Using *Inuit Qaujimajatuqangit* (*IQ*) to Guide Cervical Cancer Care Among Inuit Communities: Implications from A Scoping Review

by

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Submitted in partial fulfilment of the requirements
for the degree of Master of Science

at

Dalhousie University
Halifax, Nova Scotia
July 2019

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Abstract

This thesis is part of a larger research project that aims to use *Inuit Qaujimajatuqangit* (*IQ*) – the unified system of Inuit knowledge, culture and philosophy, in the development of culturally-relevant cervical cancer care among Inuit communities. Specifically, a Joanna Briggs Institute (JBI) scoping review was conducted to identify the characteristics of Indigenous healing strategies in Canada, as well as approaches to improving cultural relevance of healing strategies to local Indigenous contexts. Any attempt to promote Indigenous healing – including programs and services, policies and guidelines, models and frameworks, and Indigenous narratives and expert opinions – were considered for inclusion. This scoping review included primary research of all study designs, text and opinion papers, and publications by Canadian governments and Indigenous organizations.

A three-step search was conducted in CINAHL, Sociological Abstracts, PsycINFO, MEDLINE and Academic Search Premier in December 2018. Searches for grey literature were performed in iPortal, Canadian Electronic Library, and ten Canadian government and Indigenous organization websites in February 2019. Two key journals were hand-searched for eligible studies. Data included in this review were limited to articles published from 2008 onward. Theses and dissertations and non-English articles were excluded. Data extraction was performed using a charting table developed specifically for this review.

Fifty-nine (59) articles were included for extraction, 30 of which were primary studies. A wide diversity of characteristics was identified, including 19 guiding principles, 9 main components, and 11 human resources. Eight (8) culturally-relevant approaches were identified from the 30 primary research studies. Taken together, results from this review support a decolonizing approach through upholding Indigenous knowledge, respecting Indigenous rights to self-determination, and recognizing Indigenous resilience and agency.

By aligning scoping review results with the *IQ* framework, this thesis concluded with implications for future research pertaining to cervical cancer prevention and treatment among Inuit communities. Although this thesis began with a primary focus on Inuit, it is anticipated that results will have national and international relevance to other Indigenous populations. This knowledge will potentially inform health care providers, researchers, and policy makers to transform Indigenous health.

List of Abbreviations Used

AHF	Aboriginal Healing Foundation
CAAN	Canadian Aboriginal AIDS Network
CBPR	Community-Based Participatory Research
CIHR	Canadian Institutes of Health Research
HPV	Human Papilloumavirus
HR-HPV	High-Risk Human Papilloumavirus
IQ	*Inuit Qaujimajatuqangit*
ITK	Inuit Tapiriit Kanatami
JBI	Joanna Briggs Institute
JBISRIR	JBI Database of Systematic Reviews and Implementation Reports
LR-HPV	Low-Risk Human Papilloumavirus
MMIWG	Missing and Murdered Indigenous Women and Girls
NCCAH	National Collaborating Centre for Aboriginal Health
NIHB	Non-Insured Health Benefits
NWAC	Native Women's Association of Canada
Pap	Papanicolaou
PHAC	Public Health Agency of Canada
Pauktuutit	Pauktuutit Inuit Women of Canada
RCT	Randomized Controlled Trial
STI	Sexually-Transmitted Infection
TB	Tuberculousis
TRC	Truth and Reconciliation Commission of Canada

Acknowledgements

This Master's thesis would not have been possible without the incredible people in my life. First, my greatest thanks go to my supervisory committee: Dr. Audrey Steenbeek, Dr. Marilyn Macdonald, and Dr. Cathy MacDonald, for your remarkable guidance and mentorship. You encouraged me to tap into an entirely new area, to think broadly and critically, and to strive for excellence in research. Thank you for your time, patience, and thoughtful feedback.

My sincere thanks to the Aligning Health Needs with Evidence for Transformative Change: A Joanna Briggs Institute Centre of Excellence, Dalhousie University. Through the JBI training at the Centre, I was able to obtain the essential knowledge and skills to conduct my first scoping review. Additionally, I am deeply grateful for the funding I received from Mitacs, Faculty of Graduate Studies, School of Nursing, and my supervisor Dr. Steenbeek. Your generous support created conditions for me to pursue my Master's in Canada.

Finally, I want to express my deepest gratitude for my wonderful family and friends, who supported me continuously in this whirlwind of journey. To my mother XU Wenqing, thank you for loving me unconditionally and being my rock. My greatest friends Noelle, Rachel, Joshna, Krystal, Ge, Qiaomu and Chelsea – thanks for enduring my weirdness and being my family away from home. To my father YU Hexiang, we reconnected over the course of this Master's, therefore this thesis is dedicated to you.

Chapter One: Introduction

Indigenous Peoples – including First Nations, Inuit, and Métis – are the original inhabitants of the land now called Canada long before the arrival of European settlers. Stretching back to time immemorial, Indigenous Peoples created unique languages, cultures and traditions that were grounded in local ways of knowing. Despite the negative effects of colonization (e.g., residential schools, forced relocations and cultural oppression; C. MacDonald & Steenbeek, 2015), Indigenous Peoples have shown incredible strengths and resilience, and many maintain fully functional knowledge systems to present days. Today, Indigenous Peoples are active participants in the global society while continuing to pass on their cultural heritage to future generations. This should be acknowledged as salient evidence of courage, motivation, resilience, and resourcefulness of Indigenous Peoples; in spite of the many hardships that they endured.

For Inuit living in the Canadian Arctic, striving for health and wellness requires considerable wisdom given the unique circumstances in remote, Northern communities. Factors such as geographical isolation, transient healthcare workforce and limited access to health services affect Inuit health on many indicators (National Collaborating Centre for Aboriginal Health [NCCAH], 2011). For instance, in terms of sexual health, Inuit women are disproportionately affected by human papillomavirus (HPV) (Hamlin-Douglas, Coutlée, Roger, Franco, & Brassard, 2008; Healey et al., 2001; Totten et al., 2015); a group of related viruses that can be transmitted between people through skin-to-skin contact (Centres for Disease Control and Prevention, 2016). Research has shown that persistent infection with high-risk, carcinogenic types of HPV is strongly associated with cervical cancer (Walboomers et al., 1999). This is concerning, as routine screening tests – such as Papanicolaou (Pap) smears, are not always accessible or sought after in Northern communities. On top of many pressing issues unique to the

Northern context (e.g., housing, livelihoods, and food security; Inuit Tapiriit Kanatami [ITK], 2014), Inuit women face the challenge of unequal access to culturally-competent care. Women who experienced historical trauma (e.g., sexual assault from residential schools) often feel unsafe to have the Pap test performed due to traumatizing memories that the procedure might trigger or due to distrust of clinicians (C. MacDonald, Martin-Misener, Steenbeek, & Browne, 2015). Without timely screening and treatment, Inuit women are at risks of poorer health outcomes. The age-standardized incidence rate of cervical cancer, for instance, has been known to be three times higher among Inuit than the national average (Gaudette, Altmayer, Wysocki, & Gao, 1998; Kelly et al., 2008).

To address health inequities, Indigenous Peoples acknowledge the legacy of colonization and the importance of cultural revitalization in all sectors of Canadian society, including health care. This requires on the part of health care providers to embrace Indigenous ways of knowing with an open mind. As such, promoting Inuit health must start from understanding Inuit beliefs, values and worldviews.

Inuit Notions of Health and Wellness

Indigenous Peoples have unique ways of conceptualizing health and wellness. For Inuit, health is an essential component of *Inuit Qaujimajatuqangit* (*IQ*) – the traditional knowledge of the Inuit (Karetak, Tester, & Tagalik, 2017). By definition, *IQ* is an assembly of "Inuit beliefs, laws, principles and values along with traditional knowledge, skills and attitudes" (Nunavut Department of Education Curriculum and School Services Division, 2007, p. 22). *IQ* encompasses the totality of Inuit culture, setting expectations for social interactions as a living set of values and practices (Stern, 2013). Like other Indigenous knowledge systems, *IQ* is highly contextualized, originating from extensive experiences of Inuit living off the land (Karetak et al.,

2017). The accumulative wisdom gained from observations, reflections, and interactions with the natural world gradually turned into a unified system of cultural knowledge, which has kept the Inuit alive and well in the unforgiving Arctic for thousands of years (NCCAH, 2015). In collaboration with Inuit Elders, the Government of Nunavut has formally adopted the *IQ* framework grounded in four *maligait* (big laws): working for the common good; respecting all living things; maintaining harmony and balance; and continually planning and preparing for the future (Tagalik, 2012). *Maligait* apply to every aspect of life and are regarded as ethical commitments that provide continual direction for living well in communities (Karetak et al., 2017).

In addition, six *piqujarjuat* (guiding principles) have been identified by Inuit Elders as part of the *IQ* framework. These principles are: *Pijitsirniq* (serving); *Aajiiqatigiingniq* (consensus decision-making); *Pilimmaksarniq* (skills and knowledge aquisition); *Piliriqatigiingniq* (collaborative relationships or working together for a common purpose); *Avatimik Kamattiarniq* (environmental stewardship); and *Qanuqtuurunnarniq* (problem solving) (Lévesque, 2014, p. 121). The guiding principles of *IQ* set expectations for Inuit ways of doing, with certain flexibility that allows people to apply them differently in various circumstances (Karetak et al., 2017). Taken together, the laws and principles of *IQ* are recognized as the compass for "living a good life", based on respectful relationships and contribution to the wider community (Tagalik, 2018). For many Inuit, *IQ* provides a sense of self, belonging and direction in life which together, build a strong cultural identity (Tagalik, 2012). This notion of cultural health is closely related to Inuit wellness by ensuring loving, healthy, and supportive relationships that are required in the making of capable individuals (Tagalik, 2000, 2009).

Over generations, the complex knowledge system of *IQ* has been passed down through storytelling, observation and direct participation in daily activities (Karetak et al., 2017). It is the diligent preservation and renewal of *IQ* that becomes the foundation of Inuit resilience (Kirmayer, Dandeneau, Marshall, Phillips, & Williamson, 2011). Even in critical situations that Inuit had not encountered in their entire history (such as rapid colonization and forced assimilations), they adapted to drastic social changes in a few short years. A high cost has been paid, however, as indicated by the many health gaps prevalent in Northern communities. In order to regain health and wellness, there is an urgent need to incorporate *IQ* both within and outside the communities.

