Voices for Indigenous Maternal-Child Health and Wellness

Alberta Health Services
Maternal Newborn Child & Youth Strategic Clinical Network™

Table of Contents

Land Acknowledgment 1
Acknowledgments 2
Contact 3
Introduction 4
Background 5
Project Description, Research Objective, Study Methods, Study Results 9
Recommendations 12
Conclusion 17
Appendix A 18
Appendix B 20
Appendix C 21
Appendix D 22

Land Acknowledgement

IMNCY honours the First Peoples of these lands and their deep ancestral relationship to this place. We acknowledge that we live and work on the territories of Treaty 6, Treaty 7, and Treaty 8, as well as Métis Regions 1, 2, 3, 4, 5, and 6. These territories are home to many Indigenous Peoples, such as the Blackfoot, Cree, Dené, Saulteaux, Anishinaabe, Stony Nakoda Sioux, and Tsuut'ina, as well as the Métis Nations of Alberta and the 8 Métis Settlements.

We acknowledge and respect that these Treaties were signed on these lands, making us all treaty people. We recognize the legacies of colonization and ongoing impacts of settler colonialism on Indigenous Peoples that truncated Indigenous women's knowledge and healing work.

We are committed to a proactive co-design approach that seeks to address disparities in maternal-infant health and wellness and are empowered by Canada's *Truth and Reconciliation's 94 Calls to Action*, *MMIWG Calls for Justice*, *and the United Nations Declaration on the Rights of Indigenous Peoples.*

We dedicate ourselves to collaborate with Indigenous Peoples, Nations, and communities in Alberta to prioritize Indigenous-led solutions for maternal-infant health and wellness, with a firm commitment to reconciliation and decolonization.

Acknowledgments

This community-informed work was made possible by the participation of First Nation and Métis mothers, fathers, midwives, grandmothers, and young parents from across Treaties 6, 7, and 8. Voices from Mikisew Cree First Nation, Sucker Cree First Nation, Ermineskin Cree Nation, Kainai Blood Tribe, the Métis Nation of Alberta, Calgary, Edmonton, Lethbridge, and Okotoks are honoured throughout this report. Thank you for honouring us with your voices.

Information Design by Elle Wilde.

Contact

This report was prepared by Alberta Health Services' (AHS) Indigenous Maternal, Newborn, Child & Youth (IMNCY) Standing Committee in partnership with First Nations and Métis urban Indigenous Peoples, and non-Indigenous healthcare workers across AHS.

For more information, please contact:

Deb McNeil
Scientific Director
Maternal Newborn Child and Youth
Strategic Clinical Network
Alberta Health Services
debbie.mcneil@albertahealthservices.ca

Angie Wong
Senior Consultant
Innovation & Research
Indigenous Wellness Core
Alberta Health Services
angie.wong@albertahealthservices.ca

Introduction

Lack of comprehensive access to maternal-child healthcare has dire impacts on expectant parents, especially in remote communities that have limited access to province-wide health service provisions.[1] The Indigenous Maternal, Newborn, Child & Youth (IMNCY) Standing Committee of the Maternal Newborn Child & Youth Strategic Clinical Network™ (MNCY SCN™) understands the critical state of Indigenous maternal-child health and wellness in Alberta.

IMNCY has sought to identify community-led and community-based solutions that work *with* First Nations, Métis, and Inuit (FNMI) mothers, families, communities, and organizations to improve the quality of maternal-child health and wellness. This report honours the voices of Indigenous mothers, fathers, grandparents, traditional birth attendants, and non-Indigenous healthcare workers, who took the time to share their experiences of pregnancy and access to maternal-child healthcare services in Alberta. It is by no means a fulsome representation of all FNMI in Alberta, however, the research is guided by principles of community-based participatory research (CBPR).[2]

The goal of this stage of the research is to better understand how co-design recommendations, methods, and approaches can be used to identify priority areas that Alberta Health Services (AHS) can support for better Indigenous maternal-child health outcomes. The engagement approach used for this project was the first step in honouring the co-design method to meaningfully understand how FNMI access maternal-child health services in Alberta, and where AHS can provider stronger support.

As such, the voices of participants are highlighted throughout the report to honour the wisdom of their words and to take seriously their perspectives on access, priority areas, and the integral nature of Indigenous women's healing work. Engagement sessions were in the form of one-on-one interviews, focus groups, and sharing circles virtually and in-person, guided by a set of semi-structured interview questions. Participants expressed personal challenges accessing care and offered solutions for how AHS can provide better services to new mothers, parents, and families in both urban and rural/remote settings.

The results of this report highlight several structural and individual ways in which AHS can support better access for Indigenous mothers and families to maternal-child health and wellness services, including co-design initiatives on midwifery and birthing in community. There was particular emphasis in areas of prenatal care and on-reserve midwifery services, which participants believe can have long-term impacts racism experienced by Indigenous Peoples, as well as on the number of child apprehensions against Indigenous families. Though there is an emphasis on healthcare providers to exercise better boundaries of respect when providing care by learning about the histories of settler colonialism in Alberta, there were also strong calls for institutional accountability, including the ultimate need for self-determination and sovereignty in healthcare.

Background

Indigenous Health & Wellness in Alberta Treaty History

Treaties are historic legal agreements between the Government of Canada and Indigenous Nations, and provinces and territories often define the parameters of rights for and obligations to Indigenous Peoples. 19th century settler expansion disrupted the socio-political, economic, and cultural governance systems of the Blackfoot, Cree, Chipewyan, Dene, Sarcee, and Stony (Nakoda Sioux) peoples of Treaties 6, 7, and 8 territories.[3]

When Indigenous leaders and representatives signed the treaties, it was not clear that it meant ceding or surrendering authority over their own lands. The Crown merely implied that treaties were agreed upon on the basis of peace and friendship, miscommunicating land seizure. Although a medicine chest clause was included in Treaty no. 6, it was generally not upheld (see Appendix A).

