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The members of the project team and the reviewers have duly completed their conflict-of-interest declarations and no situations of real, apparent, or potential conflict of interest have been identified.

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FOREWORD

The Institut national de santé publique du Québec is a public health expertise and reference centre located in Québec. Its mission is to support Québec's Minister of Health and Social Services, regional public health authorities, and local, regional and national institutions in performing their duties and responsibilities.

The État des connaissances (state of knowledge) collection brings together a variety of scientific publications that summarize and relay what the science has to say on a number of issues. To that end, it uses rigorous methods to review and analyze the scientific literature and other relevant information.

This knowledge synthesis was prepared at the request of the Ministry of Health and Social Services and funded under the Indigenous health agreement. It follows from an update to the Stratégie gouvernementale pour l'égalité entre les femmes et les hommes (gender equality strategy) drawn up by the Secrétariat à la condition féminine du Québec in response to a guideline calling for the promotion of Indigenous perspectives on gender equality in support of actions by various stakeholders involved in the health and wellbeing of First Nations and the Inuit.

Current and future actions targeting gender equality need to be adapted to the realities of First Nations and Inuit women. This knowledge synthesis is intended to help guide those actions by explaining the systemic and structural factors that influence social inequalities in health according to Indigenous women and girls.

While this document is primarily intended for employees of the Secrétariat à la condition feminine involved in implementing the gender equality strategy, it is relevant to all public health stakeholders involved in Indigenous women's health.

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HIGHLIGHTS

While Indigenous women are central to local development, lifelong social inequalities in health can be a barrier to their full participation in the social, cultural and economic life of their community. Current and future actions targeting gender equality need to be adapted to the realities of First Nations and Inuit women. This knowledge synthesis is intended to help guide those actions by explaining the systemic and structural factors that disproportionately influence their health and wellbeing.

- The qualitative literature on which this synthesis is based comprises eleven peer-reviewed articles and three research reports. The analysis identifies five health-related areas in which Indigenous girls and women report being at a disadvantage: violence (experiences of gender-based and domestic violence), sexual health (e.g., access to screening tests), perinatal health (pre- and post-delivery care and services), mental health (including stress and anxiety), and health behaviours (e.g., food security and smoking).
- Indigenous girls and women point to factors favourable to their health and wellbeing: cultural continuity, culturally safe healthcare services, and self-determination. Being connected with their culture, participating in cultural and spiritual activities, establishing a relationship of trust with care providers, and involving women in significant decisions about the community are all seen as beneficial, for example by ensuring easier access to health services and a better sense of their mental health.
- The negative impact of certain systems—health, justice, education and social services—on the health and wellbeing of Indigenous girls and women comes up in nearly all the selected literature. For example, women may remain in a situation of domestic violence because they have no other viable option or in order to avoid alerting youth protection services, which they mistrust. Moreover, participants living in remote areas report gaps in the availability of services: a lack of continuity, transportation unavailable or expensive, and employee turnover.
- Issues related to colonial governance and ideologies hold an important place in the discourse of Indigenous women. Many participants describe experiences of racism, discrimination, marginalization and historical trauma negatively affecting their health and wellbeing. Those experiences are a barrier to accessing care and services, and also contribute to the normalization of violence against Indigenous women.
- Participants report taking on many domestic chores and responsibilities, which exacerbates gender inequality and negatively impacts their health. Responsibility overload, coupled with a lack of recognition and validation, increases stress while reducing access to care. Women report being overwhelmed by the responsibilities others expect them to assume.

SUMMARY

Context

While Indigenous women are central to local development, lifelong social inequalities in health can be a barrier to their full participation in the social, cultural and economic life of their communities.

Social inequalities in health are unfair and avoidable differences in health status between social groups. For example, people who are less affluent and less educated are generally in poorer health than those who are more fortunate. A more recent perspective on social inequalities in health is that they arise from unequal power relationships between social groups, whatever the disadvantaged group may be.

Indigenous girls and women face more issues affecting their health and wellbeing than do Indigenous men and non-Indigenous women. Their life expectancy is shorter than that of non-Indigenous women, and they are at greater risk of attempting suicide and of premature delivery. Furthermore, Indigenous women experience more violence, especially sexual and domestic, and are more likely to die of homicide than are non-Indigenous women and Indigenous men.

Objective

Current and future actions targeting gender equality need to be adapted to the realities of First Nations and Inuit women. This knowledge synthesis therefore aims to identify the systemic and structural factors that exacerbate social inequalities in health as expressed by Indigenous girls and women.

Results

The selected literature comprises 14 publications (11 peer-reviewed articles and 3 research reports) whose study populations live in various parts of Canada. In a majority of cases, the participants were women over the age of 18 who identify as First Nations or Inuit. Three studies included adolescent participants, who are referred to as “girls” in this synthesis. Sample size ranged from 12 to 164 respondents.

The analysis of the results identifies five health-related areas in which Indigenous girls and women report being disadvantaged: violence (lived experiences of gender-based and domestic violence), sexual health (e.g., access to screening tests), perinatal health (pre- and post-delivery care and services), mental health (including stress and anxiety), and health behaviours (e.g., food security and smoking).

Positive influential factors

- Indigenous girls and women view cultural continuity as a core issue. A connection with their culture and participation in cultural and spiritual activities are beneficial to women's health. Adolescent girls associate such opportunities with reducing gender-based violence and reappropriating a healthy sexuality. Mental, sexual and perinatal health are enhanced by family cohesion, the reestablishment of women's traditional roles in leadership, intergenerational knowledge sharing and the practice of midwifery.
- One study suggests that Indigenous self-determination could mitigate the impact of local mining operations. According to Indigenous women, their involvement in implementing solutions could limit social disruptions associated with the opening of a mine (an increase in gender-based violence, mental health issues and psychoactive substance use).
- Four studies point to the positive influence the health system can exert. Competent staff, cultural safety and positive relations with health professionals all result in a greater use of services. Moreover, women living in an urban context where Indigenous-specific health services are available see a connection with better mental health.

Systemic challenges

- Five studies explore the health repercussions of inadequate and unsafe health services. The health system's inflexibility, for example, negatively impacts patient experiences with perinatal care. Long wait times and the need for multiple consultations are exhausting and a source of stress for patients, thereby reducing access to services.
- Distrust of the social services system is addressed in one study. According to the Inuit women interviewed, the fear of losing custody of their children increases the risk of domestic violence. Not wanting to draw the attention of authorities to their domestic situation, women hesitate to ask for help.
- Three studies found that obstacles encountered in dealings with the police and justice system are harmful to women's safety and, by extension, their health. Participants experiencing violence report barriers to obtaining assistance: ineffective handling of complaints, long response times to emergency calls, lack of round-the-clock patrols in northern villages, onerous bureaucracy, a lack of cultural skills and follow-up, and distrust.
- Another three studies, all conducted in Indigenous communities, look at the education system and its failure to teach about sexual consent, budget management and health behaviours.

Resource issues and geographic isolation

- Regarding community infrastructure and resources, gaps in services (e.g., a lack of shelters) can increase the risk of experiencing domestic violence. Many women reported staying in a violent relationship because no other viable option was available.

- Four studies examined the impact of geographic isolation on access to sexual, perinatal and mental health services. Participants spoke of the stress associated with birth evacuations and the lack of available transportation to the site of a cervical cancer screening test.

Burden of social roles: A barrier to equality

- Participants report assuming many gendered domestic tasks and responsibilities. Responsibility overload accompanied by a lack of recognition causes stress, even among girls, who say that social expectations are higher for them than for boys.
- Women report being unable to attend medical appointments because no one is available to look after their children.

The legacy of a colonial history

- Participants report recent lived experiences of various forms of racism and discrimination that have an adverse effect on their health by, for example, creating an access barrier to care.
- Many government programs, such as residential schools, the slaughter of sled dogs and forced sedentism, were rooted in an ethos of domination and assimilation. The repercussions on health and wellbeing are still felt today, including in the normalization of violence against Indigenous women.

The next step

A better understanding of the factors influencing social inequalities in health discussed in this synthesis could be a first step towards actions targeting gender equality. It is important to note that direct collaborations in a perspective of self-determination—i.e., by and for Indigenous women—are essential to implementing policies and programs that are fair, inclusive and adapted to their needs.

Methodology

The scientific and grey literature reporting on the language of Indigenous women and girls about social inequalities in health and influential factors (determinants) of health were documented and analyzed using a systematic and reproducible approach. First, themes associated with social inequalities in health were grouped using an iterative process. A deductive approach based on a codes model was then applied to the influential factors identified. Categorization was based on the Loppie and Wien (2022) model of systemic (core) and structural (root) determinants.

1 INTRODUCTION

The involvement of Indigenous women in supporting the development of their family and community, as well as in ensuring the health and wellbeing of loved ones, is beyond question (Halseth, 2013). Traditionally, they have assumed a variety of important and respected roles throughout their lives that they then pass on to future generations of women: teachers, leaders, mothers, healers, Elders, supporters and Knowledge Keepers. To this day, they are crucial to the social organization of their communities (Maertens, 2022).

On the other hand, Indigenous girls and women face more issues affecting their health and wellbeing than do Indigenous men and non-Indigenous women. They have a shorter life expectancy than non-Indigenous women and are at a higher risk of attempting suicide, delivering prematurely and being the victim of human trafficking (NIMMIWG, 2019; Halseth, 2013; Statistics Canada, 2015). Moreover, Indigenous women experience more violence, especially sexual and domestic, and are more likely to die by homicide than either non-Indigenous women or Indigenous men (Halseth, 2013; Muckle, Bélanger, *et al.*, 2020).

Given that these social inequalities in health limit their ability to act and are a barrier to participating fully in the social, cultural and economic development of their communities, the issue needs to be addressed.

1.1 Sociodemographic portrait based on survey data

Sociodemographic data collected as part of three health surveys—two in Québec and one pan-Canadian—provide a brief portrait of Indigenous women (employment, income, education, housing and family).

Qanuilirpipitaa? 2017

According to a 2017 health survey of Nunavik Inuit, a majority of women over the age of 16 (61%) had not completed high school. Nearly one of every two women was working full time, but the same proportion reported not having enough money to meet their needs (Riva *et al.*, 2020b). More than a third of Inuit women (35%) lived in overcrowded housing, defined as more than one person per room. Moreover, nearly one woman out of five (18%) said that their home was in need of major repairs (Riva et al, 2020a). Finally, about 70% of women were under the age of 19 when they became pregnant for the first time (Moisan *et al.*, 2016).

First Nations Regional Health Survey

This survey was completed by a sample of all Québec First Nations living in communities with the exception of the Cree Nation. In 2015, 53% of women were employed, a slightly higher proportion than for men. More than a quarter of women (28%) had a college or university degree, but at the same time more than a third (36%) had not finished high school (FNQLHSSC,

2018a). Finally, women were about 20 years of age on average when they first became pregnant (FNQLHSSC, 2018b).