Laying Foundation for the Future

To address high rates of HPV and cervical cancer among the Inuit, a three-day workshop was held in Iqaluit, Nunavut in April 2018 to plan for future research endeavours. The objective of the workshop was to engage researchers, community members, and key knowledge users as a collaborative team to promote health and well-being of the Inuit as it pertains to cervical cancer. Through discussion, there was a consensus among the team that an Inuit-specific cervical cancer prevention and treatment program is needed. Core elements of *IQ* – such as the four *mailigait* – should be utilized throughout the program to inform the development of culturally-relevant care. Our team also agreed that before designing a new program, a comprehensive scan of current literature is essential. Nevertheless, based on results of a preliminary search, there was little literature on HPV or cervical cancer among Inuit. This would mean that a traditional systematic review is not feasible at this stage. In order to lay a solid foundation for our future project, creative ways are needed to approach a larger body of literature which can then be applied to an Inuit context.

This leads to the initial conceptualization of this study: To explore diverse Indigenous healing strategies in Canada, with an eye to derive Inuit-specific implications for cervical cancer care. This strategy was chosen with full acknowledgement of the diversity among Indigenous Peoples, rather than a one-size-fits-all generalization of distinct groups. It is recognized that Indigenous Peoples in Canada are from diverse backgrounds, with each group having their own histories, languages, lifestyles and perspectives (Kirmayer, Tait, & Simpson, 2009). Despite many differences, Indigenous Peoples have experienced similar realities in terms of land dispossession, cultural oppression and historical trauma as a result of colonization (C. MacDonald & Steenbeek, 2015). This shared predicament has contributed to common health concerns; for example, higher cervical cancer rates were reported in various Indigenous groups compared with their non-Indigenous counterparts (Kelly et al., 2008; Letendre, 2008; Louchini & Beaupré, 2008). It is further emphasized that Indigenous Peoples have demonstrated remarkable resilience in upholding their values, beliefs, and traditions. The resilience and cultural heritage of Indigenous Peoples have been consistently described as protective factors in adversities (Chandler & Lalonde, 2009; Linklater, 2014). In light of this, although there is an enormous diversity within Indigenous population, the hope and determination to heal is a shared opportunity for all.

Today, Inuit and other Indigenous Peoples in Canada are actively engaged in reclaiming their cultural knowledge to create a decolonized society, while advancing the wholistic well-being of their peoples as equal citizens. Concerted efforts are needed to close the gap in health outcomes, socio-economic status, and access to care between Indigenous and the settler Canadian population. The collective endeavors of Indigenous Peoples and allies have contributed to a growing number of healing strategies in Canada; for example, the Aboriginal Healing

Foundation (AHF) had funded a wide range of community-based initiatives since its establishment in 1998, the majority of which made innovative use of traditional healing practices (Archibald, 2006). Many Indigenous organizations have put forward strategic plans, guidelines, and protocols with careful consideration to Indigenous values and taboos (Canadian Aboriginal AIDS Network [CAAN], 2018; ITK, 2013b; Pauktuutit Inuit Women of Canada [Pauktuutit], 2017). In addition, Indigenous leaders, scholars, and community members are more than ever actively asserting themselves through powerful speeches and writings that create transformative changes in their communities (M. Battiste, 2000). The hope is that by learning from a broad array of existing strategies, implications can be derived to promote Inuit healing: the reconnection with *IQ* and its continual application in moving toward harmony and balance.

Purpose of Study

Despite the strong resurgence of Indigenous healing, limited effort has been made to systematically synthesize existing literature. To fill this gap, this research aims to identify characteristics of Indigenous healing strategies in Canada. Key features that emerge consistently from literature will be summarized to inform the future cervical cancer program for Inuit. Specifically, the following research questions will be addressed:

1) What are the characteristics (e.g., guiding principles, main components and human resources) of Indigenous healing strategies in Canada?
2) What approaches have been used in research process to improve the cultural relevance to local Indigenous contexts?

Through the lens of *IQ*, this research will conclude with recommendations for cervical cancer prevention and treatment among Inuit communities in Northern Canada. Although this research starts with a primary focus on Inuit, it is hopeful that findings will have national and

international relevancy to other Indigenous populations. This knowledge will potentially inform health care providers, researchers, and policy makers to transform Indigenous health.

Chapter Outline

Chapter Two presents a literature review on Inuit health related to cervical cancer. By discussing the history of Inuit as well as the barriers and facilitators faced by Northern communities, this chapter establishes the significance of this research with an eye to reinforce wellness, resilience, and healing. Chapter Three provides an overview of research methods based primarily on an a-priori protocol that outlines the inclusion criteria and plan for data extraction. Chapter Four presents main findings of the scoping review; tabular forms and figures will be used along with narrative text. In Chapter Five, findings from the scoping review will be critically analyzed to derive implications for future Inuit cervical cancer research. Chapter Six concludes this research by summarizing main findings and re-iterating the significance of *IQ.*

Chapter Two: Literature Review

Research involving Indigenous Peoples is not new. As early as in the 1500s, Indigenous Peoples of North America captured the imagination of Western explorers, missionaries and anthropologists who authored most of the early writings about Indigenous Peoples (Younging, 2018). In particular, much interest had been focused on Inuit as their ability to survive in the harsh Arctic environment was rarely found in any other population. Early writings by European settlers often described Indigenous Peoples as a primitive and underdeveloped group in need of Western civilization (Younging, 2018). The root of such racist perceptions ran deep in the settlers' society, resulting in colonial ideologies that were far-removed from Indigenous cultural realities (Vowel, 2016). In recent years, although notable gains have been made to support a positive portrayal of Indigenous Peoples, inappropriate stereotypes continue to exist in contemporary literature. It is the intention of this chapter to resist such harmful narratives and shift the focus to the wisdom and strengths of Indigenous Peoples; a critical piece that should be addressed when Indigenous voices continue to be underrepresented in critical discussions regarding their own issues (M. Battiste, 2000).

To date, there is a dearth of literature about cervical cancer among Inuit women in Canada's North. Existing resources are primarily epidemiological data that point to high rates of incidence and individual risk factors with little regard to the impact of colonial history. The complex interplay of historical, social, environmental and cultural determinants of Inuit health remains poorly understood. Furthermore, little is known about how Inuit knowledge can be applied in contemporary contexts to promote health outcomes. This chapter aims to start addressing these gaps by offering a brief history of Inuit life; their stories of resilience, adaptability, and creativity will set the stage for this research. This chapter further discusses the

major health concerns related to cervical cancer, as well as current health resources and priorities in northern communities. Lastly, this chapter concludes with a focused examination that looks at the role of culture and self-determination in Indigenous health and healing.

The Inuit in Canada: A Resilient People

In the global context, the term "Inuit" refers to the Indigenous people who traditionally inhabit the circumpolar regions in what are now Alaska, Northern Canada, Greenland, and Chukotka (Bjerregaard & Young, 1998; Stern, 2013). Before the 1970s, these Arctic people were usually known as "Eskimos", an Algonquin Indian word that describe a style of snowshoes (Parrot, 2008). In recent decades, however, "Inuit" (singular: Inuk) has become the preferred term internationally except for Alaska, where "Eskimo" remains in common use (Stern, 2010).

A wealth of evidence – including geological, archaeological and genetic – has shown that many Inuit populations likely share a common ancestry with Asia, and migrated to North America via the Bering Strait at least 5000 years ago (Bjerregaard & Young, 1998; Grygier, 1994). In modern times, Inuit across the circumpolar North continue to have many similarities, but different colonial histories and Western administrations have led to varied daily experiences (Stern, 2013). For example, traditional values that are common in one community might be described differently in another, or non-existent at all (Pauktuutit, 2006). In this thesis, "Inuit" pertains to the group in Northern Canada unless otherwise stated.

Pre-contact Inuit life. Before sustained contact with non-Native peoples, Inuit lived in small hunting camps, often in family units, and maintained seasonal migrations based on the availability of game (Stern, 2013). A highly efficient material culture was developed over centuries, including the very pinnacle of technologies for hunting, traveling, building shelter, making clothes, and preparing nutritious food. Sea mammals and caribou were hunted for meat

and skins. Long trips between hunting spots were made possible with dogs and sledges which were the essential means of transportation in pre-contact era (J. Bennett, Rowley, & Evaloardjuk, 2004).

Life in the Arctic can be very challenging. The weather is typically harsh and unpredictable, with fluctuations in animal population on changing routes of migration. In dealing with these dangerous uncertainties, Inuit have historically developed an intimate knowledge of the physical world around them, as well as responsible environment stewardship (Karetak et al., 2017). From an early age, Inuit children were encouraged to carefully observe their surroundings and treat all living things properly. All elements in nature, including air, water and land, are regarded as life sustainers that require careful preservation (Karetak et al., 2017). Animals, in particular, are believed to have human-like feelings and consciousness and were therefore treated with the most respect and care (Stern, 2010). Even after the animal's death, the carcass had to be butchered in a respectful way that shows the hunter's gratitude (J. Bennett et al., 2004). For Inuit, all elements in nature are intricately interconnected, which ties Inuit survival to the well-being of the larger ecosystem. Essentially, "the only way our environment can protect us, with its abundant resource of wildlife, plants, and other sources, is for us to protect it." (Karetak et al., 2017, p. 59) In Western societies, this notion of sustainable development only came into the spotlight a few decades ago, whereas the Inuit have upheld these fundamental values for millennia.

One feature of traditional Inuit life was the close connection among family and kinship members, who were constantly involved in intensive collaboration (Pauktuutit, 2006). In the harsh and barren environment, even the most skilled hunter cannot always guarantee success. To be fully prepared, Inuit had to rely on each other and establish rapport. Unique traditions were

developed to reaffirm valued relationships, including *attiiniq*, the naming practice (J. Bennett et al., 2004). Traditionally, when a child was born, he or she would receive a name of a recently deceased relative. The name was believed to carry spiritual elements of the namesake, which would later manifest in the child in the form of similar skills, habits, or personality as the deceased person. Therefore, although the newborn would be disciplined by their parents, they would also be treated with love and respect as if an old member had come back to the community (Tagalik, 2000). Through the birthing of a child, the bonds between community members were renewed and strengthened. Inuit placed a high value on cooperation and helpfulness, which was reflected in food sharing with those in need, and information exchange about good hunting and fishing spots (Stern, 2013). Being open to assist others at all times was held as a virtue, in the belief that good fortune is passed on and generosity will be repaid in the future (J. Bennett et al., 2004; Karetak et al., 2017). In contrast, behaviours that might cause division within the group – such as personal conflict and competition – were generally discouraged (Pauktuutit, 2006). Holding evil thoughts against others was a taboo since it would eventually lead to trouble and misfortune on the one with ill intentions (Karetak et al., 2017). It was through these beliefs and taboos that a close-knit, harmonious kinship system was maintained in a demanding environment.

