unwelcome when accessing the care they need and deserve. This theme shares links with the piece of cultural competence as the harmful stereotypes informing the misdiagnoses often stem from a place of misunderstanding, ignorance, or lack of cultural knowledge. Further, racialized discrimination is linked to the theme of disconnection as the findings indicate that where disconnection is present, so too is the opportunity for providers to dismiss Indigenous women's cultural and spiritual beliefs and their medical symptoms and concerns. Finally, this theme is connected to advocacy as participants expressed repeated instances where they needed to advocate for their care, for their truth to be validated, and for their beliefs to be accepted.

Advocacy

Within the stories shared by participants, there was an evident trend of advocacy across their experiences. The advocacy theme includes advocating for one's truth to be heard, advocating for the medical care needed, and advocating for others by being supported or supporting someone else. The stories told by the participants contributed to the narrative of Indigenous women needing to advocate for themselves, their families and community members to receive adequate and equitable care.

Several participants supported the sub-theme of advocating for the care they needed but were not receiving. One participant shared how she needed to persistently advocate for the care she wanted as it aligned with her personal beliefs around health and wellness. Specifically, she explained,

> *"And I had to put my foot down when given their recommendation for a treatment that did not make sense to me (ex., the extraction of a whole organ when only part of it needed to come out). When told how they would proceed with treatment, a part of me said, no, I am not going to go through the extraction of my whole thyroid when only half of it needs to come out. I needed to advocate for myself as an Indigenous woman. I am someone who believes in alternate medicines. I do not believe there is a one-size-fits-all model for health, wellness, and healing. I wanted to have time before the surgery to build my health team since I believe that if we can all work together, it will be a better form of care."*

Another participant echoed this experience when she shared a similar story of having to advocate and educate herself on the care she required.

> *"I had to; what do you call it? When you have to fight for yourself? Advocate. You know, I had to advocate for myself. I had to get myself to get tested. And they were like, "Why do you want to test yourself?" I pushed for a colonoscopy and an internal specialist up north. And when he disagreed, I would say, "Well, I know you disagree, but I do agree because I'm in pain, and I need to be diagnosed because I'm sick and very sick," and it turns out they found diverticulitis, right?"*

In support of the sub-theme advocating for their truth, some participants reflected on their experiences and shared how their truth had often been discredited. One participant shared,

> *"Oh, that was another thing I could not seem to get; nobody believed me."*

Another participant shared,

> *"[They were] dismissive of my beliefs, what was happening with my body, and what was true for me. But you know, I was lucky enough and strong enough, and at my own rate, to advocate for myself when I needed it. Like especially for birth control."*

Complementary to the sub-theme of advocating for truth was the sub-theme of advocating for others. Participants shared multiple instances of needing support or supporting someone else when accessing care. The majority of the participants reinforced this sub-theme. There was a strong trend of advocating for or by family members. One participant shared how she supports her mother in seeking the care she needs because her mother is hesitant to pursue medical care on her own due to past experiences of racism and her time in the residential school system,

> *"I have witnessed [things] through my mom because my mom does have a chronic illness. She is epileptic, which she got from a head injury at a residential school. Just the racism that I see my mom go through. I sometimes had to advocate for her because she never trusted the doctor. So, I have to really force her almost and argue with her about getting help when she didn't want to go to the doctor because she didn't like how they would talk or treat her."*

Similarly, another participant shared how her negative experiences with the mainstream healthcare system affected her advice to other family members regarding their healthcare choices. She explained,

> "*So, I am fighting with my niece, not fighting with her, but I'm giving this information to my niece because she's being forced, well, they're trying to force her to get this IUD. And I said, "Don't do it." I was forced into it because they thought it was covered under your medical or what we Indians deserve. So, I said I don't do it because it's wrecked my body."*

Another participant supported this sub-theme by explaining how she felt the need to bring a friend with her to appointments to feel like her narrative was being heard and understood by the care provider. She described,

> *"I had to bring a friend in to help me with that conversation with a new female Doctor from Ontario because I just felt like she didn't believe me. I felt like she wasn't listening to what I was saying then. I was going through some challenging experiences, chatting with her about it, and she didn't believe me at all. She tried to help, but I didn't know her. I only knew her for that short time. And I didn't feel heard, so I brought in a friend for that."*

The presented patterns within the data support the emergent theme of advocacy. The findings demonstrate how nuanced accessing health care within the mainstream system is for an Indigenous woman and what a prominent role advocacy plays, in one form or another, in each of their experiences. This theme is linked to racialized discrimination as participants were required to advocate when they were met with dismissive behaviours from providers. Further, this theme is connected to the piece of cultural competence and understanding of Indigeneity as a lack of knowledge by providers often left the participants fighting for their beliefs to be accepted.

Self-determination

When reflecting on their experiences, some participants noted that they felt a lack of autonomy over their bodies and the choices being made about their care. This theme includes patterns of self-determination and decision-making through body autonomy. This theme does not discuss self-determination through land sovereignty. Participants noted how their body autonomy increased with age. One participant shared how, throughout her life, she had gained more autonomy over her health and medical decisions; however, that was not always the case as she describes,

> *"And so, I would get opinions rather than actual helpful diagnoses. Or they thought it was related to my menstrual health or reproductive systems. I had a vaginal exam to explore what was going on in my stomach, which looking back, I was in my very early 20s, so I didn't have the autonomy I have now."*

Another participant shared her experience with a specialist who did not support the connection between body autonomy through self-determination and decision-making. She reflected on how this interaction made her feel and shared,

> *"You know our body is ours. And if you take my heart rating or reading with the EKG and stuff like that. They think [my body] is theirs and like it is for them to own. But it's our body. It's our right to say no or yes. But at the same time, I know nothing about the body. So, it's difficult to know what to say yes or no to."*

While less prominent than other themes, the data's patterns that support the self-determination theme are equally as essential to present. Self-determination and decision-making through body autonomy are deeply connected to the sovereignty of Indigenous Peoples and their land. As this research intends to contribute to the self-determination of all Indigenous Peoples, these findings must be presented and discussed to understand their profound implications on the health and prosperity of Indigenous women, their families, communities, and nations. This theme is linked to settler colonialism as decades of colonization have stripped Indigenous Peoples of their sovereignty and autonomy, land and body.

Settler Colonialism

The theme of settler colonialism was spoken of less among the participants than other themes. As defined by the literature review, the theme of settler colonialism acting as an access barrier includes the lack of trust that Indigenous Peoples have for colonial institutions due to historical and personal experiences. Further, this theme consists of the presence of power imbalances within the mainstream system due to the legacy of colonialism, the inability to form trustworthy relationships between patients and providers, and the notion of colonial practices being considered superior to alternative approaches to health and wellness.

Of the participants who spoke to aspects of settler colonialism, the inability to form trustworthy and equal relationships with healthcare providers was discussed primarily. One participant's experiences supported the sub-theme of power imbalances while interacting with healthcare professionals and explained how this lowered her comfort level when accessing healthcare. Specifically, she shared,

> *"I was thinking like this is my health here, and right now, it's almost like I'm being scolded, like what I heard was that he was the professional and I needed to be quiet. I get [that they were an expert], but I'm also an academic. We ask questions all the time. And that is what I was doing; I was asking those questions."*

Another participant reinforced the sub-theme of being unable to build trustworthy relationships with providers as their experiences had made them feel as though there was a lack of transparency when interacting with providers. She explained,

> *"But otherwise, into my young adulthood, it was a lot of like walk-in clinic-type situations until I found the doctor that would take me, I guess. And even then, honestly, I do not really trust him. And as soon as I could, I switched to a new office. Then, sometimes, I wondered if he was a real doctor. I was like, I do not know, doctors tend to, and I experienced so many times to just be like, "Oh, that is normal." Like they will not actually explain what is happening with your body, like you know something is going on again. They are just dismissive, like, "That's normal, and they won't actually have any transparency."*

The examples within this theme demonstrate how settler colonialism's legacy remains in today's healthcare system. However, each participant felt the lasting impacts of colonialism uniquely. This theme is linked to connection, as participants noted how it was challenging to foster relationships with providers when they could not trust them. Further, this theme is tied to self-determination and is also associated with the use of alternatives, which will be subsequently presented.

Geographical limitations and structural exclusion through physical accessibility

The theme of geographical limitations and structural exclusion was less prominent in the participant's experiences. This theme includes the general ability to access healthcare physically and the present restrictions, such as the overuse of the system, the wait times incurred by patients, and accessing care within or outside of a reservation. In addition, this theme includes notions of structural exclusion, which is a condition of settler colonial, structural racism, and neoliberal state structures which intentionally excludes sub-populations from economic, social, and political activities under the premise that the exclusion of the sub-population allows for increased vitality of the larger population. The majority of participants made a point of mentioning their ability to physically access care when they needed it. There was minimal attention given to wait times throughout the participants' stories; however, there was a shared recognition and understanding that our current healthcare system is strained and physicians are overworked.

A similarity shared among the participants who spoke about physical access to care was that it is not solely about being able to access it. Still, it is about how accessing care makes them feel. One participant expressed this notion quite eloquently at the beginning of our interview. She shared,

> *"Access sometimes is hard because there are times when I get turned away, but sometimes it's easy to get the access, but it's hard to get the respect."*

Few participants shared the everyday experiences of feeling unsafe when visiting institutions with evident colonial roots. One participant provided an example of how the geographical limitations that Indigenous women can face intersect with the impacts of settler colonialism, therefore creating a condition of structural exclusion. She shared how her access to care was limited due to the colonial roots of the institutions near her. She explained,

> *"I'll share, for example, if you have to deal with pregnancy, and there is not that option for you, then you go on a waitlist. So, if you are from the north, you go on the waitlist, but back in the day, you could not go to Commox, to [the hospital there] because it was Catholic. So, then you are stuck waiting for Campbell River."*

The distinction of accessing care within the community or reservations created a point of difference among participants' responses. The notion of accessing care comfortably and safely within their community was reflected differently between the two participants. One shared how accessing care within their community is preferred as they feel a sense of familiarity and comfort with the providers. Specifically,

> *"And, like I said before, I have had a regular nurse practitioner in my community for quite a number of years now, and that works for me. My nurse practitioner handles most of my diabetes things, and I do that if I need to see my specialist, my endocrinologist. I can also take care of my reproductive health in my community. And you know, in a way that we recognize as good, familiar, and safe. So personally, yeah, I am really comfortable with that."*

Another participant noted a dissimilar experience when accessing care within her community. This participant shared how access to healthcare services can be challenging when living within their community due to the size and the proximity to people they are personally connected to and how this nuance of accessing care within their community made the services feel unsafe. She shared specifically,

> *"Before, I did live in my community, and I would not have access to my community because of the services available for mental health. Like, I am not going to see that person because that person is a cousin of mine… But I come from a very small town and community, and even accessing services at a crisis center doesn't feel safe."*

The same participant expressed how accessing healthcare outside her community posed different barriers that she saw as even more challenging. She shared how the services available to Indigenous folks always seemed generalized and scripted and did not consider the uniqueness of their Indigeneity. She explained,

> *"Yeah, and as an Indigenous person, we are stuck in a place of "okay, because you are Indigenous, this is what you qualify for." And this is going back to any mental health support. "So okay, well, you can call the Kuu-Us line," which is housed in Port Alberni and services all of British Columbia. Kuu-Us is a Tseshaht name. I am not Tseshaht; even though we have similar practices, it is not the same."*

The presented examples demonstrate how the physical ability to access healthcare received minimal consideration in participants' experiences; however, how accessing the care made participants feel remained a prominent point of reflection in their decision-making processes when accessing healthcare. This theme is tied to settler colonialism as the effects of structural exclusion and the displacement of Indigenous folks are rooted in the lasting impacts of settler colonialism.

Disconnection

The theme of disconnection speaks to the lack of relational connections between patients and providers and the system through which individuals seek care. This theme speaks to the need for consistent relationships with providers. Further, disconnection encompasses the notion of Indigenous patients being unable to connect to the practices and procedures followed in the colonial system. This theme only includes the Western, mainstream healthcare system and providers.

A common theme shared among participants was how disconnection between patient and provider often leads to unsafe interactions, sub-standard and dismissive care, and inconsistent care being administered. One participant supported the sub-theme of feeling a stark disconnect from providers when seeking care at a walk-in clinic as they did not have a primary physician. She explained,

> *"I moved to the Nanaimo area. I did not have a physician. I did go to a walk-in clinic and saw this physician. Female doctor, and because I was unattached [from any other physician], I was attached to her. But that was not my choice; we clashed on many levels. And then I realized the clash I felt was because she had an English accent, so I was constantly triggered by knowing a bit about the history of colonization."*

Another participant echoed a similar experience with a specialist she was seeing. She shared,

> *"We did not align in any way. He seemed to be very conservative in nature. I am someone who likes more holistic types of medicines. And because of the nature of the concern (possible papillary carcinoma diagnosis), I thought, I am just going to see if I can build a team, a medical team, right? This is my health. I should be able to be taken care of. So, I remember asking him once if he would like to connect with [my naturopath], and he would not have it. We just butted heads. He would not even consider the idea. He said that I was wasting my money and that it would not help my situation."*

The data's patterns also supported the sub-theme of experiencing inconsistent care and treatment from providers when a relational connection did not exist. It was supported by participants reflecting on the inconsistent care they received when utilizing walk-in clinics or care from a physician that they needed to be connected to. One participant specifically shared,

> *"And then, after my doctor retired, things were very inconsistent. We did not have a family doctor until I had health concerns. So, I am really glad not to have to utilize walk and clinics anymore because I can access safe and consistent healthcare and my community."*

Finally, the sub-theme of disconnection from the system itself as an Indigenous woman was supported by a participant's experiences as she reflected on how the system was built without the potential users of it in mind. Specifically, she shared,

> *"And I think that system itself was created by people that do not need these types of resources. Right. So, it is like those who come from a place of privilege have set this all up. And that is not working for people who do not come from that. And there is a big disconnect [between the people who created the system and those who use it]. A gap right like, if you want to know what it is like, come live in the town, see what it is like, right?"*

This theme demonstrates the contrast of experiences when a relational connection between the patient, provider, and the system itself does not exist. Additionally, these examples speak to the importance of connection in receiving safe, comfortable, and consistent care for Indigenous women. This theme is linked to connection as they act as counterparts. Further, this theme is connected to the synergy of systems, which discussed the relationship, or lack thereof, between the healthcare systems themselves – which will be addressed in a subsequent section of the findings chapter.

Question Two:
Could you tell me how these experiences affected your decision to return or not return to that service provider to receive care?

Experiences affect on one's decision to access healthcare

Reluctance and purposeful delay in seeking care

For this question, participants reflected on how their experiences affected, if at all, their decision to access health care moving forward. A pattern was identified within the stories recounted by participants. There appeared to be an overwhelming connection between those who had endured negative past experiences and their decisions around accessing healthcare moving forward. Participants with negative past experiences supported the theme of a reluctance and or purposeful delay to seek further care, even if necessary, and active avoidance of specific healthcare facilities due to past experiences. This pattern within the data was identified when participants reflected on how their experiences affected their decision-making. This was an emerging theme within the data as it was not considered in developing the initial conceptual framework; however, further exploration of it was deemed necessary based on the information provided by the participants.

One participant shared how a particularly negative interaction with a staff member at her doctor's office affects how she accesses healthcare. She explained what accessing care looked like after that experience and reflected on the trust she had lost because of this situation. She shared,

> *"That [experience] definitely, yes, has guided my decision not to want to receive care, but only go there when I absolutely need to. Like right now, I was due for one of my injections yesterday. And I know that in a few days, my joints will become an issue for me, especially with the rain and the clouds today, the weird air pressure and the sun and everything; the weather will really start to impact my joints.*
> *So, I know that I will only call that doctor's office once I am in pain and it starts to impact my quality of day-to-day life. I am really relying upon the pharmacy to do that grunt work for me, and it is easier for me to do. So, what I do is I go online and to my prescriptions account and request it there; if that does not work quickly enough, I will call the pharmacy and request a refill request, and they will call my doctor's office and process that for me. So, I would much rather go through that long-distance avenue than call my rheumatologist's office and say, "Hey, I was absolutely due for this prescription yesterday; I need it now."*
> *So, if I have not heard anything by next week, or it has not been renewed, then I will start to make moves.*
> *Which? Yeah, just saying that out loud sounds like it is, yeah. I hear it differently when I speak it out loud."*

The same participant added,

> *"So ultimately, I continue to access care there because if I do not, my body cannot handle going there. But mentally, it is uncomfortable for me, and that has guided my decision to transfer to a new practitioner."*

Another participant echoed this theme of reluctance and purposeful delay by sharing that she stays home until she can no longer handle the pain she is experiencing (PAR7). Another participant's reluctance to seek care for her chronic illness supported this theme within the data (PAR1). She shared that while she remains reluctant to seek care due to her past negative experiences, she continues because of the urgency and severity accompanying her health conditions. Specifically, she shared,

> *"Well, no, I have no choice because I got pneumonia again after my surgery. I was having difficulty breathing, and I was not going to wait until it got worse, so I went to the hospital, and they took me in immediately. But I will put it like this: I dread going to the clinic or the hospital. But when you absolutely have to, you have to, whether you like it or not."*

Further, another participant supported the theme of reluctance and delay in seeking care by sharing how her experiences with a specific physician affected her decision to return for the care she needed. She shared that she did not want to return for care because she found that physician incredibly triggering due to their colonial connections (PAR2).

Participants supported the sub-theme of avoiding specific facilities due to past negative experiences. The findings demonstrate that those who noted active avoidance of a particular healthcare facility did so due to past experiences of racialized discrimination. One participant supported this by explaining her feelings toward accessing hospital services and how those experiences can be highly triggering and harmful for Indigenous folks. She explained further,

> *"So, when I am back home, my mom's doctor is actually in the hospital, which is really triggering because the hospital is quite racist. We, in general, do not get treated very well. You know. In general, we just do not get treated very well. And I hate going to that hospital. I hate going there to visit. I hate interacting with any of the staff there. You know it is really triggering and upsetting, and you do not want to deal with them, and you do not trust that they have your best interest in mind."*

Another participant reiterated this theme by sharing that they have not returned and will not return to a specific hospital because of what she believed to be race-based discrimination (PAR3).

One participant spoke to the systemic nature of the treatment of Indigenous patients, particularly women, within the healthcare system and reflected on her negative experiences. She explained how this pattern of mistreatment leads her to shut down and internalize the harmful things said and done to her. Specifically, she shared,

> *"And then to be continually treated differently, like it is not just one doctor. Oh, that is another thing I realized: it is not just talking to one doctor or person. I realize there is a pattern, so that pattern is within me, right? Where is if I had some advocate or somebody there to help guide me, it would have been a lot less painful, you know, so I realize now that some of the things that, like when somebody asks me something, and I talk to them, and then they are not believing me, or they are not helping me. I shut down*

> *and think, okay, forget it, I am a wingnut. Instead of pushing forward and saying no, this is a real issue. So, therefore, it keeps getting worse, right? So, I am going to counselling, trying to work on that."*

One participant presented a glaring contrast to the others' experiences as the majority of their experiences with the mainstream system had been positive and therefore affected their decision-making regarding access to healthcare in a dissimilar way. The participant supported that her past positive experiences positively affected her decision-making. She shared,

> *"I know what is available to us at the different levels, and I am comfortable accessing it because we have had good experiences."*

The participants' stories demonstrated that negative experiences with the healthcare system can lead to delaying necessary treatment, a reluctance or extreme hesitation to access care, and the avoidance of specific care providers and medical facilities.