Indigenous Peoples Survey

The target population of this Canadian survey was individuals over the age of 15 who self-identify as Indigenous and live off reserve. In 2016, half of Indigenous women (52%) held a post-secondary degree (Arriagada, 2021). About three of every five women (63%) had full-time employment, which was fewer than for men (71%). On the other hand, about one in two women (49%) felt that they would not be able to handle an unexpected expense of $500. The unemployment rate among First Nations women was 14%. About half of unemployed women reported not having the qualifications required for available jobs (Anderson, 2019).

1.2 Social roles of Indigenous women: Historical context

Before coming into contact with European colonizers, Indigenous societies generally exhibited balance and complementarity in the roles of men and women (Indigenous Foundations, 2009). All roles were considered important and each had its rightful place. Many nations were matrilinear, i.e. had a social organization in which kinship is traced through the mother's lineage. Women were held in high social esteem, especially in their role as mothers and Knowledge Keepers.

Furthermore, many Indigenous societies had a non-binary perspective of gender, with non-cisgender individuals fully accepted as part of the community (Merasty *et al.*, 2021). *Two-spirit*, a term first introduced by Elder Myra Laramee, refers to anyone who self-identifies as having both a masculine and a feminine spirit. She describes it as a sexual, spiritual and gender identity that was historically associated with specific roles in the community. Nowadays, two-spirit generally refers to non-binary Indigenous individuals, but the precise meaning and use vary among languages, nations, communities and individuals.

Colonization disrupted the social roles of girls and women (NIMMIWG, 2019) when a patriarchal European value system with a binary definition of gender was imposed (Indigenous Foundations, 2009; Perreault, 2015). The Canadian government and Christian churches targeted Indigenous women, whose core role in the organization of communities made them barriers to domination by the colonizers and to the imposition of a heteropatriarchal model (Simpson, 2016).

As a result, a multitude of practices aimed at controlling and assimilating Indigenous peoples and women were adopted, including forced sedentism, territorial dispossession, the slaughter of sled dogs, the Sixties Scoop of Indigenous children for adoption by non-Indigenous families, residential schools, and the 1876 *Indian Act*. The *Indian Act* redefined social roles within Canada's First Nations by replacing ancestral political, social and family systems with a Western model that bypassed Indigenous women. The *Act* gave men a greater role in governance, which

led to, among other things, the normalization of masculine domination within band councils (Maertens, 2022).

This short historical sketch highlights issues related to colonialism that impact Indigenous girls and women and exacerbate their social inequalities in health.

1.3 Data on social inequalities in health among Indigenous peoples

Social inequalities in health are unfair and avoidable differences in health status between social groups. Such inequalities affect all of society on a continuum. For example, people who are less affluent and less educated are generally in poorer health than those who are more fortunate. Inequality of access to conditions that influence health—such as income, employment, education and healthcare—has a greater impact on certain groups, including Indigenous peoples and women (Public Health Agency of Canada, 2023). A more recent perspective on the issue of social inequalities in health is that they arise from unequal power relationships between social groups, whatever the disadvantaged group may be (Carde, 2020).

In short, the historical, social and economic context of Indigenous girls and women exposes them to many more health-related disparities compared with Indigenous men and non-Indigenous women (Halseth, 2013). Moreover, the health of two-spirit individuals has been particularly impacted by the imposition of a Western values system.

Physical health

- On average, Indigenous women have higher levels of cholesterol, glycemia, dyslipidemia and diabetes than non-Indigenous women (Dyck *et al.*, 2010; Halseth, 2013; Jaffer *et al.*, 2021).
- In Canada, higher rates of cardiovascular disease are reported in First Nations (17%), Inuit (18%) and Métis (17%) women compared with non-Indigenous women (14%) (Jaffer *et al.*, 2021).

Mental health

- Indigenous women are three times more likely to attempt suicide than are other Canadian women (Halseth, 2013).
- More than eight of every ten Indigenous women (82%) living in an urban context report symptoms of severe depression (Benoit *et al.*, 2016).
- Two-spirit individuals are more likely to suffer from depression and anxiety, use psychoactive substances, attempt suicide and experience violence than are members of the heterosexual cisgender Indigenous population (a person whose gender identity corresponds with the sex registered for them at birth) (Hunt, 2016).

Sexual and reproductive health

- Rates of cervical cancer and cancer-related death are higher among Indigenous women than non-Indigenous women (Halseth, 2013).
- Higher rates of premature delivery are seen among Indigenous women compared with their non-Indigenous counterparts (Sheppard *et al.*, 2017).
- Indigenous women have a higher probability of contracting and dying from HIV/AIDS than non-Indigenous women (Public Health Agency of Canada, 2014; Halseth, 2013).

Moreover, social norms, values and attitudes dictating gender behaviours and roles also affect the health and wellbeing of men (World Health Organization, 2021). The following examples serve as a reminder that it is important to look beyond disparities between Indigenous women and men in striving for health equity.

- Masculinity norms rationalize risky health behaviours such as smoking, not wearing a condom, alcohol abuse and neglecting to seek healthcare (World Health Organization, 2021).
- Indigenous men have a shorter life expectancy than both Indigenous women and non-Indigenous men and are at greater risk of committing suicide (Halseth, 2013; Kumar and Tjepkema, 2019).
- Indigenous men are underrepresented in research about victims of violence despite a three times greater risk of experiencing domestic violence than non-Indigenous men (Brownridge, 2010).
- Men living in Nunavik villages have high levels of psychological distress and suicidal ideation, and frequently report lacking sufficient income to meet their needs (Muckle, Fraser, *et al.*, 2020).

1.4 A word about intersectionality

The social inequalities in health mentioned above sometimes derive from comparing data about Indigenous and non-Indigenous women, or Indigenous women and men. In other words, those examples of social inequalities in health may be connected with gender identity, cultural affiliation or a crossing over between systems of oppression. This is called intersectionality (Morrison, 2015).

Systems of oppression are based in historically rooted hierarchies and social biases (Carde *et al.*, 2015). Examples include:

- Colonialism, which involves devaluing the culture of a land's original inhabitants and forcing them to assimilate into the colonizer's culture
- Misogyny, which is a contempt for and prejudice against that which is feminine; it can manifest as institutional exclusion and gender-based violence

- Classism, which refers to discrimination and exclusion based, for example, on social class, income, employment status or place of residence.

This means that social positions—such as being a woman, two-spirit or Indigenous; having a low income; or living in a remote area—intersect in various situations and at different times, and that those intersections are detrimental to health and wellbeing. Social stratifications do not therefore act independently of one another (Carde *et al.*, 2015). In other words, considering only the gaps between Indigenous women and men minimizes the role of other social strata.

1.5 Social determinants of health: Towards an understanding

Given the health gaps observed in the Indigenous population, factors affecting their health and wellbeing—other than non-modifiable genetic factors—must be taken into consideration. This includes, for example, culture, political environment, social exclusion and access to services (Halseth, 2013). These are social determinants of health: the social conditions that influence health, as well as vulnerability to injury and disease (National Collaborating Centres for Public Health, 2012).

With regard to social determinants of health, the conceptual framework of Loppie and Wien (2022) incorporates constraints and realities specific to the Indigenous peoples of Canada. Their model organizes social determinants of health into three levels:

- **Proximate (stem) determinants** are health behaviours (smoking, drinking, diet, physical activity, etc.), geophysical environments (housing conditions and overcrowding, access to water and transportation, etc.), employment, income, and education. These determinants have a direct impact on health status.
- **Systemic (core) determinants** are the health, social services and youth protection, justice, and education systems; community infrastructure, resources and capacities; environmental stewardship; and cultural resurgence. Environmental stewardship refers to the responsible and sustainable use of the environment and its protection by individuals and groups. Cultural resurgence designates the recuperation and regeneration of Indigenous languages and traditions and a connection with ancestral lands. In this document, cultural resurgence is referred to as cultural continuity, given that Indigenous cultures have always had a degree of vitality. Core determinants refer to the consequences of flawed social and community systems on individuals and their health, as well as, by extension, on inequalities of health.
- **Structural (root) determinants** are colonial ideologies (discrimination, racism and sexism), colonial governance (residential schools and practices aimed at assimilation), and Indigenous self-determination (ownership and control of land, resources and services, as well as decision-making power). These determinants influence health through their impact on core and stem determinants.

1.6 Understanding a social phenomenon by listening

Social inequalities are a social phenomenon generated by structural forces that distribute social determinants of health unfairly (Morrison, 2015). Our understanding of the phenomenon can be improved by listening to Indigenous girls and women. Research that uses a population-based approach to study how determinants of health act has much to gain by including those who are affected in the research protocols, for they are in the best position to describe the factors that influence their health inequitably throughout their lives (Roy and De Koninck, 2013). Qualitative methodologies can be used to gain a true sense of experiences for which actions can be taken and to understand the deep-rooted causes of a population's social inequalities in health (Felner and Henderson, 2022). Finally, the oral transmission of life stories among Indigenous peoples confirms the usefulness of qualitative methods in research about them.

1.7 Research question and objectives

Current and future actions addressing equality must be adapted to the realities of First Nations and Inuit women. Understanding the systemic and structural influential factors identified in the discourse of Indigenous girls and women can help to guide those actions. This knowledge synthesis therefore aims to answer a specific question: "How do Indigenous girls and women explain the social inequalities in health that have been observed?" It is further structured around two objectives:

- List the social inequalities in health that emerge from the discourse of Indigenous girls and women.
- Identify and describe the influential factors that come to light in the discourse of Indigenous girls and women.

2 METHODOLOGY

This knowledge synthesis uses a systematic and reproducible approach. The scientific and grey literature was surveyed for publications reporting the discourse of Indigenous girls and women about social inequalities in health and the associated influential factors. A selection of publications was then analyzed.

2.1 Deconstructing the research question

The research question was formulated using the population and situation (PS) strategy.

Population: Indigenous girls and women

Taking into account the gendered repercussions of the *Indian Act* on Indigenous wellbeing, publications had to specifically study samples of Canadian Indigenous populations and deliver distinct results for girls and women. In Canada, "Aboriginal" is a legal term meaning the First Peoples who inhabited the land before the arrival of the European colonizers. The *Constitution Act, 1982*, recognizes three distinct Aboriginal (or Indigenous) peoples: Indian (First Nations with or without status), Inuit and Métis.

Situation: Social inequalities in health and influential factors

Indigenous perspectives of health are broad and go beyond the mere absence of disease. The various facets of health (physical, mental, emotional and spiritual) are supported by different pillars that are unique for each people. Indigenous languages and cultures; social and family relationships; and a connection with the land are examples of such pillars. Indigenous notions of health and wellbeing therefore transcend the individual (FNQLHSSC, 2018c).

