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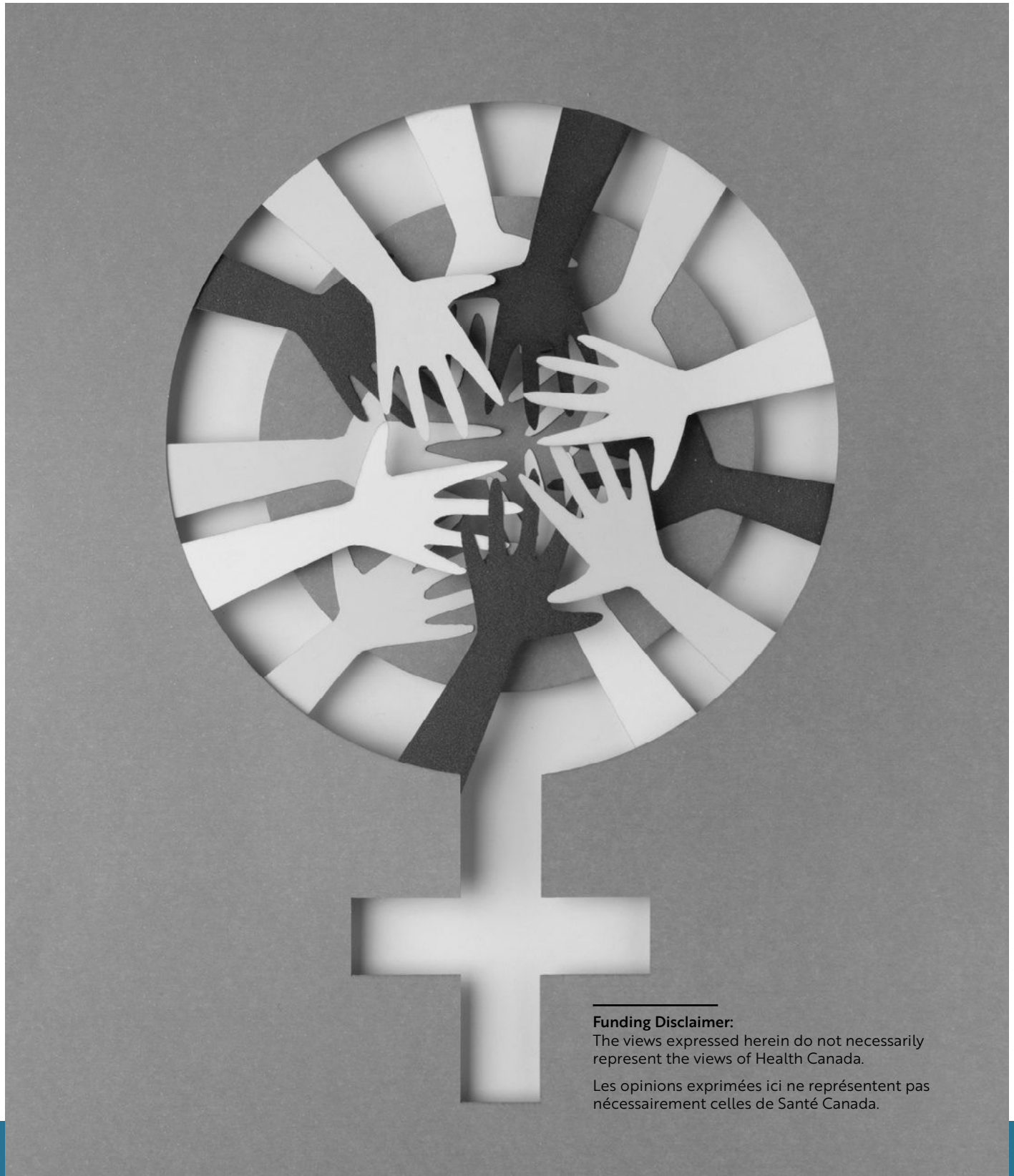
SEXUAL AND REPRODUCTIVE HEALTH



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Sexual and Reproductive Health: Barriers, Accessibility, Experiences, and Perspectives of Indigenous Women, Two-Spirit, Transgender and Gender-Diverse People