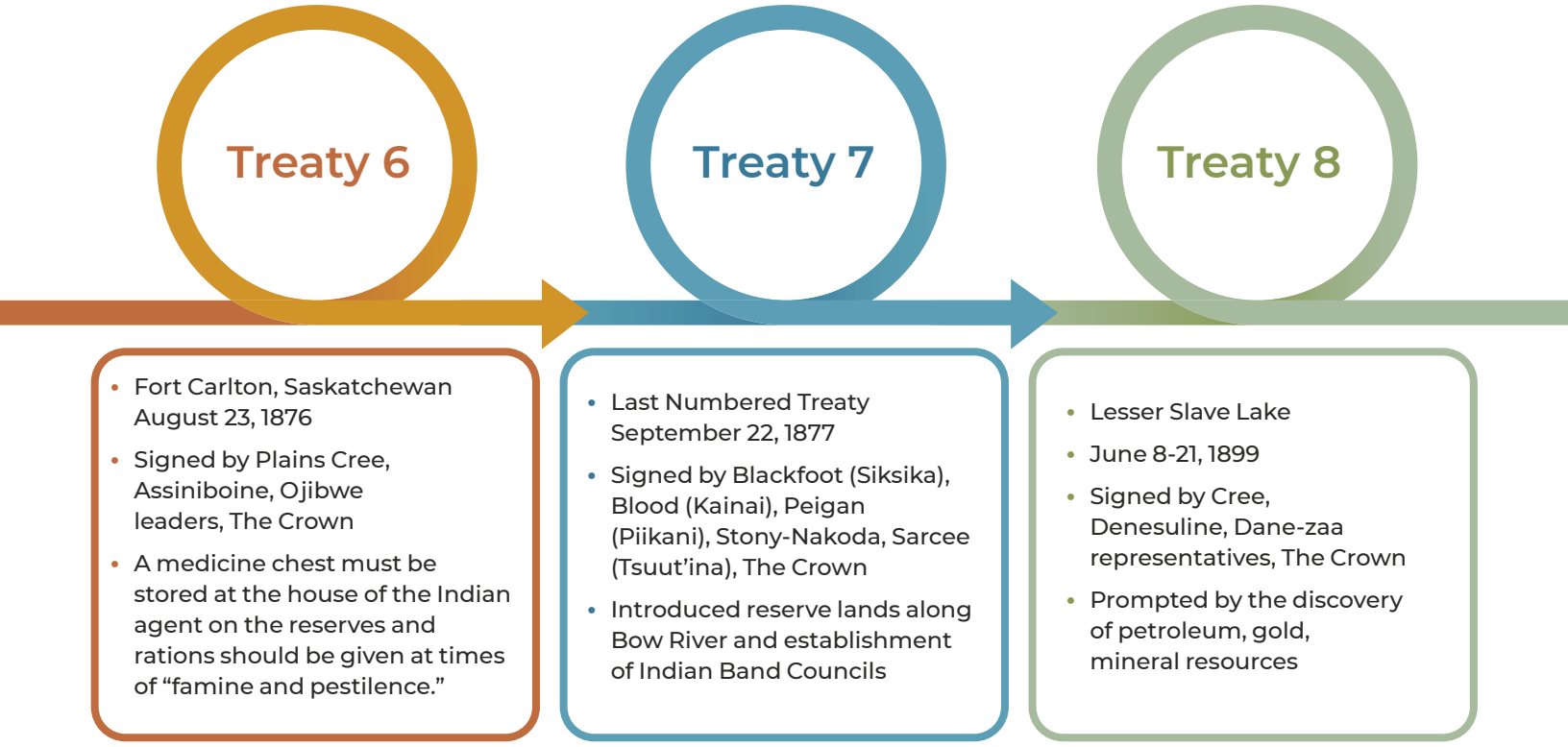


Figure 1.0 Signing of Treaty 6, 7, and 8

> "Alberta Health Services needs to know the history of Indigenous people... If there's gonna be a connection with Alberta Health Services, learn about our history first before you're gonna work with Indigenous people.... How could they support these families, the parents, when there's that disconnection there." (GN1_O21)

Beginning in 1701, British settlers, under the legal title, The Crown, sought to seize Indigenous land in favour of a new British settler colonial society. Indigenous Peoples protected their lands and succeeded in forcing King George III sign the *Royal Proclamation* in 1763, which recognizes Indigenous rights and titles to their lands.

Treaties, thereafter, were supposed to be held in good faith between The Crown and Indigenous Peoples and Nations. The Numbered Treaties, signed between The Crown and First Nations from 1871 to 1921, sought to extinguish Indigenous title to the land in favour of settler lands for industrial development and white settlement. Treaty agreements are affirmed by Section 25 of the 1982 *Constitutional Act*.

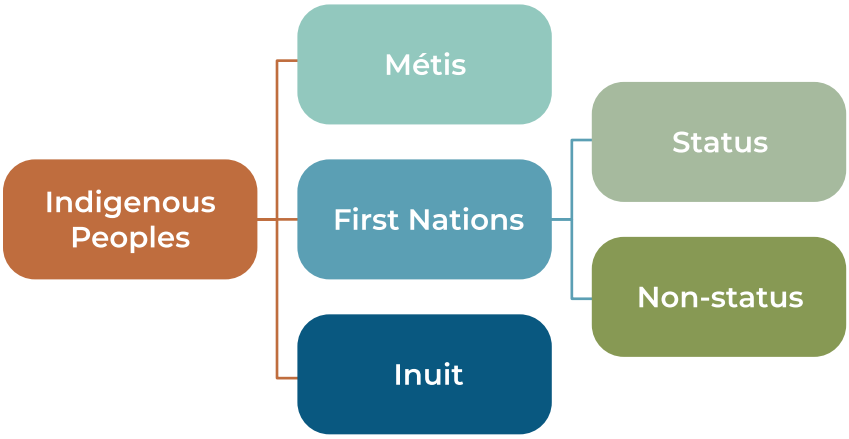


Figure 2.0 Indigenous Peoples are classified into three groups under the 1982 *Canadian Constitution*

First Nations, Métis, Inuit in Alberta

"Indigenous Peoples" is the widely accepted term to refer to the First Peoples of the country we now call Canada. Indigenous Peoples are recognized by the Canadian Constitution under three categories: First Nations, Métis, and Inuit. First Nations people are further classified by "Status" and "Non-Status" according to their registration under the *Indian Act*. There are 45 recognized First Nations and 140 reserves across Treaties no. 6, 7 and 8 (see Appendix A).

Alberta is home to the Métis Nation of Alberta (MNA), which contains six Métis Regional Zones and eight settlements containing a population of roughly 5,000 people, governed by the Métis Settlements General Council (MSGC). Formally organized under *Association de Métis Alberta et les Territoires du Nord-Ouest* in 1932, most Métis families were forced onto a federal program called scrip, which pushed families to rely on road allowances and live on tiny tracts of land such as in between railway lines.[4] The founding of the Métis Association of Alberta in 1932 sought to alleviate poverty in Métis communities and advocate for a secure Métis land base in Alberta (see Appendix A).

Inuit are Indigenous People who typically reside in Northwest Territories, Nunavut, Northern Quebec and Northern Newfoundland/Labrador. There are approximately 2,500 Inuit people living in Alberta primarily urban centres in the northern part of the province.

> "They all said our babies were spoiled and how do these spoiled babies turn into fierce warriors? Love. It's the love of the land and the community that you grew up with." (P5_M6)

Indigenous Perspectives on Maternal-Child Health & Wellness

Indigenous Ways of Knowing, including women's healing work involving midwifery and traditional parenting, have been integral to the health and wellness of Nations and families. These epistemologies and practices sustained thriving Indigenous communities for centuries. Indigenous Ways of Knowing are often considered wisdoms held by Elders and Knowledge Keepers, including Two-Spirit individuals. These knowledges were conveyed formally and informally among kinship networks through social encounters, the oral tradition, ceremony, and everyday interactions.[5] As recommendation 4 highlights below, participants are excited by the recent re-emergence of traditional parenting and birthing practices in communities and on the land.

Indigenous Peoples have always known how to care for themselves, their families, Nations, and broader networks of relations. Yet, they have also had their health prescribed and pathologized by external settler colonial models of healthcare control in recent centuries. This "pathology of the coloniality of power," Dr. Cassandra Felske-Durksen notes, makes it feel impossible to extricate oneself from colonial history. The consequence of this pathologizing is intergenerational trauma and its acute impacts on each generation (see Appendix B). To thwart the passing on of intergenerational trauma, one mother shared why it was important:

> "to tell my children that I loved them...it was important for me to verbalize that and for them to know, because my mother taught that to me because she didn't get that from her mother." (P2_J23)

Despite ongoing settler colonization, Indigenous Peoples have been taking back their health in self-determined ways using traditional birthing practices, Indigenous midwifery, and land-based knowledges. Indigenous ways of knowing are integral to the health and wellness of families and have sustained the survival of Indigenous Peoples and Nations for centuries.

When it comes to the healthcare of Indigenous patients, healthcare providers and practitioners need to be able to walk in two worlds that integrate Indigenous methods and approaches with western medical knowledges according to the context of the patient's health; but they do not have to do this alone.