Inequalities in health can be measured by looking at gaps in health indicators (e.g., life expectancy, prevalence of chronic disease, and perceived health) between two groups. Gaps can also be observed by studying indicators of proximate determinants of health (e.g., health behaviours such as smoking or being physically active, housing conditions, or negative experiences during childhood) (Raynault, 2019). Both approaches to identifying inequalities were used in searching the discourse of Indigenous girls and women.

The study of determinants underlying inequalities (referred to as "influential factors" in this study) was limited to those associated with systemic (core) and structural (root) determinants in the framework model of Loppie and Wien (2022). While "determinants" and "influential factors" are used synonymously in this synthesis, the latter term is preferred given that it resonates more closely with the language of Indigenous girls and women.

2.2 Literature search

In collaboration with an INSPQ librarian, four concepts were translated into keywords, MeSH (Medical Subject Heading) terms, and index terms: 1) Indigenous; 2) determinants of health/factors; 3) inequalities in health (with "gender" added to the search); and 4) Canada. Details about the literature search strategy are found in the appendices.

For the survey of peer-reviewed articles, an INSPQ librarian conducted searches of the Ovid (MEDLINE, Global Health and APA PsycInfo) and EBSCO (Health Policy Reference Center and SocINDEX) databases in June 2022.

The grey literature—any other type of original data published in the form of a research report—was explored using keywords similar to those used to search the scientific literature. The search was conducted by a professional with the support of a librarian. The Google search engine was used to launch general searches and searches within targeted websites. The Santécom, Cairn and Érudit databases were also searched.

After implementing the search strategy, duplicates were removed and the abstracts collected from 977 publications: 882 scientific articles and 95 documents from the grey literature. Following an inter-rater selection process, 14 publications (11 peer-reviewed articles and 3 reports from Indigenous organizations) were deemed to meet the selection criteria in Table 1. A flow diagram depicting the literature search process can be found in the appendices. Finally, it should be pointed out that although specific data about non-cisgender individuals (including two-spirit) was part of the initial search, the final corpus contains almost no such information. The selection criteria were therefore updated to reflect this.

Table 1 Selection criteria

	Inclusion criteria	Exclusion criteria
Population	Women, no age limits	Sample restricted to men
Context	Canada First Nations, Inuit and/or Métis Living on or off reserve	Not conducted in Canada Study looked at non-Indigenous persons in whole or in part
Topic	One or more social inequalities in health experienced by Indigenous girls and women One or more influential factors (root and core determinants) identified in the language of Indigenous girls and women	Limited to influential factors associated with proximate (stem) determinants (e.g., employment, education or income)
Methodology	Original qualitative study with a clearly defined methodology Sample size greater than 10 (Creswell and Creswell, 2018) Scientific or grey literature in English or French	Quantitative studies State of knowledge studies Doctoral theses and master's dissertations Commentaries and letters to the editor

2.3 Data extraction and analysis

A grid was used to extract the characteristics of publications: authors and year of publication, provinces or territories studied, recruitment, sample description, as well as social inequalities in health and influential factors that emerged from participant statements. A thematic analysis was then conducted, initially to group the social inequalities in health. This was done by two professionals using an iterative process following the data extraction. A deductive approach using the codes model described by Crabtree and Miller (1999) was then applied to the identified influential factors, which were categorized based on the terminology of root and core determinants in Loppie and Wien's framework model. Finally, the study results were reported in narrative form to reflect the language of the participants.

2.4 Quality assessment

For the peer-reviewed articles, the French version of the Mixed Methods Appraisal Tool (MMAT) analysis grid was used, more specifically the five questions on methodological quality (Hong *et al.*, 2020). Each question is answered with "1" or "0," and a quality score of 0 to 5 is calculated. Scores were categorized into three quality levels: low (score of 0, 1 or 2), average (score of 3 or 4) and high (score of 5). Two professionals were each asked to assess half of the selected publications. They consulted one another when the quality level of a given publication was in doubt.

In the case of reports from the grey literature, the Authority, Accuracy, Coverage, Objectivity, Date and Significance (AACODS) checklist (Tyndall, 2010), as translated into French by the Institut national d'excellence en santé et en services sociaux, was used. This checklist includes a series of questions evaluating six aspects of quality. Each aspect is assigned a score of "1" or "0," resulting in a final score of 0 to 6. The scores were then categorized into three quality levels: low (score of 0, 1 or 2), average (score of 3 or 4) and high (score of 5 or 6). The task of evaluating the quality of the research reports was assigned to a single professional.

2.5 Peer review

With respect to INSPQ's quality assurance mechanisms, a preliminary version of the synthesis was read and evaluated by two reviewers, who were provided with a standardized review grid covering content, methodology, conclusions, document completeness, and ethical issues. To ensure comprehensive follow-up, a table was prepared compiling the reviewers' comments and the steps taken in response to them. Given that the synthesis underwent substantial modifications during this process, a second validation of the reviewers' comments was conducted by a professional. This step was intended to ensure that the final version of the synthesis satisfied all the issues raised by the reviewers.

3 RESULTS

This section outlines and describes:

- The main characteristics of the selected publications
- Themes pertaining to social inequalities in health that emerge from the discourse of Indigenous girls and women
- Systemic and structural influential factors that reduce the inequalities
- Systemic and structural influential factors that exacerbate the inequalities.

3.1 Description of the selected publications

Table 2 lists the 14 selected publications: 11 peer-reviewed articles and 3 reports from the grey literature. A vast majority of authors describe their collaboration with participants, partners or community committees in defining the purpose of the research and in interpreting and communicating the results. All of the publications are in English.

Regarding sample composition, five studies looked exclusively at First Nations girls and women, while another five focused on Inuit girls and women. The sample in the other four studies comprised girls and women who self-identify with various Indigenous peoples. While nearly all the samples were composed of adult women (over the age of 18), two samples included both adolescent girls and adult women, and one targeted adolescent girls exclusively. Sample size ranged from 12 to 164 respondents.

According to the MMAT quality assessment tool, two peer-reviewed articles were deemed to be of high quality, eight average and one low. Methodological shortcomings account for the differences in score. For example, the use of verbatim quotes and results derived from the overall data collection are cursory in some cases (Flores *et al.*, 2022; MacDonald *et al.*, 2015; Oliver *et al.*, 2015; Vang *et al.*, 2018). Moreover, study limitations are not always explained clearly or the discussion is not contextualized in light of those limitations (Corosky and Blystad, 2016; Lawford *et al.*, 2018). The three reports by Pauktuutit Inuit Women of Canada were judged to be of average quality according to the AACODS checklist, the main weakness being no mention of a peer review. In addition, the data analysis lacks a full explanation.

A detailed extraction grid can be found in Appendix 3.

Table 2 Description of selected publications

Authors	People				Location	Age		*n*	Quality score
	Indigenous	First Nations	Inuit	Métis		Women	Girls		
Peer-reviewed articles									
Beaumier and Ford, 2010			X		Igloolik, Nunavut	X		49	5 High
Corosky and Blystad, 2016			X		Arviat, Nunavut	X	X	25	3 Average
de Finney *et al.*, 2013		X			British Columbia	X		63	5 High
Flores *et al.*, 2022		X		X	Toronto, Ontario	X		13	3 Average
Lawford *et al.*, 2018		X			Manitoba	X		12	4 Average
Maar *et al.*, 2013[a]		X			Ontario	X		30	4 Average
MacDonald *et al.*, 2015		X			Eastern Canada	X		26	4 Average
Oliver *et al.*, 2015		X	X	X	Prince Edward Island, Québec, Ontario and British Columbia		X	85	2 Low
van Herk *et al.*, 2011	X	X	X		Not specified	X		21	3 Average
Vang *et al.*, 2018		X	X		Québec	X		33	4 Average
Wakewich *et al.*, 2016[a]		X			Ontario	X		85	4 Average
Reports by Indigenous organizations									
Pauktuutit Inuit Women of Canada *et al.*, 2014			X		Qamani'tuaq, Nunavut	X	X	62	4 Average
Pauktuutit Inuit Women of Canada and Comack, 2020			X		Inuit Nunangat	X		85	4 Average
Pauktuutit Inuit Women of Canada and Quintessential Research Group, 2019			X		Inuit Nunangat	X		164	4 Average

[a] These studies are based on the same sample.

3.2 Themes pertaining to social inequalities in health

Due to the nature of the data collected, it is not possible to identify differences in the prevalence of certain health problems among Indigenous girls and women compared with their non-Indigenous counterparts and Indigenous men. The analysis of the results highlights various themes pertaining to social inequalities in health with respect to which Indigenous girls and women see themselves as disproportionately affected. For the purposes of synthesizing the data and improving readability, five themes were developed based on participant experiences and an Indigenous perspective of health and wellbeing. Each theme can therefore include more than one issue that is directly related to health or that can increase the risk of health problems.

Violence

Exposure to violence is a risk factor for a range of mental and physical health problems. Participant statements in five studies identified this theme as disproportionately affecting women and girls either by a perceived increase in gender-based violence and its normalization or through marginalization and stigmatization (Corosky and Blystad, 2016; Oliver *et al.*, 2015; Pauktuutit Inuit Women of Canada *et al.*, 2014; Pauktuutit Inuit Women of Canada and Comack, 2020; Pauktuutit Inuit Women of Canada and Quintessential Research Group, 2019).

Sexual health

Participants in five studies emphasized difficulties they face in obtaining a cervical cancer screening test (Pap smear) and other types of care related to sexual health (Corosky and Blystad, 2016; Maar *et al.*, 2013; MacDonald *et al.*, 2015; Oliver *et al.*, 2015; Wakewich *et al.*, 2016).

Perinatal health

Issues arising before, during and after delivery, including access to perinatal care, the probability of using those services and participants' assessment of them, are covered in three studies (Lawford *et al.*, 2018; Vang *et al.*, 2018; van Herk *et al.*, 2011).

Mental health

Participants in five studies spoke about their mental health issues, including stress, anxiety, difficulty accessing mental health care, and how they rated their experiences with care (de Finney *et al.*, 2013; Flores *et al.*, 2022; Lawford *et al.*, 2018; Pauktuutit Inuit Women of Canada *et al.*, 2014; Vang *et al.*, 2018).

Health behaviours

Smoking and the use of psychoactive substances, as well as experiences with food insecurity, are discussed in three studies (Beaumier and Ford, 2010; de Finney *et al.*, 2013; Pauktuutit Inuit Women of Canada *et al.*, 2014).