Use of alternatives

In contrast to the predominantly negative experiences recounted by the participants when accessing healthcare from the mainstream system, there was another overwhelming trend within the data that demonstrated the positive experiences participants had with using alternatives. The use of other options includes the use of alternative medical facilities, practices, and medicines. It includes alternative approaches to health and wellness that are not commonly found within the mainstream system. Overall, participants expressed positive experiences when accessing alternatives. However, these alternatives were diverse depending on the participant's identity, history, and medical, cultural, and spiritual needs.

Participants demonstrated the connection between using alternatives and their positive experiences accessing them. At the root of these experiences were the constants of more time devoted to developing patient care and understanding and creating a relational connection between patient and provider. One participant shared how accessing care from an Indigenous-led clinic has allowed her to generate more trust in healthcare systems and providers. She shared,

> *"And again, like, only since I have been to a medical clinic that's Indigenous-led, that has elders, that has alternative medical options for us, that are culturally relevant to us that we have been able to, yeah, trust in it (the healthcare system) a little bit more. And you know, my family, children, and husband are being cared for by the same doctor. That is really important to us."*

Another participant echoed this sentiment by explaining her experience with her doctor from an Indigenous clinic. Specifically,

> *"Now I have a female native doctor, and she is awesome; I love her; she is a really good doctor. And I am not ever made to feel, you know, like I am stupid. She talks to me like she cares about me."*

As mentioned, the alternatives accessed were diverse depending on the participant. This diversity highlighted how a trusting and caring relational connection between patient and provider remained a consistent attribute of a positive experience. One participant shared how she accesses care at women's clinics that are not Indigenous-led. She shared how access to these clinics allows her to access safe and comfortable care compared to accessing through a hospital or mainstream doctor's office. Specifically, she shared,

> *"So [I am] grateful that we now have clinics that are geared to just women's health where there is no rush. And that is because these clinics are run by nurse practitioners who take 20 minutes, if not longer, to get to know you, right?"*

Like the above instances, another participant shared her experiences with a naturopath. She explained,

> *"I had a naturopath who specialized in oncology. That is why I was seeing him to get the right treatment, which was great, and I had a lot of different vitamins. The approach was amazing. And so, he was [open to] work with anybody, including my endocrinologist."*

The provided examples demonstrate how the essence of a positive experience is related to a relational connection based on trust and genuine understanding between patients and providers that then allows for safe experiences to occur. While participants noted their favourable experiences with Indigenous-led clinics, there were positive experiences with providers that were not affiliated with Indigenous clinics or Indigenous themselves but were open and understanding to the patient's needs and beliefs. This again highlights the importance of developing an understanding relationship between patient and provider.

Advocacy

A less prominent theme within the data collected for this question was the theme of advocacy, more specifically, advocating for the care that the participants need and for others. Participants appeared to continue to advocate for safe healthcare despite their previous experiences. The data collected for this question did not speak to the advocacy of Indigenous individuals working within the healthcare system.

One participant shared how she feels a sense of responsibility to encourage and empower others to access and speak up for culturally safe care, especially for family members. She shared,

> *"You know, we have to encourage others too. I think it is one thing to encourage others to like my daughter is getting older. She is coming, you know, through these stages and*

> *life like she will need to start getting birth control. And you know, I want her to be empowered and know that she can speak up for her rights and health rights. You know, and give her the skills to advocate for herself."*

Another participant echoed the theme of advocating for care despite their negative experiences when accessing healthcare. She shared how advocating for culturally safe care for Indigenous women is needed to make changes and improve the current healthcare system. She shared,

> *"It is something I am learning. I am learning how to advocate. I am learning how to pick up that phone and make that appointment with that doctor again. Even though they are telling me, "No, it is probably just nerve damage down there." And I am like, that is unacceptable, and shouldn't you be giving me something to fix the nerve damage and heal the nerves, to stop the pain, you know? So yeah, we are changing it by naming it. Things will get better."*

Again, one participant presented a stark difference within the theme of advocacy. This participant has had mainly positive experiences, which she believes have allowed her to gain confidence and comfort when interacting with the healthcare system. Further, these experiences will enable her to take control and initiative over her healthcare decisions and how, when, and in what form she decides to access care. She provided examples of using urgent primary care clinics and seeking assistance from online resources, and she often uses 811 (PAR4).

The examples provided speak to how the nature of one's experiences can affect how one feels approaching future care for oneself, one's family, and community. The experiences and their effect on participants' decision-making fell on a spectrum. On one end of the spectrum, it appeared that most of the women have to fight for the care they and their family needs and on the other end, some women have gained confidence from their experiences and use that confidence to take control of their care decisions and do so without the necessary support of others.

Racialized discrimination

Participants expressed their experiences with racialized discrimination and how those experiences affected their decision to access care moving forward. Some participants spoke to the different sub-themes of racialized discrimination; however, the overall effect on their decision to access care was unanimously consistent. The impact of their decision was harmful, leading to hesitancy and avoidance of seeking care.

One participant shared how the questions that providers were asking her made it feel as though they were generalizing her experiences as an Indigenous woman and making assumptions about her injuries based on her identity. She shared,

> *“They were very professional with me and the interaction, but I think they are just going through the motions and checking the boxes. But they should not assume that because I am Indigenous, I am getting beat up because I am not."*

Another participant shared their hesitance about their daughter accessing care in the future because of specific features of her physical identity and how her Indigenous identity is presented. Further, she explained how she is thankful for their care from the Indigenous clinic. Specifically, she shared,

> *“And she takes after my husband because she is very brown. She is very dark, with dark hair and eyes, and you know I fear how she will be treated? But thankfully, again, we have a good doctor that can for us and gives us, you know, the attention we deserve.”*

There was a divergence in participants’ responses to this question. One participant spoke to the notion of positive profiling, where she alluded to having positive experiences with healthcare based on her presented identity. The participant reflected on how if she “were more Indigenous how this would affect [her experience].” She explained how she does not identify with her Indigenous heritage as openly as others, partly due to her upbringing. Specifically, she shared,

> *“Like how I identify as being indigenous. So, I am Metis, and some people identify more as Metis or more into the culture than I do. And, like my grandmother, is Sioux Indian. The reason I am Metis is just how status works in our family and marriages. And so, if I was, say, Songhees or from another nation here, close to where I live, accessing the same hospitals and services, how would my experiences be different? Would there be bias or racism? Would there be, you know, dignity provided and good services like would my experiences still be positive? I wonder that.*

She continued to reflect upon whether her physical appearance affected the care that she received. She shared,

> *“My father's indigenous, and I have an English and like a very white mother. So, yeah, that is what I mean. Like if I was more Indigenous or identified more. Basically, if I was more visibly Indigenous, would my experiences be different? I think I have good experiences because of who I am, how I was raised, and what I look like.”*

Overall, the data collected for this question demonstrated a potential correlation between the nature of the participants’ past experiences and how this affects their decisions to access care in the future. This correlation is suggested due to the negative experiences endured by most of the participants and how this can lead to a delay or avoidance of seeking care in comparison to the sole participant who spoke to her mainly positive experiences and how she feels empowered to access care and in control of her healthcare decisions.

Question Three:

Based on your experience(s), do you feel you received the suitable or appropriate standard of care and treatment for the healthcare service that you were seeking?

For this question, participants reflected on the care they have received throughout their lives and considered whether they felt they had received the suitable or appropriate standard of care. To present the findings comprehensibly, each theme supported by the participants' answers will demonstrate how the fair and proper level of care was either met or not met by providers and the healthcare system.

Connection

Participants spoke to the theme of connection and how feeling connected to the approach of care being administered and establishing a relational connection with the providers allowed for the suitable and appropriate standard of care to be met. One participant supported this theme by sharing how they could build a rapport with their care provider and how the care administered was familiar to her and, therefore, something she felt connected to. Specifically, she shared,

> *"The opportunity to meet and meet as a family, to interview the physician. And him interviewing us to decide if we fit… Yeah, that practice [allowed for suitable care to be met.] And I would say, even if we go way back to when I was a child, we had house visits…. So, this physician I have now, even though he is male, I am fine with that now; his way of being and his practice are very similar to the practice I had as a child. We had nurses that came to our home when we were children…. It was the same type of thing; they would come in and have tea with my mom. And now we have the option to, I mean, I have the option to, as an Indigenous person, to decide who I want as a physician based on this interview with this doctor."*

Another participant supported the theme of connection by sharing her positive experience when she received healthcare at home and how appreciative she was of the healthcare staff making this program possible for her. She explained,

> *"They have this awesome program. It is called a hospital at home. I stayed in the hospital for two nights, and then I got to come home and do my prescriptions at home. The nurse came to see me every day to change my IV. That is an awesome program. And even the pharmacist speaks to you, like, when does that ever happen? They call you; the doctor phones you every day. So, I know some people work together as a team to get people home well."*

These examples demonstrated how the connection with providers, being familiar with the approach, and being in a comfortable environment made it possible for the healthcare system to meet the suitable and appropriate standard of care. Linked to connection was the theme of synergy among systems. The synergy of systems was considered a sub-theme and includes the link, or lack thereof, between healthcare systems.

Synergy of systems

In contrast to the appropriate care being met within the theme of connection, participants spoke to how the lack of harmony and synergy between the different healthcare systems often leads to Indigenous women needing more suitable care and impeding their overall access to healthcare. One participant supported this notion by sharing,

> *"Our systems do not communicate with each other. And I think that is a challenge for Indigenous folks, is our systems do not talk, right?" And, like I said, I am 53, and it has been disconnected for how long? It has been so long. Right? We want to be so connected. But I think with even today and technology and kind of where we are at just in medical and health services itself. We are not connected; we are so disconnected."*

The same participant further explained how accessing services from two different systems caused a disconnect in the care she received because the systems do not communicate with one another. Specifically, she categorized the current system as fragmented and working in silos (PAR2).

Another participant supported this theme by explaining how when the systems are not connected and do not communicate with one another, Indigenous folks tend to "fall through the cracks" and do not receive the appropriate care they need and deserve (PAR6).

These examples demonstrate how the disconnection between and within healthcare systems can impede the appropriate standard of care to be met for Indigenous women accessing healthcare.

Cultural competence of interactions

The theme of cultural competence among providers, the level of understanding and acceptance of Indigeneity, and a demonstration of genuine care were commonly found among the participants when answering this question. From the participant's stories, providers' cultural competence and genuine care contributed to suitable and appropriate patient care levels. One participant encapsulated what the standard of care being provided by a culturally competent doctor looks like. Specifically, she said,

> *"Like at this one hospital, the doctor sat with me and talked with me. He let me know that there was some confusion. He walked me step by step through what he was doing, and then he continued to provide, you know, further care by referring me to other folks or referring me to another unit to get an X-ray or CT scan. He did everything he could to try and find out what that pain was, which we have found out was nerve pain. And then explained that I would need a special painkiller for that."*

In contrast, participants demonstrated where they felt suitable care was not provided due to the lack of genuine care facilitated by providers. A common trend was rushed interactions when seeking care. One participant shared,

> *"The interactions were always just rushed. It was just kind of abrupt. It was more like, okay, yep, no, goodbye."*

Another participant added to this trend in the data but demonstrated how being rushed when accessing care as an Indigenous woman makes her feel. Her experience also spoke to the intimate ways women need to interact with the healthcare system. Specifically, she shared,

> *"But I also found to like it was always rushed. Every appointment was rushed, which made it really uncomfortable when it came to that time of year for my pap, right? Because you do not want to be with somebody who is going to rush. Recognizing that every female is shaped differently. So, you know, having to go through the process of finding the right instruments for my pap. That was a horrible experience because she was always in a hurry, right?"*

Further, a participant shared that Indigenous women need more suitable healthcare and believes it is a system issue. She recognized how this issue may be related to the dire state of our current healthcare system, a recognition shared among all participants. She shared,

> *"No, I do not believe I have received the appropriate care. It is everywhere. And I know that our system is broken. I know that our doctors are overworked because sometimes my doctor is very patient and very good because he is the one who diagnosed me with colitis. But I also know that he is overworked.*
> *I know that we have a lot of issues with staffing with, you know, bringing the doctors in with, you know, getting qualified people with your opioid and COVID crises and everything right. And our mental health crisis, right? So, I get all that, so I really work at it, trying to be accepting and heal me so I can get better communication."*

The examples highlighted how the cultural competence of healthcare providers within the mainstream system can contribute to the standard of care provided to Indigenous women when accessing care. It was found that the rushed interactions and overworked system lead to sub-suitable care being administered to Indigenous women, which can be particularly harmful when interacting within the system in intimate ways as most women need to. Comparatively, it was found that when there was a strong demonstration of care and understanding, the participants felt the suitable standard of care was met. This theme is linked to the notion of Indigenous-specific gendered racism through the unique forms of trauma experienced by Indigenous women when accessing health care.

One participant's reflection on the standard of care that Indigenous women receive from the mainstream system was a finding that stood alone within the data but was relevant in answering the research question. She shared how the baseline expectation that most Indigenous women have when accessing healthcare is already low, causing the reception of even adequate care to be surprising and feel more than just average care. Further, she shared that when Indigenous women receive what they deem sufficient care, it does not equal the appropriate level of care needed to feel safe and supported by the healthcare system. Specifically, she shared,

> *"No, and I do not think so because this is a general baseline of care. When we are treated with adequate care, it comes off as extremely kind and surprising. When issues come up, testing happens quickly, and issues are dealt with immediately. That is surprising."*
> *"For example, a family member of mine has had some thyroid issues come up very recently, was in the last four weeks or so, maybe a little bit longer, but she was in for testing right away, and I was so surprised because that never, I was just surprised, because there's not always urgency behind our requests, so I am really glad for her. So, I do not think that Indigenous women especially get adequate care regularly because when we do, it is really surprising and disappointing."*

This example demonstrates how the experiences of Indigenous women are unique to them and differ drastically from the experiences of non-Indigenous folks. It indicates that a trend among the experiences of Indigenous folks is that what an Indigenous person might view as safe and suitable care might be viewed by a non-Indigenous person as scarcely satisfactory.

Advocacy

From the participants' stories, the advocacy theme resurfaced as some reflected on how the necessity or ability to advocate for themselves and others affected the level of care they inevitably received. Some participants shared the experience of nearly fighting for the care they needed. One participant shared how she felt she needed to advocate for herself persistently and how this should not be the norm for women seeking care. As such, this experience affected the level of care she received. Specifically,

> *"I remember an interaction with my endocrinologist; it was like I was always fighting or had to prove something. I was an undergraduate at the time, and I remember thinking I had to fight for myself. Felt like I had to; it was exhausting, and I am the one who got the diagnosis, right?"*

Another participant reflected that her inability to advocate for herself at a younger age affected the care she received. She explained to me,

> *"I guess it was adequate enough. Like my younger self, [I did not have the] skills to stand up for myself. I wish I would have been able to do more. Yeah, I guess, or be able to speak up to my doctor when I felt like he was being discriminatory against me. Yeah, you know, when they found out I was Indigenous, the tone changed. Yeah, I wish I had the skills to speak up for myself more."*

These examples demonstrate the lengths Indigenous women commonly must go to receive even the most adequate care from the mainstream system. The tenacity and resilience of

Indigenous women are shown through their capacity to continue to advocate for themselves and their families even when faced with multiple barriers.

The data collected from this question demonstrates that the standard of care received by Indigenous women when accessing healthcare rests heavily on the cultural competence, understanding and respect presented by providers, which enables a safe and comfortable connection. In addition, when there is this lack of knowledge, participants expressed how they must advocate for themselves to receive adequate care that they have an inherent right to and should not have to fight for.

Question Four:
Based on your experiences, what do you think could be improved?

When answering this question, participants shared what they think can and should be improved in the current mainstream system. The participants offered both provider and system-based improvements. As such, this section of the findings will be divided into provider and system-based improvements and then subdivided based on the prominent themes that emerged from the participants' answers.

Provider-based improvements

Cultural competence

A common theme shared between participants was the theme of cultural competence among providers. Most participants said that their experiences make them feel that providers' cultural competence, including fostering genuine care for patients and understanding and accepting Indigeneity, could be improved within the mainstream system.

Participants stated that when interacting with Indigenous women, providers need to develop a greater sense of empathy, care and understanding to allow Indigenous women to feel safe and supported by the mainstream system. One participant shared what she feels is the number one improvement to be made by healthcare providers in the mainstream system. She shared,

> *"First, we are people. And when you are there to help people improve, you must show them that you care about them."*

Another participant echoed that a genuine sense of care for Indigenous women needs to be improved in the healthcare system. She shared how important it is that healthcare comes from a place of compassion and empathy rather than judgemental preconceptions of Indigenous women. She shared,

> *"I think it is patient care. Considering some of the interactions that I have had, not judgmental patient care but really coming from a compassionate approach or an empathetic approach, you know, and understand what that looks or means for different patients."*

The same participant began reflecting on how providers may demonstrate a greater cultural competence by developing a genuine understanding of patients. She shared,

> *"But patient care is a big one. But also really understanding the specifics of Indigenous culture. Right, like, there are more perspectives and different world views out there. And I said, like for me, as I said earlier, I like to merge different forms of medicine or different ways of healing to take care of myself; I will build that team around me to be able to do that."*

Another participant supported the theme of cultural competence through understanding Indigeneity by demonstrating how relationships between Indigenous patients and non-Indigenous providers could be drastically improved if a deeper understanding of Indigeneity were established. She explained how she has witnessed this deepening of understanding happen and how she knows it aids in developing healthier relationships and far less harmful interactions. Specifically, she explained,

> *"I have come to believe that the best way for relationships to improve is through genuine, deep understanding. Because I have witnessed so many non-indigenous people who come to develop an understanding of Indigeneity, and it is just like this great big light bulb moment for them. Then, the trajectory of their lives shifts to be more inclusive or to at least be less harmful. And those people that I have these relationships with. And if I happen to have that light bulb experience with them, or if they have that experience because of something I have shared or taught them, then that relationship is ongoing for a long time."*

Another participant demonstrated why this deep and genuine understanding of Indigeneity is so critical to the experience of Indigenous women accessing care. It could eliminate the generalizations and assumptions often made by providers who need more knowledge and cultural competence. She explained further,

> *"I think, not only that, but I think that as we have physicians from out of country coming to work in British Columbia, it should be mandatory that they take cultural competency [courses] right…. That is really important, instead of just showing up and assuming because I have a fatty liver and am an alcoholic. And once again, that is going back to ensuring that we have physicians who come from out of the country to work in our province and understand not just cultural safety and humility but Indigeneity. I think it is really important that they understand right, like do not paint Indigenous people with the same brush. Yes, we have a high percentage of First Nations People who have diabetes, but not all of us."*

Another participant supported the theme of cultural competence by understanding Indigeneity and Indigenous knowledge systems and approaches to health and wellness. She shared how accepting Indigenous approaches to wellness and holistic healing would improve our current system and how Indigenous women access healthcare. Specifically, she clarified,

> *"I think doctors need to take a two-eyed approach when working with Indigenous people. We need to be working together to have a Western approach and support wellness and holistic healing."*

The examples demonstrate how the critical components of cultural competence, like establishing a genuine and thorough understanding of the Indigenous patients and their culture grounded in care and empathy, are vital to the improvement of the healthcare system as without them, our findings would suggest, the system is not sufficiently supporting Indigenous women.