In terms of community life, there was no formal authority among Inuit in the past (Pauktuutit, 2006). To make a decision involving the entire camp, adults would gather and discuss the issue openly until a final agreement was achieved. People with special knowledge such as respected Elders might be chosen as the leader and would be consulted in decision-making, but even leaders did not have the authority to compel actions (Stern, 2013). Individual rights were highly respected, and interference from others was kept to a minimum. The practice

of non-interference applied not only to adults but to children as well, and Inuit children were often seen playing outside late at night and having food whenever they felt hungry instead of keeping a set schedule (Stern, 2010). Although individuals enjoyed a substantial amount of freedom, traditional Inuit society had clear codes of conduct that outlined general expectations. Unlike Western legal systems, these expectations were not recorded in written format or enforced by designated institutions. Instead, customary laws were followed, which often involved using social pressures (e.g. gossip, ridicule, and ostracism) to ensure that the offender would confess, make amendment, and finally return to the community as a responsible person (Pauktuutit, 2006).

Gender and sexuality. Whatever their gender, each Inuk is valued for their contribution to the larger community. In the past, gender roles were complimentary with men being responsible for hunting and women for cooking, sewing and caring for children (Pauktuutit, 2006). Such role assignments were not fixed, and Inuit men could occasionally take on women's tasks and vice versa (Stern, 2010). Doing activities that stereotypically belonged to another gender did not have negative associations, as all types of work were regarded as valuable. Meanwhile, attitudes toward sexuality were more open compared with Christian churches. In some parts of the North, there were accounts of spouse exchange in which married couples sought short-term exchange of partners for sexual relations. Such extramarital relationships were accepted as an outlet for affection without threatening the marital bonds.

In summary, traditional Inuit life in the pre-contact era was characterized by a rich material culture governed by a complex system of values, beliefs, and taboos. Although there were cases of social disruptions as in any other culture, traditional Inuit society was overall self-sufficient and well-functioning.

Inuit adaptability in social changes. Interactions between Inuit and non-Indigenous peoples increased in the mid-nineteenth century, when European explorers started to regularly visit the Arctic in search of a Northwest Passage to Asia. Closely followed were commercial whalers, who brought metal tools, rifles, cloth and food that quickly became an essential part of Inuit life. Settlements began to be established in coastal areas, which typically consisted of a Hudson's Bay Company store, a mission, and a Royal Canadian Mounted Police post. In exchange for goods, Inuit traveled to settlements regularly and traded in items procured through subsistence harvesting. Many Inuit also worked as guides and laborers on whaling ships utilizing their expertise in environmental knowledge. Over time, marine resources became depleted and the whaling industry was replaced by the more profitable fox fur. As more Inuit participated in fox trapping, attention was diverted from traditional subsistence activities and the need for consumer goods increased over time (Bonesteel, 2008).

In the 1930s, prices of fox pelts plunged to a historic low and the sole income from fox trapping could no longer support Inuit families. Many Inuit chose to move closer to coastal settlements for better livelihoods (Bonesteel, 2008). The Northern administration, however, was concerned that Inuit would become reliant on social welfare. The reaction was to relocate Inuit families to regions where, according to the administrators' belief, there would be abundant natural resources for subsistence activities (Bonesteel, 2008). The relocations were also motivated by sovereignty concerns during the Cold War; it was the Canadian government's intention to use Inuit residents as "human flagpoles" on Arctic lands. The most notorious cases occurred in 1953, when Inuit families in Inukjuak were relocated to Craig Harbour and Resolute Bay where the climate was much harsher than their original home in Northern Quebec. The Inukjuak families were later known as the "High Arctic Exiles", whose requests to return home

were repeatedly turned down by the Northern administration (Vowel, 2016). Many relocated families recalled considerable hardships which at times caused tragic starvation (Tester & Kulchyski, 1994).

In 1944, the federal government introduced the Family Allowance Program to support Canadian families with young children. Inuit parents were eligible for the program, but the condition was that children must attend residential and day schools in settlements (Karetak et al., 2017; D. King, 2006). This official policy caused a great dilemma for Inuit families, many of whom still kept a semi-nomadic lifestyle during that time. On the one hand, Inuit parents felt strongly against being separated from their children to be raised in foreign institutions. On the other hand, families were in great need of dependable income to obtain basic food and hunting supplies. Under government pressure, many Inuit parents reluctantly sent their children away. The influence of residential schools has been far-reaching and well documented in literature. The most cited impacts include the loss of languages; the gap between generations; and feelings of displacement of young Inuit who returned home after extended periods of separation (Walton & O'Leary, 2015). Time and patience are needed for families to recover from the aftermath of residential schools.

Moving forward to the 1950s, life in the settlements was far from ideal. The government housing program introduced the "matchboxes" – small wooden houses as small as 240 square feet and often without plumbing facilities; to accommodate Inuit families of up to eight people (Karetak et al., 2017). Poor sanitation in crowded housing, coupled with frequent contact with newcomers, caused a myriad of epidemics including tuberculosis (TB). According to a survey in 1945, the mortality rate from TB among Inuit was six times higher than the Canadian national average (Karetak et al., 2017). Due to limited healthcare resources in the North, TB patients were

evacuated to Southern Canada for treatment (Grygier, 1994). This would mean that Inuit patient had to leave their homes during a vulnerable time. Having to board government ships in the long journey to Southern hospitals, contact with family members was close to impossible. Before the TB epidemic was brought under control in the mid-1960s, about one third of the Inuit population had spent years away from home to combat the disease (Karetak et al., 2017). The social impact of the TB epidemic was hard to underestimate. The disabling disease left many Inuit unable to pursue land-based activities upon return (Walton & O'Leary, 2015). Many children that were sent South for treatment lost their language and had great difficulty re-integrating into community life.

Following the end of the Second World War, Inuit became increasingly concerned about their homelands being exploited by non-Natives who consistently failed to seek Inuit consultation. Things started to change when Inuit organized politically to assert their inherent right to self-governance (Bonesteel, 2008). Many young Inuit, who met each other at residential schools or vocational training centres, took the initiative to advance Inuit autonomy at national and international levels. Role models include Sheila Watt-Cloutier, the Nobel Peace Prize nominee who advocates for the protection from climate change as a fundamental human right; Simonie Michael, the first Inuk to be elected to the Government of the Northwest Territories; and Tagak Curley, a founding member and the first president of Inuit Tapirisat of Canada (now ITK) to lobby the Federal government in dealing with land claims agreements.

To date, five comprehensive land claims have been settled with four Inuit groups in Canada: Inuit in Northern Quebec signed the James Bay and Northern Quebec Agreement in 1975 and the Nunavik Inuit Land Claims Agreement in 2006; Inuvialuit in the Western Canadian Arctic signed the Inuvialuit Final Agreement in 1984; the Nunavut Land Claims Agreement was

concluded in partnership with Inuit in the Eastern Arctic in 1993; and Labrador Inuit concluded the Labrador Inuit Land Claims Agreement in 2005 (Bonesteel, 2008). Another land claim is currently being negotiated in NuntuKavut. The negotiation process with all levels of government could be extremely lengthy; the Nunavut Land Claims Agreement, for example, took 17 years to settle which eventually set the tone for establishment of the Nunavut Territory in 1999 (Stern, 2013). To reflect distinct cultural sensibilities, unique structures were developed within the Government of Nunavut which involve using Inuktitut as the primary language in workplace and adopting *IQ* as an official policy to inform decision-making across all departments (Pauktuutit, 2006; Stern, 2010). The motivation and perseverance of Inuit are integral to each step toward self-determination.

Today, the Inuit are a vibrant people from diverse backgrounds. Up to 2016, the Inuit population has surpassed 65,000 and close to three-quarters live in Inuit Nunangat consisting of four regions: Inuvialuit (Northern Northwest Territory); the Nunavut Territory; Nunavik (Northern Quebec); and Nunatsiavut (Northern coastal Labrador) (Statistics Canada, 2017). The language and culture systems remain strong in the North, with 83% of Inuit reporting the ability to converse in an Indigenous language, and 74% having participated in cultural activities (e.g., hunting, fishing, trapping, and gathering wild plants) in the previous year (Li & Smith, 2016; Wallace, 2014). The Inuit are a young population, with a median age of 23 compared to 41 for non-Indigenous Canadians (Turner, Crompton, & Langlois, 2013). The Inuit are active participants in all professions, and many are successful leaders in bettering their communities. As best summarized in a statement by Pauktuutit (2006): “Inuit have one *kamit* (sealskin boots) in the modern world, and they also have a solid foot in their distinct traditional culture” (p. 7). At the junction of past and future, increasing numbers of Inuit are actively engaged in asserting their

identity and inherent rights as a distinct, resilient people. The strong cultural resurgence presents a rare opportunity to close health gaps, including high rates of HPV and cervical cancer.

HPV and Cervical Cancer

HPV is one of the most common sexually-transmitted infections (STIs) in Canada and worldwide (World Health Organization, 2018). Studies confirm that as many as 75 percent of sexually active Canadians will have at least one anogenital HPV infection in a lifetime (Government of Canada, 2017a). To date, over 100 types of HPV have been identified, more than 40 types are known to infect the mucosal linings of the anogenital tract, the oral cavity, and the oropharynx (Public Health Agency of Canada [PHAC], 2012; Steben & Gale-Rowe, 2015). According to their association with cancer, these viruses are broadly classified into high and low risk types.

Low-risk HPV types (LR-HPV), particularly HPV-6 and HPV-11, can cause skin lesions such as anogenital warts. Anogenital warts are skin growths of different sizes and shapes, usually flesh-coloured and soft to touch. Some also grow in bumpy clusters that look like cauliflowers. They are usually painless but itching and bleeding may occur. The location of anogenital warts is varied; in women they may appear on the vulva, thigh, anus, or internally in the vagina or urethra with the cervix being a common site of HPV infection. When anogenital warts are inside the body or too small to be seen, they often go unnoticed and people may not be aware of the infection. Despite their invisibility, the warts can be transmitted to others through penetrative sex or skin-to-skin contact with an infected area (PHAC, 2012).

Of those infected, anogenital warts can resolve spontaneously over an average of six months, but there is possibility of fluctuation. For example, the number and size of warts tend to increase during pregnancy, then go away without treatment after delivery. The impact on labour

is minimal, unless excessive growth of warts obstructs the birth canal or poses a threat of massive bleeding. Research indicates that vertical transmission of HPV is possible, but the underlying mechanisms remain unclear (Steben & Gale-Rowe, 2015).