3.3 Positive influential factors

Across the selected literature, Indigenous girls and women point to factors that exert a positive influence on the five areas of social inequalities in health. In the model developed by Loppie and Wien (2022), those factors are associated with Indigenous self-determination (structural determinant) or the health system and cultural continuity (systemic determinants). The positive influential factors are set out in Table 3, followed by a detailed description.

Table 3 Influential factors that can reduce social inequalities in health

Indigenous self-determination		
Involvement of Indigenous women in decision making	**Violence, mental health and health behaviours**: Reduces specific repercussions on women's health	Pauktuutit *et al.* (2014)
Cultural continuity		
Participation in cultural and spiritual activities and a connection with the culture	**Violence**: Less violence experienced by women	Oliver *et al.* (2015)
	Sexual health: Reappropriation of sexual health	
	Health behaviours: Lowering stress reduces smoking	de Finney *et al.* (2013)
Family cohesion Reestablishment of women's traditional roles	**Sexual health**: Sharing positive ideas about women's sexuality is a lever to accessing Pap testing	Wakewich *et al.* (2016)
Transmission of health knowledge within communities	**Sexual health**: Vision of good health; sharing information on ways to take care of one's health	MacDonald *et al.* (2015)
Midwifery Presence of a support person when travelling to health services	**Perinatal health**: Perception of delivery experiences geared to the needs of women	Lawford *et al.* (2018)
	Mental health: Reduces the stress associated with birth evacuations	Lawford *et al.* (2018) Vang *et al.* (2018)
Access to a hunter and knowledge about traditional food and hunting	**Health behaviours**: Promotes food security	Beaumier and Ford (2010)
Indigenous self-determination		
Involvement of Indigenous women in decision making	**Violence, mental health and health behaviours**: Reduces specific repercussions on women's health	Pauktuutit *et al.* (2014)
Health system		
Availability of skilled professionals and cultural safety	**Sexual health**: Lever for access to Pap testing	MacDonald *et al.* (2015)
	Perinatal health: Positive healthcare experiences for patients; encourages users to access services	Vang *et al.* (2018) van Herk *et al.* (2011)
Positive relations with health professionals	**Sexual health**: Lever for access to Pap testing	MacDonald *et al.* (2015)
Access to Indigenous-specific health services	**Mental health**: Improvements in perceived mental health	Flores *et al.* (2022)

Many women see cultural continuity as a core issue

Seven studies point to a connection with culture and participation in cultural and spiritual activities as being beneficial to the health of Indigenous women. Young participants see these activities as playing a direct role in reducing gender-based violence and reappropriating sexual health by fighting colonialism, stereotypes and double standards (Oliver *et al.*, 2015). Moreover, Inuit women with no hunter in their home reported difficulty accessing traditional foods, which they tend to reserve for other family members. The presence of a hunter represents a form of food security for Inuit women (Beaumier and Ford, 2010). Mental, sexual and perinatal health also benefit from factors pertaining to cultural continuity. These include family cohesion, the reestablishment of women's traditional roles (rooted in leadership and the value attributed to motherhood), community transmission of knowledge, midwifery, and the presence of a support person when travelling to receive health services (Lawford *et al.*, 2018; MacDonald *et al.*, 2015; Vang *et al.*, 2018; Wakewich *et al.*, 2016).

Indigenous self-determination to mitigate the disturbance of mining operations

Indigenous self-determination, specifically the ability of Indigenous girls and women to make decisions for themselves, is addressed in one study that took place in a Nunavut community with a mining operation (Pauktuutit Inuit Women of Canada *et al.*, 2014). That study looked at the lack of involvement by Inuit women in decision making about the community and the mine. According to the women, being consulted about and involved in the implementation of services and solutions could limit the social disturbances observed after the mine opened (increase in gender-based violence, mental health issues and the use of psychoactive substances).

A culturally safe health system: A lever for accessing healthcare

Four studies suggest that the health system could have a positive influence. The presence of skilled healthcare professionals and a culturally safe healthcare environment are seen as a means of increasing the use of services, including Pap testing, in addition to improving patient experiences with perinatal care (MacDonald *et al.*, 2015; Vang *et al.*, 2018; van Herk *et al.*, 2011). Furthermore, positive relations with healthcare professionals increase access to Pap testing, according to Mi'kmaq participants (MacDonald *et al.*, 2015). Flores *et al.* (2022), who looked at the experiences of Métis and First Nations women during the COVID-19 pandemic, further show that participants who were able to access Indigenous-specific healthcare services saw themselves as having better mental health.

3.4 Negative influential factors: Systems

Nearly all the selected publications address the adverse influence of various systems (health, social services, justice and education) on the health and wellbeing of Indigenous girls and women. Table 4 presents data about those negative influential factors, followed by a description.

Table 4 Negative influential factors associated with systems

Health system		
Lack of follow-up and reminders	**Sexual health**: Access barriers to Pap testing	Maar *et al.* (2013)
Lack of skills and cultural safety		
Challenge of maintaining privacy in small communities		MacDonald *et al.* (2015) Wakewich *et al.* (2016)
Onerous bureaucracy	**Perinatal health**: Pregnant patients have bad experiences with care and services	Vang *et al.* (2018)
Telemedicine services not culturally adapted	**Mental health**: Lower perceived mental health	Flores *et al.* (2022)
Social services system		
Fear of having children removed by protective services	**Violence**: Women remain in situations of violence because they fear alerting child protection services	Pauktuutit and Quintessential Research Group (2019)
Justice system and the police		
Ineffective handling of sexual aggression complaints and difficulty applying legal sanctions	**Violence**: Sexual violence against women is rarely if ever reported	Corosky and Blystad (2016)
Police lack cultural skills and have little social involvement	**Violence**: Difficulty in reporting gender-based violence, especially in domestic situations	Pauktuutit and Comack (2020)
No round-the-clock patrols		
Slow processing of criminal charges and response to emergency calls		Pauktuutit and Comack (2020)
Distrust of the justice system and police		Pauktuutit and Quintessential Research Group (2019)
Education system		
Lack of education about sexual consent	**Violence**: Some women are not aware that they can refuse sexual relations	Corosky and Blystad (2016)
Health education not adapted to the population's culture or needs	**Sexual health**: Barrier to cervical cancer screening	Maar *et al.* (2013)
No education on managing a budget	**Health behaviours**: Women (who are the primary meal planners) have difficulty planning food purchases	Beaumier and Ford (2010)

The health system and barriers to accessing care

Five studies in the selected literature found the health system to be a negative influential factor, pointing to the impact of inadequate and unsafe healthcare services on health problems experienced by Indigenous girls and women.

The challenge of maintaining privacy in small communities was one concern raised. This creates a barrier to cervical cancer screening for First Nations women, some of whom prefer to receive services outside the community despite more complicated travel logistics (MacDonald *et al.*, 2015; Wakewich *et al.*, 2016). The absence of a medical reminder system, a lack of qualified staff, and cultural misunderstandings are further barriers to accessing this particular sexual health service (Maar *et al.*, 2013), all this over and above distrust of a system seen as rigid (MacDonald *et al.*, 2015).

The system's rigidity also impacts experiences of perinatal care. Bureaucratic procedures (long wait times and multiple consultations with different health professionals) can be exhausting for Indigenous patients, who report a lack of familiarity with hospital bureaucracy (Vang *et al.*, 2018). During the COVID-19 pandemic, moreover, women reported that hard-to-access and inappropriate remote medical services were harmful to their mental health (Flores *et al.*, 2022).

Distrust of the social services system

One study looked at the child protection system being especially detrimental to the wellbeing of Indigenous women. The fear of losing custody of one's children increases the risk of domestic violence, as many Indigenous mothers hesitate to seek assistance from the authorities for fear of drawing attention to their difficult family situation (Pauktuutit Inuit Women of Canada and Quintessential Research Group, 2019).

Failures of the justice system and police exacerbate gender-based violence

Barriers encountered by Indigenous girls and women in their relations with the police and justice system have a negative effect on their security and, by extension, their health. Three studies looking at the justice system included Inuit participants, who reported barriers to obtain help in situations of violence (Corosky and Blystad, 2016; Pauktuutit Inuit Women of Canada and Comack, 2020; Pauktuutit Inuit Women of Canada and Quintessential Research Group, 2019). Various shortcomings were reported by participants: ineffective handling of sexual aggression complaints and other criminal charges, slow response times to emergency calls, a lack of round-the-clock patrols in northern communities, and an onerous bureaucracy. Also mentioned were a lack of cultural skills and follow-up on the part of the police, as well as a distrust of the justice system.

An education system

In three studies, Indigenous girls and women spoke about deficiencies of the education system. Education about sexual health and consent is insufficient and does not correspond to the needs

and culture of Indigenous girls and women (Corosky and Blystad, 2016; Maar *et al.*, 2013). This specifically puts them at a higher risk of violence since they do not always know that they can refuse sexual relations. Moreover, deficiencies in education about budget management exacerbate problems with grocery purchases, in turn leading to food insecurity. Inuit women report being responsible for family meals and sometimes going without food so that others can eat (Beaumier and Ford, 2010).

3.5 Negative influential factors: Resource issues

A second category of negative influential factors concerns community infrastructure, resources and capacities, factors that may reflect the socioeconomic situation of a community or locality. Table 5 summarizes these influential factors, followed by a detailed description.