System-based improvements

Cultural competence by understanding of Indigeneity and Indigenous rights

To begin this section of the findings, one of the participants' reflections that was dissimilar from the rest will be focused on. Her answer explicitly spoke to the need for more understanding regarding Indigeneity, the inherent rights of Indigenous Peoples in Canada, and the lack of cultural competence within our society. She explained how increasing this understanding is critical to improving the healthcare that Indigenous Peoples, specifically women, receive. Further, she believes that a way to surge improvements within the current system is for individuals in positions of power to take a top-down approach, educating themselves and others on Indigeneity and the inherent rights of Indigenous Peoples. From this approach and the genuine understanding that could stem from it, she believes there could be a positive impact on how Indigenous women access and receive healthcare. Specifically, she explained,

> *"Yeah, so I think a deeper level of understanding and education will improve those relationships.*
> *And I think it needs to come from the top down, especially like wouldn't it make such a big difference if somebody with authority, and white presenting, came and explained why Indigenous People could shut down the highway in protest, for example? Not many people know that that highway, like in Tsawout, was built through the village, and therefore, they have the Federal authority to close that highway at any time, anytime they want."*

She continued to explain why this approach is necessary to improve the treatment of Indigenous women in the healthcare system,

> *"Instead, I think people assume that we are just out in the middle of the road, causing a disturbance and have no right to do that. But what if the Premier, or even our Prime Minister, explained that situation? Yeah, they do have a right to do this. That would dismantle so many systems and so many belief systems. And obviously, he would probably receive a lot of hate and backlash. And I think people also assume that we can use the same avenues for change, or whatever it is that we desire, the same way that non-indigenous folks do. Many non-indigenous women, especially white women, will think, "Well, why do you have to be so drastic in your issues?" "Why can't you just make*

> *a phone call, write a letter, or follow the request form system on their website somewhere? Then it is problem solved, right." And I do not think many people understand that those do not work for us. We do not get the response. We do not get any acknowledgement or anything. So yes, I think deeper understanding and people in positions of power acknowledging that understanding and teaching that understanding will make the biggest impact. Yeah, there is a lot, but I think getting Indigenous people in positions of authority in healthcare would go a long way and improve levels of understanding."*

While this participant was the only one to explicitly mention this as an aspect of cultural competence from a high-level system-based perspective, presenting it establishes a strong foundation for the remaining findings to build upon and connect to.

Advocacy

A pattern among the participants' answers regarding advocacy was having a more significant presence of Indigenous folks working in the mainstream healthcare system as providers or advocates to improve the care and safety of Indigenous women. Many participants spoke of feeling overwhelmed or lost at one point when accessing the mainstream system. They shared the perspective that having a more significant presence of Indigenous individuals throughout the system would improve the care they receive and the system overall. One participant supported this by sharing how having advocates within the system would have helped her personal experience but would help improve the care that many Indigenous women currently receive. She shared how she felt like her voice was not loud enough and how this feeling deeply frightened her. She shared,

> *"Being able to have somebody advocate for me because I thought about this afterwards, like why didn't I access this, or how could I access, or could I have accessed, or is there something out there? Right, we need a place that we can contact and where we can phone up a group of people and say, "Hey, I am having trouble with this," and they can help you along, you know, instead of being so lost because at first, I had no idea. So, to have somebody I could safely talk about my private parts with and get them dealt with and not feel scared right now, I am scared that it might be too late by the time they diagnose me properly. That is my biggest fear, and I feel like nobody is hearing me."*

Another participant supported this notion of how additional help navigating the system would have improved the care she received and would most likely do the same for other Indigenous women. Specifically, she noted,

> *"I am thinking, what would have been helpful for me was if for somebody that I could have gone to, and that could have been that support for me that while walking me through the medical system, which is a navigator role, but really provided advocacy support, too, because I had to do that by myself."*

The same participant continued to support this pattern but noted a critical caveat to consider when Indigenous folks are working within the mainstream healthcare system. She explained,

> *"Anybody Indigenous working in health, there is always that protection concern that I have for them because I understand that the work is hard and being in that environment can be overwhelming and quite taxing since there is a lot always going on. Taking care of and being really mindful about the Indigenous folks working in the healthcare system since this is a systemic issue - systems change means needing a shift in policy."*

These examples demonstrate that increasing the presence of Indigenous folks within mainstream healthcare has been seen by many of the participants as an approach to improving not just the level of care that Indigenous women currently receive by helping them feel less disoriented and safer but also improving the system overall by the knowledge and perspective they would bring. This theme is connected to the use of alternatives, as increasing the presence of Indigenous folks within the mainstream system may affect the acceptance rate of alternative forms of health and wellness among providers and throughout the system.

Use of alternatives

Another theme supported by the collective was how using alternatives affects the overall care the Indigenous women receive. This theme included making space for alternative knowledge systems within mainstream healthcare, increasing the presence of Indigeneity within the mainstream system, and the overall support and acceptance of alternatives.

Participants discussed how making space for alternative knowledge systems within the mainstream could improve Indigenous women's care. One participant shared how incorporating alternative knowledge systems that are not strictly Western science-based could improve the current system. She explained,

> *"In some way or another, this information needs to be incorporated into the curriculum. Right. It is a struggle to include that because of the science-based nature. Like when you look at Western systems and Western culture, it is based on science, like numbers and numerical values. So, we are looking at a system that's very like it is either this way or that way, nothing in between. It is like mechanics or an engineer's concept of ones and zeros to make something work. I always use those hand in hand with the medical system quite frequently. But yeah, if something is broken, then you change the part. There is not too much in between. It is a system of change that needs to happen, and I think it needs to come from all directions inside and outside, which I know is starting to happen, but not at a fast-paced scale. But yes, maybe even being open to alternate forms of care."*

Another participant previously supported this notion of incorporating different knowledge systems when they stated that an improvement at the provider level would be accepting and incorporating a two-eyed approach to administering care (PAR6).

Participants supported the notion of increasing the presence of Indigeneity and Indigenous lead centers within the healthcare system as an improvement to be made. One participant shared how this prospect genuinely excites her and makes her feel more comfortable about accessing care in the future. She shared,

> *"I was thinking about that (improvements to be made), and my counsellor actually was telling me they are planning on trying to have a First Nation clinic out here, right? And that is something we really need. So, the idea is that they are more culturally sensitive and, you know, so there is a lot of safety. I think that is the biggest thing is safety."*

Overall, there was a recognition that for these improvements to occur, there needs to be acceptance and demonstrated support by the mainstream healthcare system for Indigenous knowledge regarding health and wellness. One participant spoke about how the system needs to accept Indigenous wellness and holistic healing methods and work with them to create the best care for Indigenous patients (PAR6). In support of this, another participant shared how accepting and funding alternative healing methods would improve the care provided to Indigenous women. Specifically, she shared,

> *"It is all-natural or Indian medicine access or funding, or fund the people, the knowledge keepers who have been doing this for thousands of years or passed down through generations."*

Another participant supported accepting alternatives and shared how making them physically available within the mainstream system would drastically improve care for Indigenous women. She explained,

> *"Even having alternate forms of care in the same vicinity, like, why not have a naturopath, you know, why not have other folks and alternatives also within the vicinity."*

These system-based improvements highlight how impactful it would be for Indigenous women if there were a system-wide acceptance and incorporation of alternative knowledge systems, alternative approaches to health and wellness, and a more substantial presence of Indigenous values in healthcare facilities. This theme is connected to settler colonialism, as the colonial roots of Western medicine are often at odds with and threatened by alternative knowledge and belief systems. Additionally, the use and acceptance of alternatives are also connected to the theme of self-determination and decision-making for Indigenous Peoples, as they have inherent rights to decide what is in the best interest of their themselves, their families, and communities under the law and this can and should include the use of Indigenous knowledge systems.

Self-determination and decision-making

The theme of self-determination and decision-making was spoken of less than other themes among the participants. Nonetheless, this theme is significant in answering the research questions and discussing these findings. Few participants talked about the importance of

Indigenous decision-making. One participant discussed how the opportunity to make decisions about the care she and her family receive positively affected her overall experience accessing healthcare from the mainstream system; however, she noted that this opportunity was long overdue. Specifically, she shared,

> *"And now we have the option, I have the option to, as an Indigenous person, to decide who I want as a physician based on this interview with this doctor. But, like, we are in 2023, and we are finally at a place as Indigenous people where we have the option to interview a physician and decide who that is and if that is who we want."*

Another participant supported the importance of Indigenous Peoples being at the center of decision-making and controlling their health and wellness needs.

> *"And you know, we need to be handing back power to Indigenous people to be fully in charge of our health. That means dollars. That means infrastructure, which is happening, I guess."*

The same participant shared with me how all those involved in the current healthcare system must understand their role and responsibility in the national action plan for protecting Indigenous women and girls and how improving healthcare is essential to achieving the Calls to Action. Specifically, she explained,

> *"But doctors can be so sterile, it is so as a matter of fact, and you know they are just cold and general, I feel. Not all doctors are like that, but if we do really want to improve the health of individuals, women, specifically, you know, having women doctors or feminist doctors that fully understand what their role is and related to the calls for justice even, and how health is a really big pillar is one of the four main pillars of services that could protect women's safety. When we are thinking of the National Action Plan for protecting Indigenous women and girls. I think health is one of the four areas where they really can make a difference in Indigenous people's lives if they were serious about caring for Indigenous women."*

These examples demonstrate how advancing self-determination and decision-making is vital to Indigenous women and their families' treatment, care, and prosperity. As one of the participants reflected, that requires changes to infrastructure and intentional funding for Indigenous knowledge and knowledge keepers to make the health and wellness of Indigenous Peoples a priority of our country.

Synergy of systems

A less prominent trend throughout the data collected for this question was experiences that supported the theme of the synergy of systems. While mentioning this theme was less deliberate, it is connected to the more prominent connection, a solid finding to emerge from the data collection. One participant spoke about how the disconnection between and within our current healthcare systems can contribute to the sub-standard and incomplete care that

Indigenous women often encounter when interacting with the healthcare system. Specifically, she shared how improving this disconnection could significantly enhance Indigenous women's current state of care (PAR2).

The sentiment of needing a greater sense of physical connection between the healthcare systems was echoed by another participant who reflected on her experience when this connection was present and how it positively affected the care she received. Specifically, she shared,

> *"The positive aspect of the difference in the service she is giving me as a doctor is that she will call me if I have not seen her in a while.*
> *And I know there is a new system where they can see all our previous visits, or when we have visited the hospital, she will get a notification. Like, I took my daughter to the hospital, and she called us the next day and was like I saw your daughter visited the hospital. Is everything okay?*
> *So, that was, you know, whatever that system is put in place, that has definitely captured us as far as making sure that we are not falling through any cracks, I guess."*

The examples demonstrate how increasing the connection within and amongst the healthcare systems and authorities is seen by some of the participants as an improvement that would enhance the experiences of Indigenous women when accessing care. This theme is linked to the broader theme of connection as both demonstrate the effect that relation, or lack thereof, has on the experiences of Indigenous women accessing care.

The data collected from this question indicate that provider-based improvements center around increasing providers' cultural competence, which means developing a genuine sense of care, understanding, and empathy for Indigenous patients. Further, the findings for system-based improvements demonstrate the need for collective acceptance and an increasing presence of Indigeneity within the healthcare system, along with the importance of self-determination by understanding and honouring the inherent rights of Indigenous Peoples regarding health and wellness decisions.

Question Five:
Are there any alternatives to what is offered in B.C.'s healthcare system and its medicines, practices, and treatments you access?

When answering this question, participants spoke about the use of and their familiarity with alternative practices, medicines, and treatments. An emergent pattern throughout the data collected for this question was the collective support of and belief in holistic approaches to health and wellness. One participant explained how she has been moving toward a more holistic approach to health and away from prescription treatments (PAR2). Another participant supported this trend in the data by explaining that she believes in a "more well-rounded approach" and does not believe there is a one-size-fits-all regarding health and wellness (PAR4). Another participant shared their belief in "whole medicines and treatments" (PAR7).

In addition, many participants preferred holistic alternatives before accessing care from the mainstream system for various reasons. One participant expressed reluctance to use prescribed medication because of their discomfort with them and fear of their potential adverse side effects. She shared that she prefers natural medicines because of her familiarity and comfort. She explained,

> *"For example, a doctor would recommend, or wanted to recommend, that I take antidepressants, but my big fear was around becoming dependent on pharmaceuticals or becoming addicted to something that I did not want to be addicted to. So, I was very intentional also to ensure that, and whatever ways I could try to find alternatives, you know, to Western medicine."*

Another participant echoed this trend by sharing that she prefers to frequent naturopaths and other alternatives before accessing Western medicines and treatments. She explained,

> *"Absolutely, yes. I prefer to go to a naturopath or a health food store. I do spend a lot of time in the food store to find out what works for me, and then I start adding that to my diet. I would prefer to be able to see a naturopath, to see a qualified one, of course, and health food options like, you know. How can I say that, instead of buying your regular over-the-counter cough medicine to buy the elderberry with Echinacea kind of thing, you know, it is an immune booster and can heal you, right."*

Finally, there was shared support among participants for the use of alternatives as they provide a way to utilize the ceremonial and spiritual knowledge that plays a critical role in many Indigenous Peoples' approaches to health and wellness; however, they are often unacknowledged and undervalued in the mainstream system. One participant specifically shared,

> *"In terms of more holistic practices outside of provincial care, yes, I do a lot of my own cultural practices and medicines and plant medicines. I practice a lot of spirituality. I am a very spiritual person; I am not religious; I am spiritual and do those practices. So, things like cold water bathing. You know, that thing that we have done since before the beginning of time, like that kind of practice, and you know, using medicines for cleansing in different ways, spiritual cleansing, not bodily cleansing."*

Another participant echoed how vital ceremony is to their overall health and wellness and how it is something she utilizes outside the mainstream system.

> *"And then, of course, like within my own household. I have the support and power to, you know, to pray within our family and exercise that. So, a big part of my wellness is around the ceremony I do for myself. I have been trained in Indigenous focusing oriented trauma therapy, which has given me a lot of tools to do a lot of the healing that I need to do on my own to support others in their healing. Like having those skills and access to*

> *teachers and the ceremonies that provide the healing, being on land, being by the water, all of those things that support our identity, and support, you know, our holistic self."*

Among the participants' answers, there were some divergences. One is that alternatives are preferable but not always an option because their acceptance is low among mainstream intuitions and providers, making them expensive to access if individuals do not have the applicable healthcare benefits (PAR2). A participant noted that the lack of acceptance of alternative care methods can lead to the care needed by Indigenous women not being accessible. She explained further,

> *"And I am grateful to have the benefits through work; otherwise, it is costly. It is expensive. So, I feel privileged that I can do that, and I am grateful to have that. I hope the healthcare system will recognize (acupuncture) as a form of healing, especially for mental health. Yeah, if they could do that, that would be ideal. If they can recognize acupuncturists and naturopaths. I think we would be on a better path than prescriptive medicines. I would love to see that down the road."*

Another variance within the data collected from this question was the effect that displacement or structural exclusion has on Indigenous folks being able to access the alternative medicines and practices they need. A participant noted her experience of dislocation and how it has caused her to be disconnected from the traditional knowledge and techniques that hold incredible importance regarding her approach to health and wellness. She explained how this notion of dislocation has affected her ability to access the alternatives she requires,

> *"Well, I live in an urban center, and I am dislocated from my own land, so I am not on my own traditional territories. And I actively seek and look for medicines and permissions from, you know, whose territories they are on to find and harvest the medicines that I use. It is harder to get it in the city. Yeah, but you also need the teachers. Many families fall through the cracks because they have been displaced intergenerationally, maybe from their lands or teachers."*

Another participant spoke of a similar feeling of dislocation and the loss of knowledge and traditional practices. She shared the need to support the traditional knowledge keepers as much of the traditional understanding of Indigenous Peoples has been lost due to the decades of colonialization and colonial rule over the medical systems. Specifically, she shared,

> *"There are people who have lost that, right? We have lost the knowledge of what Devil's Club is really for. Like [having that knowledge] would be just a huge help."*

The examples demonstrate how using alternatives among Indigenous women is blatant and preferred as a primary course of treatment. Further, the findings highlight how alternative practices make and hold space for spirituality and ceremony and contribute to a more well-rounded and holistic approach to health and wellness, which most participants supported.

Question Six:
If yes, does accessing and using these alternatives affect your decision to access or return for care within B.C.'s healthcare system?

When answering this question, participants examined how alternative options affected, if at all, their decision to access the mainstream healthcare system. Most participants confirmed that using alternatives influenced their decision to access care. Participants commonly voiced how feeling mentally and physically safe when accessing care and receiving care that honours and aligns with their beliefs was vital during their decision-making process.