In comparison, high-risk HPV types (HR-HPV) are more likely to lead to the development of cancer, such as in the cervix. The cervix is the lower part of the uterus leading into the vagina; cervical cancer occurs when there is a malignancy of the cells lining the surface of the cervix. The carcinogenesis of cervical cancer can be broken down into six stages: 1) susceptibility of uninfected individuals; 2) infection with HR-HPV; 3) persistent HR-HPV infection; 4) cervical intraepithelial neoplasia limited to the cervical epithelium; 5) carcinoma in situ; 6) invasive cervical cancer with potential for widespread dissemination (Brassard, 2018). It is estimated that over 99 percent of cervical cancers are caused by persistent HR-HPV infection, 70 percent by two types of HR-HPV, namely HPV-16 and HPV-18. Despite the well-established causal link between HR-HPV and cancer, most people with healthy immunity will gradually clear the viruses out of their systems, so the lesions will resolve on their own. However, a small proportion of persistent HR-HPV infection does cause uncontrolled growth of abnormal cells and eventually, progress to cancer (PHAC, 2012, 2017c).

During pre-cancerous and cancerous stages on the cervix, symptoms may range from absent to mild, and the lesions can develop over years without women's knowledge. Therefore, early detection is key to successful treatment. Cervical cancer can be treated effectively if found at an early stage through a screening test, such as Pap.

Screening tests. In Canada, the Pap test is the most frequently used modality to identify HPV-related cytological abnormalities. During a Pap test, a speculum is used to open the vagina and a small sample of cells is obtained from the surface of the cervix by a brush. Sampled cells

are then smeared onto a glass slide (conventional cytology) or placed in a liquid fixative (liquid-based cytology) and sent for microscopic examination. If a Pap test shows abnormal results, women may be referred for further testing (e.g. colposcopy, biopsy) to confirm the nature of the changes. And if histological results come back positive, women will be referred for cancer treatment (Canadian Partnership Against Cancer, 2011).

The majority of regions in Canada have well-established, organized cervical cancer screening programs; all women within a specified age range (as per provincial/territorial screening guidelines) are eligible. However, in three regions with large Inuit populations (Northwest Territories, Nunavut, and Quebec), organized cervical cancer screening programs are not currently available. Instead, opportunistic screening may be obtained through primary health care providers (Canadian Partnership Against Cancer, 2017).

There is variation among provinces/territories in recommendations regarding the start age, testing intervals, and stop age of cervical cancer screening. Nationally, the Canadian Task Force on Preventive Health Care (2013) recommends routine screening for cervical cancer every three years for women aged 25-69. For women younger than 24 and older than 70, routine screening for cervical cancer is not recommended. Nunavut recommendations differ from those of the Task Force in that the start age is younger; the Pap test is suggested for sexually active women aged 21 and above. After three consecutive annual normal tests, the screening frequency may be reduced to every three years until age 69 (Canadian Partnership Against Cancer, 2017).

In addition to a Pap test, the other screening approach to cervical cancer is HPV DNA testing, which identifies infection with HPV prior to, as well as in the presence of cytological abnormalities. As such, it is more sensitive than a Pap test but less specific. The adoption of HPV DNA testing as an entry-level screening method is controversial; some do not recommend it

because results would not change treatment. Those who advocate for HPV DNA testing, on the other hand, credit this method in that its sensitivity makes it a better predictor of potentially serious HPV-related disease (Steben & Gale-Rowe, 2015). At present, HPV DNA testing is neither included in a woman's regular check-up, nor covered by provincial/territorial cancer screening programs. Some provinces (i.e. British Columbia, Manitoba, and Québec) are considering this method for primary screening and in Ontario, implementation of HPV DNA testing for routine primary screening is in planning stage (Canadian Partnership Against Cancer, 2017).

There is emerging research about the potential of HPV self-sampling to increase screening participation among Indigenous women. Zehbe et al. (2016) conducted a randomized controlled trial (RCT) with 11 First Nations communities, the results of which show that the average uptake of screening was higher in the self-sampling arm. Women who-self sampled in the RCT reported comfortable to very comfortable with the experience, and the majority of self-samples (95%) were adequate for HPV testing (i.e., with good DNA integrity). Similarly, a research study in Inuvik reported on the capacity of Inuit women to collect high quality self-samples; 97% of the samples were usable and over half of Inuit women preferred self-sampling to routine Pap test performed by a health care provider (Cerigo, Macdonald, Franco, & Brassard, 2012). More research is needed to explore how self-sampling can be used to overcome screening barriers and increase women's participation.

HPV vaccination. While there is no cure for HPV infection, vaccination is an effective means to reduce the risk of contracting the virus(es). In Canada, three HPV vaccines are currently authorized for use: Gardasil, Cervarix, and Gardasil 9. Gardasil, a quadrivalent vaccine (HPV4 vaccine), was approved in 2006 to protect against four types of HPV: two that cause

anogenital warts (HPV-6 and HPV-11) and two that cause cervical cancers (HPV-16 and HPV-18). In 2010, a bivalent vaccine Cervarix (HPV2 vaccine) was authorized for use in female Canadians for the prevention of HPV types 16 and 18 -related cancers. Gardasil 9, the newest HPV9 vaccine, became available to the Canadian public in 2015 to protect against an additional five HPV types (31, 33, 45, 52, 58) that are associated with anogenital cancers (Tunis, Ismail, & Deeks, 2016).

The National Advisory Committee on Immunization recommends all three HPV vaccines for females aged nine to 45 years, including those who have had previous Pap test abnormalities, cervical cancer or genital warts. Pregnant women, however, are not encouraged to receive HPV vaccination. For boys and men, Gardasil and Gardasil 9 are indicated in all aged nine to 26 years. Since HPV is sexually-transmitted, immunization prior to sexual debut is ideal for both sexes to maximize the benefit of the vaccine (PHAC, 2017c; Tunis et al., 2016). HPV vaccines are not recommended for children under nine years of age because data are insufficient to support such intervention among this population. An exception would be if the child is at risk of HPV exposure (e.g., have a history of sexual abuse or have been diagnosed with a sexually transmitted infection); in such cases, HPV vaccines may be considered for young children under nine years of age (Government of Canada, 2017a).

Approaches to HPV vaccination vary across Canada. Normally, these vaccines require three equal doses to be given over six months. Specifically, HPV4 and HPV9 vaccines should be given at months zero, two and six; and HPV2 vaccines given at months zero, one and six. For immunocompetent, non-HIV infected children aged nine to 14, a two-dose immunization schedule is feasible as long as there is at least a 24-week gap in between (Tunis et al., 2016). In Nunavut, a school-based HPV immunization program was established in 2010 to cover routine

vaccination for all female students in Grade 6. Young male students, however, are not currently covered through the school-based immunization program. Outside of the schools, all females born after 1998 can receive the vaccine free of charge at community health centres throughout Nunavut. The extended eligibility is to ensure that girls who did not receive all three doses in Grade 6 will still be able to complete the vaccine series if they wish (Canadian Partnership Against Cancer, 2017).

After immunization, regular screening is still important for women to prevent cervical cancer. The reason is twofold. Firstly, despite high efficacy, HPV vaccines can only protect against targeted types of HPV. In other words, immunized individuals can still be affected by some cancer-causing types of HPV that currently available vaccines are not indicated for. Secondly, HPV vaccines do not relieve an existing infection, nor do they change related health outcomes (i.e., vaccines cannot treat pre-cancerous or cancerous changes) (PHAC, 2012, 2017c). The limitations of HPV vaccines accentuate the importance of long-term surveillance and routine screening at population level.

HPV infection among Inuit. In Canada, HPV is not a nationally notifiable disease (PHAC, 2017b). Available studies indicate that HPV infection is a growing public health concern in Inuit population. A cross-sectional study in 1999 comprising 80% of Nunavut's population showed a 26% prevalence rate of HR-HPV among Inuit women (Healey et al., 2001). A more recent study in Nunavut (2008 to 2009) found an overall rate of 29.9% for any-type HPV and 19.9% for HR-HPV in a sample of 4,043 women, 89.2% of whom were Inuit (Totten et al., 2015). A study in Northern Quebec found similar results among Nunavik women; the baseline prevalence of any HPV and HR-HPV was 29% and 20%, respectively (Hamlin-Douglas, Coutlée, Roger, Franco, & Brassard, 2008). In a follow-up study for the same cohort in Nunavik,

nearly 40% of women acquired a new any-type HPV infection in two years, with HR-HPV infections acquired at a higher rate than LR-HPV and persisting for longer durations (Bennett et al., 2015). Other HPV surveillance studies conducted in the Canadian Arctic include Northwest Territories, Labrador and Yukon, all with any-type HPV prevalence rates above 20% (Jiang et al., 2011, 2013; Severini et al., 2013).

Research shows that HPV infection is more common in Indigenous women compared to non-Indigenous counterparts, although the differences were not always statistically significant (Jiang et al., 2011, 2013; Totten et al., 2015). According to Brassard et al. (2012), risk factors for Indigenous women include younger age, single marital status, current smoking, lifetime deliveries, use of hormonal contraceptives, and the number of sexual partners in the last year. A unique feature observed in Indigenous women is the U-shaped distribution of HPV prevalence rates; the highest incidence was found in young women less than 20 years old and a second peak in women of 50 years and older. This unique distribution specific to age may be related to social and lifestyle factors (e.g., early onset of sexual activity, new sexual partners later in life). However, information on sexual activity was not collected in available research thus the underlying reason remains unknown (Bennett et al., 2015; Jiang et al., 2011, 2013).

Despite a few studies documenting prevalence rates of HPV in the Canadian Arctic, there is a lack of comprehensive, up-to-date, and ethnic-specific surveillance data in Inuit regions (E. Cameron, 2011). It has been well documented that Inuit women are underrepresented in national surveillance, and that STI screening is implemented on a sporadic basis in Northern communities (E. Cameron, 2011; NCCAH, 2012). As such, the actual rates of HPV could possibly be higher than reported, whereas there is no openly accessible data to confirm the current state of infection. Also concerning is the fact that available data were mostly collected in pre-vaccination era; that

is, before school-based immunization programs became available (R. Bennett et al., 2015; Gauthier, Coutlée, Franco, & Brassard, 2015; Hamlin-Douglas, Coutlée, Roger, Franco, & Brassard, 2008; Jiang et al., 2013). The lack of baseline data from both before and after systematic immunization make it hard to evaluate the effectiveness of HPV vaccines. One direct consequence is the difficulty in public health planning, which in the North is further complicated by geographic isolation, shortage of staff and various social determinants (E. Cameron, 2011).

Social Determinants of Inuit Sexual Health

Despite great improvement, Inuit communities continue to experience worse health on a variety of indicators including: life expectancy, infant and maternal mortality, communicable diseases, non-communicable chronic conditions, and mental health issues (E. Cameron, 2011). These disparities are rooted in historical, economic and socio-political determinants that do not support good health. The National Inuit Sexual Health Strategy identified ten social determinants that are key to Inuit sexual health in Canada (Pauktuutit, 2017). These determinants are: housing; cost of living and food insecurity; education; mental wellness; safety and security (with a focus on violence against women and children); intergenerational trauma; substance use; gender; health services; and stigma and discrimination. This section will discuss these factors in further detail next.