In Canada, Indigenous communities face persistent challenges in sexual and reproductive health (SRH), encountering barriers like limited access, poor quality of care, and discrimination within the health care system (Horrill et al., 2018). The experiences of Indigenous women, girls, Two-Spirit, transgender, and gender-diverse (WG2STGD) individuals in navigating health care systems are shaped by historical legacies of colonization and assimilative government policies such as residential schools and forced and coerced sterilization (MacDonald and Steenbeek, 2015). These legacies, alongside ongoing systemic discrimination, disproportionately hinder Indigenous women and gender-diverse individuals from accessing responsive SRH care (Bacciaglia et al., 2023; Horrill et al., 2018). This review explores the historical context of colonization, disparities in SRH outcomes and barriers to accessing sexual and reproductive health care. By examining these barriers, experiences and perspectives, this review strives to foster a more equitable and trauma-informed approach to SRH for Indigenous communities. In doing so, we hope to not only highlight the challenges faced by Indigenous individuals but also contribute to ongoing efforts to improve the accessibility and quality of SRH services.

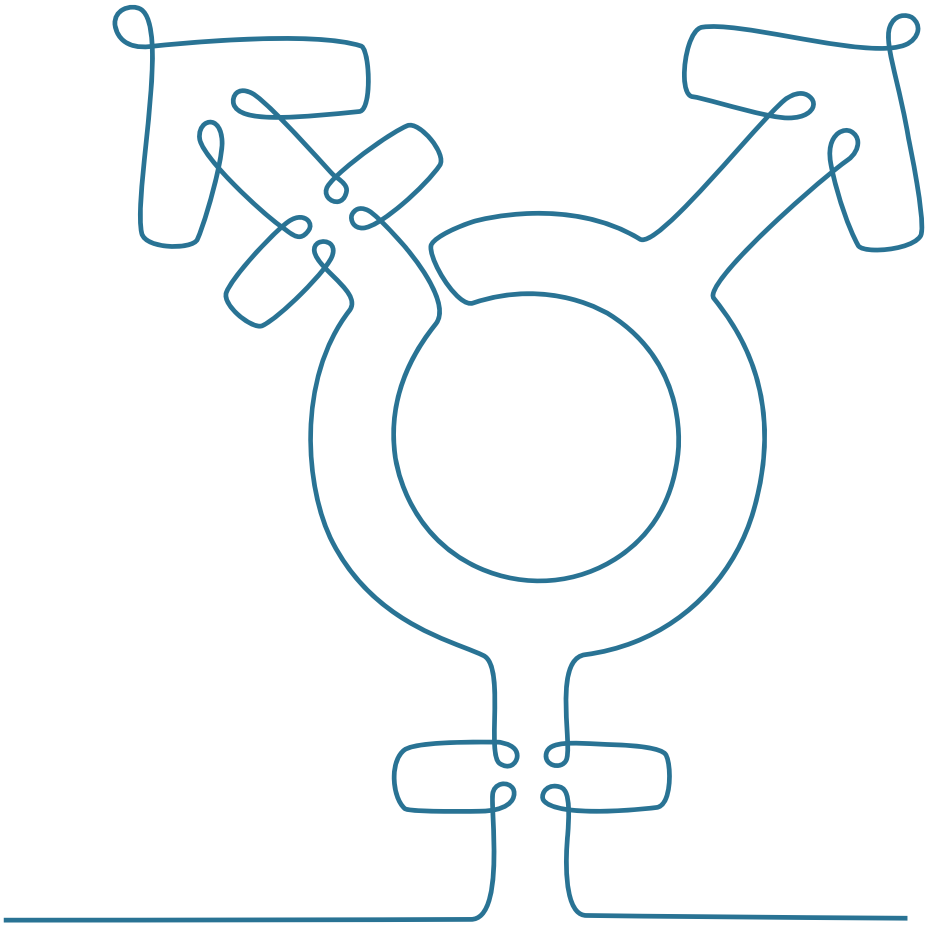
Legacy of Colonization: Shaping Indigenous SRH Experiences

The challenges in Indigenous SRH stem deeply from the enduring impact of colonization and assimilation policies on Indigenous communities. Colonization significantly altered traditional practices, eroded cultural knowledge, and disrupted Indigenous ways of life, leaving a lasting impact on Indigenous individuals' health and well-being (MacDonald and Steenbeek, 2015). The loss of traditional healing practices forced Indigenous people to accept foreign medicines and rely on patriarchal health care systems (MacDonald and Steenbeek, 2015).