Participants expressed how they chose to access healthcare that aligned with their beliefs. This often meant accessing alternatives to the mainstream healthcare system as the mainstream system often devalues and diminishes the beliefs of Indigenous Peoples. One participant explained their experience with mainstream providers who were dismissive of using alternatives and closed off on employing a two-eyed healthcare approach. Specifically, she shared,

> *"I really would advocate for merging [systems] or even having the healthcare system work with all forms of alternate care. The alternatives have no problem working with the science-based or medical system, no questions asked; of course, yes, absolutely, but I have not always received the same message from the other side. It is usually, "Oh, you are wasting your money, or you know that is not going to help." Alternative medicine is helping me; I have always gone through science-based medical support. And it has felt like a band-aid approach and, at times, has not taken care of what is happening. And so, that is when I include alternative forms of medicine so I can get to the root of the matter."*

The same participant reinforced this theme within the data by explaining how, metaphorically, the mainstream system acts as a band-aid approach to health and wellness, as it often does not address the root of the issue but rather merely the surface. She explained how this way of thinking has affected her decision to access care and utilize alternative approaches to gain a more holistic approach to her mental and physical health and wellness. She explained further by beautifully articulating this metaphor,

> *"I do not know if this is exactly what they (mainstream physicians) are saying, but it is as if there is something wrong in one area; there is nothing wrong in any other area. But the way that I see it is that we are made up of how much water, and then I use the example, if we went to a lake, and there was a lightning strike on one part of the water. Where does that lightning strike? [It strikes] the other parts of the lake, right like they tell you, to get out of the water. So, it hits more than just that one area. It is not an isolated incident, right? As it affects other parts, too. And so that is how I look at my own form of health: if something is going on in one area, then other things are going on too."*

Another participant supported this theme within the data. She feels her care aligns with her beliefs regarding a holistic and complete approach to health and wellness. She explained the difference between seeing a physician from the mainstream system and accessing a naturopath or acupuncturist. Specifically, she shared,

> *"I wanted to move to a more holistic place because, with a physician, you are coming in and sharing with them this is what is going on. But if you see a naturopath and acupuncturist, they look at your whole being. Yeah, like, how are you doing mentally? How are you doing physically? Are you eating? Are you getting enough sleep? Whereas the physicians are like come in, tell me what is going on and try this! It is all connected, right? The naturopath and acupuncturists also focus on the connection between the heart and the mind. So, when you see them, you leave feeling grounded because they focus on all those key components of your well-being that are all connected holistically, right?"*

In addition, participants reflected on how their decision to access healthcare from the mainstream system was affected by using alternatives as they presented both mentally and physically safer options for Indigenous women. One participant supported this by sharing how the availability of alternatives affects her decision to access the mainstream system as it protects her mental health. Specifically, she shared,

> *"Yeah, it does [affect my decision]. Especially for my mental health. I will do my cultural remedies first, or I will do a mix of them. So, I will try my own therapies before I call up one of the counsellors, or I prefer psychologists. That is what works best for me. So, I try to fix things myself before I get to that. I don't know why, if it is a control thing or just hesitant to interact outside of that, or I am not sure."*

Another participant spoke to this theme of alternatives being safer for Indigenous women's mental health by sharing how she feels heard and supported and does not need to constantly retell her story as she often does when accessing care from the mainstream system. She explained the difference between the care received from the two distinct providers,

> *"That is just it, the need to feel heard. That is the challenge right now…. within our whole healthcare system. We are always in a hurry, we are always in a hurry, and I think that is where the frustration comes from. As somebody who has sat back and watched, it is like, if you just slowed down and really took the time to get to know the person, the outcome of that visit or that experience would have been so different. [Alternatively], acupuncture has been helpful in working with anxiety without having to share my story over again."*

A difference within the data collected for this question was a response from one of the participants who spoke of her experience with a naturopath. She expressed how the unfamiliarity and discomfort with the naturopath's methods contributed to discontinuing care. She shared,

> *"I do not think I would return because I did not trust her. But I mean, maybe she is great. Maybe she has fixed many people, and that would be awesome. But I could not deal with it."*

The examples illustrate how the use of alternative methods and approaches to health and wellness affects the decision-making of Indigenous women when it comes to accessing healthcare. Commonly, themes of aligning with one's beliefs, feeling mentally and physically safe when accessing care, and overall trust in providers appeared to have contributed to the decisions made by Indigenous women about their healthcare.

Summary of Findings

The analysis identified multiple patterns within the data that supported themes recognized as factors affecting Indigenous women's decision-making when accessing healthcare in B.C. and contributed to answering the research question and problem. The key findings from the analysis that will be discussed in the subsequent chapter are the reluctance to access, the preference to utilize alternatives, the lasting impact of settler colonialism, how experiences of racialized discrimination and Indigenous-specific gendered racism impact their decisions, the effects that geographical limitations and structural exclusion have on decision-making, the vitality of connection, the perseverance and tenacity of Indigenous women demonstrated by their advocacy; and the importance of self-determination and decision-making for the prosperity of Indigenous Peoples.

Chapter 6: Discussion

This study intended to explore how experiences with the B.C. healthcare system affect Indigenous women's decision to access healthcare services and the implications that follow. The approach to this study aimed to inform readers of the individual experiences of Indigenous women when accessing healthcare rather than generalizing an entire population. An additional objective was to contribute to the collective benefit of amplifying Indigenous women's voices while advancing the self-determination of Indigenous Peoples and cultures by honouring Indigenous data governance principles and approaches to research.

Further, this study proposed adding to the present field of knowledge by ensuring that strength-based components were presented in the findings and discussion. Too often, inquiries involving Indigenous Peoples focus on difference and deprivation, contributing to the harmful stereotypes attributed to Indigenous Peoples and their ways of life and the division between Indigenous and non-Indigenous folks. Findings that spoke to instances of difference were only represented through the perspective of the Indigenous contributors directly involved in this exploration, ensuring that conclusions were solely supported by Indigenous Peoples, their stories, and experiences.

Finally, the approach and design of this study endeavour to highlight the strengths and weaknesses of the healthcare system by encouraging efforts to decolonize their practices and policies.

Revisiting the Literature and the Conceptual Framework

While the literature review provided insight into the various conceptual issues that explain the disproportionate barriers Indigenous Peoples experienced when accessing, or attempting to access, healthcare in B.C., the literature did not paint a complete picture of the issue being studied. The literature primarily associated the conceptual issues of racialized discrimination, the lasting impacts of settler colonialism, structural exclusion and geographical limitations, exclusionary practices and inflexible systems which devalue the traditional methods of Indigenous Peoples, and experiences of Indigenous-specific gendered racism with the phenomenon being studied.

The literature review informed the development of the conceptual framework. As indicated in my positionality statement, the conceptual understanding of this issue was primarily informed by the information gathered from the literature review. The conceptual framework acted as my idea for exploring this research issue, i.e., what concepts would be investigated further through the interviews to understand this phenomenon completely. As such, the conceptual framework inspired the questions posed to the participants during the interviews. This allowed for the concepts identified by the literature to be amplified or contradicted while holding space for emergent data that contributed to the discoveries of this study. As the discussion will demonstrate, emergent findings were discovered, adding to the conceptual understanding of this issue. Therefore, a complementary conceptual framework was created to illustrate a new consideration of this issue, which included the initial concepts identified in the former literature as well as the emergent conceptual findings that were supported by the themes identified throughout the participants' data, such as connection, advocacy, and self-determination and decision making.

Key Findings

The outcomes from this study were ample and were reported on in-depth due to the research's goal to amplify the voices and experiences of Indigenous women. However, the key findings, those that will be discussed in this chapter and have their significance interpreted, are those that are directly related to answering the research question and the intentions of this exploration. As such, only some discoveries that were previously presented will be interpreted.

The analysis identified multiple themes within the data as factors affecting Indigenous women's decision-making when accessing health care in B.C. The pre-existing literature reinforced some, and others were emergent and provided new insight into the phenomenon being explored. The themes that will be discussed in this chapter are:

- Reluctance to access;
- Use of alternatives;
- Settler colonialism;
- Racialized discrimination & Indigenous-specific gendered racism;
- Geographical limitations & structural exclusion;
- Connection;
- Advocacy;
- Self-determination & decision-making;
- Cultural competence by understanding Indigeneity (to be addressed in the recommendations).

Findings Reinforced by the Literature Review

Before discussing the outcomes reinforced by the pre-existing literature, it is essential to understand the approach taken regarding specific findings, specifically those that supported the themes of racialized discrimination and Indigenous-specific gendered racism.

During one of the interviews, I shared a significant moment with one of the participants. As the interview ended, she shared her knowledge and beliefs about carrying the loads of others, how we carry them, how long we carry them, and how we let them go. She encouraged me to let go of the things that would not serve the other participants or me. This conversation has stayed with me throughout my research journey and will stay with me long after finishing. It has guided my decisions and grounded this work. There was a constant focus on what would advance the lives and rights of these women and their communities while deeply being aware of what could harm them.

With that, I struggled with the notion of discussing findings related to experiences of racialized discrimination. Not because I did not think it was necessary to highlight the ongoing racism that Indigenous Peoples face daily or honour the stories of these remarkable women, but because I thought it might add to the division that exists between Indigenous and non-Indigenous people. Suppose we recall the work of Dr. Jennifer Walker and Maggie Walters. In that case, we remember the harm that can come from studies involving Indigenous Peoples primarily grounded in differences and disadvantages. It perpetuates the harmful stereotypes that influence the majority of people's understandings of Indigenous Peoples, therefore informing an extremely incorrect and incomplete picture, which leads to further damage.

However, this thesis has a unique opportunity to discuss the outcomes that supported instances of racialized discrimination in a way that highlights the harm that generalizing Indigenous women creates while decreasing the impact that discussing them might have on the participants and other Indigenous women. As these conclusions were supported directly by the lived experiences of Indigenous women who consented to their outward distribution, the discussion can bring awareness to an issue rather than create more of a divide between non-Indigenous and Indigenous folks.

Reluctance to Access

The literature discussed how “Indigenous people have admitted their reluctance to continue accessing health services after their experiences with discrimination in the healthcare system” (Wylie & McConkey, 2018, p. 38 & Loppie et al., 2014). Further, the literature indicated that Indigenous people are likely to postpone accessing the healthcare they need until it is absolutely necessary because of negative experiences, which often leads to more frequent visits to the emergency room rather than visiting a primary physician with whom they have a connection (Turpel-Lafond, 2020). This paper’s primary research indicates that participants who had negative experiences with the healthcare system, i.e., facing discrimination, supported the theme of reluctance or purposeful delay to access care. This finding was additionally supported by those few participants who had positive experiences feeling very comfortable when accessing care and, therefore, could tend to themselves in more proactive and preventive ways. Some participants shared the extreme measures they would take to avoid interacting with specific providers and institutions, often delaying the required care. This discovery also demonstrated that participants had discontinued care before they had completed their treatment because of negative experiences when interacting with the mainstream system. The literature directly reinforced this notion (Wylie et al., 2020). The data analysis shows that reluctance and purposeful delay are the primary implications stemming from negative experiences, primarily race-based discrimination, faced by Indigenous women. This contributes to the multiple barriers impeding their access to equitable care. It further demonstrates the crucial effect of their experiences on their decision to access. The result appears to be a collective state of avoidance to seek the care they need.

These findings are not necessarily unexpected, as the literature briefly indicated reluctance among many Indigenous people when accessing healthcare (Turpel-Lafond, 2020 & Wylie & McConkey, 2018). However, further discussion about the implications of this finding was deficient. The literature spoke to the many Indigenous patients receiving late diagnoses (Wylie & McConkey, 2018 & Loppie et al., 2014). The primary data supported the notion that the high rate at which Indigenous patients receive late diagnoses is partly due to the reluctance that many Indigenous people feel surrounding accessing healthcare because of negative past experiences (Wylie et al., 2020). However, without an understanding as to why Indigenous people, namely women, move this way throughout the system, it is easy for non-Indigenous folks to believe the perpetual stereotype that Indigenous people choose not to take care of themselves and that this is why they experience drastically inferior health outcomes compared to non-Indigenous folks.

This research aspires to dismantle these harmful stereotypes by amplifying the voices of Indigenous women. The women's voices indicated that it is not their decisions that contribute to the divergence between the health outcomes of Indigenous and non-Indigenous women, as harmful stereotypes perpetuated throughout the millennia would make one believe (Walker, 2022 & Walter, 2016). Instead, the system through which mainstream healthcare is accessed maintains this difference as the colonial practices entrenched in the system reinforce the inferiority of Indigenous peoples and their traditions, influencing Indigenous women's reluctance to access the care they need (Wylie & McConkey, 2018).

Use of Alternatives

The findings revealed a stark contrast between the experiences participants had when accessing healthcare from the mainstream system and when they sought care from alternatives. The trend within the data indicated a potential correlation between the use of other options and the positive experiences participants had while accessing them. As stated in the preceding chapter, at the root of these experiences was the notion of more time and care devoted to developing patient understanding and creating a relational connection between the patient and provider.

The positive experiences were diverse among the participants. The diversity among the experiences was interpreted to speak to the ability of alternatives to address and honour the uniqueness and individuality of each woman in ways that the mainstream system does not. Further, the primary data indicates that throughout the diverse experiences, the importance of a trusting and understanding relational connection between patient and provider remained consistent. This study revealed that while many participants spoke to having positive experiences with Indigenous providers and Indigenous-led clinics due to the inherent connection that is available for them to make, other participants discussed their ability to foster a relational relationship with non-Indigenous providers when the provider was open to and understanding of the participant's individual needs, values, and beliefs. This was reasoned significant because it demonstrates the genuine possibility that non-Indigenous providers can not only make Indigenous women feel safe and comfortable when interacting with them, but if they are willing to, providers can create space for alternative knowledge and approaches that can help Indigenous women feel understood and supported when accessing healthcare. Once again, this finding emphasizes how developing a greater understanding of Indigeneity has a vital impact on the experiences of Indigenous women when accessing healthcare. In addition to the effect this discovery appears to have on Indigenous women’s decisions, it further indicates the potential for improved healthcare interactions and outcomes for Indigenous and non-Indigenous folks. A model of healthcare that is grounded in openness and understanding regarding the uniqueness of each patient, while it might seem idealistic, based on the findings of this study, would be more effective than the current approach and could, therefore, lead to better health outcomes for all patients.

In addition, the primary research supported what the supplementary literature review discussed regarding Indigenous perspectives of health and wellness as the participants expressed collective support of and belief in holistic approaches to health and wellness that exist in a balance between the physical, emotional, mental, and spiritual realities of an individual (Auger et al., 2016; Katz et al., 2017; FNHA, n.d.d; Hill, 2014 & Loppie-Reading & Wien, 2009). Many participants indicated that their motivation behind accessing alternatives was to support a more “well-rounded approach” to their health than the “one-size-fits-all approach” offered by the mainstream system. In many ways, accessing alternatives was preferred by the participants as it allowed them to access care that aligned with their beliefs regarding health and wellness.

This finding is complementary to the previous interpretation of how alternative approaches to wellness can serve the individual needs of Indigenous women better than the mainstream system currently can. This study’s primary data indicates that the participants were able to have more positive experiences with the alternatives they utilized because they held space for the individual beliefs of each woman, which allowed for a more well-rounded, suitable, and safe experience when accessing healthcare. In addition, the mainstream healthcare system has proven to be less accommodating to alternative approaches, specifically Indigenous perspectives on health and wellness (IRSHDC, 2021; Loppie et al., 2014; Turpel-Lafond, 2020 & Wylie & McConkey, 2018). The participants' stories confirmed this, as some experienced a lack of willingness or outright refusal from mainstream providers to consider other approaches. Again, this demonstrates how the beliefs held by many of these participants, a holistic and balanced approach, were not honoured by the mainstream system. This led us to our next point of discussion, a collective preference to access alternatives first.

A consistency found throughout the participants' stories was a shared preference to utilize holistic alternatives before accessing care from the mainstream system. This preference was held for various reasons depending on the individual. The literature spoke to this phenomenon and interpreted it as an approach used by Indigenous women to mitigate negative encounters with the mainstream healthcare system (Kurtz et al., 2013). While this paper’s conclusions did not discredit the literature’s interpretation, gaps were identified. Primarily, the literature’s understanding of Indigenous women’s preference to access alternatives before the mainstream system neglected to consider how alternatives often hold space for and honoured the incorporation of ceremonial and spiritual knowledge, which play critical roles in many Indigenous People’s approaches to health and wellness. Without this information, the literature’s interpretation of why Indigenous women prefer to access alternative methods first could be deemed incomplete. Therefore, an argument could be made for this paper to add to the current understanding of this issue effectively.

Settler Colonialism

While the theme of settler colonialism was rampant throughout the pre-existing literature (Burnett et al., 2020; Loppie et al., 2014; Loppie-Reading & Wien, 2009; Muller, 2022; Turpel-Lafond, 2020; Wylie & McConkey, 2018 & Wylie et al., 2019), direct mention of its impacts on the participants' decisions to access healthcare was not as blatant within the data collected. As this concept was interlaced throughout the literature, it was expected to also figure prominently within the data of this study; however, that was not the case. It could be argued that direct mention of settler colonialism did not occur because settler colonialism is at the root of each one of these findings. The geographical limitations faced, the discrimination endured, the devaluing of Indigenous knowledge, the lack of connection, the preference to use alternatives, and the need to persistently advocate for themselves and their right to make decisions for themselves and their families it is all rooted in and interconnected with the lasting impacts of settler colonialism. The effect of settler colonialism is in the air that Indigenous People breathe, the water they drink, and the land where they live. The significance of this discovery rests in the fact that it was not independently addressed. This was interpreted to demonstrate that the lasting impacts of settler colonialism receive recognition and weight through its connection to every other conclusion made within this paper, regardless of the direct mention of it.

Racialized Discrimination

Attitudes

The literature was consistent in its interpretation of how racialized discrimination in the form of stereotyping tended to lead to sub-standard care being administered by providers and, therefore, created an access barrier for Indigenous Peoples (Burnett et al., 2020; Loppie et al., 2014; Nelson et al., 2018; Turpel-Lafond, 2020 & Wylie & McConkey, 2018). This was confirmed by the primary data gathered in this study as most of the participants spoke to instances of profiling and "painting all Indigenous People and women with the same brush," which led to providers making ill-informed medical decisions, causing not only sub-standard care and misdiagnoses but, in some cases, lifelong health impacts. This confirmation was not unexpected because, as previously mentioned, much of the literature that discusses Indigenous People's experiences accessing healthcare enforces the disadvantaged state many Indigenous people face when accessing. What is significant is not what generalizations were being made but that they continue to be made by healthcare providers, consciously or subconsciously. It was understood that the generalizing and profiling that the participants experienced stemmed from ignorance or lack of knowledge on behalf of the providers. As such, providers would generalize an entire group under the same definitions and apply that to each person within that group. This demonstrates that there is still a substantial gap in what is currently understood about Indigenous Peoples, culture, and history within the healthcare system and arguably within society in general. This gap must be addressed to cease gathering Indigenous women under the same umbrella. It also stands to reason why many participants preferred accessing alternative approaches to the mainstream system as they proved their willingness to provide the time and care it takes to understand and appreciate a person's uniqueness while demonstrating their openness to understanding new beliefs and approaches to health and wellness.

In keeping with the literature on the concept, participants' experiences supported the notion of the mainstream healthcare system being unwelcoming and inflexible to Indigenous forms of healing (IRSHDC, 2021; Loppie et al., 2014; Turpel-Lafond, 2020 & Wylie & McConkey, 2018). Further, participants supported the literature's interpretation of Indigenous medicines and healing practices often devalued by the mainstream system. They shared instances of providers unwilling to collaborate with wellness approaches that fell outside the Western realm of comfort and expertise.

Behaviours

The data analysis supported the notion of exclusionary practices acting as a barrier to adequate healthcare for Indigenous Peoples. The spectrum of experiences expressed by the participants demonstrated instances of outright denial of care to dismissive microaggressions by providers. This is significant because the literature indicates that Indigenous folks, particularly women, are treated for diseases and conditions at later stages of diagnosis (Vlassoff, 2007). However, from the stories shared by participants, this could be partly because of the dismissive behaviours that Indigenous women consistently meet with when they disclose their medical concerns to physicians. Even if the reluctance to seek care from the mainstream system was decreased among Indigenous folks, if providers do not believe and validate their concerns, diagnoses will continue to be missed, causing later-stage awareness of severe health conditions.

An unexpected outcome that aligns with the theme of racialized discrimination was the notion of presented identity as an Indigenous woman and positive profiling. Participants who self-identified as "white-passing" shared how their given identity affected the care they received when interacting with the healthcare system. One participant explained how providers' attitudes and treatment only changed after she disclosed her Indigenous identity. Another reflected on how she believes her care and treatment are equitable and safe because she does not present or "look Indigenous." This is significant because it indicates a potential trend of Indigenous women receiving more suitable and respectful care based on their physical appearance and how their Indigeneity is outwardly presented and perceived. This may indicate that the discrimination faced by Indigenous women is not about being Indigenous but about looking Indigenous. As this study stated, a race-based discriminatory response was triggered when certain providers became aware of a participant's Indigeneity. This demonstrates the necessity of a greater understanding and appreciation for Indigeneity and Indigenous beliefs and values throughout healthcare systems and our societies. Further, there is a strong indication of the progress necessary for healthcare institutions to develop and uphold more antiracist practices and policies that address systemic racism.