Indigenous Midwifery & Bringing Birth Back to Community

Women's healing work and midwifery, specifically, are crucial for Nations seeking to rematriate birth in their communities. Midwifery and use of medicinal plants was seen as integral to intergenerational, female-centered knowledge. Across several nations, it was the grandmothers who were considered the custodians of life—being present and supporting lifecycle events.[6] It is critical to highlight that the introduction of western biomedicine did not replace Indigenous medicine and traditional midwifery, although Indigenous midwifery and women's healing work were relegated under the classification of domestic work in the late 19th century.

Yet, a practicing Métis midwife shared with us that land-based connection and teachings have been integral to Indigenous ways of life from time immemorial and continue to be practiced today by Indigenous midwives:

> "we learn about the medicine of the land that have always securely held us through pregnancy." (P5_M6)

When someone becomes pregnant, it is celebrated, and the Nation welcomes the gift of a new child into the community. Given the striking disparities in maternal and child health, sustained action that supports self-determined

forms of midwifery and childcare in the Nations are required to maintain the momentum of AHS' commitment to improving Indigenous maternal-child health. This should be comprised of supporting on-reserve head start, prenatal, and postnatal programs by funding of co-design implementation. Indigenous midwifery education is a critical component of supporting traditional birthing practices and initiatives in birthing centres; training Nations' members as midwives has had positive results and sustained co-developed programming is a key element of success of these programs.

For instance, in Edmonton Zone, the MERCK for Mothers initiative supports Edmonton's Pregnancy Pathways program to provide safe housing and wrap-around services to homeless and vulnerable pregnant women. Members of Samson Cree Nation and Ermineskin Nation in the town of Maskwacis share a community garden that encourage improved nutrition and working with the land through traditional teachings. In North Zone, Kee Tas Kee Now Tribal Council, which services Loon River First Nation, Lubicon Lake Band, Peerless Trout First Nation, Whitefish Lake First Nation, and Woodland Cree First Nation, have long-standing head start programs that are also widely available to Treaty 8 residents. Little Red River Cree Nation also has initiatives to increase access to enhanced maternal-child health programs.

There is significant evidence of improved health outcomes for Indigenous women and children when maternity care and birthing options are closer to home. A Two-Eyed Seeing approach is ideal for supporting Indigenous women and Two-Spirit-led maternal-child health services, which means AHS cannot always be the only health authority to prescribe practices and solutions. Rather, as one Elder participant shared:

> **"I always think a doctor and an elder or something like that should work together. You know we should close that gap." (GN2_O21)**

Historically Defining Indigenous Health: Indian Hospitals & The Alberta Eugenics Board

Unique to the treaties of Alberta is the medicine chest clause of Treaty no. 6, which states that "a medicine chest shall be kept at the house of each Indian Agent for the use of and benefit of Indians at the direction of such agent."[7] Historians highlight that the medicine chest clause was rarely upheld.[8] Understanding Indigenous maternal-child health and wellness in Alberta requires a robust historical awareness of how historic access to medicine, health, and wellness were restricted for Indigenous Peoples. This longstanding history of colonial-mandated healthcare is further evidence for why so many Indigenous Peoples generally do not trust the provincial healthcare system, despite contemporary recognition from national and international organizations on the urgency of supporting Indigenous rights to self-determined healthcare (see Appendix C)

Instead, Indian hospitals and legislation such as the 1928 *Sexual Sterilization Act* determined and restricted the health and wellness of FNMI in Alberta. AHS is associated with this history, which has had long-standing repercussions on the healthcare relationship between FNMI and AHS.

As the only provincially governing health authority in the country, AHS must formally recognize that it comes from a complex institutional history that was federally mandated to target and mandate the control of Indigenous maternal-child health and wellness using sexist legislation, the institutions of Indian hospitals, the Indian Residential School System, and the Sixties Scoop phenomenon.

Indian Hospitals

Indian hospitals were marketed as tuberculosis sanitoriums, which justified the forcible removal of Indigenous children and people from their families and communities for non-consensual treatment.[9] These segregated spaces often took away patient autonomy and pathologized Indigenous health under the gaze of white Euro-Canadian health officials, who operated from the fundamentally flawed colonial assumption that Indigenous People did not know what was best for their health and the health of the community.

The Alberta Eugenics Board

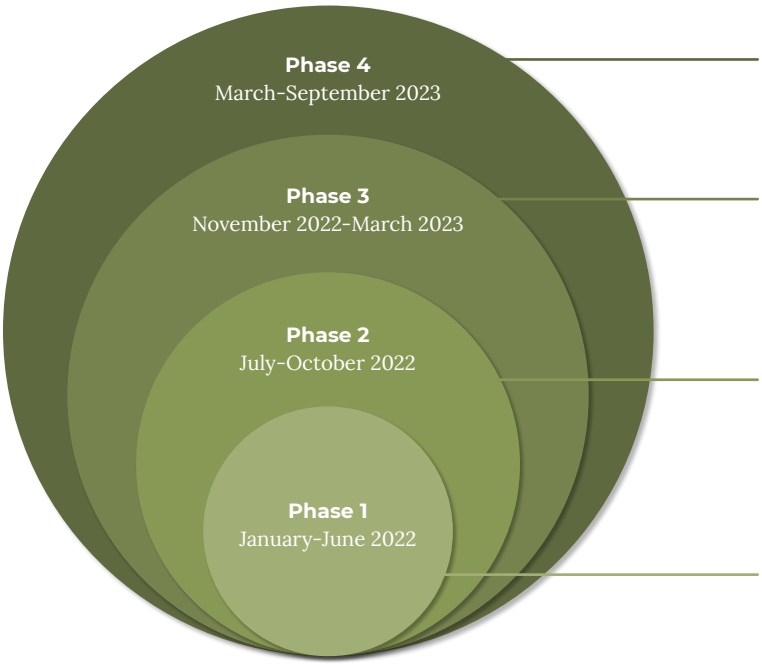
The Alberta Eugenics Board was founded in 1928. In this same year, *The Sexual Sterilization Act* was passed by the provincial government, which made legal medical procedures to prevent Albertans as well as Indigenous women from having children. The Charles Camsell Indian Hospital in Edmonton became the primary site to conduct non-consensual sterilization against Indigenous peoples deemed 'mentally deficient'.

Project Description, Research Objective, Study Methods, Study Results

Project Description & Research Objective

The purpose of this research is to develop co-design recommendations, methods, and approaches based on principles of community-based participatory research (CBPR)[10] to identify priority areas that AHS can assist in for better Indigenous maternal-child health outcomes in Alberta. The objective of IMNCY is to co-design with FNMI mothers, families, grandmothers, Elders, and knowledge keepers new and existing initiatives related to maternal-child health services, community birthing practices, and to examine data that prioritizes quality improvement.

The engagement approach used for this project was the first step in honouring the co-design method to meaningfully understand how FNMI access and prioritize maternal-child health and wellness in Alberta. Participants expressed personal challenges accessing care and offered solutions for how AHS can provide better services to new mothers, parents, and families in both urban and rural/remote settings. Participant informed solutions have helped the research team uncover key themes that identify solutions to address maternal-child health service needs. The primary objectives were to first, understand what FNMI mothers, parents, and communities want to prioritize and find solutions for in terms of maternal-child health and wellness; second, consider the role of AHS in serving interested FNMI initiatives in implementing community-led solutions for better access to maternal-child services.