Housing. Compared to the "matchboxes" built in the 1950s, living conditions in the North have improved significantly in recent decades. That being said, substantial housing shortages and poor quality of existing homes are still prevalent. In 2011, one third of Inuit lived in crowded conditions (i.e., more than one person per room in a dwelling) compared to 3% for non-Indigenous Canadians. 35% of Inuit homes were in need of major repairs that year and in contrast, the figure was 7% for non-Indigenous households (Wallace, 2014).

The stability and quality of housing are closely related to physical, mental, and emotional health (Krieger & Higgins, 2002). In overcrowded homes, tensions resulting from lack of privacy and personal space often escalate into aggressive behaviours (ITK, 2014). Inuit women are particularly vulnerable in these situations, but safe housing alternatives are few in Northern communities. To date, there are 15 shelters and transitional homes in Inuit Nunangat which serve both women and children across four Inuit regions. Meanwhile, over 70% of communities do not have women's shelters (ITK, 2014; Pauktuutit, 2019b). This means that women sometimes have to stay in a household where their personal safety is in danger. Other options include couch surfing with relatives or friends, which will exacerbate crowding in other households; or applying with local social services to be flown to another community, which often causes lengthy delays awaiting flights to be arranged (Halseth, 2013; ITK, 2014).

Safety and security. The alarming rate of violence against Indigenous women is a critical concern. As of 2010, 582 cases of missing and murdered Indigenous women and girls (MMIWG) were recorded in the national database developed by Native Women's Association of Canada (NWAC, 2010). It is anticipated that much more violent crimes targeting Indigenous women went unreported, as police agencies do not always record the victims' Indigenous identity (NWAC, 2015). The truth that thousands of Indigenous women and girls have been lost to various forms of violence is shocking and unacceptable. In 2019, more than 400 survivors and families attended the National Inquiry into MMIWG. It was concluded that the endemic level of violence experienced by Indigenous women over the decades amounts to genocide that is perpetuated by colonialism, racism and sexism (The National Inquiry into MMIWG, 2019). To make concrete changes, an intersectoral approach is needed to encounter the institutionalized

apathy and lack of will that allow violence to prevail (The National Inquiry into MMIWG, 2019).

In Northern communities, Inuit women are at high risks of violence with other social determinants (e.g., remoteness, housing, and cost of living) coming into play. Nunavut Territory, for example, has 6.5 times the national reported spousal abuse rate and more than 10 times the national average of sexual assault (NCCAH, 2010, 2012). Data from Nunavik show similar concerns, with 49% of women stating that they had been victims of sexual assaults or attempts to commit sexual assault as a minor (Anctil, 2008). In addition to strangers, the perpetrators of violence could also be acquaintances, family members, and intimate partners. Understanding the unique relationships that women experience, as well as the circumstances specific to their families and communities, is the first step to end the cycle of violence.

To regain the fundamental right to safety, Indigenous women are empowering and standing up for each other as sisters from Nation to Nation. A repeated assertion is that women are experts in creating transformative changes, and therefore their rightful place must be regained within all levels of society to bring forward meaningful solutions (The National Inquiry into MMIWG, 2019).

Mental wellness and intergenerational trauma. As with most women, healthy sexuality is built on a high level of self-esteem, positive self-image, and confidence to make clear communication – all of which are strongly connected to mental wellness (Rand, 2014). A major factor that negated Inuit mental wellness was the imposition of residential schools, where children were often abused, physically or sexually, instead of learning in a safe environment (Walton & O'Leary, 2015). By the time the last residential school was closed, a substantial proportion of Inuit had attended these institutions in their youth (D. King, 2006). Research

indicates that residential schools often adversely affected the subsequent parental skills of students who, in their adulthood, experience a rift created between generations (NCCAH, 2010). Many Inuit parents reported feeling distant from their children and lacking the confidence to take on educational roles (Steenbeek, 2004).

Things began to change when Inuit gathered their strengths to push for the prosecution of perpetrators of violence at residential schools. In 1995, two separate investigations were launched in Chesterfield Inlet which involved documented sexual and physical abuse of students. Solid evidence was found which eventually led to 13 sexual abuse charges against three Catholic priests and 41 charges against one civilian staff member (D. King, 2006). More former students came forward to share their truths, whose collective efforts laid the groundwork for the Indian Residential Schools Settlement Agreement. With the largest class-action lawsuit in Canadian history comes the formal apology from the government in 2008; and the establishment of the Truth and Reconciliation Commission of Canada (TRC) which held seven National Events across the country. The thousands of residential school survivors who brought their experiences to light in these Events have taken the initiative to seek justice and promote healing.

Substance Use. The individual and collective trauma sustained from colonial violence is often a catalyst for high-risk coping responses such as smoking, drinking, and substance use. The results of the 2012 Aboriginal Peoples Survey show that over half (52%) of Inuit aged 15 and older are daily smokers; and that 23% of Inuit women of the same age group self-reported heavy drinking (i.e., five or more drinks on a single occasion at least once a month; Wallace, 2014). A study in Nunavut reveals the concurrent use of drugs and alcohol among Inuit youth at a rate two to three times higher than their peers in Southern Canada (Pauktuutit, 2019a). These concerns deeply impact Inuit women's health in that, for one, smoking has been consistently identified as

a risk factor for cervical cancer (PHAC, 2017a); and secondly, women and girls under the influence of alcohol and drugs are vulnerable to unsafe sexual practices – a contributing factor to the spread of STIs.

The unique circumstances in the North determine that tremendous resolution and wisdom are needed to cope with stressors in a healthy way. Many Inuit women find it hard to quit smoking for reasons including: to suppress appetite and save food for their children; to take a break from child care; to deal with difficult emotions; to relieve loneliness; and to be part of a social network (Pauktuutit, 2012). Providing resources to support these practical needs as well as culturally-safe treatment options is key to reduce harmful coping mechanisms.

Health services. Inuit women face multiple barriers in accessing health care, especially in isolated communities where there is no year-round road access or permanent physicians. Out of 52 communities scattered across Inuit Nunangat, most do not have a hospital and the provision of health care is mainly delivered through Community Health Nurses (ITK, 2014; NCCAH, 2011). The community-based nursing staff are educated to perform a wide range of medical services, who can also consult other health professionals by distance in complex cases (Waldram, Herring, & Young, 2006). However, a full range of medical services has yet been achieved in the North due to limited staffing and facilities; which means that Inuit have to leave their homes to access specialized care. A direct result is the delayed diagnosis and treatment of potentially serious conditions, such as cervical cancer. The lack of timely cervical cancer care has at least partially contributed to the higher mortality rates of Inuit women (ITK, 2014; NCCAH, 2011).

Since the 1950s, the medivac system has been central to compensate for a lack of comprehensive services in Northern territories by transferring patients to regional “hubs” (e.g., Iqaluit, Yellowknife, Rankin Inlet, and Puvirnituq) on air ambulances; or to Southern Canadian

cities such as Edmonton, Winnipeg, Ottawa, and Montreal if specialist services are required (ITK, 2014). Although medevac flights provide a practical means to link patients to much-needed care, such medical travels incur significant costs to Northern health departments. It is estimated that about 32,000 medevac trips were made in 2016 to 2017 at a total cost of 74 million dollars. The need for long-distance transportation and accommodation significantly increases the medical spending per person; an average $10,154 was spend on each patient in Nunavut under a total budget of $365 million, compared to $3,867 per person in Ontario with an overall $52 billion health budget (Davey-Quantick, Anselmi, & Mathisen, 2018). The social and emotional costs are high as well in that patients have to endure prolonged separation from families in a vulnerable time (ITK, 2014; NCCAH, 2011).

For Inuit registered with a recognized Inuit Land Claim organization, medical travels are insured through the Non-Insured Health Benefits (NIHB) program which also covers dental and vision care, prescription medications, medical devices and appliances, and some services such as mental health crisis intervention (Bonesteel, 2008; Waldram et al., 2006). However, some beneficiaries have questioned the accessibility of NIHB program delivery by describing a common scenario that faces rural and remote communities: "…when Non-Insured calls you, you're expected to travel from your house, leave your job, leave your kids, leave your husband and come out to this appointment within hours or the next day. And if you can't make it out, you get penalized for missing that flight. The policies of Non-Insured are really impacting the access to specialists that they need to see." (Allan & Smylie, 2015, p. 26)

Northern health workforce. In Canada, many Inuit communities are small and remote, with a few resident nurses responsible for a variety of medical and administrative tasks. Harsh climate, geographic isolation and heavy workload lead to significant challenges of recruiting and

retaining permanent nurses, resulting in high turnover rates of staff (ITK, 2014; NCCAH, 2011). During the 1970s, the annual turnover rate of medical staff in some Inuit communities was reported to be as high as 86% (Bonesteel, 2008). The provision of specialist services is in greater crisis with dentists and family doctors flying in only a few times a year to see patients for short durations. The lack of sufficient and stable health human resources impedes the continuity of care, which often translates into lowered effectiveness (NCCAH, 2011). This is especially true for sensitive topics such as sexual health, in which a trusting relationship must be built so that patients feel safe and comfortable to talk about their private concerns.

The need for Indigenous health care providers to address current staffing shortages has been well-recognized. Compared to non-Indigenous providers, Indigenous health professionals have an edge in understanding the distinct health priorities of their communities within specific cultural contexts (NCCAH, 2011). The cultural sensibility of Indigenous providers is built through years of lived experience in Indigenous communities, which for non-Indigenous providers would understandably take longer to achieve. The unique strengths of Indigenous health professionals, however, should not discount the many challenges of working in diverse community settings. The hard work of Indigenous providers is not always met with high recognition that they deserve due to the aftermath of colonization that set white providers as the "professional" and Indigenous as the "uneducated" (Etowa, Jesty, & Vukic, 2011; Huria, Cuddy, Lacey, & Pitama, 2014). In isolated Northern communities, health care delivery is further complicated by anonymity and confidentiality issues given the close-knitted nature of small populations (NCCAH, 2012). This means that Inuit health care providers need to work with great caution to avoid the blurring between personal and professional boundaries which may deter acquaintances from seeking consultation.

Despite recent efforts to increase the number of Indigenous health professionals in Canada, such as the $100 million five-year Aboriginal Health Human Resources Initiative, Indigenous Peoples continue to be underrepresented in all health occupations including nurses, physicians, and social workers (Allan & Smylie, 2015). In 2018, 32% of nursing positions provided through the Government of Nunavut remained vacant, and up to 150 short-term contract nurses were recruited annually from Southern Canada to fill these vacancies (Davey-Quantick et al., 2018). A number of efforts have begun to attract more Indigenous individuals to work in the health care system. For example, a partnership nursing program is offered by the Nunavut Arctic College and Dalhousie University with an aim to prepare Inuit graduates with entry-level nursing knowledge and skills, as well as enhanced awareness and respect for Inuit culture (Dalhousie School of Nursing, n.d.). As more Indigenous professionals graduate and enter the workforce, it can be anticipated that health care will become increasingly relevant to Indigenous Peoples.