Indigenous-specific Gendered Racism

The literature spoke to the concept of Indigenous-specific gendered racism, racism explicitly experienced by Indigenous women and other women-identifying individuals, and how it manifests as a barrier to accessing healthcare. Various reasonings were provided throughout the literature about why Indigenous women bear the burden of racist encounters compared to their male counterparts. These reasons included the fact that women inherently interact with the healthcare system and providers in regularly intimate ways, along with the experience of receiving misogynistic or gender-based stereotypes from providers. The literature concluded that Indigenous women commonly discontinue necessary treatments or avoid care entirely (IRSHDC, 2021; Kurtz et al., 2013 & Turpel-Lafond, 2020).

The findings of this study directly support the literature's interpretations of how Indigenous-specific gendered racism affects Indigenous women’s access to healthcare (IRSHDC, 2021; Loppie et al., 2014 & Turpel-Lafond, 2020). In addition, the analysis demonstrated this concept's implications on Indigenous women’s decision to access care in the future. It appeared that participants avoided specific providers and facilities after experiencing gender-based stereotyping because they felt their truth was being predominated by a narrative based on harmful stereotypes, causing the care they needed to be sacrificed. In cases where gender-based discrimination occurred, participants expressed how the providers' focus would shift from the current needs of the participant to addressing the stereotypical narratives about Indigenous women. This often led to the individual not getting the care they needed as the providers' attention was elsewhere. This is significant because it demonstrates that even when Indigenous women access healthcare, the harmful stereotypes society has constructed about them bar them from receiving the attention and effort from providers they need and deserve. As one of the participants said, “If any Indigenous woman walks into a hospital, they (providers) automatically assume that [we] were abused.” These automatic generalizations are incredibly harmful to the care Indigenous women receive and the women themselves.

Further, the findings revealed that experiences with gender-based discrimination often led to women discontinuing or avoiding seeking care entirely, directly supporting the literature’s interpretation (IRSHDC, 2021; Kurtz et al., 2013 & Turpel-Lafond, 2020). As such, the analysis has strengthened the current literature by amplifying the voices of Indigenous women specifically. Overall, the existing literature presents a gap as studies about Indigenous people accessing healthcare do not specifically focus on the experiences of Indigenous women. These answers, therefore, make that gap a fragment smaller.

Geographical Limitations & Structural Exclusion

As the findings indicated, geographical limitations were spoken to less than the other prominent themes, consequently establishing their dominance in the discussion. However, this concept was central within the literature reviewed and informed the conceptual framework and the interview questions. The findings from the primary research shone a different light on this aspect of Indigenous women’s experience when accessing healthcare compared to the literature. The literature consistently considered geographical limitations a primary barrier for Indigenous people accessing healthcare (Burnett et al., 2020; Loppie et al., 2014; Nelson et al., 2018 &Turpel-Lafond, 2020). This interpretation was deficient for multiple reasons. This interpretation was based on Indigenous people and did not specifically consider Indigenous women’s position.

Further, the literature demonstrates how geographical limitations created physical barriers for Indigenous people but lacks information regarding how these barriers made the respondents feel. The analysis indicated that what was essential to these women was how they felt when accessing care, whether in their community or outside; what was common among them all was that they prioritized safety and respect. This added a layer of complexity to the pre-existing literature's interpretation of this barrier as it appears to no longer be an issue of simply impeding physical access. As one of the participants noted, there was only one hospital near them that they could access due to their geographical location, which presented an initial geographical limitation. However, this hospital was catholic and showed deep colonial roots in its practices and policies. As such, this added a barrier as the participant had to travel to another facility because they felt unsafe visiting a facility with evident colonial roots. Again, the literature only briefly discussed the need to travel to specific locations to access necessary treatment (Muller, 2022).

This concept's prominence within the current literature caused it to be included in the conceptual framework. However, what was unexpected about this concept was the minimal attention it received from the participants. Most participants made a point of mentioning their ability to physically access care when they needed to. There was minimal discussion of how wait times or the strained healthcare system affected their decision to access care. What was spoken of, as previously discussed, was how their inevitable visits made them feel and how those experiences affected their decisions regarding their healthcare moving forward. When developing the conceptual framework that guided the development of the interview questions, assumptions were made about what the answers might look like for each of these questions. Given the state of B.C.'s healthcare system and how overworked providers and staff are, it was assumed that more focus would be placed on the ability to see a physician or schedule an appointment. When considering this, after working to position myself where I feel I can make an educated assessment as to why this might be the case, I believe it once again solidifies what is most important to these women when accessing healthcare. This finding was interpreted to mean that what is vital is how these women were made to feel when accessing care, more so than wait times and distance travelled.

Finally, the concept of structural exclusion received inconsistent consideration within the data collected as it did within the pre-existing literature (Loppie et al., 2014; Loppie-Reading & Wien, 2009 & Muller, 2022). Structural exclusion displayed itself when participants considered their current access to traditional knowledge and ways of healing. Participants spoke to the effect that displacement or structural exclusion had on Indigenous folks being able to access the resources they need to treat themselves in ways that align with their beliefs and ways of being, a finding minimally supported by the literature (Loppie-Reading & Wien, 2009). This was understood as a direct impact of structural exclusion on the preservation and prosperity of Indigenous knowledge and Peoples. It demonstrates the lasting effect of structural exclusion influenced by settler colonialism on Indigenous Peoples' lives and healthcare decisions. This finding was understood as a harmonizing indication of the disconnection many participants feel towards the mainstream healthcare system as their connection to their traditional land and knowledge has been and continues to be removed. In addition, this demonstrates the intersection between settler colonialism and structural exclusion. Settler colonialism forcibly removed Indigenous Peoples from their land, their primary source of wellness. As the prosperity of Indigenous populations heavily relied on their connection and proximity to their land, settlers recognized this. They made efforts to exclude Indigenous Peoples by removing them from their land. Consequently, these deliberate actions of assimilation increased the vitality of the settlers while decreasing the dynamism of Indigenous Peoples. The effects of structural exclusion imposed by colonial settlers are felt today through the displacement that many Indigenous Peoples, including participants of this study, experience regarding their connection to land and traditional knowledge.

New Growth in the Field of Knowledge and Unforeseen Breakthroughs

Connection

The literature briefly discussed how relational connections are essential to attaining meaningful and safe healthcare interactions for Indigenous Peoples (Katz et al., 2017 & Hill, 2014). However, this concept was only focused on within the literature that was part of the supplementary review to achieve a greater understanding of Indigenous perspectives on health and wellness and was therefore not included in the development of the conceptual framework or interview questions. With that, it is essential to note that the concepts of relationality and connection were lacking from the pieces of literature upon which the conceptual framework was based. Therefore, the initial understanding of this phenomenon was incomplete. The emergent findings from the primary research are significant as they assist in filling in the gaps in the current literature.

As mentioned in the previous chapter, connection is a significant concept within Indigenous epistemologies, as there is a common belief that everything in the universe is connected from one person to another (Joseph, 2020). For most participants, the relational connection, or lack thereof, between patient and provider profoundly affected their decision-making processes regarding access to healthcare. Participants expressed discomfort and misalignment during healthcare interactions without a relational connection. However, the low rates of patient-provider attachment among Indigenous Peoples were discussed in the literature and interpreted as a consequence of the multiple barriers impeding access to healthcare for Indigenous Peoples (Turpel-Lafond, 2020 & Wylie & McConkey, 2018). Among the obstacles discussed, the need for more connection or relationality between patient and provider was not one of them. Therefore, an interpretation of how vital a feeling of connection is for Indigenous women in their decision-making process was not provided. The need for acknowledgement and understanding given to the concept of connection and relationality within the established literature might demonstrate the disconnection between those conducting the research and those contributing to its results and knowledge generation. Without an initial understanding of how fundamental the concept of connection is within Indigenous culture and knowledge systems, scholars might not recognize the importance of findings that support it and, therefore, neglect to discuss it.

It was indicated that connection with providers and a sense of connection to the system through which participants access care affected their decisions. The conclusions drawn from the participant’s stories strongly indicated how having an established relational relationship with their providers allowed them to feel safe when accessing care and encouraged them to seek preventive/continuous care when needed. Further, the findings suggested that the lack of connection that Indigenous Peoples feel towards the mainstream system affects how they access healthcare as it often does not align with their personal beliefs, i.e., a holistic approach to wellness. The participants expressed how difficult it is to receive complete or adequate care without a relational connection to the system through which they receive care and its providers.

Finally, in alignment with the theme of connection, discoveries were made regarding the synergy, or lack thereof, between the current healthcare systems. This concept was not spoken of in the literature; however, our primary research indicated that the need for more connection amongst the healthcare systems was viewed as a contributing barrier to Indigenous people accessing adequate healthcare. The data analysis revealed that disconnection allows Indigenous folks to “fall through the cracks” of the system more regularly. The frequency to which Indigenous folks are forgotten or neglected was deemed as an influencing factor in Indigenous women’s decision-making. This paper suggests that if someone felt that a system repeatedly disregarded them, their likelihood of returning to that system, even when needed, was low. It was understood that the probability is lower than someone who felt seen and cared for by the system.

An unanticipated outcome was the frequency to which this relational connection was fostered between the Indigenous participants and a non-Indigenous provider. While participants did speak to their higher level of comfort accessing care from Indigenous providers or Indigenous lead health clinics, the outcomes from the analysis nonetheless demonstrated the potential for the foundation of a relational connection to be formed with a non-Indigenous provider. This is incredibly significant as it exhibits a strength-based finding that helps diminish the “us versus them” mentality between Indigenous and non-Indigenous folks (Loppie et al., 2014, p. 2). This study intended to highlight the strengths and weaknesses of the current system. It could be argued that the ability to foster connections between patients and providers is a growing strength that can improve Indigenous women's experiences when interacting with the mainstream healthcare system if it is given the attention, priority, and resources it requires.

Advocacy

While the literature spoke to the reality of Indigenous women being the social fabric of their families and communities and often the decision-makers regarding the health and wellness of their families (IRSHDC, 2021, & Kurtz et al., 2013), the notion of advocacy and having to fight for the care that they deserve persistently, was not explored nor given the attention it justifies. The participants spoke about the prevalence of advocacy when accessing care. Many expressed how they have had to advocate for safe and respectful care that aligns with their beliefs and for their truth to be heard and honoured. The participants of this study expressed the reality of having to do this for themselves and others. The participants noted that a lack of advocacy or an inability to insistently fight for the care they deserve commonly leads to substandard and unsafe care being administered.

The argument could be made that this was revealed because the data was collected directly from those who have experienced this phenomenon. This means that the analysis could appreciate these women's authentic perspectives and lived experiences, how their experiences affect their decisions, and the implications that follow. An interpretation of how consistently and unrelentingly Indigenous women must advocate for the care they and others deserve may not have been shown in past literature as the opportunity for Indigenous women to openly share their experiences when interacting with the healthcare system was not provided to them in the way that this research aimed to do. Therefore, past inquiries may have prevented these discoveries from emerging. These women's real and raw voices are necessary to understand the literal or metaphorical walls they face when accessing healthcare.

Also, these findings are significant due to their contribution to the current field of knowledge about Indigenous women’s experiences when accessing healthcare in B.C. They highlight not only the perpetual barriers between Indigenous women and safe and respectful healthcare that aligns with their beliefs, but they also capture the perseverance that Indigenous women embody for themselves, their families, and their communities. This is something the pre-existing literature did not adequately address. This notion was briefly mentioned by Wylie and McConkey (2018) but once again was not elaborated on, and therefore its implications were not fully discussed. Wylie and McConkey noted, "Some patients avoid services altogether, while others prepare to be mistreated by health care providers before accessing services” (2018, p. 38). This nuance of the experiences of Indigenous people, let alone women and other women-identifying folks when accessing healthcare, was spoken to by one of the participants of this study. She shared how the baseline expectation that most Indigenous women have when accessing healthcare is already relatively low, which causes the reception of even average care or urgent attention to be unanticipated. This was interpreted as another example where Indigenous women must preserve past their realistic fears and worries of being mistreated to receive the healthcare they rightfully deserve.

This finding sheds new light on the phenomenon being studied, as previous literature scarcely scratched the surface. This research uncovered how these women's experiences have made them feel and how that affects their decisions to access healthcare moving forward. In this case, this was interpreted to mean that when an Indigenous woman enters a healthcare interaction with the expectation of being mistreated, with the feeling of being treated as less than and then mistreated, that feeling is perpetuated and continues to live within them. One of the participants spoke about the multiple instances where providers would not believe her and made her feel like what she was feeling was irrational. She shared how constantly being told she was “crazy” made her start to feel that way; she began to internalize it. Suppose Indigenous women are met continuously with care that makes them feel less than others. In that case, I think it could be anticipated that those feelings would begin to spread to other areas of their lives and continue to divide the experiences of Indigenous from non-Indigenous folks.

These outcomes were revealed because this exploration was designed to be human-centred and bring a tangible understanding to this issue. Understanding how these experiences have made these women feel allows the reader to understand this issue on a human level and develop genuine empathy for those who live these experiences daily.

Self-determination and decision-making through body autonomy

Only a few pieces of the literature discussed the theme of self-determination and decision-making (Loppie et al., 2014; Loppie-Reading & Wien, 2009 & Turpel-Lafond, 2020); however, the discussion primarily focused on providing historical context with little attention given to its connection to body autonomy and increased health outcomes. The findings indicated that these concepts play considerable roles in Indigenous women's decisions to access healthcare. When the participants could decide on the specifics of their care, they had positive experiences accessing healthcare. The analysis indicates the opposite: when participants felt their autonomy over their bodies and their decisions were lacking or threatened, they had negative experiences with the healthcare system.

These interpretations are significant because they demonstrate how advancing self-determination and decision-making, including body autonomy, is vital to improving the treatment, care and prosperity of Indigenous women and their families. As the findings indicate, the involvement of Indigenous women in decision-making regarding healthcare positively contributes to their body autonomy and overall experience when accessing healthcare.

These conclusions have an additional meaning due to their connection to settler colonialism, specifically, discriminatory legislation such as the Indian Act (1985), which states that Indigenous Peoples do not have the capacity or autonomy to take of themselves or their children, leading to forcible removal and mass assimilation. Self-determination and decision-making regarding healthcare and body autonomy are deeply connected to the sovereignty of Indigenous Peoples and their land. A commonly shared belief amongst Indigenous culture is the connection, respect, and responsibility that Indigenous Peoples have towards land. This is an essential aspect of their ways of being. Throughout the decades of colonization, however, Indigenous Peoples have been forcibly removed from their traditional lands, cultures, and knowledge, and settlers destroyed their respect and responsibility for their lands and each other. The assimilation efforts of settlers made it so that the bodies of Indigenous Peoples, primarily women and girls, were forcibly regulated at the cost of their autonomy over their bodies and decision-making (Wilson, 2015). This connection between sovereign land and sovereign bodies, which Dr. Wilson claims are inseparable from one another, is demonstrated through the analysis as participants expressed how they felt a lack of autonomy over their bodies and decisions regarding their treatment when interacting with the mainstream (Western) healthcare system. Participants who utilized alternative approaches never mentioned a feeling of diminishing autonomy; inductions drawn from the participants' stories suggested it to be the opposite.

Finally, this is significant because it demonstrates the need for healthcare providers to understand Indigenous history and Indigeneity at large. Without an understanding of Indigenous history and the history of settler colonialism and its lasting impacts, it could be argued that it might be more commonplace for providers to conduct themselves without being fully aware of how their actions are perceived and deeply felt by Indigenous women. Healthcare providers might not be able to recognize how Indigenous women interpret their actions because they do not understand or are ignorant of these women's realities. When writing these findings, a conscious effort was made not to speak for the women who participated so what was put forward could be considered well-informed interpretations free of researcher bias. There is a deep connection between the lasting impacts of settler colonialism and how Indigenous women might feel when interacting with a care provider who does not understand how those impacts manifest. There has been so much taken from Indigenous women that their autonomy over their decisions and their bodies is paramount, perhaps more than someone who has not experienced this kind of assault. Therefore, it could be argued that when an Indigenous woman's autonomy, body or otherwise, is threatened or not thoughtfully considered by providers, it can create a very unsafe environment for them and further contributes to the barriers they face when accessing healthcare.

The design and the methodologies behind this paper allowed for findings like this to be amplified. This study was focused on understanding how the experiences of Indigenous women affected their decisions to access healthcare. With that, the interview questions were engineered in a way that focused on teasing out instances of lived experiences. Recognizing the connection between settler colonialism, self-determination, and the experiences of Indigenous women when interacting with the healthcare system might only have been possible because the design focused on understanding the lived experiences of human existence.

Additionally, the point could be made that this study was able to reveal these meaningful conclusions because the research team went into this exploration informed not only on the conceptual components that lend themselves to the phenomenon being studied but also understood what was important to Indigenous people when they are involved in academic inquiries. I was not searching throughout the women's stories to find excerpts that supported the theme of self-determination and body autonomy; however, because I was very aware of those concepts before speaking with the women, they were much easier to identify and impossible to neglect. Therefore, this analysis has reinforced and strengthened the findings of previous literature while demonstrating new understandings of this phenomenon.

Wise Practices and Ways Forward

The suggested practices and ways forward have been based on the findings from question four of the interviews, which directly asked participants what they think could be improved within the current healthcare system to provide safe and suitable care for Indigenous women based on their experiences. This question was essential as recommendations involving Indigenous Peoples should be made with their direct involvement.

Findings from this question indicated that provider-based improvements centred around increasing the cultural competence of providers, which to the participants meant developing a genuine sense of care, connection, understanding, and empathy for Indigenous women. Findings contributing to system-based improvements indicated the need for shared acceptance and increased presence of Indigeneity within the current system. The findings also denoted the collective importance of understanding and upholding self-determination throughout the healthcare system by honouring the inherent rights of Indigenous Peoples regarding health and wellness decisions.

For Healthcare Providers

As this study aims to reduce the generalization in our society, it is imperative to note that not every healthcare provider lacks empathy, understanding, or cultural competency skills. However, there are always ways to improve and grow, no matter where someone may fall on the spectrum of these attributes. With that, there was a collective opinion among the participants that healthcare providers could improve their cultural competency by committing to fostering genuine trust-based relationships with patients and by demonstrating an understanding and acceptance of Indigeneity.

This research recommends:

- Entering patient-provider interactions with compassion, understanding, and openness.
- Addressing internal biases that one might have and reflecting on how preconceptions might impact professional relationships with patients.
- Being open to new perspectives that might fall outside one's personal beliefs or professional expertise.
- Recognizing and understanding that Indigenous Peoples and communities are not homogenous and taking the time to learn about the uniqueness of each patient. Recognize, embrace, and honour differences.
- Accepting and encouraging collaboration with alternative approaches to health and wellness by embodying a two-eyed approach.
- Recognizing the time required to build trust-based relationships with patients and the impact those have on the health outcomes of many Indigenous women seeking care.
- Understanding and being sympathetic to the effects of historical, intergenerational, collective, and individual trauma on individuals and how it manifests in patient's behaviours and decisions.
- Prioritizing individualized care that aligns with the patient's values, beliefs, and needs.