- Qualitative content analysis using coding & themes; verified findings and priority areas with participants
- Data collection and hosting engagement sessions (1:1 interview, sharing circle, focus group) with participants primarily in Calgary Zone
- Service mapping Calgary & South Zones off-reserve Indigenous-serving mat-child programs; connected with Indigenous-serving/Indigenous-led maternal-child organizations and family services & non-Indigenous healthcare providers across all AHS Zones
- Prepared research protocol, eligibility criteria, interview materials for University of Calgary Research Ethics approval; vetted by University's Indigenous Research Support Team

Study Methods

CBPAR is defined as a "systematic inquiry, with the participation of those affected by the issue being studied, for the purposes of education and taking action or affecting social change."[11] We used CBPAR principles to guide this research, including 1) recognizing that community is a unit of identity; 2) co-learning through co-design, 3) emphasizing relevance of community-defined problems, 4) disseminating knowledge gained from engagement sessions to all involved.[12] The content analyzed has been adapted to align with organizational Indigenous health priorities, even though they may not reflect the actual reality of Indigenous maternal-child health and wellness.

Engagement sessions were carried out as semi-structured sharing circles, focus groups, and one on one-interviews held virtually and in-person. One set of interview questions was administered in each engagement session, and further information supports such as AHS's toll-free Indigenous Support Line, the Indian Residential School Hot Line, MMIWG's Aftercare Support Line, and the contact information of the Principal Investigator were provided. Engagement sessions were recorded, transcribed, and analyzed using a qualitative content analysis approach wherein each engagement session was subject to a thematic review followed by a comparative analysis to grey literature. A 4-page findings document was compiled and presented to the participants in an email, which generated further engagement with participants by asking them for feedback on findings. Participants were not asked to prove Indigenous identification (status cards and memberships). The intention was to collect qualitative data on the meaning of healthy pregnancy and healthy children from the perspective of FNMI using engagement sessions in the form of sharing circles and focus groups (hosting 5-8 virtual sessions).

Limitations

Engagement sessions were primarily conducted in Calgary Zone with the informed knowledge of geographical remoteness and technological access (wifi, cell phone). While the research team intended to engage directly with Nations especially in North and Central Zones, third party advising from Kee Tas Kee Now Tribal Council affirmed the difficulties of reaching remote reserves with restricted access to wifi and mobile phone services, which are precisely the voices that we hoped to highlight in this report. With this geographical limitation in mind, the data collected during engagement sessions is not a fulsome representation of *all* FNMI maternal-child health experiences across Alberta or even within the Southern Alberta.

The findings are promising, however, as the voices unanimously called for improved access to maternal-child service and to address inequitable maternal-child healthcare service provisions.

Accountability

We understood that the nature of this work on the state of Indigenous maternal-child health and wellness could be triggering to participants. The IMNCY Accountability Framework was utilized to frame the engagement sessions and respect the voices of participants. To hold ourselves accountable to this work, we offered mental health supports after each engagement session and were acutely aware of the need for Indigenous Peoples speaking for themselves. In listening to our participants and making personally critical reflections on each engagement session, we adjusted the interview process (within the standards of the CHREB), and further welcomed opportunities to decolonize our primarily western way of thinking about Indigenous health by taking on the responsibility to teach each other. This was deeply informed by an Elder who told us:

> **"I think you're tasked with teaching [other] white people about who they are…ask yourself How does the society in which I come from, a society in which I was raised, perpetuate colonial practices, thereby, perpetuating trauma, racism, systemic racism."**
> **(GN2_O21)**

Study Results

Results from the engagement sessions generated priority solutions that highlight what AHS can do institutionally to support traditional parenting and birthing practices. Engagement sessions were in the form of one-on-one interviews (9), focus groups (1 with 3 participants), and sharing circles (2 with the same 4 participants) virtually (10) and in-person (2), guided by a set of semi-structured interview questions.

There was unanimous expression to improve the quality of health for FNMI mothers, families, and communities with the realistic understanding that it may not be possible to directly address all broader social determinants of health, service gaps, and restrictions in access to prenatal services. These prioritized solutions require a robust historical understanding of the history of Indigenous health service provision, which can directly address racism experienced by Indigenous Peoples and child apprehension against Indigenous families today. Participants expressed the need take their pain to be taken seriously by healthcare providers through listening and understanding, which is informed and comprehensive care that may have long-term impacts on improving anti-Indigenous racism. Lastly, the need for co-design, institutional collaboration, and community-led solutions was unanimously stated. The following recommendations, therefore, come directly from the voices of IMNCY's co-design work, and we take seriously community-informed efforts to decolonize research, practice, and engagement in the institution of provincial healthcare.

- Accountability to Alleviate Anti-Indigenous Racism
- Choice is a Voice (Voice is a Choice)
- Providing Culturally Safe and Comprehensive Care
- Supporting Traditional Birthing Practices
- Creating Integration and Implementation Together

Recommendations

ONE:

Accountability to Alleviate Anti-Indigenous Racism

Our findings pointed to an urgent need to be accountable to alleviating racist encounters for Indigenous patients. We heard that there needs to be greater institutional accountability to ultimately end stigma against Indigenous peoples by addressing racism inside the organization and acknowledging with respect that there is a lack of trust due to historic and personal experiences. One organizational recommendation was utilized the blanket exercise, a "very powerful tool" that is generally an Indigenous-led cultural sensitivity training exercise. The visceral experience of the blanket exercise is meant to generate humility and a deeper understanding for histories of colonization and ongoing settler occupation. While "the understanding of how things affected us from the past has to be learned, the judgment has to stop." Alongside participating in these organizational training exercises, healthcare providers are reminded that they ought to be good guests when directly interacting with Indigenous patients and entering the communities of First Nations, which means adjusting attitude when entering community. As one Grandmother underscored,

> **"if you have a different attitude [when] you go into a community, then you'll be accepted. It's about acceptance, it's about attitude." (GNP4_O21)**

This means clear communication is a primary step towards being a good guest and developing trust between AHS and communities.

> **"Having better communication with the AHS side of things and AHS communicating more clearly as to what they're doing there and why they do what they do when they come to visit moms," (GNP1_O21)**

While clear communication is also important to providing comprehensive care, it can also lessen the triggering of intergenerational trauma. Indigenous children are severely overrepresented in the Canadian child welfare system, and against the historical backdrop of normalizing child theft into the Indian Residential School System, participants underscored the fundamental hesitation towards unexpected visits from AHS healthcare providers. As one mother-scholar-artist declared:

> **"We had a lactation consultant after the birth that came to the house, but I didn't feel comfortable with her there…history repeats itself. I'm very comfortable in the history of colonization and the government stealing Indigenous children. I didn't realize that the lactation consultant was coming and I felt like this was a check-in on me and I'm like, 'if I don't present myself accordingly, am I going to be seen as a bad parent because I'm indigenous?" (P2_J23)**

This powerful statement reveals the foundational impacts of intergenerational trauma at the physiological and emotional levels. Such that hesitancy from Indigenous mothers can be addressed through stronger AHS cultural competency training and supports.