Stigma and discrimination. Research suggests that Indigenous patients may delay or avoid health care even when there are perceived needs of such services (Waldram et al., 2006). Reports of racial biases and negative stereotypes from health care providers are frequently cited barriers; for instance, in a study examining First Nations Women's encounter with mainstream health services, women recounted situations when doctors and nurses belittled their health conditions, resulting in denied or poor treatment (Browne & Fiske, 2001). A few fatal cases have been reported resulting from such lack of medical attention, including the death of Brian Lloyd Sinclair in 2008, who died from a bladder infection after a 34-hour wait in the ER without receiving any treatment (Allan & Smylie, 2015); and Hugh Papik, an Inuvialuit man died from a massive stroke after staff mistakenly determined his symptoms for drunkenness (CBC News,

2017). These tragic cases indicate that being identified as Indigenous might result in reduced chances of receiving prompt, adequate and respectful care as other Canadians. When such differential treatment is perceived or anticipated, some Indigenous patients are reluctant to access health care, or might choose to avoid health services at all (Allan & Smylie, 2015).

The phenomenon of Indigenous Peoples being treated unfairly in the health care system has wider historical and socio-political roots. Browne (2009) argued that the dismissing attitudes reported in some health professionals are not reflective of their personal philosophies, but rather socially-constructed outcomes caused by long-standing colonial assumptions of Indigenous Peoples. Over the years, the media have played a huge role in conveying false images of the "drunken Indians" who were irresponsible and narcotics-seeking (Allan & Smylie, 2015; Vowel, 2016). These pervasive colonial discourses became a lens through which Indigenous patients are understood in the health care system, whose behaviours are so often taken out of contexts and interpreted as "trouble-making". The everyday practice of clinicians may be shaped by such negative connotations, despite the fact that most providers believe in equitable and compassionate care (Browne, 2009). The fact that many institutions do not have a qualified translator for unilingual Indigenous patients – many of whom are Elders –often exacerbates misunderstanding (Allan & Smylie, 2015; NCCAH, 2011). Compounded by heavy workload in clinical settings, health professionals face significant barriers in providing culturally responsive care.

Recognizing the healthcare needs specific to Indigenous populations has led to a number of policy statements and guidelines, as well as educational programs intended for different levels of trainees (Allan & Smylie, 2015; Baba, 2013). In the Northwest Territories, for example, the territorial government is piloting a cultural safety training for all health care staff. The topics that

are covered in training include: different cultures in the territory; the history of colonization and residential schools; and the challenges of providing care in rural, remote communities (Blake, 2018a, 2018b). Despite such educational efforts, there are currently no standardized criteria for learners and administrators to evaluate learning outcomes consistently (Baba, 2013). Although generally well-received by participants, the impact of existing educational programs on health delivery remains largely anecdotal. This is concerning because cultural competency cannot be taught overnight, and education alone does not guarantee sustained change. The fatal cases of Indigenous patients reported in this section are the clear evidence of cultural biases that still exist in today's health care systems. A potential strategy is to develop a set of national core competencies for working with Indigenous clients, which will better prepare health professionals for culturally safe care (Baba, 2013).

While the scope and length of this section is to identify some of the most relevant determinants related to Inuit sexual health rather than provide an exhaustive analysis, this choice should not be interpreted as the less importance of factors that are not discussed here. Social determinants such as gender, education, income and food insecurity have been explored extensively elsewhere in Indigenous health literature (Halseth, 2013b; ITK, 2014; Reading & Wien, 2012; Richmond & Ross, 2009). Like other Indigenous populations, Inuit women are dealing with the intersectionality of multiple determinants on a daily basis in addition to the challenges unique to Northern contexts. It takes exceptional strengths in women to navigate such demanding situations seamlessly; who in the meantime are taking care of families; exceling in all walks of life; and striving for better future of their communities. This strong resilience in women is what the communities need to move forward.

Moving Toward Healing and Wellness

Although severely disrupted by colonial policies, Indigenous knowledge systems continue to exist and evolve. Recent decades have seen enormous strides made by Indigenous Peoples and allies to regain the rightful place of Indigenous knowledge along with their efforts to raise public awareness. One significant advancement has been the official apology from the Canadian government to residential school survivors. As noted in the Apology, "It has taken extraordinary courage for the thousands of survivors that have come forward to speak publicly about the abuse they suffered. It is a testament to their resilience as individuals and to the strength of their cultures (Indigenous and Northern Affairs Canada, 2010, para. 6)." The Apology has been recognized as an important step in the right direction toward a mutually respectful relationship between Indigenous Peoples and the Canadian state. There has been growing public dialogue about truth and reconciliation, a historical knowledge that many Canadians know little about (TRC, 2015a). The subsequent cultural and socio-political advancements created opportunities for a new wave of contemporary Indigenous healing.

Indigenous healing represents a complex body of health knowledge and practices embedded in Indigenous ways of knowing. Given the fact that each group of Indigenous Peoples – as well as each person within a community – has unique historical experiences of colonization, the meaning of healing is inherently variable. In the past, Indigenous healing referred primarily to the use of traditional herbal medicines and other remedies in treatment of physical ailments (Waldram et al., 2006). Although contemporary forms healing do not exclude such practices, there are additional layers of meaning that accentuate psychosocial and spiritual well-being (Waldram, 2014). Indigenous healing as cited in current literature is characterized by an ongoing connection to the past, based on the specific beliefs, values, and practices that go back to a time

prior to European contact (Karetak et al., 2017; Waldram, 2014). It has also been described as a life-long journey that requires personal agency, thus cannot be achieved without individual willingness and readiness (Waldram, 2008). In its broadest sense, healing can be viewed as "the transition that restores the person, community, and nation to wholeness, connectedness, and balance" (Green, 2010, p. 32). This definition resonates with the wholistic worldviews of *IQ* by promoting a return to meaningful relations that were once disrupted by colonization.

The broad nature of Indigenous healing determines that a one-size-fits-all approach is unlikely to be effective; rather, healing should acknowledge the uniqueness of individual experiences embedded in a historical context (Waldram, 2014). This section will next discuss culture and self-determination as powerful tools to promote health equity, self-reliance and involvement of Indigenous Peoples in all levels of society.

Culture as treatment. Despite the personal nature of healing, a couple of themes have emerged consistently out of healing discourses by Indigenous thinkers and allies. One often cited theme is culture, which has been defined as "… a dynamic and adaptive system of meaning that is learned, shared, and transmitted from one generation to the next and is reflected in the values, norms, practices symbols, ways of life, and other social interactions of a given culture" (NCCAH, 2004, p. 1). According to this definition, culture is socially constructed with a collection of core values and practices that are claimed as shared experiences (Kirmayer et al., 2009). This definition also implies that culture is durable, the impacts of which are lasting and intergenerational among members of a particular group. These two characteristics are strikingly similar to the concept of historical trauma; "a collective complex trauma inflicted on a group of people who share a specific identity or affiliation", and "the legacy of numerous traumatic events a community experiences over generations" (Evans-Campbell, 2008, p. 320). Given these

similarities, it is likely that culture can be utilized as a source for healing within Indigenous individuals, families, communities, and nations.

Early scholars tended to describe Indigenous cultures as bounded sets of specific traits, continuously linked to an identifiable past or tradition (Kirmayer, Simpson, & Cargo, 2003; Waldram, 2009). The flaw in this notion is twofold. Firstly, it denies the very existence of Indigenous cultures in modern societies by adopting a static, past-oriented approach that seems useless in contemporary contexts (Waldram et al., 2006). Second, the notion implies that Indigenous and dominant cultures are fundamentally incompatible – a dividing practice that perpetuates the Othering and marginalization of Indigenous Peoples (Kirmayer et al., 2009). In fact, anyone in search of evidence against these myths need to look no further than the growing Indigenous population in urban metropolitans, who are active participants of all sectors of modern society. Therefore, Indigenous cultures should be understood as ever-evolving entities that are shaped by the constant flux of historical currents and contemporary forces (Kirmayer et al., 2003; Waldram et al., 2006).

Pan-Indigenous cultural norms. Considerable similarity exists in the cultural concepts held by North American Indigenous Peoples (Little Bear, 2000). Indigenous concepts of personhood are "ecocentric", which constructs the self in relations with families, communities, environment, animals, and spirits (Kirmayer et al., 2009). This common philosophy gave rise to the phenomenon of certain healing practices being widely adopted across Canada; examples include smudging, tobacco offering, sweat lodges, healing circles, bush therapy, and powwow dancing (Kirmayer et al., 2003; Waldram, 2014). The pan-Indigenous healing movement has presented a unique opportunity to form a collective voice in socio-political causes. For service providers, common healing approaches have the added benefit of reducing workload, based on

the premise that a generic program is potentially applicable to diverse populations. There are particular issues to consider, however, regarding the appropriateness of pan-Indigenous healing approaches. Naturally, such approaches tend to obscure variations among distinct groups and the constant transformation of cultural identity (Kirmayer et al., 2009). It is important to recognize the great diversity of Indigenous cultural norms, especially between groups from vastly different geographies. Inuit, for example, may feel rather disconnected from Indian tribal elements such as the Eagle Feather. Even within the same Indigenous group, variation exists in knowledge and attitudes about cultural traditions (Kirmayer et al., 2003). Insofar as Indigenous Peoples have resisted concerted efforts at assimilation, centuries of European contact would mean that elements of Christianity, biomedicine and popular culture are entrenched within Indigenous practices (Waldram et al., 2006). Assuming Indigenous clients would always prefer the "traditional" approach is inappropriate by implying a default exclusion from dominant cultures, which would reinforce stereotypes and marginalization.

Self-determination as source of resilience. Researchers have come to recognize the strengths in Indigenous Peoples as resilience; the ability to maintain or return to balance after experiencing hardships (Denham, 2008). While it is common to associate resilience with individual character traits (e.g., intelligence, perseverance, good humour), resilience has, in the context of Indigenous healing, increasingly become a collective process that extends to families, communities and larger social groups (Dion Stout & Kipling, 2003; Kirmayer et al., 2011). Therefore, resilience in a broader sense can be viewed as a collective agency that pertains to the shared resolutions to act with purpose and make positive attainments (Kral & Idlout, 2009). This communal dimension of resilience is particularly relevant to Indigenous Peoples, who have historically resisted longstanding forms of oppression designed to undermine self-reliance and

local control. To strengthen resilience at the community level, Indigenous Peoples must strive for self-determination and the power to make decisions regarding their own lives.