For Healthcare Institutions

The mainstream healthcare systems need to implement policies and practices that make space for alternative knowledge systems and approaches regarding health and wellness. This could include;

- Incorporating Indigenous beliefs and approaches in training materials for all staff to develop a baseline understanding of Indigenous culture and history.

- Implementing changes in the development of healthcare facilities ensures that alternative forms of care are in the vicinity.
- Ensuring support for ceremony and other cultural practices vital to the prosperity of Indigenous Peoples' health and wellness.
- Creating dedicated spaces where Indigenous practices can be conducted safely without fear of judgment or mistreatment.
- Establishing security and funding for Indigenous knowledge keepers within the mainstream system.
- Creating a cultural shift within the healthcare system by moving away from normalizing colonial practices that reinforce the inferiority of Indigenous peoples and traditions (Wylie & McConkey, 2018).

The mainstream healthcare systems need to understand the inherent rights of Indigenous Peoples and how those rights relate to their health and wellness. This could include;

- Handing back power to Indigenous Peoples to be fully in charge of their health and healthcare decisions.
- Understanding the role and responsibility of healthcare systems in the national action plan for protecting Indigenous women, girls, and 2SLGBTQQIA+ people and how improving healthcare outcomes is essential to achieving the Calls to Action.
- Recognizing the inherent rights of Indigenous Peoples publicly and openly by all levels of government.

The mainstream healthcare systems need to incorporate a more significant presence of Indigenous folks working within the system as providers or advocates to improve the care and safety of Indigenous women.

This research recommends:

- Increasing the number of Indigenous navigators and advocates in the current system.
- Increasing protection for Indigenous individuals who currently work in the system.
- Collaborating with First Nations governing bodies and Indigenous health authorities in B.C. to develop programs that increase the inclusion and retention of Indigenous representatives and advocates.
- Strengthening all levels of education curricula to include information about the importance of increasing the presence of Indigenous health practitioners and medical staff within the current healthcare system.

Finally, the mainstream system must collaborate with other healthcare authorities to increase connection and cohesion.

Answering the Research Question

To recall, the research question explored was: *How do Indigenous women in B.C. experience barriers to accessing healthcare services, and how do their experiences influence their future decisions regarding continuing to access care from mainstream systems?*

Entering this research, the conceptual framework was the primary understanding of the factors that affect Indigenous women's decision to access healthcare services in B.C. Asking this research question allowed this research to uncover whether the concepts found in the previous literature created a complete picture of those influencing factors or if there were knowledge gaps that this research could inform by speaking with Indigenous women in a very in-depth and personal manner. The research team found that the understanding entered into the study was incomplete, as other factors presented themselves once conversations were had with Indigenous women about their firsthand experiences.

The answer to the research question is that multiple factors influence Indigenous women’s decision to access healthcare. Like the literature, this research indicated that experiences of racialized discrimination strongly influenced Indigenous women's decision to access healthcare. These experiences often lead to hesitancy when needing care or a purposeful delay in accessing care until absolutely necessary. The literature confirmed this and considered it a significant factor affecting Indigenous women’s decision to access care.

Further, it appears that a factor affecting Indigenous women’s decision-making regarding their healthcare was having their truths predominated by narratives based on harmful gender-based stereotypes. Such experiences often lead women to avoid specific providers and facilities, affecting their decision-making and limiting their access to equitable healthcare.

Additionally, it was found that participants preferred to use alternative approaches to health and wellness before accessing the mainstream healthcare system, which presented itself as a factor that influenced Indigenous women's decision to access healthcare. It appeared that preference was given to alternative approaches as they hold space for Indigenous beliefs and knowledge while also providing the time and care it takes to formulate a relational connection between patient and provider. As such, this finding was deemed a significant factor that affected Indigenous women's decision to access healthcare in B.C.

Another factor that appeared to affect the decision-making of the Indigenous women who contributed to this study was the effects that displacement or structural exclusion has on Indigenous folks’ ability to access the traditional knowledge and resources needed to treat themselves in ways that align with their personal and cultural beliefs. Having been forcibly removed from their traditional knowledge and resources, the decisions made by many Indigenous people are not aligned with their values and beliefs, consequently drawing them further and further from their traditional heritage.

The above presents the answers to the research question that were anticipated due to the existing literature. The following are the answers to the research question that indicated gaps in the current literature that this research has begun to uncover and therefore contributed to the current field of knowledge along with the profession of public administration.

This study indicated that the relational connection, or lack thereof, between patient and provider, profoundly affected the decision-making process for most women who participated in this research. The findings strongly indicated that having an established relational connection with their provider positively influenced their decision to access care. The women said that these relationships allowed them to feel safe and encouraged them to seek preventive/continuous care rather than discourage them. Further, the conclusions signified that many participants' lack of connection to the current healthcare system affects their decision to access care. They often feel misaligned with current practices, policies, and providers. As such, participants expressed how they commonly decide to prioritize alternative approaches over the mainstream system.

Ultimately, the disconnection within the current healthcare systems was interpreted to be a contributing factor affecting Indigenous women's decision-making processes. Participants spoke about the existent disconnection causing Indigenous Peoples to fall through the cracks. It was understood that if one regularly experienced the feeling of neglect or disregard from the system they were attempting to seek care from, their decision to seek care in the future may be tainted by these negative interactions.

The findings of this research demonstrated the perseverance that many Indigenous women need to embody for themselves and, at times, for others to continue to fight for equitable care. This finding answered the research question differently than others might have, as the direct effect of needing to advocate for oneself persistently was not addressed directly by the participants but rather interpreted throughout the analysis process. The findings indicated that many Indigenous women expect to be mistreated when entering a healthcare interaction. It was presumed that if they were met with mistreatment or a feeling of being treated as less, then the possibility that this feeling could be perpetuated through other areas of their lives may increase. These feelings may be internalized, and the individual may begin to believe them as the truth. In a way, this finding answers the research question by demonstrating the effects that the mistreatment, judgment, and discrimination that occurs within the healthcare system for Indigenous women can have on them. If these women begin to internalize the injustice they face, they may not only discontinue care because they feel like no one will believe them or care but because they start to believe what they have been told and feel they do not deserve the care they need. This demonstrates the immense impact our words, interactions, and microaggressions can have on people, especially those who are members of visible minorities.

Finally, the findings indicated the importance of enhancing self-determination and decision-making for Indigenous women as they expressed having more positive experiences when they had the equal opportunity to make decisions about their care and, most notably, the treatment of their person. As there is a proposed correlation between having positive experiences and continuing to seek care, the advancement of self-determination could influence Indigenous women's decisions regarding their healthcare. This effect was primarily seen in the decision to access alternative approaches before accessing care from the mainstream system.

Limitations and Future Research

The data collected for this research was from a relatively small sample of participants with unique characteristics. As such, the new understanding of this issue cannot be generalized to the broader population. However, the objective of this study was not to generalize the findings to broader populations but rather be able to understand the unique situations that Indigenous women face when accessing healthcare in B.C. and transfer these findings to similar problems. In addition, the validity of this study was not solely measured by Western metrics but was also determined by Indigenous methodologies of relational accountability. By recognizing my relational responsibility to each participant and their relations, I could accurately and honestly present the findings in a way that upholds the validity of their experiences and truths. The present sample size was sufficient for this research and the chosen methodologies, especially considering the constraints on obtaining research contributors such as physical time and emotional energy. When designing this study, the research team was mindful of the possibility of participation fatigue due to the level of engagement currently being asked of Indigenous Peoples. Therefore, these considerations were accommodated into the design and participation parameters by requesting one in-depth interview.

As previously addressed in the methods and methodologies chapter, a phenomenological research approach may present limitations by way of researcher-induced biases influencing the study's outcome (Charlick et al., 2016). This limitation was addressed early in the research design, and steps were taken to mitigate the potential impacts of this limitation adequately. By reflecting on my positionality in this research, I remained deeply aware of how my personal biases and preconceptions could guide the analysis of this study. By keeping a bracketing journal, drafting a reflection piece, and continuously engaging in reflective dialogue with my supervisor, the research team is confident that the findings of this research are based on the emergent themes identified from the participants' stories and experiences and have not been influenced by personal biases.

As the *In Plain Sight* report illustrates, “Despite progress and efforts made, the current healthcare system continues to reflect the legacy of colonialism” (Turpel-Lafond, 2020, p. 181). Making cultural competency courses mandatory for healthcare providers is not the sole solution to solving this problem. Based on this research, it is proposed that the answer to this problem is revitalizing the connection between human beings. Without connection and understanding one another, it is easy to judge; it is easy not to care, discriminate, and even hate. However, once a relationship is fostered, judgment often dissipates and makes space for understanding and openness. We have lost our sense of connection to one another. With that, for future research, there needs to be a focus placed on how we can revitalize this connection because without it, no matter how many courses and seminars we take on these concepts, the realities of those affected by these issues are lost. It is suggested that future research probe how institutions can create and maintain cultures and environments based on connection, relational accountability, understanding, and compassion.

Summary and Revisiting the Conceptual Framework

As demonstrated, the review of relevant literature supported the development of the conceptual framework. As such, the conceptual framework that informed the basic understanding of the phenomenon being studied was adequate when analyzing that perspective. The conceptual framework proved inadequate at the data collection and analysis stage. The conceptual framework required more substance as it displayed a surface-level understanding of the issue. While it did focus on genuine problems like experiences of racialized discrimination, the lasting impacts of colonialism, and Indigenous-specific gendered racism, an understanding of how those concepts manifest in the realities of Indigenous women was not grasped until the data collection and analysis began. Once new themes were uncovered, such as advocacy through the persistence and perseverance that many Indigenous women must embody to receive equitable care and the lack of connection that many Indigenous women feel towards the mainstream system and providers, a much deeper and tangible understanding of the issue was unlocked. Therefore, this new understanding created an additional perspective through which this issue could be viewed. As such, a complementary conceptual framework was designed to include the emergent findings and paint a more complete picture of the phenomenon being studied.

Conclusively, how this study approached understanding the phenomenon of access to healthcare for Indigenous women appeared to reveal new perspectives. The intention to appreciate, articulate, and amplify the experiences of Indigenous women to understand further what factors affected Indigenous women's decision-making when accessing healthcare was achieved. The partially inadequate conceptual framework is justified because there can only be an understanding of what those factors might be once Indigenous women have been consulted. This study strived to reduce the amount of generalization that figures prominently in most of the historical and current literature regarding Indigenous Peoples. As such, the findings from this study cannot be generalized to all Indigenous women living in B.C. What this study can do and has done is present a more complete picture of Indigenous women’s realities so that readers can understand and appreciate their choices.

Figure 2

Complementary Conceptual Framework

Complementary Conceptual Framework Explanation

Once the data collection and analysis stages were completed, it became evident that this research had revealed new understandings of this issue that were not captured in the initial conceptual framework. The image of a tree inspired the complementary framework. The tree's roots in the model symbolize the “roots” of the problem or what was already known about this problem. Based on the discoveries made throughout this research and the previous understanding of this issue, the tree trunk represents what is necessary to help Indigenous women feel safe and supported when accessing provincially funded healthcare and to aid in advancing the self-determination of Indigenous Peoples in academia and the current healthcare system. The tree’s branches represent the significant findings from this research as they are considered “new growth” that can contribute to decolonizing the healthcare system and academic research. The two conceptual frameworks complement each other as they provide a more thorough understanding of Indigenous women’s decisions to access healthcare in B.C.

Chapter 7: Concluding Thoughts

This study sought to amplify Indigenous women's voices, allowing their stories and experiences to be heard. Further, by illuminating their experiences, this study will contribute to a deeper understanding of how Indigenous women living in B.C. move through the mainstream healthcare system and how their experiences affect their decisions.

Simultaneously, this study intended to communicate a more human-centred understanding of the issue of access to healthcare for Indigenous women in B.C. By doing so, readers have been provided not only a deeper understanding of the intricacy of this issue but also the tangible impacts of something as fundamental as accessing healthcare on Indigenous women's realities.

Addressing the Gap and Noting Unexpected Implications

When this research began, a gap in the current literature was identified. There was an evident lack of understanding regarding how disconnection and misalignment with the current system and providers affect Indigenous women's decision-making and how they access healthcare. The findings indicate how establishing relational connections with both providers and the method through which these women access care were both factors that affected the participants' decision to access care. There was a strong indication that establishing relational connections with providers allowed these women to feel safe and supported when accessing care. It empowered them to seek preventative and continuous care as desired. The findings indicated that profiling and stereotyping leading to sub-standard care were commonplace without connection.

In addition, the findings from this study suggested new interpretations of this phenomenon that were not included in the current literature. Specifically, the literature routinely spoke about the consequences of the multiple barriers Indigenous Peoples face when accessing healthcare; however, these interpretations often lacked how the obstacles made the respondents feel. For example, this study indicates that the issue of access to healthcare can no longer be classified as an issue of impeding physical access but now demonstrates an additional layer of complexity due to how past experiences make Indigenous women feel and how this contributes to their ability to access healthcare at the same frequency and ease that non-Indigenous folks do.

Further, the findings revealed the tenacity and determination that Indigenous women must embody to pursue care for themselves and others despite enduring negative experiences. Finally, this study demonstrated the inseparable connection between sovereign land and sovereign bodies and how the advancements of Indigenous Peoples' inherent rights through self-determination and decision-making are essential not only for the safety and sovereignty of Indigenous women and girls' bodies but for the preservation and prosperity of Indigenous Peoples at large.

By way of design, this research filled an additional gap in the current field of literature as the research team continuously demonstrated a commitment to upholding Indigenous data and representation principles. This study endeavoured to produce a piece of literature that served a collective benefit by presenting strength-based findings. Such findings focused on illuminating the strength and perseverance of Indigenous women and the potential for the mainstream system to administer complete care by broadly accepting alternatives and prioritizing relational connections with patients.

Conveying the Larger Significance

To this day, studies on this issue are being published without consideration for or incorporation of Indigenous data governance and representation principles. As explained previously, neglecting to honour Indigenous data governance principles harms Indigenous self-determination and sovereignty. Advancing Indigenous sovereignty and self-determination should be the primary goals of all research that involves Indigenous Peoples and their data. As such, this study offers an additional understanding of this topic, as continuous efforts have been made to uphold and employ these principles by ensuring that Indigenous data collected throughout this research is only used with the consent, inclusion, and knowledge of Indigenous Peoples.

This study advances past research because its findings indicate that misjudgements and mistreatment occur when relational connection is lost. Therefore, it is crucial to study this issue through a methodology that allows readers to understand individuals' experiences and those experiences through a humanistic lens. The humanistic approach within this research allows the reader to understand this issue and how it touches those affected. Most importantly, the approach compels readers to develop a genuine empathy for the Indigenous women who live these experiences, or similar ones, every day.

As mentioned in the introduction chapter, one of the goals of this research was to convey the individual experiences of Indigenous women when accessing healthcare rather than generalizing an entire population and reducing someone’s lived experiences to a statistic to be cited. This study has demonstrated how accessing healthcare impacts the individual realities of the Indigenous women who contributed to this research. By highlighting the distinct experiences of the participants, this study has effectively demonstrated the gravity of this issue while honouring the uniqueness of each women’s experience.

Research Implications

The design of this study has created an opportunity to examine implications for future research. As the consequences of conducting research outside of Indigenous data and representation principles have been thoroughly discussed throughout this study, subsequent research on this topic or any research that involves Indigenous Peoples requires a deep appreciation and application of Indigenous data and representation principles. In addition, successive research needs to be grounded in the four R’s of Indigenous research. By doing so, researchers and their teams can add to the field of knowledge in ways relevant to the affected Indigenous communities. They also respect Indigenous values and foster reciprocal and relational connections between those contributing to the research and those drafting it. In this way, academia can work towards reconciling with Indigenous Peoples by demonstrating genuine efforts to advance self-determination and sovereignty through data governance and research design.

Strategic Implications

The study's findings relating to the participants' preference and use of alternative approaches to health and wellness could inspire policy changes that sanction increased funding to such practices and practitioners. In addition, provincial healthcare coverage could be expanded to cover the services of alternative approaches to ensure that their use becomes and remains more accessible for Indigenous folks, regardless of this status. Findings from this research indicated that while alternative methods to the mainstream system are preferred, accessing them can be difficult because they are often not covered by Plan W and other provincial healthcare coverage (British Columbia Government, 2023). Noted in the discussion chapter, incorporating alternative approaches to health and wellness provides the opportunity for a more well-rounded healthcare experience for all; therefore, increasing what is currently covered by provincial healthcare regarding alternative healthcare could benefit diverse groups of folks across B.C.

This finding could also encourage a change in practice regarding the infrastructure planning of hospitals and care centers. The discoveries demonstrated how proximity to alternatives was noted as an improvement that could be made to the current mainstream system. Future infrastructure planning could consider and incorporate space for alternative practitioners. This could include physical spaces for ceremonies and other spiritual practices to be conducted safely and without judgment. Further, future infrastructure planning and design should be in consultation with the Indigenous communities whose land the facility is resting on. This way, the specific needs of each Indigenous community could be considered, which hopefully would lead to a greater sense of belonging and safety when visiting care facilities.

Further, this study denoted the importance of a relational connection between patient and provider, especially for Indigenous women seeking more intimate care. Policies and practices that mandate specific intake procedures could be developed to help facilitate the creation of a relational connection. Findings from this study suggested that facilitating initial interviews between Indigenous patients and practitioners aided in developing a relational relationship. While participants recognized the strained state of the B.C. healthcare system, findings supported the shared experience of rushed interactions with providers. As such, a best practice could be to develop a policy that ensures practitioners spend a certain amount of time with each patient they see to help mitigate some of the rushed interactions that hinder the ability to build a trustworthy connection.

It is important to note that the strategic implications suggested above have been informed through the findings of this research. They have been inspired by the consistencies found throughout the participants' experiences and stories. While these implications are substantiated by evidence of this research, it is essential to remember that the findings cannot be generalized to the broader population; the same is true for the strategic implications. These implications would be an excellent foundation for future policy and practice changes after further consultation with Indigenous groups to ensure their specific and unique needs are met.

Areas for Future Research

This research has appeared to uncover information about this phenomenon that has been lacking from the current field of knowledge, i.e., how vital relational connection is to the health outcomes of Indigenous women and how the system itself is a source of limitation instead of what harmful societal stereotypes would have one belief effectively placing this onus on Indigenous women's choices. A founded suggestion could be that future research explores how relational connections can be fostered in a colonial-based healthcare system with strained resources and, therefore, limited time to foster these relationships.