TWO:

Having a Choice is Having a Voice (Having a Voice is a Choice)

One prominent frustration expressed by participants was feeling that their health concerns and pain were not taken seriously by their healthcare provider. The problem of not taking Indigenous pain seriously is that it contributes to the dangerous idea that Indigenous Peoples ought to be dependent on western medicine and forms of care. Rather, as with all people seeking medical assistance, Indigenous mothers, parents, and families want to be heard and taken seriously when they seek aid before, during, and after pregnancy. Parents want to feel that there are options or choices available that help to support access to re-normalizing traditional maternal care and parenting methods. It involves putting power back in the hands of mothers and

> **"allowing moms to make ...more of those decisions for themselves and not telling them, like, this is what you have to do...it's important to be able to have a say in your own health." (P1_N17)**

This means that western health practitioners should respect parents' choices by listening to how their concerns are voiced, providing comprehensive and informed choices that work with the parents and families. When Indigenous patients feel that they have a choice in determining their health because healthcare providers listen to their concerns, they feel that their voice has given them that choice, which is an important element of respecting the development of sovereignty. Respect for Indigenous parenting and familial values can have long-term impacts on ending child apprehension and supporting the development of a sovereign sense of self. This is because

> **"sovereignty starts with the individual and people model sovereignty. Even when the baby is in the belly... the child welfare system will never give that. They will never be able to encourage the development of this sovereign self." (GN2_O21)**

Sovereignty is not limited to adults who can exercise a liberal individual sense of self; rather, it can further be understood as a humanist worldview that encompasses the entire spectrum of human life from infancy, childhood, adolescence, through to adulthood and older adulthood. Such statements are evidence for the ways in which multiple perspectives and philosophies can provide a fuller picture of maternal-child health directly, and the world more broadly.[13] Two-Eyed Seeing approaches have a harmonizing effect between western and Indigenous sciences, allowing healthcare providers and practitioners a more wholesome approach to delivering and the conscious choice of one lens over the other depending on the health circumstance of the patient.

THREE:

Provide Culturally Safe and Comprehensive Care

Crucial to listening to the voices and choices of Indigenous mothers and families is acting wherever possible to provide culturally safe and comprehensive care. This may be in the form of on-reserve midwifery services in the form of pre- and post-natal care information packages and physical materials. These supports should be collaborative and "*...be a community-based project for the mat-child...*" This affirms the idea that cultural safety during pregnancy means being surrounded by "*whoever the mother wants there*," and seeing and feeling like maternal-child supports are familiar: "*...even just seeing...faces that you recognize and that are familiar can help build a safe space and build a safe atmosphere.*" At these nascent stages of trust building, however, supporting capacities for self-determined maternal-child healthcare means supporting Indigenous women-led initiatives and projects. In building these trusting relationships, Indigenous midwives can support expectant Indigenous mothers:

> **"It has to be a community-based project for the mat-child program so that you cannot just have somebody with a health background, but an elder and another mommy [who has] already got kids and can talk to the young ladies." (GN1_O21)**

These recommendations implicitly embody a Two-Eyed Seeing worldview that can draw on both Indigenous health and western medical knowledge in the appropriate contexts of the Indigenous patient's health needs, inherently generating an ethical space where one worldview does not subsume the other. Rather, these spaces would engage the patient and healthcare providers, including western healthcare practitioners and Elders or traditional knowledge keepers, in dialogue to affirm "human diversity created by philosophical and cultural differences."[14]

FOUR:

Ongoing Support for Traditional Birthing and Parenting Practices

In being accountable to recognizing historical colonization and ongoing settler colonialism, this report takes seriously the recommendations for supporting traditional birthing practices. The noticeable shift in cultural and historical recognition about Indigenous issues has increased an acceptance of turning and returning to traditions by FNMI:

> **"It's really beautiful that…there's more of an acceptance on things that really weren't accepted prior. But now because there's more of a platform for us to talk … the things that people thought were not normalized …[now, we are] really like taking it back to the root of our people." (P1_N17)**

This exciting reclamation of culture and traditional knowledge was delightedly shared by mothers and grandmothers. Grandmothers expressed their eagerness to talk to young parents and young people to pass on their traditional birthing knowledges and practices to the next generations, saying that "*…we talked to them about the Moss bag, the cradle boards, baby swings. We go into all that and the benefits for the baby: the bond in comfort, safety, development, and the grandparent's special role in raising the children.*" This beautiful duty to younger generations from older ones exhibits an intimidate worldview that implicitly involves cyclical forms of care intergenerationally, which involve Indigenous women-led midwifery and traditional birthing practices. As one midwife shared:

> **"I think it's important to include midwives especially from someone who is First Nations. To have Indigenous midwives is so important… because they understand a lot of the background, culturally. They understand a lot of the circumstances that surround the patient and they build a relationship with them over the course of the nine months that they have together." (P4_M3)**

AHS can support this particular recommendation with the guidance of MNCY and IWC to look into existing AHS spaces in facilities to foster this knowledge translate, which facilitates in the passing of intergenerational knowledges about traditional parenting between Elders or knowledge keepers (including midwives and doulas) and new parents. The wealth of knowledge that would come from these supportive initiatives could produce quality improvements in Indigenous maternal-child health and may have subsequent impacts on child apprehension into the welfare system, as per commitment 6.2. In some settings where, for instance, sacred knowledge is shared, AHS does not need to be present; in such cases, the organization must respect those forms of self-determination in health and wellness. As one Blackfoot scholar underscored:

> **"What can Alberta Health Services do? Just get out of the way. You know, really get out of the way….Let us get back to what we've always known so. Just get out of the way while, while we rebuild our capacity." (GL_F1)**

Supporting existing and co-designing Indigenous women and Two-Spirit-led initiatives on reserve and in urban centers can make ethical space (see Appendix D) for multiple generations to heal, helping to disrupt intergenerational trauma, which was commonly discussed by participants.

FIVE:

Co-Design, Co-Creation: Implementation Together

Participants emphasized the need for AHS to continue its commitment to building strong relationships with FNMI by working to implement community-based programs, information networks, and physical materials informed by Indigenous birth workers, including doulas and midwives, grandmothers, Elders and knowledge keepers. Elder participants were thoughtful in stating their recommendations for collaboration between western healthcare providers and Elders and traditional knowledge keepers. Others noted that if parents are expected to attend prenatal classes, then supports around access, including transportation and reimbursement of travel costs should be provided:

> **"Raising a healthy a child [requires] community supports regardless of your marital status…it means you have a community and community hub programming that's easily accessible by public transit with preference of the programmer to be able to provide you with gas reimbursements if you need it or public transit access at no cost to you." (P5_M6)**

The accrual of these social determinants of health influence access. One midwife participant expressed her frustration at the lack of comprehensive services by noting how

> **"lots of people on reserve don't have access to a vehicle, so they have the early years program drive them to appointments or groceries…I know that [transportation] is a huge barrier for some other people that live on other reserves." (P4_M3)**

Hearing this, MNCY and AHS may have opportunities to examine existing pre and post-natal care services and open pathways to expanding those services. If AHS can act upon this in direct ways, it means that supporting co-designed maternal-child health initiatives are generative of ethical space between Indigenous mothers and AHS healthcare providers. This is because both "cultural groups are able to acknowledge their differences and navigate ways to work together with humility, honesty, and commitment."[15] Implementing these supports together means restructuring or adjusting hiring practices, which will have broader systemic influence in areas such as child welfare:

> **"You see a face that you recognize that you know you can inherently trust, and they will protect you from like the very real fears of newborn apprehensions." (P5_M6)**

Conclusion

The participants who shared their voices in this report have highlighted prenatal care, on-reserve maternal-child services, and midwifery as priorities for healthy pregnancy and health children in Alberta. *The Indigenous Health Commitments* report of AHS is a foundational roadmap for working with Indigenous communities based on listening, understanding, acting, and being, which involves *Etuaptmumk* or Two-Eyed Seeing (see Appendix D). By supporting community initiatives (birthing in community, head start, prenatal), Indigenous women's healing work in the form of midwifery, and FNMI-led solutions through Two-Eyed Seeing, AHS and FNMI health leaders can work together to address the long-term impacts of child apprehension and racism against Indigenous Peoples. It is hoped that the experiences, recommendations, and solutions voiced throughout this report are taken seriously to improve the maternal-child health outcomes of First Nations, Métis, and Inuit in Alberta.