While Indigenous Peoples have never been passive recipients of colonial regimes, significant changes are occurring in recent decades as Indigenous Peoples regain control over various aspects of community life. Some crucial aspects of self-determination have become the leading sources of resilience, especially in its systemic sense. These include the retelling of collective history, the stewardship of traditional lands, and the engagement in health care.

The retelling of collective history. Indigenous notions of collective history traditionally link a sense of self to the shared values, customs, and traditions passed down through family and the greater community (Denham, 2008). The discourses related to collective history reflect how a people conceive themselves in the world, which in turn shapes individual ways of knowing and being (Kral & Idlout, 2009). For centuries, the narratives of Indigeneity were controlled by Western scholars and mass media who often portrayed Indigenous cultures as primitive, inferior and unequal to dominant social norms (Younging, 2018). The majority of contemporary literature is more recognizant of the historical context of ongoing inequalities, but some persist in conveying a grim outlook for Indigenous communities as a hopeless and victimized realm (Linklater, 2014; Younging, 2018).

To recover from past turmoil and current injustices, Indigenous Peoples are empowering each other to rise above the dreary circumstances and begin the process of naming, discussing, and owning the narratives about community life (Kauki, 2015). Shifting the focus toward positive outcomes – the strengths, merits, and highlights that recognize the significant contributions made by Indigenous Peoples, nurtures a sense of cultural pride that is at the root of self-determination (Kral & Idlout, 2009; Linklater, 2014). For example, from a contemporary

Mi'kmaq perspective, the treaties negotiated with the British Crown are agreements to bring the European newcomers into co-existence in keeping with the moral values of peace, friendship, and reciprocity. As such, the discourse related to this excerpt of Mi'kmaq history is no longer framed by dispossession but is seen as the reclamation of cultural values that transcended material benefits (Kirmayer et al., 2011). Through the dynamic cycle of retelling and learning, a strong cultural identity is renewed which becomes the foundation for physical, mental, and emotional well-being (Denham, 2008).

The stewardship of traditional lands. Indigenous concepts of the person are grounded in connections to the land has been traditionally used for millennia (de Leeuw, 2015). For Indigenous Peoples, the land not only provides for physical survival, but also forms the basis for a wide range of cultural activities (e.g., hunting, gathering, camping, ceremonies) that are integral to emotional support and spiritual guidance (Kirmayer et al., 2011; Richmond & Ross, 2009). In light of this, any forms of damage and appropriation of Indigenous lands are direct assault on Indigenous personhood (M. King, Smith, & Gracey, 2009). At the time of colonization, many Indigenous Peoples were physically displaced from their traditional lands under the Indian reservation system and forced relocation policies (NCCAH, 2013). In contemporary times, large-scale industrial exploitation and rapid climate changes pose new threats to both the land and the people (M. King et al., 2009). As guardians of their traditional territories, Indigenous Peoples are actively asserting themselves in their rights to receive free, prior, and informed consent in terms of development within their territories. In the face of irresponsible projects that put Indigenous well-being at risk, Indigenous communities have stood in solidarity with each other and remained undeterred in their stewardship of the land. Landmark battles have been won, including the Delgamuukw court case in 1997 and the Haida Nation case

in 2004 (Teegee, 2018). Despite hardships and setbacks, Indigenous Peoples hold up to the faith that more victories will come in the future (see Unist'ot'en Camp [2019] for the ongoing fight of Wet'suwet'en people in against the Coastal GasLink pipeline in their unceded territory), as more Indigenous Peoples are actively engaged in land claims and other forms of political negotiation as equal partners with Canada (Kirmayer et al., 2011).

The engagement in health care. Indigenous communities are often given healthcare services by the government without being adequately involved in the design and delivery of programs, but this situation is changing. During the 1980s, several initiatives were taken to facilitate the transfer of programs and services to First Nations and Inuit community control. One example is the Health Services Transfer program initiated in 1988, which sparked a wave of health transfer agreements signed by First Nations tribes (Waldram et al., 2006). Following this movement, many Indigenous-oriented and community-based programs have emerged. Noted strengths of these health provisions include their holistic approach; the integration of Indigenous and Western knowledge; the focus on interdisciplinary team including traditional healers; and the collaboration of all levels of governments (Bonesteel, 2008, p. 79). The reported changes in health outcomes after the transfer process suggest that the best knowledge comes from within the community, instead of top-down approaches of which Indigenous Peoples have little control. It was recognized that Indigenous health and wellness should move in the direction of self-determination, with assistance from the government in way that fit Indigenous priorities (Kral & Idlout, 2009).

In addition to health delivery, Indigenous communities are working with universities and institutions to make health research increasingly relevant to their people. There is growing participation in high-quality research that is conceived, developed, implemented and applied

within and by the communities to address local concerns (Association of Canadian Universities for Northern Studies, 2018). For external researchers, core knowledge documents have been developed that provide information about local contexts and expectations for respectful relationships. Common recommendations include relationship building before commencement of research; adequate consideration of community input throughout the process; tangible benefits for the community in the short and long term; recognition of Indigenous contribution and local expertise; timely reports on research results; and capacity building in pursuing Indigenous-led research (Association of Canadian Universities for Northern Studies, 2018; Nickels, Shirley, & Laidler, 2006). Large-scale research collaborations are increasing (e.g., the 2017 Nunavik Inuit Health Survey), and it remains to be seen whether these initiatives will eventually enhance self-determination in health and healing. Indigenous Peoples envision a future when people have a firm hand on not only the delivery of services, but also the direction of collective endeavours (Waldram et al., 2006).

Summary

The health outcomes of Inuit are deeply impacted by colonization and a chain of rapid social changes that disrupted the transmission of Inuit culture. Historical trauma continues to have a lingering effect within the older generation as well as younger Inuit, creating myriad social and health disparities. Inuit women further experience gendered discrimination and violence from both within and outside of their communities. In light of this, women's sexual health extends far beyond personal lifestyle choices to the much broader issues of systemic inequalities.

While there is an urgent need to address high rates of HPV and cervical cancer among Inuit, many challenges are present including the sensitive nature of sexual health; different

perspectives on health and personhood; and the lack of reliable health indicator data at population level. More importantly, underlying socio-economic disparities such as housing, safety, mental wellness, substance abuse and health services will continue to impact negatively on health. As Archibald and Grey (2000) articulated, “Until housing shortages are gone, until there is an economy that can support the growing number of young people reaching employment age, until the education system can produce more high school graduates, and until a wide range of post-secondary opportunities are available in the north, the situation is unlikely to change” (p. 61). Clearly, a wholistic approach is required to address the complex driving forces behind sexual health.

In recent years, significant efforts have been made to promote healthy sexuality among Indigenous women. Leaders in this field include Pauktuutit, Native Youth Sexual Health Network, NWAC, and CAAN. In the meantime, more Indigenous communities are engaged in health delivery and health research by seeking collaborations with governments and academic institutions, in recognition that the most effective solutions will be those from the community. However, substantial work is needed to develop a comprehensive cervical cancer prevention and treatment strategy for Inuit. Existing research suggests an Inuit-specific, trauma-informed, and culturally-grounded approach. In tandem with these features, Indigenous resilience should be placed at the centre to empower women as strong mothers, daughters, grandmothers, and friends despite roadblocks on the journey to wellness.

A review of literature indicates that cervical cancer care for Inuit is a highly-specialized area with little existing evidence. This research is undertaken to expand the much-needed discussions around this critical health need. It is hoped that by exploring “what works” for Indigenous healing in general, valuable insights will be gained that can potentially guide

culturally-relevant cervical cancer care for Inuit. The next chapter will discuss the theoretical underpinnings and methods of this study.

Chapter Three: Methodology

The Joanna Briggs Institute (JBI) approach to scoping reviews was chosen for this research for two primary reasons. The first reason is that the JBI conceptualizes evidence not only in terms of *Effectiveness*, but also *Feasibility*, *Appropriateness*, and *Meaningfulness* (Pearson, Wiechula, Court, & Lockwood, 2005). These four dimensions constitute the FAME scale which is at the centre of the JBI Model of Evidence-based Healthcare (Jordan, Lockwood, Munn, & Aromataris, 2018). When no formal research exists in a given topic, expert opinions can be used as the "best available" evidence (JBI, 2018). This contextualized understanding of evidence is particularly useful in this research because Indigenous healing strategies often exist in the form of grey literature rather than peer-reviewed articles. It is not uncommon for Indigenous writers to use poems, stories, and personal narratives in describing sources of healing. The JBI approach allows the inclusion of these diverse evidence that would traditionally be excluded from systematic reviews. It is hoped that through this unique approach, Indigenous knowledge and opinions will be identified and drawn upon as credible evidence.

The second reason is that JBI has developed a variety of rigorous methodologies for the conduct of systematic reviews and knowledge synthesis, as outlined in the JBI Reviewer's Manual (Aromataris & Munn, 2017). Similar to other types of JBI systematic reviews, scoping reviews begin with an a-priori protocol that is peer reviewed and accepted by the JBI. When the scoping review is completed, the final report is subject to peer review a second time and any deviations from the protocol should be clearly addressed (Peters et al., 2017). The JBI also offers reporting guidelines and checklists (Tricco et al., 2018) to aid in the standardized reporting of systematic reviews; it is highly recommended that all manuscripts comply with these guides in order to be considered for publication in the JBI Database of Systematic Reviews and

Implementation Reports (JBISRIR) – the official journal of the Institute. The abundance of methodological support and scrutiny provided by the JBI motivates authors to improve the consistency and transparency of their research so that the risk of bias is mitigated.

Based on these strengths, a JBI scoping review will be conducted to explore characteristics of Indigenous healing strategies in Canada. A search in JBISRIR, Cochrane Library, PROSPERO, CINAHL and MEDLINE in September 2018 found no relevant systematic reviews (completed or underway) on this topic. The title of this review was initially registered in the JBI database in July 2018 as "*Health and wellness strategies reflecting traditional Indigenous perspectives: A scoping review protocol*". Since then, substantial changes have occurred which eventually led to the final protocol titled "*Characteristics of Indigenous healing strategies in Canada: a scoping review protocol*". Drawing upon the final manuscript accepted by JBISRIR, the following section details the review questions, inclusion criteria and other methods. The publisher has granted permission to use the final peer-reviewed manuscript in this thesis. For additional information, see Wolters Kluwer Health (2018).

The Scoping Review Protocol

Review question. This scoping review aims to address two primary questions:

1) What are the characteristics (e.g., guiding principles, main components and human resources) of Indigenous healing strategies in Canada?

2) What approaches have been used in research process to improve the cultural relevance to local Indigenous contexts?