Final Reflections

Before conducting this research, I knew very little about Indigenous methodologies and approaches to research. I soon learned that a cornerstone of those methodologies is relational accountability. Relational accountability contributes to the significance of this research outside of academia. While it was vitally important that this research honoured and employed Indigenous methodologies, relational accountability is significant because it is also a way of being. It is an understanding of the responsibilities and accountabilities we owe one another as humans living on this planet. Relational accountability recognizes that there is no hierarchy of humans. There is no superior or inferior way of living. Instead, mutual and reciprocal respect for one another grounds our actions, interactions, and relations. It could be argued that if there was a greater acknowledgment and commitment to the accountability that we owe to one another by recognizing that our actions and choices have consequences outside of our immediate realities, instances of inequity and discrimination would lessen because we would realize that how we decide to move through this world as individuals ultimately affects the collective. Being exposed to what relational accountability is and the impact that it could have on our society if it were unilaterally presumed and practiced is genuinely the larger significance of this study.

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Appendix A: Recruitment materials

A1: Outreach Poster

Exploring access to healthcare for Indigenous women

Study Description

We want to hear YOUR voice

We are researching how Indigenous women's **experiences** with the healthcare system affect their decision to access care.

We hope to **illuminate** the strengths and weaknesses of the current health system while **amplifying** Indigenous women's voices.

Interested in participating?
Please contact me at
[redacted]

Participation Options

30 min. one-on-one interview by zoom

Single-session focus group

$20 honorarium

to each participant who participates in an interview

Eligibility

You identify as Indigenous

You identify as a woman

You have lived and accessed healthcare in BC

Research team: Dr. Susanne Thiessen & Paige Smith, MPA student

A2: Initial communication

Hello, participant’s name,

Thank you so much for showing an interest in the research I am doing with Dr. Thiessen.
My name is Paige Smith, and I am a master’s student at the University of Victoria studying public administration.

I am connecting with you because you showed an interest in our study by “liking” our post. Would you be interested in participating in a one-on-one 30–60-minute interview with me? The interview and the study will focus on Indigenous women’s experiences accessing healthcare in British Columbia.

After the one-on-one interviews, there will also be an opportunity to participate in a small focus group.

Let me know if you would like to receive more information about our research, and I will send you additional information. Feel free to ask me any questions you have about our research as well.
Please let me know if you remain interested in participating.

Thank you so much for your time and consideration.

Kindly,
Paige

A3: Invitation to participant letter

Dear participant’s name,

Thank you for expressing interest in potentially participating in my research study. Your participation is incredibly valued.

Indigenous women have been disproportionately impacted by multiple barriers that have complicated or limited their healthcare access. The specific needs of Indigenous women have yet to be adequately and rightfully addressed, causing further obstacles to access and patient retention to develop. Indigenous women deserve to receive safe and suitable care; however, for this to happen, the voices of Indigenous women need to be amplified. Their experiences and stories need to be heard. With this, I invite you to share your experiences.

There are evident colonial roots in the Canadian healthcare system. The literature on access to health care for Indigenous Peoples, namely women, suggests that the colonial origins of the system are not the only variable contributing to the overall problem of lack of access. To work toward decolonizing the healthcare system, the truth must be heard. This research wishes to amplify your truth as an Indigenous woman and your experiences with the healthcare system in BC. Your truth has been silenced for too long; this research wants to change that.

For this reason, my study will explore how Indigenous women's experiences with the healthcare system have affected their decision to access or continue healthcare.

As mentioned in the initial posting, my name is Paige Smith, and I am conducting this study as a requirement for my master’s degree at the University of Victoria. I am a second-generation Canadian of European descent. I recognize that I am an uninvited outsider on these lands and that many of my identity factors symbolize the traumatic history of colonialism within this country. Recognizing this, I understand how essential it is to build trust and respect-based relationships with the potential participants of this study. With sensitivity and respect for the differences between Western and Indigenous knowledge systems and methods, I hope to bring an equal yet amplifying voice to your experiences and my research.

Again, your potential participation in this study is highly valued. **While participation is not paid, I acknowledge the value and contribution of Indigenous knowledge and will recognize your contribution with a gift.**

The main goal behind this research is to add to the path toward reconciliation. This research has the possible ability to not only bring awareness to your truth and lived experiences with the healthcare system as an Indigenous woman but also to inform non-Indigenous people and institutions about the steps that need to be taken to make Indigenous women feel safe, understood, and supported when accessing healthcare.

The individual interviews and single-session focus groups are scheduled from Monday, February 27th to Friday, April 28th. These dates are subject to change depending on participant availability. The interviews will take approximately 30-60 minutes and will be conducted virtually via Zoom. The focus group will take about one hour to complete. The focus group will be conducted virtually via Zoom. Your privacy and confidentiality will be kept at all stages of the research process. All requests for anonymity will be honoured and respected, as well as all requests to stop participating at any time throughout the study. You have the right not to share any information which you may find sensitive. Once the University of Victoria approves this study, you will receive an electronic copy of my thesis.

If you remain interested in sharing your insights and are available for an interview or focus group session, please get in touch with me via email [redacted] or [redacted]

Thank you once again for your consideration and openness.

With gratitude,
Paige Smith, MPA student

A4: Sample follow-up email to participants

Hello, participant’s name,

I hope this email finds you well. I wanted to connect with you again about the research study that Susanne and I are doing.

Would you still be interested in learning more about our study and potentially participating in an interview?

I would be happy to send you more information about our study. If you remain interested, please let me know, and we can set up a time to meet virtually.

If you are no longer interested, please let me know.

Thank you again for your consideration. I look forward to hearing from you.

Warmest regards,
Paige Smith

Appendix B: Consent Form

B1: Informed Consent Form for all participants

Introduction:

My name is Paige Smith, and I am a master's student at the University of Victoria. I am researching Indigenous women's experiences with the British Columbia (BC) healthcare system. This research aims to explore how experiences with the healthcare system influence Indigenous women's decision to access and continue to access care.
I am completing this research as part of my master's degree and inviting you to participate.

You are under no responsibility or duty to participate in this research. You are free to withdraw at any point of your involvement.

Activities:

If you participate in this research, you will be asked to:
1. Attend an informal, 30-minute interview with the researcher, me, either virtually or in person.
AND/OR
2. Attend a one-hour focus group session with five to seven other participants.
You can participate in both an individual interview and a single-session focus group.

Eligibility:

You are eligible to participate in this research if you:
1. Identify as an Indigenous woman.
2. Are between the ages of 18 – 55.
3. Have lived and had an experience with the healthcare system in BC.

You are not eligible to participate in this research if you:
1. Have only received healthcare from alternative sources.
2. Do not consent to have the audio of your participation in either the interview or focus group recorded.

I plan to include 6-10 participants in this research.

Risks:

There are minimal risks in this study. Some possible risks include sharing personal stories where experiences were negative or positive. To decrease the effect of these risks, you can stop participation at any time and refuse to answer any question(s) that are asked during the interview or focus group. I will also be under the supervision and guidance of my supervisor, Dr. Susanne Thiessen, an Indigenous woman and professor at the University of Victoria. I will work under her guidance throughout the entire project.

If, during or after your participation in this study, you require speaking to someone about your mental health or any emotional discomfort you may be feeling, Dr. Thiessen and I have developed a list of available resources. If necessary, these resources are available upon request.

Benefits:

If you decide to participate, the direct benefits are the opportunity to louden your voice and experiences in a safe and kind environment. The possible benefits to others are that the research may support improving the current healthcare system in understanding and

supporting Indigenous Peoples and practices. While your participation is not paid, I recognize the value of Indigenous knowledge and will recognize your contribution with a gift.

Confidentiality:

The information you provide will be confidential to the extent legally allowed. I will keep your identity confidential, including using a fake name, not a legal or chosen name, to identify you in the analysis and dissemination of this research. I will assign a fake name to any institution you might mention when answering questions and telling your story. I will secure your information by ensuring that all data collected is stored on my devices, to which only I have access. Your data will be encrypted and password-protected.

I will keep your data for three years. Then, I will delete all electronic data and destroy all paper data.

Use of your data:

Your data, the answers, and the stories you choose to share with me will only be used to disseminate this thesis.

After you have participated in an individual interview, focus group, or both, I will provide you with a summary of the answers offered and the conversations that took place to ensure that I have captured your valued contribution accurately. You can provide feedback to the summary should you feel adjustments are necessary.

Ongoing consent:

To ensure that I have your ongoing voluntary consent throughout the research process, I may need to contact you again after your participation has been completed. Please provide me with your preferred means of communication and the time and days of the week you prefer to be contacted. Please select and provide one or both:

Email: ____ Phone number: ___________________________________

What are your preferred times and days to be contacted through your preferred means of communication?
Please select one or all that apply:

Morning (8 am – 12 pm) Afternoon (12 pm – 5 pm) Evenings (5 pm – 7 pm)

Please select one or all that apply: Weekdays (Mon – Fri), Weekends (Sat-Sun)

Contact Information:

If you have questions, please contact me at [redacted]

My supervisor is Dr. Susanne Thiessen. She works at the University of Victoria and is supervising me on the research. If you have any questions about the scholarly aspects of the research or any other questions, you can contact her at [redacted]

You may verify the ethical approval of this study or raise any concerns you might have by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

For in-person Interviews:

Participants will be advised if they have or may have come into contact with an individual who has tested positive for COVID-19. Contact information for participants will be stored in a separate file from research data in the event that follow-up is needed.

Voluntary Participation:

Your participation is entirely voluntary, meaning that you choose to participate after understanding the purpose of the research and its possible risks and benefits as fully as reasonably possible.
If you wish to stop participation after you start, there will be no penalty to you. You will not lose any benefit to which you are otherwise entitled. If you wish to stop participating at any time, you can tell me, Paige Smith, in person or contact me via email at [redacted] or by phone at [redacted]

The same right to withdraw from participating in this study applies to whether you are participating in an individual interview or the focus group. Any data or information you have provided for the sake of this research up until your point of withdrawal will be destroyed and no longer used in this study's analysis and dissemination stages if you so choose.

If you withdraw from the individual interview, your data will not be used. If you withdraw from the focus group, your contributions will be summarized anonymously so that the conversational nature of the data can be retained.

Audiotaping:

I would like to use a voice recorder to record your responses. This is solely to analyze and disseminate data for the final paper. You cannot participate if you do not wish to be recorded. This data will also be protected on my devices and permanently destroyed from my belongings after three years.

If you decide to participate virtually in an individual interview or the virtually held focus group, then.

"Please be advised that this research study includes data storage in U.S.A. As such, there is a possibility that information about you that is gathered for this research study may be accessed without your knowledge or consent by the U.S. government, in compliance with the U.S. Freedom Act."
This is only a possibility because Zoom has data servers that can be in the U.S.

Please sign here if you consent to have your audio recorded:

Signature: _____________________

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

You will be given a copy of this form for your records.

Participant Signature: _____________ and Printed Name: _____________

Date:

Researcher's Signature: ____________ and Printed Name: ______________

Date:

Appendix C: Interview Questions

C1: Individual interview questions

Research question:
What factors affect Indigenous women’s decisions in accessing healthcare services in British Columbia?

Question 1:
Can you share any of your experiences with the healthcare system that you have personally accessed in B.C.?

Question 2:
Could you tell me how any of these experiences affected your decision to return or not return for care to that service provider?

Question 3:
Based on your experience(s), do you feel that you received the suitable or appropriate standard of care and treatment for the healthcare service that you were seeking?

- If not, can you share why you feel that way with me?
- If yes, could you share with me why you feel that way?

Question 4:
Based on what you have shared with me, what do you think could be improved?

Question 5:
Are there any alternatives to what is offered in B.C.’s healthcare system and its medicines, practices, and treatments that you access?

Question 6:
If yes, does access and/or the use of these alternatives e If yes, does access and/or the use of these alternatives affect your decision to access or return for care within B.C.’s healthcare system?

Appendix D: Resources for Participants

D1: Available resources for participants

Mental Health and Crisis Support Line
A crisis support service for Indigenous Persons provided by the Indian Residential School Survivors Society (IRSSS)
This service is:

- Free
- Confidential

Provides non-judgemental emotional support for Indigenous Peoples.
Call **604-985-4464** or the toll-free line at **1-800-721-0066.**
Service is available in English.

Resource from: https://victoria-southisland.pathwaysbc.ca/service_categories/13

Hope for Wellness Helpline - Online Counseling Service
The Hope for Wellness Help Line offers immediate mental health counselling and crisis intervention to all Indigenous peoples across Canada.
This free and confidential service provides non-judgemental emotional support for Indigenous Peoples 24 hours a day, seven days a week.
There are experienced and culturally competent Help Line counsellors who can help if an individual:

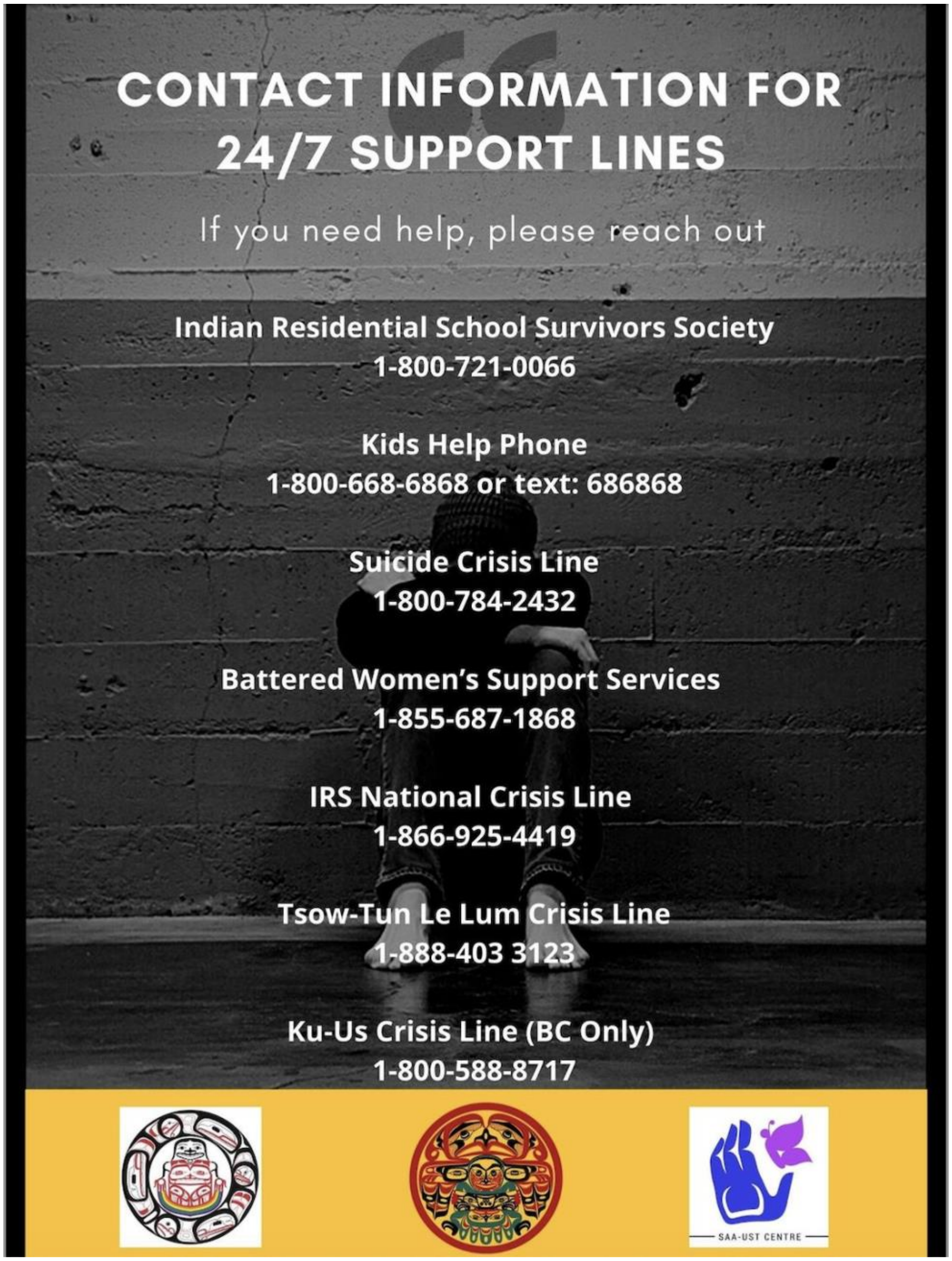
- wants to talk
- is feeling distressed
- have strong emotional reactions
- are triggered by painful memories

Call the toll-free Help Line at **1-855-242-3310**, 24 hours a day, seven days a week, or use the online chat box to connect with a counsellor online.

Resource from: https://victoria-southisland.pathwaysbc.ca/service_categories/13

Victoria Native Friendship Centre - Mental Health Liaison
The Mental Health Liaison assists individuals in connecting with appropriate resources and provides advocacy, support, and awareness on mental health issues.
Call: 250-384-3211 or email: shona@vnfc.ca

D2: Resource Brochure



CONTACT INFORMATION FOR 24/7 SUPPORT LINES

If you need help, please reach out

Indian Residential School Survivors Society
1-800-721-0066

Kids Help Phone
1-800-668-6868 or text: 686868

Suicide Crisis Line
1-800-784-2432

Battered Women's Support Services
1-855-687-1868

IRS National Crisis Line
1-866-925-4419

Tsow-Tun Le Lum Crisis Line
1-888-403 3123

Ku-Us Crisis Line (BC Only)
1-800-588-8717

SAA-UST CENTRE

Appendix E: Member Checking and Honorarium Communication

E1: Sample Email

Good morning, participant’s name,

I hope you are doing very well. I have attached a summary of our interview to this email. Within it, I have identified some emerging themes supported by the experiences you shared with me.

Please note that you are referred to in the summary as "participant" for confidentiality and anonymity reasons. And any mention of an institution has been replaced with a fictitious name for anonymity. Please let me know if anything else you would like anonymized is mentioned in the summary.

Once you have had a chance to read it, please let me know if there is anything you would like to change, edit, or add to this summary. If you are comfortable with this summary moving forward without changes, please let me know at your earliest convenience.

Also, let me know what you would like your honorarium gift to be.

Thank you again for sharing with me; your contribution is incredibly valuable and appreciated.

Kindly,
Paige

E2: Sample Email

Hi, participant’s name,

I hope you have been well since we last spoke.

I wanted to share my research findings and discussion chapters, which your valuable contributions helped develop.

If you have any questions or concerns about these chapters and their contents, please feel free to let me know. I will submit my thesis to the Faculty of Graduate Studies on Friday, November 3rd. At that point, I can no longer alter its contents.

Again, thank you for your vulnerability and willingness to share your stories and experiences with me. Without your contribution, this research and its future implications would not be possible.

With gratitude and warmth,
Paige

Appendix F: Bracketing Journal

Feb. 25, 2023

I am working on this paper's "importance of the study" section. Recently, I watched a TED Talk by Dr. Evan Adams on wellness and two-eyed seeing. In this video, Dr. Adams spoke to the dangers of generalizing a population and cited the populist notion of the "Indian problem." Unsure of what that referred to, I googled the term. I learned it was attributed to Duncan Campbell Scott of Indian Affairs in 1918. When I went to read the official quote Scott gave, I found myself having a challenging time reading it. At first, I scrolled back up the page because I did not want to read the horrible words that Scott once spoke. However, I realized then that caving into ignorance and ignoring the situation's reality and history will not allow progress toward truth and reconciliation. Learning about the historical wrongdoings the settler colonialism brought to the Indigenous Peoples of what is now known as Canada is the "truth" aspect of truth and reconciliation. Reading and learning about past instances that make us uncomfortable is essential for progress and healing. Without knowing what happened in the past, we are unable to make efforts to rewrite those wrongs or even acknowledge the immense mistakes of the settler population, of which I am a part.