Table 5 Negative influential factors pertaining to operational issues

Community infrastructure and resources		
Community's remote location	**Violence**: Women wanting to leave a violent situation find it difficult to do so	Pauktuutit and Comack (2020) Pauktuutit and Quintessential Research Group (2019)
	Sexual health: Barrier to accessing Pap testing	Maar *et al.* (2013)
	Perinatal health: Birth evacuation doesn't meet women's needs; difficult to travel to services	Lawford *et al.* (2018) Van Herk *et al.* (2011) Vang *et al.* (2018)
Staff turnover	**Violence**: Difficult to report violence; limited shelter space	Pauktuutit and Comack (2020) Pauktuutit and Quintessential Research Group (2019)
	Sexual health: Barrier to accessing Pap testing	Maar *et al.* (2013) Wakewich *et al.* (2016)
	Mental health: Continuity of mental health services is compromised	Pauktuutit *et al.* (2014)
Underfunding of services High cost of air travel outside the community	**Violence**: Women remain in situations of violence for lack of a viable option	Pauktuutit and Comack (2020) Pauktuutit and Quintessential Research Group (2019)
Gaps in services for Indigenous women dealing with violence, addiction or mental health issues	**Violence**: Barriers to reporting domestic and sexual violence; violence against women may increase because of other people's addiction and mental health problems	Pauktuutit *et al.* (2014) Pauktuutit and Comack (2020) Pauktuutit and Quintessential Research Group (2019)
	Mental health: Little continuity in services	Pauktuutit *et al.* (2014)
	Health behaviours: Arrival of the mine brought more disposable income and social disruption; increased use of psychoactive substances	
Insufficient legal infrastructure	**Violence**: No holding cells; gender-based violence	Pauktuutit and Comack (2020)
Increased presence of temporary male workers	**Violence**: More sexual violence against women	Pauktuutit and Quintessential Research Group (2019)

Table 5 Negative influential factors pertaining to operational issues (continued)

Community capacities		
Gendered household chores and responsibilities	**Violence**: Dependence on the income of a violent partner for childcare	Pauktuutit and Comack (2020)
	Sexual health: Access barriers to care (e.g., the need to look after children)	Corosky and Blystad (2016) MacDonald *et al.* (2015)
	Mental health: Source of stress (e.g., higher social expectations on girls than boys); birth evacuation provokes anxiety (e.g., need to look after older children)	de Finney *et al.* (2013) Flores *et al.* (2022) Vang *et al.* (2018)
	Health behaviours: Women primarily responsible for meals; they may eat less to leave more for other family members; smoking is a way to manage stress	Beaumier and Ford (2010) de Finney *et al.* (2013)

Lack of infrastructure and resources

Gaps in services for Inuit girls and women caused by a lack of community infrastructure and resources (e.g., housing shortages) are identified as a factor increasing the risk of experiencing domestic violence (Pauktuutit Inuit Women of Canada *et al.*, 2014; Pauktuutit Inuit Women of Canada and Comack, 2020; Pauktuutit Inuit Women of Canada and Quintessential Research Group, 2019). Many women reported staying in a violent relationship due to lack of other options. Moreover, given that many northern communities are accessible only by airplane, women wanting to leave a situation of violence are faced with the high cost of travel. Similarly, gaps in legal infrastructure (e.g., no holding cells) make it more difficult to request and receive assistance in situations of violence (Pauktuutit Inuit Women of Canada and Comack, 2020).

In addition, four studies show the impact a community's remote location has on access to sexual, perinatal and mental health services (Lawford *et al.*, 2018; Maar *et al.*, 2013; Vang *et al.*, 2018; van Herk *et al.*, 2011). Participants mentioned, for example, the stress associated with birth evacuations (Vang *et al.*, 2018) and lack of transportation to a location offering cervical cancer screening (Maar *et al.*, 2013).

Continuity gaps in social and health services for Indigenous girls and women (including mental health and addiction treatment services) are reported in three studies (Maar *et al.*, 2013; Pauktuutit Inuit Women of Canada *et al.*, 2014; Wakewich *et al.*, 2016). For example, Inuit women mention social disruptions following the opening of a mine, including an increase in the use of psychoactive substances—a situation exacerbated by gaps in addiction services (Pauktuutit Inuit Women of Canada *et al.*, 2014). Furthermore, staff turnover reduces access to cervical cancer screening for First Nations women (Maar *et al.*, 2013; Wakewich *et al.*, 2016).

Community capacities: Responsibility overload

The domestic chores, roles and responsibilities assumed by Indigenous girls and women can be considered part of a community's capacities, inasmuch as they are a form of social resource.

However, the unequal distribution of responsibilities in Indigenous communities contributes to social inequalities in health, as demonstrated in seven studies.

The stress spawned by those responsibilities has repercussions on mental health (de Finney *et al.*, 2013; Flores *et al.*, 2022, Vang *et al.*, 2018). For example, participants described different ways that the COVID-19 pandemic had adversely affected their mental health. The situation was aggravated by responsibilities falling specifically to women, such as caring for children and helping them with their online education (Flores *et al.*, 2022). Moreover, domestic responsibilities are a barrier to healthcare, as some women mentioned not having anyone else to look after the children and home so that they could go to an appointment (Corosky and Blystad, 2016; MacDonald *et al.*, 2015). Young First Nations women report that adolescent girls in their community smoke due to stress. The responsibility to provide care (e.g., looking after younger brothers and sisters) and perform domestic chores (e.g., cooking and cleaning) is a major source of stress. These responsibilities are assigned more often to girls than to boys (de Finney *et al.*, 2013).

In addition, food insecurity affects Inuit women more than men. Given their primary responsibility for family meals, they report regularly skipping meals or taking smaller portions to allow other family members to eat first (Beaumier and Ford, 2010). In short, gendered responsibilities have specific repercussions on the health and wellbeing of Indigenous girls and women.

3.6 Negative influential factors: Colonialism through the years

The selected publications show the influence of colonialism over the years on the health and wellbeing of Indigenous girls and women. Table 6 summarizes the negative influential factors associated with colonialism, followed by a description of the results.

Table 6 Negative influential factors rooted in colonialism

Colonial ideologies		
Discrimination based on • HIV status • Socioeconomic status • Race • Sex • Sexual orientation and gender identity	**Violence**: Marginalization and stigmatization of women living with HIV; perception of an increased risk of violence for young people who reveal their sexual orientation or gender identity	Corosky and Blystad (2016) Oliver *et al.* (2015)
	Sexual health: Access barrier to cervical cancer screening; lower probability of requesting help with HIV	MacDonald *et al.* (2015) Wakewich *et al.* (2016) Oliver *et al.* (2015)
	Perinatal health: Access barrier to care; lower probability of using services; negative care experiences for patients	Vang *et al.* (2018) Van Herk *et al.* (2011)
Imposition of patriarchy	**Violence**: Sexual violence experienced by women; marginalization and stigmatization of women living with HIV	Corosky and Blystad (2016) Oliver *et al.* (2015)
	Sexual health: Access barrier to healthcare	Corosky and Blystad (2016) MacDonald *et al.* (2015)
	Mental health: Social roles result in stress	de Finney *et al.* (2013)

Table 6 Negative influential factors rooted in colonialism (continued)

Colonial ideologies (continued)		
Normalization of violence against Indigenous women	**Violence**: Sexual violence experienced by women	Corosky and Blystad (2016) Pauktuutit and Comack (2020) Pauktuutit and Quintessential Research Group (2019)
Hypersexualized stereotypes of Indigenous women	**Violence**: Marginalization and stigmatization of women living with HIV	Oliver *et al.* (2015)
	Sexual health: Lower probability of requesting help with HIV	Oliver *et al.* (2015) Wakewich *et al.* (2016)
Colonial governance		
Residential schools	**Violence**: Normalization of violence against women	Pauktuutit and Comack (2020) Pauktuutit and Quintessential Research Group (2019)
	Sexual health: Body shame and shyness due to experiences of sexual aggression; loss of contact with the family; no family education about the body and intimacy	Maar *et al.* (2013) MacDonald *et al.* (2015) Wakewich *et al.* (2016)
Slaughter of sled dogs Forced sedentism	**Violence**: Normalization of violence against women	Pauktuutit and Comack (2020) Pauktuutit and Quintessential Research Group (2019)
Eradication of traditional birthing practices	**Perinatal health**: Delivery methods not geared to women's needs	Lawford *et al.* (2018)

Colonial ideologies: Interactions tainted by discriminatory beliefs

Participants' experiences reflect the persistent beliefs and visions rooted in colonialism that portray Indigenous peoples—women in particular—in a pejorative light. This is especially seen in the form of discrimination based on race, sex and serological status, which increases the marginalization and stigmatization of women living with HIV (Oliver *et al.*, 2015). Furthermore, discrimination against sexually diverse and non-cisgender individuals makes young people hesitant to reveal their gender identity and sexual orientation because of the risk of violence (Corosky and Blystad, 2016). Finally, participants see the imposition of patriarchal values and the banalization of gender-based violence as the cause of marginalization and sexual violence experienced by Indigenous women (Corosky and Blystad, 2016; Oliver *et al.*, 2015; Pauktuutit Inuit Women of Canada and Comack, 2020; Pauktuutit Inuit Women of Canada and Quintessential Research Group, 2019).

Two studies show that the sexual health of Indigenous girls and women is especially impacted by gender-based discrimination and stereotypes. The young women in Oliver *et al.* (2015) recounted events in which they were subjected to hypersexualized stereotypes of Indigenous women. Those stereotypes create a double standard whereby men are authorized to be sexually active while women are encouraged to be sexually passive. As a result, Indigenous women face greater rejection and difficulty than men in obtaining help if they contract HIV. According to First Nations women in Ontario, access to screening tests is also affected by the hypersexualized stereotype of Indigenous women (Wakewich *et al.*, 2016). The fear of stigmatization associated

with the HPV virus is a barrier to cervical cancer screening, while women are also blamed by their partners for STIs. In short, both studies detail the sexual health issues expressed by women who are affected by gender stereotyping.

Impact of a history of colonial governance

Two studies examine the role played by residential schools, as well as other policies aimed at acculturating Indigenous peoples, in fostering gender-based violence. The slaughter of sled dogs and forced sedentism of the Inuit, which disrupted their traditions and value systems, is associated with an increase in gender-based violence (Pauktuutit Inuit Women of Canada and Comack, 2020; Pauktuutit Inuit Women of Canada and Quintessential Research Group, 2019).

Residential schools have also been connected with sexual health issues. Women speak of body shame and shyness caused by the sexual assaults they endured as being an access barrier to care (MacDonald *et al.*, 2015; Maar *et al.*, 2013). Moreover, sending children to residential schools separated families and limited the education Indigenous girls and women received at home about their body and intimacy, thereby erecting another barrier to sexual health (Wakewich *et al.*, 2016).

Finally, First Nations women who experienced birth evacuation point to the eradication of traditional delivery practices. They explain that the almost total disappearance of traditional practices has left them feeling dissatisfied with their delivery experience (Lawford *et al.*, 2018).

4 DISCUSSION

The discourse of Indigenous girls and women examined in this knowledge synthesis sheds light on five themes pertaining to social inequalities in health: violence; sexual, perinatal and mental health; and health behaviours. Participants explain those inequalities by citing various influential factors. Positive influential factors, as well as negative factors related to systems, discrimination, and gendered roles and responsibilities, are discussed below. The section closes with an evaluation of the strengths and limitations of the approach.

4.1 Importance of focusing on strengths

In striving for health equity, a strengths-based approach is just as important to improving the health of Indigenous men as it is that of Indigenous women. Such a perspective involves identifying and supporting the various strengths and motivations, as well as factors for resilience and protection, that foster the wellbeing of Indigenous populations (FNIGC, 2020). That said, it nevertheless important to specifically identify strengths perceived by Indigenous girls and women. Their discourse in the selected literature points to three positive factors—self-determination, cultural continuity, and culturally safe care and services—, making it imperative to establish conditions that allow those strengths to prosper.

First, the only data compiled about self-determination was collected in a community with mining operations. That study showed the potential advantages of involving women in decision making (Pauktuutit Inuit Women of Canada *et al.*, 2014). The importance of such involvement is also described in the literature (NIMMIWG, 2019). Direct collaborations and a perspective of self-determination, i.e. by and for women, are critical in implementing policies and programs that are fair, inclusive and adapted to their realities.