Various assimilative government policies, like the residential school system contributed to the erosion and destabilization of traditional Indigenous gender roles and the disempowerment of Indigenous women (MacDonald and Steenbeek, 2015; Wakewich et al., 2015). Pre-contact, Indigenous communities were characterized by egalitarianism–valuing both genders equally. Indigenous women held central roles in their communities, serving as decisionmakers, healers, caregivers, and guardians of community traditions and values (Kubik et al. 2009; MacDonald and Steenbeek, 2015). However, the colonial legacy significantly shifted this dynamic to a male-dominated hierarchical system, which devalued, and marginalized women, positioning them as

inferior to men (Boyer and Bartlett, 2017; MacDonald and Steenbeek, 2015; Wakewich et al., 2015). Amidst this historical context, the forced and coerced sterilization of Indigenous women stands as a stark example of colonial violence (Clarke, 2021; Ryan et al., 2021). This practice involved sterilizing Indigenous women without their free and informed consent, rooted in eugenic ideologies that controlled reproductive rights (Leason, 2021; Ryan et al., 2021). This act contributed to a history of colonization and further severed the connection between Indigenous women and future generations, impacting their holistic health and well-being and deepening mistrust in health care systems (Boyer and Bartlett, 2017; Clarke, 2021; Ryan et al., 2021). This deep-seated mistrust remains a significant barrier to accessing adequate sexual and reproductive health services, leading Indigenous individuals to often forgo necessary care due to fear and suspicion.

Understanding this historical trauma and the resulting mistrust is crucial for comprehending the contemporary experiences, challenges and barriers faced by Indigenous WG2STGD individuals in accessing SRH services. The enduring legacy of colonization continues to be felt through generations of Indigenous Peoples, shaping their relationships with the health care system, and influencing their ability to access essential SRH services. In examining these barriers, experiences, and perspectives it is essential to address the historical context to dismantle these barriers and foster a more equitable and trauma-informed approach to SRH for Indigenous communities.



Diverse Experiences in Indigenous SRH

Indigenous communities in Canada face a multitude of challenges related to sexual and reproductive health (SRH) which may manifest in various forms, each impacting the well-being and livelihoods of Indigenous individuals and communities. These disparities are not isolated incidents but are deeply rooted in systemic and colonial barriers that have been imposed over generations (MacDonald and Steenbeek, 2015). They can include STBBIs, cervical cancer, maternal health concerns, and increased rates of sexual violence. These inequalities underscore the enduring impact of historical injustices and discrimination on the sexual and reproductive health of Indigenous women, girls, Two-Spirit, transgender, and gender-diverse individuals.

SEXUALLY TRANSMITTED AND BLOOD-BORNE INFECTIONS

Sexually Transmitted and Blood Borne Infections (STBBIs) pose a critical concern within Indigenous sexual and reproductive health experiences. Indigenous women face a higher risk of contracting HIV/AIDS than the non-Indigenous population (Kubik et al., 2009). Notably, from 1998 to 2012, nearly half (48.6 per cent) of reported HIV test results among Indigenous people were from women. Similar trends appear in hepatitis C, chlamydia, and gonorrhea, where Indigenous communities exhibit an elevated risk of infection (PHAC, 2014).

Experiences with STBBIs are further compounded and exacerbated by interconnected factors such as stigma, involvement in sex work, substance use, and racialized health disparities (Lys et al., 2018). Stigma, prevalent in perceptions of Indigenous WG2STGD individuals, greatly affects their willingness to seek testing and treatment for STBBIs (Wakewich et al., 2016). Moreover, Indigenous women are disproportionately represented in street-level sex work, limiting their ability to mitigate STBBI risks (Gamelin et al., 2022). Similarly, substance use contributes to the prevalence of STBBIs. Substance use before or during sex, escalates sexual risk behaviours and STI diagnoses (Estrich et al., 2014). However, injection drug use is a primary exposure category for HIV/HCV infections among Indigenous communities (Pearce et al., 2021, p.2). These factors highlight the complex experiences of Indigenous communities regarding STBBIs.

Historical and structural factors, particularly the impact of colonization, disrupted the traditional means of intergenerational communication about sexual health. As a result, parents and Elders lack the means to effectively transmit sexual health knowledge to younger generations (Rand, 2016). This knowledge gap leads to misconceptions among Indigenous women regarding their risk for STBBIs, as some perceive themselves as not at risk due to inactive sex lives or long-term monogamous relationships (Gamelin et al., 2022; Mikhail et al., 2021). The absence of comprehensive sex education further contributes to the rising infection and transmission rates (Mikhail et al., 2021).