Appendicies

Appendix A: Treaties with First Nations in Alberta, Métis Nation, and Métis Settlements

Treaty no. 6: Treaty no. 6 spans across central Alberta and Saskatchewan. It was signed by Plains Cree, Assiniboine, and Ojibwe leaders and representatives of The Crown on August 23, 1876 in Fort Carlton, Saskatchewan. During treaty negotiations, lieutenant governor of Manitoba and the Northwest Territories introduced the creation of reserves for Indigenous peoples, promised to assist them in agriculture, and avoided explicit discussions of land cession, which he believed that signing the treaty implied. This was protested by Plains Cree leader Pitikwahanapiwiyin (Poundermaker) who argued that the exchange for Indigenous title to their land was unfair. In exchange for their Indigenous title to the land, The Crown would provide an annual cash payment of $25 per chief and $5 for all band members; a one-time cash payment of $12 for each band members; reserve lands of approximately 2.5 sq. km per family of five; schools on reserve. Treaty no. 6 also states that a medicine chest must be stored at the house of the Indian agent on the reserves and rations should be given at times of "famine and pestilence." Scholars have noted that despite the promises of Treaty no. 6, Plains Cree were "deliberately starved to make way for the railway and settlement,"[16] revealing the complex and competing economic and politics priorities of British settlers.

Treaty no. 7: Treaty no. 7 was signed on September 22, 1877, between the five Nations of the Siksika (Blackfoot), Kainai (Blood), Piikani (Peigan), Stoney-Nakoda, and Tsuut'ina (Sarcee), and the government of Canada. It is considered the last of the Numbered Treaties. Unlike the mention of the medicine chests in Treaty no. 6, Treaty no. 7 does not contain any promise of medical assistance. Anglo farmers and American settlers invaded Plains Cree lands to settle and set up trading forts; outbreaks of smallpox were common; and major food sources such as the buffalo were quickly diminishing. The terms of Treaty no. 7 include reserve lands along the Bow River given to the Siksika, Tsuut'ina, and Kainai; the Piikani were placed on a reserve near Crow's Creek; the Stony Nakoda were given reserve lands in Morleyville. Treaty no. 7 also included a number of stipulations related to the creation of the Indian band, as set out by the federal *Indian Act*. It outlined cash payments to all members; annual payments to chiefs and every minor chief, including a Winchester rifle, ammunition, and a new suit of clothes every three years; and the promise to pay the salaries of teachers who taught on reserves (if a school was available).[17] Farming and agricultural tools were oral promises made by Crown representatives.

Treaty no. 8: Treaty no. 8 was signed on June 8, 1899, and covers the territories of northern Alberta, northwestern Saskatchewan, northeastern British Columbia, and the southwest region of the Northwest Territories. It is home to 39 autonomous nations. The Crown pursued treaty negotiations when a Canadian geological survey discovered minerals, petroleum, and tar sands deposits along the Athabasca River in the 1880s.[18] The Klondike gold rush that began in 1896 saw an influx of white settlers to the region, which prompted The Crown to considered treaty negotiations. Representatives of the Cree, Denesuline, and Dane-zaa were reluctant to sign Treaty no. 8 as it failed to properly outline hunting, trapping, and fishing rights. A number of oral promises were made that were not embodied in the written treaties themselves, including the oral promise to provide medicine.

Métis People in Alberta: Métis families and networks have a unique history. They were produced from 'country marriages' between Indigenous women and French, Scottish, and British men.[19] Métis history is often said to have begun in the Red River settlement of Manitoba during the fur trade era of New France. The Métis worked with European fur traders, the Hudson's Bay Company (HBC), and Northwest Company as interpreters, guides, trade negotiators, and labourers. In 1814, the HBC issued the 'Pemmican Proclamation' which sought to conserve all buffalo meat exclusively for HBC company men; this meant the potential starvation of Métis families at the Red River settlement and sparked discussions of the distinctness of *Michif* or Métis identities. Louis Riel was a Métis political leader and founding member of the province of Manitoba whose father, Louis Riel Sr., had experienced the repercussions of the Pemmican Proclamation after settling in Red River in 1812. Louis Riel would later draft the *Manitoba Act* of 1870, which stipulated that the Métis would receive title for land they already farmed and would receive an additional 1.4 million acres in farmland for the use of their children. The *Manitoba Act* has since been amended multiple times, including with a revision to government law which took land away from the Métis.

The Métis Nation of Alberta and the Métis Settlements of Alberta General Council: Alberta contains a Métis homeland with six regions under the Métis Nation of Alberta. Although formally organized under *Association de Métis Alberta et les Territoires du Nord-Ouest* in 1932, most Métis families were forced onto a federal program called scrip, which pushed families to rely on road allowances and live on tiny tracts of land such as in between railway lines.[20] Scrip historically obscured Métis claims to land, however, in 2016 case of Daniels v Canada (Indian Affairs and Northern Development), the Supreme Court of Canada ruled that Métis people are considered 'Indians' according to Section 91 of the 1867 *Constitutional Act*. The Métis are also recognized as a legally, politically, and culturally distinct Indigenous People of Canada by Section 35 (2) of the 1982 *Constitutional Act*. In 2017, the federal government co-signed the MNA-Canada Framework Agreements, which assists in settling outstanding Métis land claims. The Métis Settlements of Alberta General Council protect the rights and autonomy of Métis people living in Alberta and have their own distinct land-based governance model, outlining hunting and trapping rights, traditional harvesting, and co-management of resource development.

Appendix B: Institutionalizing Indigenous Health

The Residential School System: Indian Residential Schools were funded by the government of Canada from the 1880s to the 1990s. As many as five generations of Indigenous children were subjected to the violence of the schools, in which torture, physical abuse, sexual assault, and hunger were common.[21] The federal government estimates that at least 150,000 First Nations, Métis, and Inuit children were sent to residential schools.[22] Rates of death from tuberculosis in residential schools were atrocious, particularly in the first few decades of the 20th century.[23] Several survivors testified in the Truth and Reconciliation Commission (TRC) final report that they had developed addictions as a coping mechanism to try and grapple with the trauma and pain they experienced in the schools.[24] The devastating impact of the schools in terms of producing Indigenous homelessness and forced pregnancies across Canada is noteworthy. It also worth stating that Indigenous women who sought access to shelters in the city of Calgary told a team of researchers that they had grown frustrated with the frequency with which they had to disclose details of traumatic life events in order to be considered for a range of services. Researchers have commented on "the requirement of repeated trauma disclosure or victimhood to gain services" and critiqued service provision systems that ask Indigenous women "to capitalize on their pain to gain needed supports."[25] It is important to report dutifully upon the larger history of policy violence against Indigenous peoples in Alberta to inform policy discussions as well as broader public discourses about reconciliation. It is for this reason that we now turn to the role of the Sixties Scoop.

The Alberta Eugenics Board: The establishment of what were termed 'Mental Hygiene Clinics' were created in Calgary and Edmonton in 1929, in Lethbridge in 1930, and in Medicine Hat in 1933.[26] A 1937 amendment made these procedures less restrictive by significantly revoking the need to obtain consent from those deemed 'medically deficient'. This facilitated the growth of sterilization procedures across the province. This legislation was explicitly ableist in that it targeted those with developmental or physical disabilities and was also exceptionally racist in practice, contributing to the broader network of policy violence organized against First Nations people in Alberta.