March 9, 2023

Today, I am conducting the first one-on-one interview for this paper. I have been trying to identify and label or acknowledge my biases. I have identified an aspiration that I have within me to ensure that the participants feel comfortable throughout the interview process. This is not an uncommon desire when conducting research. However, my passion may be disproportionate compared to other researchers, and I am unsure whether this stems from a bias of mine. There may be a chance that my considerable desire to make each participant feel comfortable initiates from my feeling of difference and separation as a non-Indigenous settler conducting research with and for Indigenous Peoples. I may be placing more onus on these interviews than other interviews solely because I recognize my position as a settler and what that means for fostering a connection between myself and an Indigenous individual. Because of this, I am creating a divide between myself and the participants. I want to find the balance between recognizing my position as a settler on this land and acknowledging what that means for establishing a trust-based relationship while maintaining an impartial position as the researcher of this phenomenon.

March 12, 2023

A bias I had going into my first interview was expecting that the participants had negative experiences accessing healthcare or felt the standard of suitable care was unmet. I was surprised when my first participant did not immediately speak to these negative aspects of their experiences. However, as I was able to note this assumption and recognize the impact it could make on the conclusions of this study, I believe I could remain impartial and seek only the participant's truth from their stories. I reflected on where and how I had formed this preconception. I think this bias grew from my incomplete knowledge of this phenomenon. My initial understanding of this phenomenon has been primarily based on academic literature, which tends to paint a strictly negative picture of the experiences that Indigenous Peoples have had with the healthcare system in BC. My preconceived notions of this phenomenon did not influence the discreditation of the participant's experiences. Still, this experience did expand my perspective and even illuminated the possibility that what I have read in the literature is not the entire story or finished picture. This realization sounds quite rudimental; however, I must recognize where my understanding is and how it shifts and swells throughout the data collection stage.

March 13, 2023
Reflecting on my first interview, I compared my experiences to theirs. I would think about how my experiences may differ or relate to theirs. During the first interview, the participant expressed how they felt as though doctors and other healthcare providers did not seem to want to answer their questions, which made the participant feel like their questions were irrelevant and consequently made them stop asking questions altogether. Upon reflection, I thought about the times when I felt the same. I often have many questions for the healthcare providers, and I feel like my questions were not validated or considered. However, the participant stated that they have always felt this way and stopped seeking answers to their questions because of how providers have made her think in the past. I realized that I have not experienced the same outcomes from these experiences. I have continued to ask questions and eventually obtain answers. I feel as though this is a representation of my privilege and position as a settler within this society. I have the privilege to continue to ask questions without fear of negative consequences repercussions. Frankly, I am not sure if the same could be said for an Indigenous woman seeking to do the same.

March 15, 2023
I have my second interview today. I am trying not to bring any preconceived notions into this interview that I may have drawn from my last interview. I will explore each answer given more because I feel like in my first interview, I was very hesitant to do that. I am approaching this interview with a clear mind, meaning I am not looking to confirm answers given in the first interview. I am letting the interview flow and the themes emerge independently.

March 29, 2023
I have completed three interviews. I must be conscious of my tendency to find connections between the interviews. While this is a step in my method of analysis, I must bracket each interview to identify and appreciate the uniqueness of everyone, their stories, and the data that comes from them. I think being aware of this and making a conscious and physical note of it aids my ability to do so.

When conducting the first steps of the data analysis process for the completed interviews, I was able to identify connections across emergent themes. However, there were subtle differences across the connections, which speaks to the uniqueness of each participant's experiences. So, while the literature on this topic tends to present a universal understanding of the phenomenon of access to healthcare for Indigenous women, this study is beginning to demonstrate the unique elements of each woman's experiences and how generalizing this issue does not accurately understand its complexity.

April 10, 2023

After my most recent interview, I thought about how this interview differed from the previous ones and how that would affect my research. This participant shared very distinct experiences in comparison to the other participants. As such, I found that I was searching for data from this interview that would complement or "fit" with the previous discussions and the themes that had already begun to emerge. I must acknowledge these patterns within myself, not only for the credibility of my research and design of this study but because these moments are examples of my Western ways of knowing pushing their way to the front of my brain and not allowing for the two-eyed seeing approach to this research to take place. For the two-eyes-seeing method to be applied, I must remain mindful of the multiple truths that will present themselves throughout this research process. Recognizing this allows for the research to demonstrate the value of various realities that can exist for a single phenomenon and how this allows for a more complete picture of understanding to be formed.

May 4, 2023

The more I learn about this topic and the more connections I make between concepts, the clearer my understanding of this phenomenon. After each interview, I was presented with another perspective and understanding of this phenomenon.

May 12, 2024

An essential component of interpretative phenomenological analysis, IPA, is moving to the next case by attempting to bracket previous themes to remain open-minded to honour the individuality of each participant. While I have remained open-minded entering each new conversation with a participant, it was difficult for me not to see how contrasting this aspect of IPA is with components of Indigenous research methods, particularly the connection element in Indigenous research and knowledge-sharing practices. With each conversation, I found that I could make connections between them all, and I found myself grappling with the notions of ensuring that my mind was open to new knowledge and emerging themes while recognizing that the connections being made across the data being collected were essential to honouring the importance of connectivity in Indigenous research methods. This struggle that I felt to balance both Western and Indigenous approaches to research was necessary to experience because it illuminated what is needed to truly embody a two-eyed approach to research.

Appendix G: Reflection Piece

My position

When I started this research, I drafted an initial positionality statement where I considered who I was, the experiences that I have had, the education I hold, and how each one of those factors intersects with the research that I want to do. I was very aware of the history of settler colonialism. I understood that my position in this research would be a white, Canadian settler, cis-gendered female who wanted to make a difference and add to the current endeavours towards reconciliation. This was, quite truthfully, what I wanted to do. I wanted to help. I tried to amplify the voices and experiences of Indigenous women, which is still the goal of this research. I want to amplify the experiences of Indigenous women, their stories to be heard, and people to listen.

The above was the extent of my understanding of my position in this research. I understood the privilege and position that I was bringing to this research. I recognized the position of being a settler and the privilege that settler colonialism gives me. I understood that this dynamic could make it difficult for potential participants to trust me and feel comfortable sharing with me. In theory, I understood that. I understood the logic behind it.

I thought I had prepared myself. I thought I had learned the correct ways to position myself in a culturally respectful manner and in a way that I had indeed come to understand who I was and how my positionality would impact this research. I had taken the mandatory ethics course, paid close and considerate attention to the section on conducting research involving Indigenous participants and incorporated that learning throughout the entire design of this research. Truthfully, I thought this was enough. I felt I fulfilled my obligation as a non-Indigenous researcher conducting research with Indigenous Peoples. Throughout this process, I realized that my assumption needed to be corrected.

The knowledge and experience of Dr. Susanne Thiessen, a Gitxsan woman and Indigenous scholar at the University of Victoria, has guided this research. Again, consulting with and being under Susanne's close supervision and guidance would be sufficient to demonstrate my engagement and consideration of Indigenous Peoples, Indigenous principles of governance, and Indigenous methodologies and knowledge systems. Without the guidance of Dr. Susanne Thiessen, this research would not have been possible. I am eternally grateful for the guidance, support, and compassion Susanne has shown me throughout this process.

This was the position that I took in this research. I understood the history and impacts of settler colonialism and researched and developed a literature review on this topic. In my professional life outside of academia, I have heard the stories of how settler colonialism impacts the everyday lives of Indigenous People. I consulted with and received ethical approval from the university and the Indigenous researchers of the University of Victoria. Like I said, I thought this was enough. This is not to say that everything I had done up to this point was not incredibly important, because it was. It was a strong starting point, especially as a Canadian settler supporting reconciliation and the self-determination and sovereignty of Indigenous Peoples. I soon realized the considerable commitment and effort required to improve my understanding of Indigeneity and settler colonialism and where this learning journey would take me.

I realize there is a pattern of me saying, “I thought this was enough,” and “I thought I had done everything right.” I do not want to give the impression that I was doing something wrong; however, as this process began to unfold, I realized what I had prepared for was just the tip of the iceberg of the learning ahead of me. I began to recognize the reflection that was needed for this research to reach its goal of advancing the inherent rights of Indigenous Peoples regarding self-determination and sovereignty. It required that I make sense of how I would position myself in a way that amplifies the truth of the women who participated in this research as a settler with a primarily colonial understanding of how to conduct research.

Reflecting on Indigenous data

When learning more about Indigenous governance principles, specifically Indigenous data governance and representation principles, I became aware of the difference between wanting to help and being a helper. This distinction is something that Dr. Jennifer Walker speaks to in her research on data governance principles. I learned that when we frame our efforts, no matter how genuine or well-intended they are, in a way that says, “I just want to help,” there is an air of pity and superiority that comes from that position. It adds to the narrative that Indigenous people and communities cannot help themselves. Therefore, it implies that Indigenous Peoples need to be supported by settler communities to function effectively. This narrative is incredibly damaging, not only to the everyday lives of Indigenous Peoples but to the goal of self-determination. I learned that it is better to frame your intentions from the position of a helper. Dr. Walker highlighted the difference between being a helper and wanting to help by using the metaphor of stewarding the water of a river. To help would look like building an apparatus of sorts and making the water go where you want it to go while being a helper would look like moving away the roadblocks in a way that aids the water flow where those you are helping want it to flow. This was an immense learning moment because it demonstrated how I should frame my motivation for this research. I learned that how one communicates one's intentions, even good ones, can damage certain people. If I continued to frame my motivation for this research by saying that I wanted to help Indigenous women, all that would do is add to the narrative that Indigenous women cannot help themselves. I would be further contributing to a false and damaging narrative. If I framed my intentions as wanting to be a helper, the narrative shifts, and I am now working alongside Indigenous women to amplify their truth and experiences. In a small way, I believe this paper could contribute to the sovereignty, self-determination, and advancement of Indigenous Peoples and communities. As such, I would describe my position in this research as a humble helper working alongside Indigenous Peoples in their collective journey to healing and self-determination.

When writing this thesis, I continuously considered what grounded my work. Conducting this kind of research is only possible by acknowledging Canada's shared history with colonization. It is also essential to recognize that because of this history, we settlers all have a shared responsibility towards reconciliation and advancing the sovereignty and self-determination of

Indigenous Peoples. This is something that I have struggled to navigate. I ask myself, *"What is my responsibility as a Canadian settler conducting research with and about Indigenous Peoples?"* This is a critical moment in my self-reflection journey of recognizing my responsibility and relational accountability to this research and those who contributed to its generation.

Authentically, I feel a sense of responsibility not only for my experience as a researcher but, most notably, for the experiences of the contributors to this research and the stories they have shared with me. I think it is imperative to acknowledge that presenting the stories of these seven women is not a direct reflection or representation of all Indigenous peoples or women. Suppose I were to make statements that generalized their experiences as the experience of all Indigenous women accessing healthcare that could be incredibly harmful to the Indigenous communities and the women within them. As Dr. Adams, the former Deputy Provincial health officer responsible for Aboriginal Health, stated, it is incredibly harmful to generalize the health and wellness of Indigenous people and their experiences around health and wellness. It is this populist notion of the "Indian problem," the same problem that Dr. Walker warns us about, that of Indigenous Peoples not being able to take care of themselves, that can be so harmful. This research intended not only to discuss aspects of difference solely from the perspective of Indigenous women but also to present this research in a strength-based way that can be used to advance Indigenous Peoples and their communities. As stated within various sections of this paper, the majority of what is reported on regarding the health and wellness of Indigenous Peoples continues to stigmatize their entire population and generalize their experiences. If this research continues to present similar findings, then this research is doing a disservice to all Indigenous Peoples. A paramount motivation behind this study is to highlight the uniqueness of each woman's experience while understanding the connections between them all. If this study were to generalize the experiences of each woman, then I believe the gravity of the situation would be diluted. However, I am struggling with how to effectively do this to meet the goals and objectives of this research within the constraints of a colonized institution.

This research should be a testament to how research with and for Indigenous Peoples should no longer be institution-focused but community-focused. I only fully considered the importance of consultation after designing and conducting research. Again, when I began this process, my consultation with Dr. Thiessen and my approval from the university were sufficient for consultation and engagement with Indigenous Peoples. However, in hindsight, a more significant effort to consult with Indigenous community members would have increased this research's relational accountability and practical implications. I consulted with Dr. Thiessen extensively on this research. I committed myself to learning and conducting this study in a way that respects and is relevant, reciprocal and relational to Indigenous Peoples, their practices, knowledge systems, beliefs, and values.

Relationality and responsibility

Before this research, I did not fully consider and appreciate my responsibility for carrying these women's stories and knowledge. I always knew I would be given a very personal glimpse into their lives and experiences; however, I needed to realize the responsibility I then held to represent their truths in a way that honours them. For so long, the fact has been controlled by white settlers, and while I am still contributing to that pattern, I realized just how important it is that the voices of these women are accurately represented and heard within this research. It is their stories. It is their knowledge. However, it is my responsibility to honour their truths by accurately capturing them in the presentation of this research.

One of the participants shared with me, *"Try not to carry things that are not going to serve you or us."* Throughout this journey, I have learned that this sentiment is fundamental, mainly when conducting research with Indigenous Peoples. It is vitally important that the design, execution, and outcome of studies involving Indigenous Peoples serve a collective benefit and mitigate potential exposure to harm. By asking myself, "*Does this serve the women who contributed to this study and their communities,*" I was able to remain accountable to the women who contributed to the creation of this paper by ensuring that nothing was presented that would not serve them while developing a piece of literature that serves a collective benefit.

One of the contributors asked me to reflect upon the difference between my perception of this issue at the beginning of this process and where it is now. In doing so, I could identify some monumental learning moments for me. One of which was reflecting on the initial literature review I had conducted. The review focused on the idea of access to healthcare for Indigenous Peoples with a specific focus on the experiences of Indigenous women, although research that specifically spoke to women's experiences needed to be more extensive. This review informed my initial understanding of this issue and the foundation of this study. However, I realized that because the literature was rampant with what Dr. Walter refers to as the 5D's of Indigenous data and representation, so was my perception of this issue. The starting point through which I was viewing this phenomenon of access to healthcare painted the Indigenous experiences in a way that spoke almost exclusively to the 5D's of Indigenous data and representation. With that, I brought this initial assumption with me into the research. A belief that there would be constant stories of despair, difference, and disadvantage. Moreover, this is not to say that there were no stories like that. I want to bring attention to the fact that at the beginning of this work, my mind did not make space for the possibility of stories that feel outside of the 5Ds.

So, entering into this research, I had the assumption that each participant would share with me instances of discrimination or racism that they have faced. This assumption is based on the literature and the news, showing an incomplete image of an Indigenous person seeking healthcare services. One that is solely depicted as a disadvantaged and deprived individual. This was not the case for every participant. There was a spectrum of experiences.

What should be taken away from this experience is that the assumptions we enter into a situation with are incomplete, as they are merely informed by what we have selected to subject ourselves to and what has been deemed relevant and factual information to present to the public. I entered this process with an assumption of what Indigenous women's experiences accessing healthcare were like because of what I had previously read and what had been portrayed in the media. What needs to be understood by academics, journalists, and anyone else who displays information about Indigenous Peoples is that that may be the only information someone has about Indigenous Peoples. People are going to believe what they choose to believe. Nevertheless, what we can do as academics is contribute knowledge to the current field that presents a complete and more multifaceted image of a phenomenon that is not diluted or generalized.

That is why this research is so important and valuable. The findings have come directly from Indigenous women's lived experiences and voices. It is their truth. Even if this research includes instances that focus on differences and disadvantages, they have been supported directly by the voices of Indigenous women. It is not someone else telling their story. While I think it is important to note that statistics and instances of difference and disadvantage do have their place in research and have the potential to bring a benefit to Indigenous communities, that cannot be the only thing that we report and publicize about Indigenous communities because that is the complete image that people will form in their minds. This leads to harmful narratives perpetuating through society.

Merging of two worlds

During this process, I was reading *Braiding Sweetgrass* (2013) by Robin Wall Kimmerer in my spare time. This book is about Indigenous wisdom, scientific knowledge, and the teachings of plants and speaks to how Indigenous research approaches often are not met with the same acceptance regarding their credibility and validity that Western methods are within academic contexts.

When designing this research, I wanted to take a two-eyed approach to its methods, methodologies, and dissemination. However, I found it challenging to execute a two-eyed process. It was easy for me to write about taking a two-eyed approach. However, I often needed clarification on implementing the approach that met the standards I had initially proposed.

Only when I read a chapter in *Braiding Sweetgrass* did this struggle between merely articulation and execution cease. This chapter spoke to the notions of credibility and reliability within research. This chapter and the teachings from Shawn Wilson (2001) provided me with a complete understanding of how relational accountability is the foundation of credible and reliable analysis. Recognizing and honouring my responsibility to all of my relations within this research strengthens this study's credibility. There is an understanding that as a researcher, you are positioning yourself in a reciprocal relationship that respects Indigenous culture and the integrity of their values and produces a final piece of work relevant to the Indigenous Peoples involved in its creation and their communities.

This all made sense to me and was what I wanted this paper to embody; however, applying Indigenous research methods was challenging because my knowledge was solely rooted in colonial practices until this endeavour. In addition, I was nervous about the pushback I might receive when defending my thesis within a colonial institution, as the approach to knowledge generation has not been solely rooted in colonial methods. By reading *Braiding Sweetgrass* and diving deep into the teachings of Shawn Wilson, I gained a better understanding of how to apply Indigenous research methods. Kimmerer spoke of her experience learning how to weave baskets and how this experience showed her the immense respect that is owed to the trees that give their life for us to make baskets and the responsibility that comes from the individual making the basket because they are not producing something out of someone that gave their life for that sole purpose—recognizing that responsibility is a step towards employing Indigenous research methods. Kimmerer further explained how to her, "writing is an act of reciprocity with the world. It is what [she] can give back in return for everything that had been given to [her]. Such a thought could make a person set down their pen" (Kimmerer, 2013, p. 152).

These words resonated with me because I have felt an immense responsibility throughout this project to each woman who has contributed to this research. The outcome of this study must be worth these women being willing to revisit these times in their lives and share their experiences and knowledge with me. I need to ensure that the words I write are worth it and that something relevant to Indigenous women, their families, and communities comes from this research.

I want to proceed toward decolonizing the current way research is conducted, especially when involving Indigenous Peoples. I hope this research can be left to Indigenous scholars at UVic to generate a feeling of reciprocity between the research team and those who contributed. Kimmerer said it best when speaking to the material we use to produce items; however, its sentiment had large applications. "By using materials as if they were a gift and returning that gift through worthy use, we find balance" (Kimmerer, 2013, p. 153). I will forever consider the knowledge shared with me as a gift, and I hope this paper has proven to be of worthy use.