CERVICAL CANCER AND SCREENING

Cervical cancer stands out as a significant issue within Indigenous communities' sexual and reproductive health. It constitutes 30 per cent of all cancers among Indigenous women, with British Columbia's First Nations women being 92 per cent more likely to receive this diagnosis than non-First Nations women (First Nations Health Authority, 2020; Healey and Meadows, 2007). Structural barriers impede Indigenous WG2STGD individuals from accessing crucial HPV related care and Pap screenings, contributing to these elevated rates (Gamelin et al., 2022). Additionally, mistrust in health care services, past traumas, and geographical remoteness act as significant deterrents to screenings (First Nations Health Authority, 2020). Colonization's enduring impact fosters negative body perceptions, shame, and stigma surrounding the female body, creating barriers to accessing essential treatments like Pap screenings (Wakewich et al., 2016). The physical and mental discomfort associated with these screenings and preferences for self-sampling tests due to privacy concerns and physical discomfort add further complexity. Despite a preference for self-sampling, confidence in accurate self-sampling remains a challenge, hindering efforts to improve screening rates and overall cervical health among Indigenous communities (Gamelin et al., 2022; Wakewich et al., 2016).

MATERNAL HEALTH AND BIRTHING EXPERIENCES

Maternal health and birthing experiences among Indigenous women, girls, Two-Spirit, transgender, and gender-diverse individuals pose multifaceted challenges in Canada. These individuals face heightened risks and complications during pregnancy, with Indigenous women having twice the risk of maternal mortality compared to non-Indigenous women (Kolahdooz et al., 2016). Factors like prenatal weight gain, higher rates of gestational diabetes, and mental health struggles, worsened by inadequate support systems due to common medical evacuations from remote communities, compound these challenges (Bacciaglia et al., 2023; Elamurugan et al., 2022; Healey and Meadows, 2007; Kolahdooz et al., 2016).

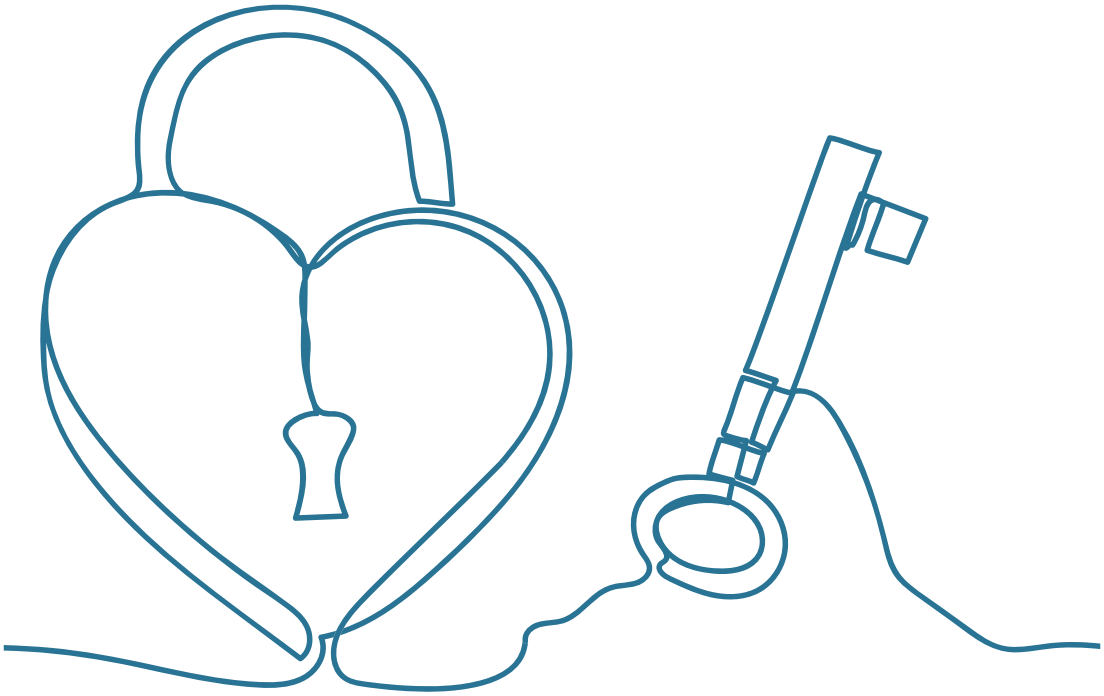
The historical displacement of culturally significant birthing practices has disrupted the traditional communal celebration of childbirth within Indigenous communities (Bacciaglia et al., 2023; Doenmez et al., 2022). Western-based overmedicalization of sexual and reproductive health care further impedes access to culturally responsive care, particularly for those living in remote areas (Hayward and Cidro, 2021). Medical evacuations to urban centres isolate individuals from their support networks, exposing them to increased racism, discrimination, and abuse. This process not only disconnects individuals from crucial cultural knowledge but also undermines birthing autonomy which is vital for holistic birthing experiences (Bacciaglia et al., 2023; Hayward and Cidro, 2021; Healey and Meadows, 2007). The loss of Traditional Knowledge leaves birthing individuals feeling disconnected, and an increased focus on medical interventions during birth, like induction and caesarean section has led to various complications and issues, which neglect the emotional, mental, and spiritual aspects that are integral to Indigenous well-being (Doenmez et al., 2022; Hayward and Cidro, 2021).