The Sixties Scoop: The term 'Sixties Scoop' refers to a policy period in Canada wherein a considerable number of Indigenous children were removed from their families and communities by child welfare workers.[27] This process was introduced when federal and provincial governments adopted new approaches to the provision and funding of services for Status Indians in Canada. In *Indigenous Writes*, Métis scholar Chelsea Vowel's research suggests that at least 11, 132 children with Indian Status were 'scooped' from their families between 1960 and 1990; however, the figure is likely much larger (as high as 20,000) given that non-status First Nations, Métis, and Inuit children were also caught up in the Sixties Scoop.[28] The mass removal of Indigenous children was coupled with their placement in non-Indigenous families, which created what Vowel calls "cultural amputees," or Indigenous peoples whose connection to their land, identity, language, and cultural was severed.[29] Indigenous scholar and therapist Peter Menzies explains how of the victims of the Sixties Scoop were "forced to assume the values of another culture that derided their own belief system," which left "Aboriginal children…in a cultural vacuum, relating neither to mainstream culture nor to their own community."[30] Thus, similar to the Indian Residential Schooling system, the Sixties Scoop took Indigenous children from their families and placed in acculturating settings that endeavoured to assimilate them and absorb them into the Canadian politic. Numerous studies have disclosed that Indigenous children were often subject to forms of physical and mental abuse when they were placed with host families, especially those that held anti-Indigenous and racist views about First Nations, Métis, and Inuit.[31] Some critics have argued that for these reasons the Sixties Scoop in fact embodied and amplified the core policy objectives of the Residential School system.[32] In 2018, Alberta Premier Rachel Notley offered an official apology on behalf of the provincial government for its historic role in organizing the mass removal of Indigenous children from their families and communities.[33]

It is worth noting here, that the term 'millennial scoop' has also been used to refer to the continuation of the practice of forcibly removing Indigenous children from their homes in recent years. This was largely brought to light by a major Canadian Human Rights Tribunal decision in 2019, which found that 40,000 to 80,000 Indigenous children had been wrongfully removed from their families and deprived of services between 2006 and 2017.[34]

Appendix C: National and International Recognition of Indigenous Rights

Jordan's Principle: Jordan's Principle is named after Jordan River Anderson who was born in 1999 and from Norway House Cree Nation in central Manitoba. Jordan was born in the Winnipeg hospital where he stayed his entire life as a medically complex child with a tracheostomy. At the age of 2, Jordan was stable enough to go home, but his house required homecare adaptions before he could leave. Jordan's homecare adaptions became the primary funding issue that neither the province nor the federal governments could agree upon. Even a foster home in Winnipeg had been found for Jordan so that he would not have to travel back to Norway House. Given that Winnipeg and Norway House Cree Nation are located in the province of Manitoba, where Jordan would have lived, the federal government believed that the province of Manitoba ought to be fiscally responsible for Jordan's homecare adaption. At the same time, the provincial government of Manitoba believed that as a First Nations boy from a federal reserve, Jordan's healthcare jurisdiction fell in the lap of the federal government which administered Indigenous health under the *Indian Act*. The consequences of this back-and-forth indecision between provincial and federal health authorities was Jordan's death in 2005 after he felt into a coma and still in Winnipeg hospital.

Joyce's Principle: Joyce's Principle is an Indigenous health document and call to action for provincial government of Quebec to acknowledge systemic racism. It was created after Joyce Eschequan Facebook livestreamed two healthcare workers making racist taunts and remarks at Joyce while she lay hospitalized in Jollliete hospital—the nearest hospital to her home in Atikamekw Nation. An inexperienced nurse who worked there for only a few months was responsible for nine other patients; she improperly administered a heavy sedative which put Joyce into a heavy coma and from which she later died. The emergency physician, Dr. Alain Vadeboncoeurm, who examined Joyce's body and her medical records, found that she would have lived if she was properly monitored.

MMIWG Calls for Justice: In *The Final Report of the National Inquiry Into Missing and Murdered Indigenous Women and girls*, 231 Calls for Justice were developed. Pertaining to maternal-child health and wellness, section 7.3, under the "Calls for Health and Wellness Service Providers," states that healing supports for the "revitalization of Indigenous health, wellness, and child and Elder care practices" ought to be "land-based and about harvesting and the use of Indigenous medicine for both ceremony and health issues. This may also include matriarchal teachings on midwifery and post-natal care for both woman and child."[35]

Truth and Reconciliation Calls to Action: The Canadian Truth and Reconciliation Commission was initiated in 2007 under the Indian Residential Schools Settlement and Agreement—one of the largest class-action settlements in Canadian history. It sought to facilitate reconciliation between former students, their families, their Nations, and the broader Canadian population. One of numerous TRC reports published by the Commission includes 94 Calls to Action that acknowledge that the current state of Indigenous health is a result of "previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties."[36] Action 19 and 55 (iv) in particular state the need to establish measurable goals that "identify and close gaps in health outcomes" with efforts directed towards infant mortality and maternal health.[37]

UNDRIP: Recognizing Indigenous Peoples and Nations in a Canadian context requires broader understanding of the international respect for Indigeneity as a global category. Indigenous Peoples and Nations across the world have been impacted by European colonization. The *United Nations Declaration of the Rights of Indigenous Peoples* (UNDRIP) is a contemporary document that universally recognizes that "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 programme through their own institutions."[38]

Appendix D: Two-Eyed Seeing Approach and Ethical Space

Ethical Space: according to Indigenous methodologies outlined by Willie Ermine and Martin Hill, an ethical space where Indigenous and western medical practitioners work together on equal frameworks for the health and wellness of the Indigenous patient. An ethical space in the healthcare system is a "neutral zone between entities or cultures" where one worldview does not subsume the other.

Two-Eyed Seeing: Mi'kmaw Elder Alberta Marshall defined the term Two-Eyed Seeing as a way to facilitate the bridging of Indigenous and western medical and health knowledge.[39] Two-Eyed Seeing considers the strengths of western and Indigenous knowledge and values their differences to produce diverse perspectives. Guided by these frameworks and institutional commitments, these commitments keep AHS accountable: they help us to listen to and understand the state of Indigenous health, be with Nations and individuals seeking healthcare assistance, and act upon contributing to strengthening Indigenous Health in respectful and reciprocal ways. To be persistent in advancing a cultural shift towards accountability to Indigenous Nations and Peoples' health means taking meaningful action, building sustained, reciprocal, trusting partnerships and relationships.

Endnotes

1 Verna Yiu, Kathryn Todd, Casey Eagle Speaker, Wally Sinclair. Indigenous Health Commitments: Roadmap to Wellness, Alberta Health Services (January 2020).

2 Maria Pontes Ferreira, Fidja Gendron, "Community-based participatory research with traditional and indigenous communities of the Americas: Historical context and future direction," International Journal of Critical Pedagogy 3, no. 3, (2011), 153-68. Bruce Dr. Friedman, Community-Based Participatory Action Research: It's All About the Community. Cognella, 2020.

3 Settler colonialism is distinctly a British-Canadian model of imperialism, which sought Indigenous Peoples and Nations to cede, give up, or surrender authority to control and own their homelands. See: J. Reading & R. Halseth, Pathways to Improving Wellbeing for Indigenous People: How Living Conditions Decide Health (National Collaborating Centre for Aboriginal Health, Prince George, BC, 2013); C. Reading & F. Wien, Health Inequalities and Social Determinants of Aboriginal Peoples' Health (National Collaborating Centre for Aboriginal Health, Prince George, BC, 2009).

4 See Campbell, Maria. Stories of the Road Allowance People. Penticton: Theytus Books, 1995; Peters, Evelyn, Stock, Matthew, Werner, Adrian. Rooster Town: The History of an Urban Métis Community, 1901-1961;

5 Rogers, Billie Joe, Kylee Swift, Kim van der Woerd, Monique D. Auger and R. Thor Halseth. "AT THE INTERFACE: Indigenous health practitioners and evidence-based practice." Prince George: National Collaborating Centre for Aboriginal Health (NCCAH), 2020.