Next, an analysis of the data underscores that cultural continuity plays a decisive role in ensuring the wellbeing of Indigenous girls and women. Those results are compatible with literature on the subject showing that cultural continuity is a key aspect of wellbeing and healing for Indigenous peoples in Canada (Chandler and Dunlop, 2018; NIMMIWG, 2019). According to our synthesis, cultural continuity is of particular importance to women's health. Specifically, revitalizing the practice of midwifery and the leadership role of Indigenous women and mothers would enhance their perinatal and mental health (Lawford *et al.*, 2018; Wakewich *et al.*, 2016).

Finally, ensuring competent and culturally safe health services and developing respectful relationships with health professionals would foster good health and wellbeing (Flores *et al.*, 2022; MacDonald *et al.*, 2015; Vang *et al.*, 2018; van Herk *et al.*, 2011). The merits of providing culturally safe social and health services to improve the health status of Indigenous populations are well known (CERP, 2019), but the data surveyed supports the specific importance that this represents for women's health. Cultural safety facilitates access to healthcare and social services, for women report that positive experiences in the past encourage use of healthcare services.

4.2 Systemic challenges still to overcome

While Indigenous girls and women identify the foregoing strengths, they also point to barriers to their health and wellbeing entrenched in the health, social services, justice and education systems. Intersecting systems of oppression are reflected in the scale of the barriers they face. For example, participants report having problems with the health system because they are women, Indigenous or mothers; live in a remote area; or have a low income. All these factors intersect in creating systemic challenges.

The Commission d'enquête sur les relations entre les Autochtones et certains services publics au Québec (CERP, 2019) demonstrated the scope of the barriers Indigenous patients face when accessing health services. Indigenous girls and women encounter specific hurdles. The selected literature shows that staffing shortages together with a lack of follow-up and reminders in the health system, as well as privacy issues within Indigenous communities, affect women's health disproportionately (Maar *et al.*, 2013; MacDonald *et al.*, 2015; Wakewich *et al.*, 2016). Participants report that when healthcare services are unsafe and ill-adapted to their needs and context, access to and use of those services is limited.

The data surveyed also points to a distrust of social services. Mothers experiencing domestic violence hesitate to lodge a complaint for fear of possibly losing custody of their children if child protection services are alerted (NIMMIWG, 2019). Their distrust is rooted in the widespread practice by non-Indigenous child protection services of removing Indigenous children—a practice that has resulted in Indigenous children being overrepresented in Canadian foster homes. They are, in fact, overrepresented throughout the continuum of services, including investigations (Fallon *et al.*, 2021). Moreover, the failure of the child protection system to recognize Indigenous culture and values severs children's relationship with their culture (NIMMIWG, 2019).

While all the studies in the corpus looking at the justice system and police services were conducted in Inuit Nunangat, the situation appears to be similar elsewhere. Women report long wait times when they register a complaint against an assailant or require emergency services (Corosky and Blystad, 2016; Pauktuutit Inuit Women of Canada and Comack, 2020; Pauktuutit Inuit Women of Canada and Quintessential Research Group, 2019). Similar problems arise in First Nations and Métis communities. For example, the Commission d'enquête sur les relations entre les Autochtones et certains services publics (2019) was launched following media revelations of sexual assaults and abuses of power by police against First Nations women. Finally, it should be noted that Indigenous women are twice as likely to report having little or no confidence in the police as are non-Indigenous women (17% vs. 8%) (Heidinger, 2022).

While only three studies, all conducted in Indigenous communities, examine the education system (Beaumier and Ford, 2010; Corosky and Blystad, 2016; Maar *et al.*, 2013), the problems identified have a recurrent theme, namely a lack of education about sexual consent, budget management and proactive health behaviours. Educating both girls and boys about those subjects would foster the wellbeing of girls. Those results are in keeping with testimonials

collected by Indigenous Services Canada (2017) concerning academic education in Indigenous communities, which point to a need for the development of personal and social skills (financial planning, adopting a healthy lifestyle and sex education). However, a significant lack of resources, funding and staff in Indigenous communities makes it difficult to offer that type of education (Indigenous Services Canada, 2017).

4.3 The legacy of colonial structures

The language of Indigenous girls and women brings to light experiences of various forms of racism and discrimination that adversely affect their health. It should be noted that racism and social exclusion are considered a determinant of health not only in the selected framework model but in others as well (Raphael *et al.*, 2021). While discriminatory behaviour tends to be less openly acceptable nowadays (Howell *et al.*, 2016), Indigenous peoples in Canada still experience other forms of exclusion (Raphael *et al.*, 2021).

Racist, sexist and classist behaviours and attitudes (pertaining to race, gender or social class) take root in discriminatory ideologies (Howell *et al.*, 2016). Such ideologies create and maintain a social hierarchy in which some people are privileged and others oppressed. For example, Indigenous peoples were oppressed by colonizers, and the resulting social hierarchy, although morally unjustified, has been maintained (Howell *et al.*, 2016). In order for an individual or organization to adopt discriminatory behaviour against a group, that behaviour must be deemed acceptable because of that group's lower hierarchical standing. Historically, many government programs—including residential schools, the slaughter of sled dogs and forced sedentism—are rooted in an ethos of domination (Simpson, 2016). The repercussions on health and wellbeing are still felt today, including in the normalization of violence against Indigenous women, as the language of participants in the studies surveyed confirms.

4.4 The burden of social roles: A barrier to equality

Women throughout the world bear a disproportionate burden of unpaid work (Gladu, 2021). Tasks associated with domestic chores, volunteer work and caring for family members generally fall to women because of patriarchal gender roles (Gladu, 2021). That type of work, which is not part of the labour market economy, is nevertheless critical to the smooth functioning of homes, communities and the overall economy. Canadian women do nearly two thirds of all unpaid work and face specific challenges because of their domestic responsibilities, such as lower economic security and issues around mental and physical health (Gladu, 2021). This situation is also reflected in the language of Indigenous girls and women.

Furthermore, women have historically assumed various key roles that are valued in Indigenous communities and that still continue in a contemporary form (mother, supporter, caregiver) (Maertens, 2022). Today, however, historical gender reciprocity has given way to a situation where women's roles are less valued than so-called "masculine" roles and jobs. In the selected literature, Indigenous girls and women talk about having to assume a multitude of gendered domestic chores and responsibilities, which accentuates gender inequalities. Responsibility

overload, together with a lack of recognition, has an impact on mental health through increased stress levels (de Finney *et al.*, 2013; Flores *et al.*, 2022). It also limits access to healthcare, since women report, for example, not having anyone else to look after the children when they have a medical appointment (Maar *et al.*, 2013; MacDonald *et al.*, 2015). Gendered expectations are harmful to the health of Indigenous girls and women, which in turn limits their full participation in the social and economic development of their communities.

4.5 Strengths and limitations of the approach

In terms of strengths, concentrating on the discourse of Indigenous girls and women made it possible to survey and describe influential factors that, in their view, are disproportionately harmful to their health and wellbeing. The perspectives of Indigenous girls and women were validated, thereby shedding light on the problems they experience, as well as on potential solutions. The approach does, however, have certain limitations.

First, the extraction and analysis of data shows overall results of the selected studies. Based on the available data and its heterogeneity, a global portrait was established, which should be seen as exploratory work to orient future efforts. For this reason, the compiled data was not analyzed on the basis of the specific Indigenous peoples studied, even though geographic, political and cultural situations can vary from one Indigenous community to another. Moreover, no analysis was conducted on the basis of age (adolescent, young adult, elder, etc.), yet a person's developmental level and associated experiences (with discrimination, for example) can vary with age. In other words, it was not possible to examine some aspects specific to a lived context.

Similarly, certain issues pertaining to social inequalities in health did not emerge from the extracted data, such as infectious and chronic diseases. In the same vein, some topics—such as the forced sterilization of Indigenous women—were absent from the discourse in the selected studies (FNQLHSSC, 2022). This may be due to the difficulty of bringing up traumatic experiences in the context of a research project.

Finally, for the sake of feasibility and obtaining a fuller understanding of social inequalities in health, only influential factors on the systemic and structural levels were considered. And yet, proximal determinants of health such as income and employment disparities go a long way towards explaining health gaps between Indigenous women and men (Hu and Hajizadeh, 2022). Given the means available, moreover, targeting proximate changes (e.g., encouraging student retention) may be more realistic than aiming for systemic changes (e.g., within the health and social services system). Nevertheless, proximate determinants have been and will continue to be influenced by root and core factors, which are the target of this knowledge synthesis.

5 CONCLUSION

This synthesis draws a portrait of the factors that influence social inequalities in health based on the discourses of Indigenous girls and women. The selected publications bring to light five themes pertaining to social inequalities in health: violence; sexual, perinatal and mental health; and health behaviours. Systemic and structural influential factors are then identified using the model of Loppie and Wien (2022).

Indigenous girls and women discuss factors that are favourable to their health and wellbeing: self-determination, cultural continuity, and culturally safe healthcare and services. This underscores the need to ensure that conditions are in place for those strengths to flourish. While recognizing certain strengths, women and girls also identify barriers imbedded in the health, social services, justice and education systems, as well as gaps in community infrastructure and resources.

The importance Indigenous girls and women attribute to the repercussions of colonial governance and ideologies is noteworthy. Many participants described experiences of racism, discrimination, marginalization and a history of trauma that adversely affect their health and wellbeing.

Moreover, Indigenous girls and women report assuming a multitude of gendered domestic chores and responsibilities, which accentuates gender inequalities. Responsibility overload, as well as a lack of recognition and validation for the work they do, impacts their health. Being overwhelmed by responsibility for others is one reason participants give for experiencing higher stress levels and reduced access to healthcare.

In short, gender equality actions adapted to the needs and realities of First Nations and Inuit women could reduce social inequalities in health. Developing an understanding of the influential factors identified in this synthesis could be a preliminary step towards those actions. Direct collaborations in a perspective of self-determination, i.e. by and for women, are key to implementing policies and programs that are fair, inclusive and adapted to their situation.