SEXUAL VIOLENCE

Indigenous WG2STGD individuals face alarmingly high rates of sexual violence, significantly impacting their sexual and reproductive health. Notably, approximately 46 per cent of Indigenous women report experiencing sexual violence, emphasizing the urgent need for action (Dion et al., 2023). Factors like alcohol access contribute to these rates, with Indigenous women more likely to link severe assaults to assailant's substance use (Perreault, 2022). Historical stereotypes perpetuated by European colonizers have led to stigmatization and constraints on discussing these issues openly (Kubik et al., 2009). Barriers, including geographic distance from essential services and mistrust of providers, hinder access to support for Indigenous individuals affected by sexual violence (Dion et al., 2023). Recognizing these barriers, both related to sexual violence, and sexual and reproductive health in general, is crucial in creating a safer and supportive environment for Indigenous individuals.

BARRIERS TO EQUITABLE SEXUAL AND REPRODUCTIVE HEALTH

Indigenous individuals, particularly women, Two-Spirit, transgender, and gender-diverse individuals face significant hurdles when it comes to accessing comprehensive sexual and reproductive health care. These barriers encompass geographical constraints, service gaps, a critical lack of cultural understanding within the health care system, and educational gaps. Understanding the complex interplay of these barriers is crucial to addressing and improving sexual and reproductive health.



GEOGRAPHIC BARRIERS

Geographic barriers are often significant impediments to accessing sexual and reproductive health services. Indigenous communities are disproportionately located in rural and remote areas, where health care facilities, services, and providers are scarce. The isolation of these regions poses a significant challenge, requiring community members to travel long distances for essential care. One of the most notable examples of this as it pertains to sexual and reproductive health is the limited availability of gynecological, postnatal, and obstetric care within many rural and remote Indigenous communities. As previously mentioned, Hayward and Cidro (2021) highlight how more than half of First Nations WG2STGD individuals living on reserves are required to travel 50 to 350 kilometres to give birth–these evacuation policies separate Indigenous individuals from their support systems and places them in unfamiliar environments (Hayward and Cidro, 2021; Kolahdooz et al., 2016; Lawford et al., 2019; Pauktuutit Inuit Women of Canada, 2022).

In the context of these geographic barriers, transportation difficulties further compound the challenges faced by Indigenous WG2STGD individuals seeking health care. The financial and personal costs associated with travel can significantly impede access to care. For instance, employed women may find it challenging to secure time off work for medical appointments or may be unable to afford to take time off (Maar et al., 2013). Moreover, various other obstacles exacerbate the situation, including a scarcity of available drivers, difficulties scheduling appointments, and a lack of accessible and available childcare support (Bacciaglia et al., 2023; Jardine et al., 2021; Maar et al., 2013). These additional hurdles make it even more challenging for Indigenous individuals in remote areas to access the sexual and reproductive health services they need.

SERVICE GAPS

Accessing sexual and reproductive health services is a fundamental right, yet Indigenous communities in Canada continue to face formidable barriers and service gaps, that have an impact on their well-being. These gaps stem from historical injustices, systemic discrimination, and a lack of cultural sensitivity within the Canadian health care system. The consequences of these service gaps are wide-reaching, affecting Indigenous WG2STGD individuals in numerous ways.