6 Pambrun, Nathalie, Karen Lawford, and Carol Couchie. "Indigenous Midwifery in Canada: An Example of Healthy Relationships." Journal of Obstetrics and Gynaecology Canada 41 (2019): S259–S262. https://doi.org/10.1016/j.jogc.2019.09.004.

7 The Crown and the Plains and Wood Cree, Treaty No. 6, Canada, Treaties, Agreements and Negotiated Settlements, August 23, 1876, https://www.aandc-aadnc.gc.ca/eng/1100100028665/1100100028667.

8 See Geddes, Gary, Medicine Unbundled: A Journey Through the Minefields of Indigenous Health Care. Victoria: Heritage House, 2017.

9 Felske-Durksen, Cassandra. "Indian hospitals: the evolution of intentional coloniality and the biology of anti-Indigenous racism," Alberta Doctor's Digest, March-April 2021.

10 Maria Pontes Ferreira, Fidja Gendron, "Community-based participatory research with traditional and indigenous communities of the Americas: Historical context and future direction," International Journal of Critical Pedagogy 3, no. 3, (2011), 153-68. Bruce Dr. Friedman, Community-Based Participatory Action Research: It's All About the Community. Cognella, 2020.

11 Green, L W, and S L Mercer. "Can public health researchers and agencies reconcile the push from funding bodies and the pull from communities?." American journal of public health vol. 91,12 (2001): 1926-9. doi:10.2105/ajph.91.12.1926

12 Israel BA, Schulz AJ, Parker EA, Becker AB, Allen AJ, III, Guzman JR. Critical issues in developing and following community-based participatory research principles. In: Minkler M, Wallerstein N, editors. Community-based Participatory Research for Health. San Francisco: Jossey-Bass; 2003. pp. 53–76.

13 See Martin, D. (2012). Two-Eyed Seeing: A framework for understanding Indigenous and non-Indigenous approaches to Indigenous health. Canadian Journal of Nursing Research, 44, 20-42.

14 Ermine, Willie. "The ethical space of engagement," Indigenous Law Journal 6, 2007.193-204.

15 Verna Yiu, Kathryn Todd, Casey Eagle Speaker, Wally Sinclair. Indigenous Health Commitments: Roadmap to Wellness, Alberta Health Services (January, 2020), 11.

16 Geddes, Gary, Medicine Unbundled: A Journey Through the Minefields of Indigenous Health Care. Victoria: Heritage House, 2017. 161.

17 See Carter, Sarah, First Rider, Dorothy, Hildebrandt, Walter. The True Spirit and Intent of Treaty 7. Montreal: McGill-Queens U.P., 1996.

18 Davidson, Debra. "Evaluating the effective of living with contamination from the lens of trauma: a case study for fracking development in Alberta, Canada," Environmental Sociology 4, no. 2 (2018), 196-209.

19 See Brown, Jennifer S.H. Strangers in Blood: Fur Trade Company Families in Indian Country. UBC Press, 1980.

20 See Campbell, Maria. Stories of the Road Allowance People. Penticton: Theytus Books, 1995; Peters, Evelyn, Stock, Matthew, Werner, Adrian. Rooster Town: The History of an Urban Métis Community, 1901-1961;

21 Tamara Starblanket, Suffer the Little Children: Genocide, Indigenous Nations, and the Canadian State (Atlanta: Clarity Press, 2018); John S. Milloy, A National Crime: The Canadian Government and the Residential School System (Winnipeg: University of Manitoba Press, 1999); Ian Mosby, "'The Abiding Condition Was Hunger': Assessing the Long-Term Biological and Health Effects of Malnutrition and Hunger in Canada's Residential Schools," British Journal of Canadian Studies 30, no. 2 (2017): 147–162; Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada, Truth and Reconciliation Commission of Canada, 2015, https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Executive_Summary_English_Web.pdf.

22 Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada, Truth and Reconciliation Commission of Canada, 2015, 3, https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Executive_Summary_English_Web.pdf.

23 Travis Hay, Cindy Blackstock, and Michael Kirlew. "Dr. Peter Bryce (1853-1932): Whistleblower on Residential Schools," Canadian Medical Association Journal 192, no. 9 (2020): E223–E224.

24 Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada, Truth and Reconciliation Commission of Canada, 2015, 136, https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Executive_Summary_English_Web.pdf.

25 Cathryn Rodrigues, Rita Henderson, Katelyn Lucas Sean Bristowe, Kaylee Ramage, Katrina Milaney, Understanding Homelessness for Urban Indigenous Families: How Can We Envision Gendered and Culturally Safe Responses (Toronto: Canadian Observatory on Homelessness, Press, 2020), 17.

26 Malcolm Bow and F.T. Cook, "The History of the Department of Public Health of Alberta", Canadian Public Health Journal, Vol. 26, No. 8 (1935): p. 393.

27 The term Sixties Scoop was first coined by Patrick Johnston in a 1983 report; see Patrick Johnston, Native Children and the Child Welfare System (Ottawa: Canadian Council on Social Development, 1983).

28 Chelsea Vowel, Indigenous Writes: A Guide to First Nations, Métis, and Inuit Issues in Canada (Winnipeg: Highwater Press, 2016), 182.

29 Chelsea Vowel, Indigenous Writes: A Guide to First Nations, Métis, and Inuit Issues in Canada (Winnipeg: Highwater Press, 2016), 183.

30 Peter Menzies, "Intergenerational Trauma and Homeless Aboriginal Men," Canadian Review of Social Policy, no. 58 (2006): 1–24.

31 Suzanne Fournier and Ernie Crey, Stolen From Our Embrace: The Abduction of First Nations Children and the Restoration of Aboriginal Communities (Vancouver: Douglas and McIntyre, 1997). Also, see Cindy Blackstock, Nico Trocmé, and Marlyn Bennett, "Child maltreatment investigations among Aboriginal and non-Aboriginal families in Canada: A Comparative Analysis", Violence against women, 10 (2004): 901–916.

32 Cindy Blackstock, "Residential schools: Did they really close or just morph into child welfare?" Indigenous Law Journal, 6 (2007): 71–78.

33 Government of Alberta, "Alberta Apologizes to Sixties Scoop Survivors, May 28th, 2018, https://www.alberta.ca/release.cfm?xID=5602290F38FE0-B9A4-A910-A0FA25640F0A9EDB

34 Travis Hay, Cindy Blackstock, and Michael Kirlew. "Dr. Peter Bryce (1853-1932): Whistleblower on Residential Schools," Canadian Medical Association Journal 192, no. 9 (2020): E223–E224.

35 Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls, 189. available online at: https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Calls_for_Justice.pdf.

36 Truth and Reconciliation Commission of Canada, United Nations, National Centre for Truth and Reconciliation, and Truth and Reconciliation Commission of Canada. 2015. Truth and Reconciliation: Calls to Action, 18.

37 Truth and Reconciliation Commission of Canada, United Nations, National Centre for Truth and Reconciliation, and Truth and Reconciliation Commission of Canada. 2015. Truth and Reconciliation: Calls to Action, 2; 6

38 United Nations (General Assembly). 2007. Declaration on the Rights of Indigenous People.

39 See Hovey, R.B, Delormier, T., McComber, A.M., Levesque, L., & Martin, D. (2017). "Enhancing Indigenous health promotion research through Two-Eyed Seeing: A hermeneutic relational process." Qualitative Health Research, 27, 1278-1287.