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APPENDIX 1 LITERATURE SEARCH STRATEGY

Ovid (MEDLINE, APA PsycInfo, Global Health)

#	Query
1	MeSH MEDLINE : "American Native Continental Ancestry Group"/ or exp "Indians, North American"/ or "Indigenous Peoples"/ or MeSH PsycInfo et Global Health : "American Indians"/ or Inuit/ or (ab#na* or aborigin* or "ai/an" or aleut* or algonqui* or (america* adj2 indian*) or amerind* or anishina* or at?ikame* or autocht* or cree* or cri or cris or dene* or eskimo* or (first adj (nation* or people*)) or huron* or indigenous or in?uit* or innu* or inuk* or iroquoi* or mal#cite* or m#tis or micmac* or "mi'#ma*" or mohawk* or naskap* or native* or tribal or tribe or tribes or wendat*).ti,ab,kf.
2	MeSH MEDLINE : "Health Equity"/ or exp "Health Inequities"/ or "Protective Factors"/ or "Risk Factors"/ or "Social Determinants of Health"/ or "Sociology, Medical"/ or MeSH PsycInfo et Global Health : "Health Disparities"/ or "Protective Factors"/ or "Risk Factors"/ or "Sociocultural Factors"/ or (access or accessibilit* or advantage* or ancestral or assimilat* or barrier* or "care system*" or colonial* or coloni#ation* or "community capacit*" or connection* or contaminat* or correlate or correlates or cultural or determinant* or determination or difference* or disadvantage* or discrepan* or dispossession* or distance* or divergence* or ecolog* or economic* or education* or employment or environment* or equalit* or equit* or facilitator* or factor* or "food insecurity" or funding* or gap or gaps or geographic* or governance or (health adj (care* or service* or system*)) or healthcare* or historic* or homeless* or housing or identit* or income* or "indian act" or inequalit* or inequit* or infrastructure* or intergeneration* or jurisdiction* or land$1 or language* or law$1 or linguistic* or "living condition*" or marginali* or mercury or metal$1 or model* or norm$1 or "odds ratio*" or opportunit* or parit* or pattern* or policies or policy or political or poverty or practice* or predictor* or preference* or psychosocial or racis* or reciprocit* or "relative risk*" or remoteness or "residential school*" or resource* or "school system*" or sedent* or social or spiritual* or status* or territor* or tradition* or trajector* or transition* or trauma* or unemployment or unequal* or variation* or versus or violence*).ti,kf.
3	MeSH MEDLINE : "Gender equity"/ or "Women's health"/ or "Women's rights"/ or MeSH PsycInfo et Global Health : Feminism/ or "Gender Equality"/ or "Gender Gap"/ or "Human Sex Differences"/ or ((bispiritu* or gender* or lgbt* or multigender* or "non-binar*" or nonbinar* or queer* or "sexual minorit*" or transgender* or "two-spirit" or wom#n or girl*) and (advantage* or affirming or alienat* or alter or barrier* or cisnormativ* or "colonial bias" or compar* or consideration* or determin* or difference* or "differential analys#s" or disadvantag* or disaggregat* or discrepan* or discriminat* or disempowerment* or disengag* or disparit* or displacement* or diverg* or equalit* or equit* or erasure* or exclu* or factor* or gap or gaps or heterocisnormativ* or imposition* or inclusi* or incorporat* or inequal* or inequit* or injustice or integrat* or interaction* or invisibilit* or justice or marginali* or "odds ratio*" or parit* or perspective* or privilege* or reject* or "relative risk*" or representation* or sensitiv* or sexism or status* or unfair* or variation* or versus or visibilit* or vulnerab*)).ti,ab,kf.
4	MeSH MEDLINE : exp Canada/ or (canada* or canadi* or alberta* or "british columbia*" or ee#ou or "james bay" or labrador* or manitoba* or "new brunswick*" or "new foundland*" or newfoundland* or "northwest territor*" or "nova scotia*" or nunav* or ontarian* or ontario* or "prince edward island*" or quebec* or saskatchewan* or yukon*).ti,ab,kf.
5	and/1-4
6	5 and (english or french).lg.
7	..l/ 6 yr=2010-2022

EBSCO (Health Policy Reference Center, SocINDEX)

#	Query
S1	TI (ab?na* OR aborigin* OR "ai/an" OR aleut* OR algonqui* OR (america* N3 indian*) OR amerind* OR anishina* OR at#ikame* OR autocht* OR cree* OR cri OR cris OR dene* OR eskimo* OR (first W0 (nation* OR people*)) OR huron* OR indigenous OR in#uit* OR innu* OR inuk* OR iroquoi* OR mal?cite* OR m?tis OR micmac* OR "mi'?ma*" OR mohawk* OR naskap* OR native* OR tribal OR tribe OR tribes OR wendat*) OR AB (ab?na* OR aborigin* OR "ai/an" OR aleut* OR algonqui* OR (america* N3 indian*) OR amerind* OR anishina* OR at#ikame* OR autocht* OR cree* OR cri OR cris OR dene* OR eskimo* OR (first W0 (nation* OR people*)) OR huron* OR indigenous OR in#uit* OR innu* OR inuk* OR iroquoi* OR mal?cite* OR m?tis OR micmac* OR "mi'?ma*" OR mohawk* OR naskap* OR native* OR tribal OR tribe OR tribes OR wendat*)
S2	TI (access OR accessibilit* OR advantage* OR ancestral OR assimilat* OR barrier* OR "care system*" OR colonial* OR coloni?ation* OR "community capacit*" OR connection* OR contaminat* OR correlate OR correlates OR cultural OR determinant* OR determination OR difference* OR disadvantage* OR discrepan* OR dispossession* OR distance* OR divergence* OR ecolog* OR economic* OR education* OR employment OR environment* OR equalit* OR equit* OR facilitator* OR factor* OR "food insecurity" OR funding* OR gap OR gaps OR geographic* OR governance OR (health W0 (care* OR service* OR system*)) OR healthcare* OR historic* OR homeless* OR housing OR identit* OR income* OR "indian act" OR inequalit* OR inequit* OR infrastructure* OR intergeneration* OR jurisdiction* OR land? OR language* OR law? OR linguistic* OR "living condition*" OR marginali* OR mercury OR metal? OR model* OR norm? OR "odds ratio*" OR opportunit* OR parit* OR pattern* OR policies OR policy OR political OR poverty OR practice* OR predictor* OR preference* OR psychosocial OR racis* OR reciprocit* OR "relative risk*" OR remoteness OR "residential school*" OR resource* OR "school system*" OR sedent* OR social OR spiritual* OR status* OR territor* OR tradition* OR trajector* OR transition* OR trauma* OR unemployment OR unequal* OR variation* OR versus OR violence*)
S3	TI ((bispiritu* OR gender* OR lgbt* OR multigender* OR "non-binar*" OR nonbinar* OR queer* OR "sexual minorit*" OR transgender* OR "two-spirit" OR wom?n OR girl*) AND (advantage* OR affirming OR alienat* OR alter OR barrier* OR cisnormativ* OR "colonial bias" OR compar* OR consideration* OR determin* OR difference* OR "differential analys?s" OR disadvantag* OR disaggregat* OR discrepan* OR discriminat* OR disempowerment* OR disengag* OR disparit* OR displacement* OR diverg* OR equalit* OR equit* OR erasure* OR exclu* OR factor* OR gap OR gaps OR heterocisnormativ* OR imposition* OR inclusi* OR incorporat* OR inequal* OR inequit* OR injustice OR integrat* OR interaction* OR invisibilit* OR justice OR marginali* OR "odds ratio*" OR parit* OR perspective* OR privilege* OR reject* OR "relative risk*" OR representation* OR sensitiv* OR sexism OR status* OR unfair* OR variation* OR versus OR visibilit* OR vulnerab*)) OR AB ((bispiritu* OR gender* OR lgbt* OR multigender* OR "non-binar*" OR nonbinar* OR queer* OR "sexual minorit*" OR transgender* OR "two-spirit" OR wom?n OR girl*) AND (advantage* OR affirming OR alienat* OR alter OR barrier* OR cisnormativ* OR "colonial bias" OR compar* OR consideration* OR determin* OR difference* OR "differential analys?s" OR disadvantag* OR disaggregat* OR discrepan* OR discriminat* OR disempowerment* OR disengag* OR disparit* OR displacement* OR diverg* OR equalit* OR equit* OR erasure* OR exclu* OR factor* OR gap OR gaps OR heterocisnormativ* OR imposition* OR inclusi* OR incorporat* OR inequal* OR inequit* OR injustice OR integrat* OR interaction* OR invisibilit* OR justice OR marginali* OR "odds ratio*" OR parit* OR perspective* OR privilege* OR reject* OR "relative risk*" OR representation* OR sensitiv* OR sexism OR status* OR unfair* OR variation* OR versus OR visibilit* OR vulnerab*))
S4	TI (canada* OR canadi* OR alberta* OR "british columbia*" OR ee?ou OR "james bay" OR labrador* OR manitoba* OR "new brunswick*" OR "new foundland*" OR newfoundland* OR "northwest territor*" OR "nova scotia*" OR nunav* OR ontarian* OR ontario* OR "prince edward island*" OR quebec* OR saskatchewan* OR yukon*) OR AB (canada* OR canadi* OR alberta* OR "british columbia*" OR ee?ou OR "james bay" OR labrador* OR manitoba* OR "new brunswick*" OR "new foundland*" OR newfoundland* OR "northwest territor*" OR "nova scotia*" OR nunav* OR ontarian* OR ontario* OR "prince edward island*" OR quebec* OR saskatchewan* OR yukon*)
S5	S1 AND S2 AND S3 AND S4
S6	S5 AND LA (english OR french)
S7	S6 AND (DT 2010-2022)

Google

	Autochtone	Facteurs d'influence	Inégalités de santé et genre	Canada
Anglais	indigenous OR inuit OR "first nation" OR metis OR aboriginal OR "native american" OR "american indian"	determinants OR trajectory OR predictor OR pattern OR correlate OR factor OR model OR system OR discrimination OR oppression OR determination OR marginalization OR colonial OR "Indian act"	gender OR sex AROUND(3) inequality OR inequity OR disparity OR role OR based OR gap OR disadvantage	Canada
Français Cairn (site :) Érudit (site :)	autochtone OR inuit OR "première nation" OR métis OR amérindien	déterminants OR trajectoire OR prédicteur OR modèle OR corrélat OR facteur OR modèle OR système OR discrimination OR détermination OR colonial OR "loi sur les indiens"	genre OR sexe AROUND(3) iniquité OR inégalité OR disparité OR rôle OR basé OR écart OR désavantage	Canada

Santécom

	Autochtone	Facteurs d'influence	Genre	Canada
Anglais	• *Indigenous* • *Aboriginal* • *First nations* • *Inuit* • *Metis*	• *inequality* • *inequity* • *determinant*	• *gender* • *sex* • *women*	• Canada
Français	• Autochtone • Premières nations • Inuit • Métis	• inégalités • iniquités • déterminants	• genre • sexe • femmes	• Canada