One of the most pressing challenges facing Indigenous WG2STGD individuals is accessing culturally safe care within the Canadian health care system (Yee et al., 2011). The health care services provided are often delivered without regard for cultural safety, causing discomfort and unease among individuals (Gamelin et al., 2022). The disconnect between the health care system, and services and Indigenous traditions, values, and worldviews perpetuates mistrust and hinders effective health care delivery (Pauktuutit Inuit Women of Canada, 2022; Wesche et al., 2013). For instance, in the Northern regions of Canada, the absence of culturally relevant care has resulted in issues surrounding informed consent due to language barriers. As many health care providers are non-Inuit and do not speak or deliver care in Inuktitut, Indigenous WG2STGD individuals often face challenges in fully understanding their treatment options, leading to potential medical complications and a lack of confidence in the health care system (Gamelin et al., 2022; Pauktuutit Inuit Women of Canada, 2022).

Maternal health gaps, specifically the shortage of midwives and Indigenous doulas in certain regions in Canada, further limit the culturally relevant maternal health services available. This absence not only reduces the choices available to pregnant individuals but also exacerbates health disparities (Hayward and Cidro, 2021; Mikhail et al., 2021). To address these gaps, it is crucial to provide more support and resources for Indigenous midwives and doulas and ensure culturally sensitive care during pregnancy and childbirth. As mentioned by Hayward and Cidro (2021), there have been recommendations for hospitals and birthing centres to develop protocols and policies that actively support traditional birthing customs and cultural practices. Similarly, it has been suggested that Indigenous-specific doula training be developed to reflect the needs and wisdom of community members, clients, and Elders–instead of adhering to Western standards (Doenmez et al., 2022)

In rural and remote areas, there has also been a reported shortage of physicians and health care providers to perform essential screenings, such as Pap smears. This service gap creates a substantial barrier to cervical cancer screening for individuals residing in these regions, contributing to the rising rates of cervical cancer among Indigenous WG2STGD people (Maar et al., 2013). Similarly, there have also been issues regarding the availability and retention of health care providers. As a result, individuals seeking health care services are met with long waitlists and limited access to screening and preventative services (Horrill et al., 2018).

LIMITED EDUCATIONAL OPPORTUNITIES

Access to education and training in sexual and reproductive health is a critical component in addressing the disparities faced by Indigenous communities. However, many communities contend with a lack of educational opportunities and training programs in this vital area, resulting in significant barriers to health care knowledge and access.

As previously mentioned, geographic isolation poses a multitude of challenges for numerous Indigenous communities. Particularly, in Inuit communities, there is a concerning absence of training programs for Inuit individuals to become medical professionals in the field of SRH. Those seeking training are forced to leave their communities to pursue education elsewhere, a situation that places immense strain on individuals who have no alternative but to separate from their families and communities to access education. The remoteness of many communities underscores the importance of local educational opportunities (Pauktuutit Inuit Women of Canada, 2022).

Moreover, the lack of comprehensive education on sexual and reproductive health in many communities has contributed to wide misconceptions. Misunderstandings about sexual health, sexually transmitted infections, cancer screening, contraception, and other related services are common (Mikhail et al., 2021). In such regions, local educational programs on sexual and reproductive health are vital to ensure that community members have the knowledge and skills necessary to make informed decisions about their sexual and reproductive health. Similarly, there exists a knowledge gap concerning the healthcare options available to Indigenous WG2STGD individuals. When it comes to labour and delivery, many people are unaware of the options at

their disposal, primarily due to the lack of information and coordinated support for parents (Pauukutit Inuit Women of Canada, 2022). It is recommended that both youth and Elders be involved in the process of education to ensure the barriers surrounding sexual and reproductive health can be removed (Pauukutit Inuit Women of Canada, 2022).

This literature review sheds light on the profound challenges in sexual and reproductive health faced by Indigenous women, Two-Spirit, transgender, and gender-diverse individuals in Canada. These challenges are deeply rooted in historical colonization, leading to disparities in health care outcomes. Moreover, key barriers such as geographical constraints, service gaps, discrimination, and limited educational opportunities hinder Indigenous individuals' access to comprehensive SRH care. In addressing these barriers, it is essential to amplify Indigenous voices and work collaboratively with communities and Indigenous-led initiatives to ensure equitable access to sexual and reproductive health care for all Indigenous communities in Canada.

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