List of organization websites used for literature search

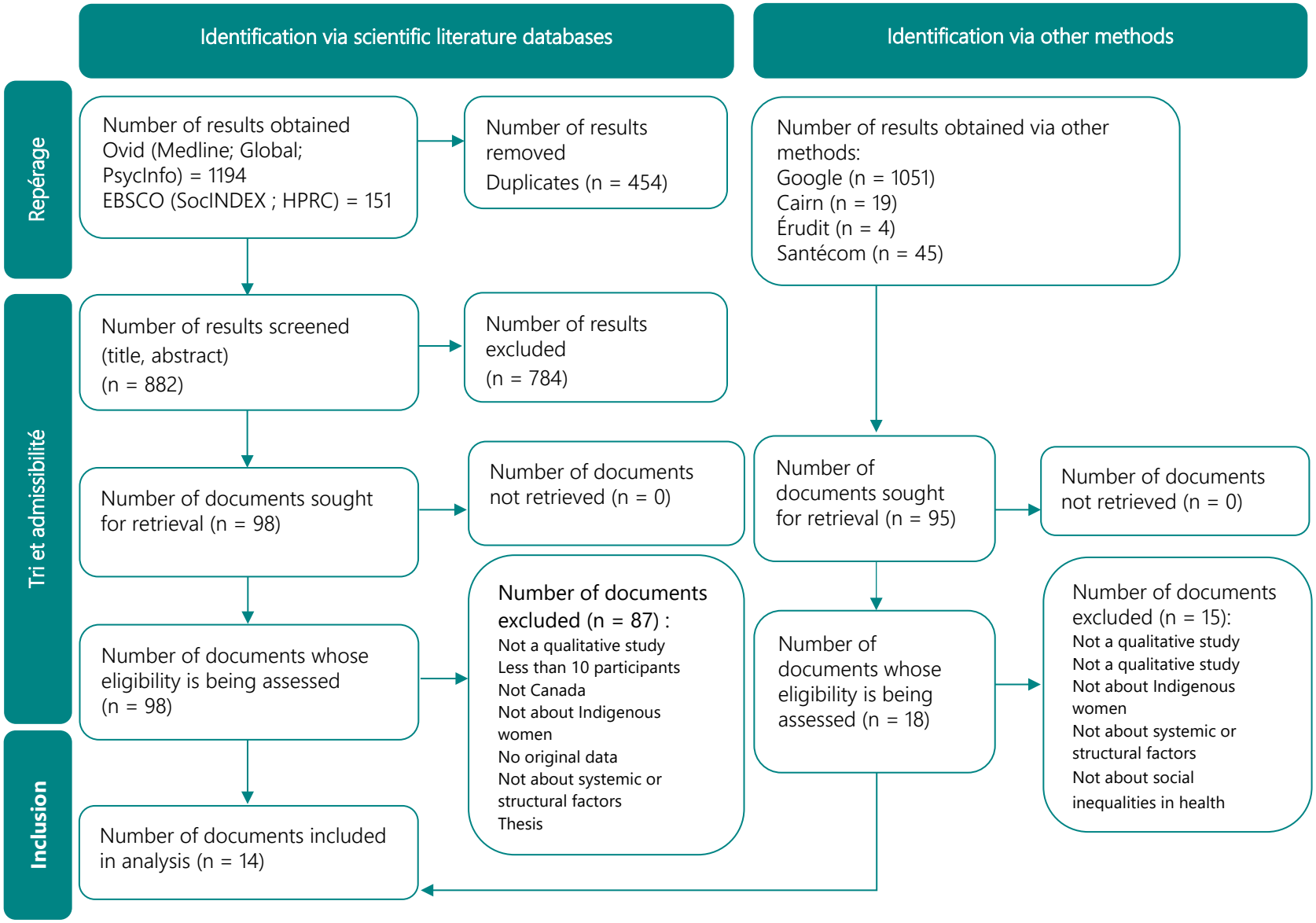
Organisations autochtones :

faq-qnw.org
nwsm.info
pauktuutit.ca
apnql.com
nrbhss.ca
rcaaq.info
arcticnet.ulaval.ca
creehealth.org
cssspnql.com
fnha.ca
fnigc.ca
sac-isc.gc.ca
inuitcircumpolar.com
paho.org
ahf.ca
reseaumtlnetwork.com
afn.ca
fncaringsociety.com
cngov.ca
itk.ca
naho.ca
nccih.ca
ccnsa.ca
nafc.ca
namhr.ca
reseaudialog.ca
sentinellenord.ulaval.ca
nativeresearchnetwork.org
iwgia.org
nwac.ca
saturviit.ca
yellowheadinstitute.org

Organisations de santé :

schoolofpublicpolicy.sk.ca
cihr-irsc.gc.ca
www150.statcan.gc.ca
phac-aspc.gc.ca
inrs.ca
prism.ucalgary.ca
cpha.ca
hc-sc.gc.ca
afm.mb.ca
mcmasterforum.org

APPENDIX 2 PRISMA FLOW DIAGRAM



APPENDIX 3 EXTRACTION GRIDS

Authors	Study objective	Methodology	Participants (*n*)	Context	Influential factors	SIH-related issues
Peer-reviewed articles						
Beaumier and Ford (2010)	Describe influences on food insecurity (access, availability and quality of food).	Case study and community research: • Semi-directed individual interviews • Discussion groups • Participant observation	Inuit aged 21 to 70 (36) Key informants (13)	Igloolik, Nunavut	Education system Community infrastructure, resources and capacities Cultural continuity	Health behaviours
Corosky and Blystad (2016)	Generate data about young people's experiences with sexual and reproductive rights and access to care; use the information to improve interventions.	Participatory research: • Semi-directed individual interviews	Inuit men aged 17 to 22 (9) Inuit women aged 16 to 22 (10) Community representatives (6)	Arviat, Nunavut	Justice system Education system Community infrastructure, resources and capacities Colonial ideologies	Violence Sexual health
de Finney *et al.* (2013)	Study adolescent females' perspective on how social context, gender and cultural background influence smoking.	Community research: • Semi-directed individual interviews • Discussion groups	First Nations aged 13 to 19 (63) Community partners (5)	Six communities in British Columbia	Community infrastructure, resources and capacities Cultural continuity Colonial ideologies	Mental health Health behaviours

Extraction grids (continued)

Authors	Study objective	Methodology	Participants (*n*)	Context	Influential factors	SIH-related issues
Peer-reviewed articles (continued)						
Flores *et al.* (2022)	Study the experiences of Indigenous women during the first year of the COVID-19 pandemic.	Ethnographic approach: • Semi-directed individual interviews	First Nations or Métis women, aged 22 to 60 (13)	Toronto, Ontario	Health system Community infrastructure, resources and capacities	Mental health
Lawford *et al.* (2018)	Describe First Nations women's experiences with and perspective on Health Canada's birth evacuation policy.	Phenomenological study: • Semi-directed individual interviews	Women who have experienced birth evacuation (7) Adults with indirect experience of birth evacuation (4 women, 1 man)	Manitoba	Community infrastructure, resources and capacities Cultural continuity Colonial governance	Perinatal health
Maar *et al.* (2013)	Study structural barriers to cervical cancer screening in First Nations women.	Participatory action research: • Semi-directed individual interviews	Health professionals (17 women, 1 man), 12 are members of Anishinaabe communities	Ontario	Health system Education system Community infrastructure, resources and capacities Colonial governance	Sexual health

Extraction grids (continued)

Authors	Study objective	Methodology	Participants (*n*)	Context	Influential factors	SIH-related issues
Peer-reviewed articles (continued)						
MacDonald *et al.* (2015)	Study the experiences of Mi'kmaq women with cervical cancer screening (Pap testing).	Participatory research: • Sharing circles • Semi-directed individual interviews • Interviews to validate the preliminary results	Mi'kmaq women aged 21 to 75 (18) Health professionals (8 women)	Eastern Canada	Health system Community infrastructure, resources and capacities Colonial ideologies Colonial governance	Sexual health
Oliver *et al.* (2015)	Study the relationship between gender and colonialism based on the real-life experiences of young people in Indigenous communities.	Participatory research: • Community workshops • Semi-directed individual interviews	Indigenous young people with a median age of 16, majority female (85)	Prince Edward Island Québec Ontario British Columbia	Cultural continuity Colonial ideologies	Violence Sexual health
Van Herk *et al.* (2011)	Study how health professionals' perceptions of the identity of Indigenous women influence that population's experiences with access to perinatal care in urban settings.	Participatory research: • Semi-directed individual interviews	Key informants: parents, Elders, program managers, and health and social services professionals (17 women, 4 men, including 9 First Nations and 4 Inuit)	Location not specified	Social services system Community infrastructure, resources and capacities Colonial ideologies	Perinatal health

Extraction grids (continued)

Authors	Study objective	Methodology	Participants (*n*)	Context	Influential factors	SIH-related issues
Peer-reviewed articles (continued)						
Vang *et al.* (2018)	Study the connection between birth evacuation and the quality of the medical relationship between Indigenous women and their health professionals.	Participatory research: • Semi-directed individual interviews	First Nations or Inuit women who have experienced birth evacuation (25) Health professionals (8)	Québec	Health system Community infrastructure, resources and capacities Cultural continuity Colonial ideologies	Perinatal health Mental health
Wakewich *et al.* (2016)	Study the influence of First Nations women's body image on their level of comfort with and participation in cervical cancer screening. Collect recommendations for overcoming barriers to cervical cancer screening.	Participatory action research: • Semi-directed individual interviews • Discussion groups	Anishinaabe women (69) Elders and health professionals (16, including 12 First Nations and 15 women)	Ontario	Health system Community infrastructure, resources and capacities Cultural continuity Colonial ideologies Colonial governance	Sexual health

Extraction grids (continued)

Authors	Study objective	Methodology	Participants (*n*)	Context	Influential factors	SIH-related issues
Research reports						
Pauktuutit Inuit Women of Canada *et al.* (2014)	Study the repercussions of mining operations on Inuit women and families.	Participatory action research: • Semi-directed individual interviews • Discussion groups • Research training workshops	Inuit women and adolescent girls (62) Key informants (e.g., education or social services professionals)	Qamani'tuaq, Nunavut	Community infrastructure, resources and capacities Indigenous self-determination	Violence Mental health Health behaviours
Pauktuutit Inuit Women of Canada and Comack (2020)	Study the appropriateness of police services in meeting the needs of Inuit women who are victims of violence.	Participatory research: • Semi-directed individual interviews • Discussion groups	Inuit women (45) Social service providers and police officers (40)	Inuit Nunangat	Justice system Community infrastructure, resources and capacities Colonial ideologies Colonial governance	Violence
Pauktuutit Inuit Women of Canada and Quintessential Research Group (2019)	Identify determinants of violence against Inuit women. Map existing assistance programs and services.	Participatory research: • Semi-directed individual interviews • Talking circles	164 participants Community members (67 women, 3 men) Service providers (44) Shelter workers (13) Key informants (37)	Inuit Nunangat	Social services system Justice system Community infrastructure, resources and capacities Colonial ideologies Colonial governance	Violence

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