Inclusion criteria. As recommended by the JBI, the inclusion criteria of this scoping review will be structured under the "PCC" mnemonic: participants, concepts, and contexts.

Participants. This review will consider literature that include First Nations, Inuit and Metis in Canada as population of interest. Although these three groups are formally recognized by the Canadian Constitution (Government of Canada, 2017b), Indigenous Peoples may prefer to self-identify by other terms derived from their nations (e.g. Anishinabek, Cree), traditional lands (e.g. Inuvialuit), or languages (e.g. Chipewyan, Dene) (Statistics Canada, 2016; Vowel, 2016). In such cases, the preferred names of Indigenous Peoples were included as search terms in this review. There was no exclusion criterion based on age, gender or health conditions of participants.

Concept. Key concepts of this scoping reviews included: historical trauma, health, healing, culture, strategy, characteristics, and culturally-relevant.

"Historical trauma" is defined as "…the legacy of numerous traumatic events a community experiences over generations and encompasses the psychological and social responses to such events" (Evans-Campbell, 2008, p. 320). For Indigenous Peoples in Canada, historical trauma has been consistently associated with colonization, forced assimilation, cultural oppression and other forms of state-wide violence (C. MacDonald & Steenbeek, 2015).

"Health" is a wholistic concept that encompasses the physical, mental, emotional, and spiritual dimensions of Indigenous well-being (M. King et al., 2009). It extends beyond the individual level and requires harmonious relationships with family, community, nature, and the spiritual world (M. King et al., 2009; Little Bear, 2000). Other terms such as balance, wellness, and wholeness have been used interchangeably in Indigenous health literature.

"Healing" in its broadest sense can be understood as "the transition that restores the person, community, and nation to wholeness, connectedness, and balance" (Green, 2010, p. 32). In order for healing to occur, there needs to be an increased understanding of Canadian history

from an Indigenous perspective, as well as inclusion of cultural activities that reconnect Indigenous Peoples to their languages, beliefs, and traditions (Waldram, 2008).

"Culture" as used in this review is a "dynamic and adaptive system of meaning that is learned, shared, and transmitted from one generation to the next" (NCCAH, 2004, p. 1). Specifically, it refers to the distinct beliefs, values, and worldviews reflective of historical and contemporary Indigenous traditions.

Whilst there is no internationally agreed definition of "strategy", for the purpose of this review, it pertains to any attempt that promotes health and healing for Indigenous Peoples of Canada, for example: 1) health services and programs; 2) polices and guidelines; 3) models and frameworks; 4) Indigenous narratives and expert opinions.

The "characteristics" of a healing strategy include, but are not be limited to, guiding principles, main components, and human resources. Existing literature that provide narrative text on any of these characteristics, either in part or as a whole, were considered for inclusion.

Finally, the term "culturally-relevant" refers to a state whereby a research study embraces Indigenous ways of knowing and considers the historical, economic, and socio-political contexts of local Indigenous communities.

Context. This review will focus on healing strategies based in Canada. According to the 2016 Census, Indigenous Peoples live in all administrative jurisdictions of Canada, including 10 provinces and three territories. Statistics show that the First Nations population are concentrated in Ontario and Western provinces, namely British Columbia, Alberta, Manitoba, and Saskatchewan. More than three-quarters of Inuit live in their traditional territories across the Canadian Arctic in four regions collectively known as Inuit Nunangat. These regions are: Inuvialuit (Northwestern Territories), Nunavut, Nunavik (Northern Quebec), and Nunatsiavut

(Labrador). In comparison, the Metis population are mostly likely to live in urban centres (Statistics Canada, 2017). Healing strategies delivered in all service settings will be eligible for inclusion.

Types of sources. This scoping review will consider both peer-reviewed and grey literature that fits the inclusion criteria. Eligible sources of evidence included: primary research of all study designs, reviews and meta-analyses, text and opinion papers, conference proceedings, newsletters, and publications by Canadian government/Indigenous organizations. Within the limited time frame of this review, theses and dissertations will be excluded.

Search strategy. A three-step search strategy will be conducted through consultation with an experienced JBI systemic review library scientist. The initial search will be undertaken in CINAHL and Sociological Abstracts followed by analysis of text words contained in the titles and abstracts along with index terms used to describe the article. A second search will then be conducted using all identified keywords and search terms across all included databases. Thirdly, the reference lists of all identified articles will be hand searched for additional records. Key journals related to Indigenous health will be hand searched for eligible studies.

Studies that were published in the year of 2008 and onward will be included. This decision is based on the establishment of the TRC in 2008, which gave rise to a new wave in Indigenous healing. Since English is the only common language that all reviewers speak, literature will be excluded if they are not available in English.

Information sources. The databases to be searched will include: CINAHL, Sociological Abstracts, PsycINFO, MEDLINE and Academic Search Premier. Searches for grey literature will be conducted in iPortal of the University of Saskatchewan, Canadian Electronic Library, and a list of Canadian government and Indigenous organization websites. These websites will include,

but are not limited to: Health Canada, PHAC, Indigenous and Northern Affairs Canada, NCCAH, AHF, NWAC, Quebec Native Women, CAAN, Pauktuutit, ITK. Two key journals – including the *International Journal of Indigenous Health* (formerly known as the *Journal of Aboriginal Health*) and the *International Journal of Circumpolar Health* – will be hand-searched for eligible studies.

Study selection. All citations retrieved by search strategies will be entered into an online systematic review platform Covidence (2018) and duplicates will be removed automatically. Two reviewers will complete titles and abstracts screening independently, selecting articles against the pre-defined inclusion criteria. Following this step, the full text articles will be retrieved and uploaded into Covidence. A team of three reviewers will independently assess the eligibility of full-text articles and provide a rationale for exclusion. Throughout the study selection phase, discrepancies between any two reviewers will be settled through discussion or a third reviewer if required.

Data extraction. The following details will be extracted from included studies in a charting table: author(s), year of publication, literature type, aim/purpose, Indigenous population, geographical location, service setting, type of strategy, characteristics of strategy, main findings/author's conclusion, and culturally-relevant approaches. Among these, culturally-relevant approaches will only be extracted from primary research studies included in this review, because other types of literature do not technically include a research process with Indigenous participants. The data will be extracted by a team of three reviewers. To begin with, three reviewers will trial the charting table on three articles and compare results. The remaining data extraction will be completed independently by three reviewers, and discrepancies between any two reviewers will be resolved through discussion.

When two or more articles included in this review describe the same strategy from different aspects, characteristics will be extracted simultaneously to complement each other. This treatment is to avoid redundancy of information and to capture the full picture of strategies included. If key data are unclear in the full-text article, the correspondence author will be contacted for further information.

Presentation of findings. Characteristics of healing strategies – including guiding principles, main components, and human resources – will be summarized in tabular forms accompanied by narrative text. As the review progresses, other characteristics may emerge from the literature and will be presented in the final report. Culturally-relevant approaches will be summarized thematically; for each category, a narrative explanation will be provided with exemplar illustrations extracted from articles. The geographical locations of healing strategies will be denoted on a map of Canada, highlighting the distribution of resources across the country.

Ethical Considerations and Researcher Positionality

The data for this research will come from existing literature and there will be no human subjects involved at any stage of the study. As such, ethical approval is not a requirement. However, it is important for the author of this research to situate herself in relation to Indigenous Peoples. The author acknowledges that she is neither an Indigenous person nor a Canadian citizen of European descendant, but an international student from China who moved to Canada to pursue postgraduate studies. Although a lack of previous relationship with Indigenous Peoples makes this research a challenging undertaking, a number of similarities between Chinese and North American Indigenous cultures have enabled the author to explore Indigenous health from a unique perspective. For example, Inuit Elder Mark Kalluak once told a story of two seals feeling dreadful of a hunter stalking above the breathing hole (Karetak et al., 2017). The seals are afraid

not necessarily because of the harpoon, but due to the hunter's reckless butchering practice that breaks ribs and bones instead of cutting carefully through the joints. The message conveyed in this Inuit fable has some interesting similarities with an old Chinese fable, Pao Ding Jie Niu ("the way that Pao Ding butchers the ox"), in which the butcherer Pao Ding is so experienced in dismembering the ox that his cleavers remain as new in spite of having been used for a long time. As Pao Ding explains, he works with his mind, letting his cleavers move freely according to natural structures of the ox. Although these two stories originate from completely different contexts, the respectful relationship with animals, the intersection of spirituality and physical work, as well as the creation of knowledge from extensive lived experiences, are essentially the same. In addition, Chinese and Inuit share similar societal values such as treating Elders with respect, maintaining a harmonious family, and placing collective interests above individual ones. These are but a few examples illustrate meaningful connections between two distinct cultures that have given the author unique insight in completing this research.

As a student in a Canadian academic institution, the author acknowledges the hierarchy of knowledge which often marginalizes Indigenous paradigms in the settlers' society. This research seeks to legitimize the validity of Indigenous knowledge by including Indigenous narratives as credible evidence. Keywords such as wellness, healing, and resilience will be incorporated into search strategies so that literature with a wholistic, strength-based focus will be retrieved. Despite these efforts, the researcher is aware of her limitations as an outsider to Indigenous communities. Findings and discussions in this research will not be representative of every Indigenous person's experience. However, based on systematic mapping of current literature, together with critical analysis under the *IQ* framework, this research will potentially make useful recommendations to promote health and healing in line with Inuit worldviews.

Chapter Four: Results

This chapter will start by describing the article selection and inclusion process that was utilized for the following scoping review. This will be followed by an overall description of included articles regarding the literature type, year of publication, geographical location, service setting, and type of healing strategy. Next, the characteristics of healing strategies will be presented as they pertain to guiding principles, main components, and human resources. Lastly, this chapter will report on culturally-relevant approaches that have been used in the primary research studies included in this review.

Article Selection and Inclusion

The initial search retrieved 2280 citations from CINAHL, Sociological Abstracts, PsycINFO, MEDLINE and Academic Search Premier. An additional 34 records were identified from iPortal, websites, hand-searching of key journals and reference lists of included articles. The final search strategies and results are included in Appendix A. After removing duplicates, 2087 articles remained for title and abstract screening, of which 132 progressed to full-text review. After full-text review, 59 articles met the eligibility criteria and were included for data extraction. A flow diagram was created to describe the selection of sources of evidence in keeping with the reporting guideline outlined in PRISMA Extension for Scoping Reviews (Tricco et al., 2018). As shown in Figure 1, reasons for exclusion at full-text review include: no details of strategy (n = 56); wrong population (n = 8); not in Canada (n = 2); published before 2008 (n = 3); and wrong study design (n = 4). The last category refers to theses and dissertations, which were excluded from this review as per protocol. See Appendix B for individual articles excluded with reasons.

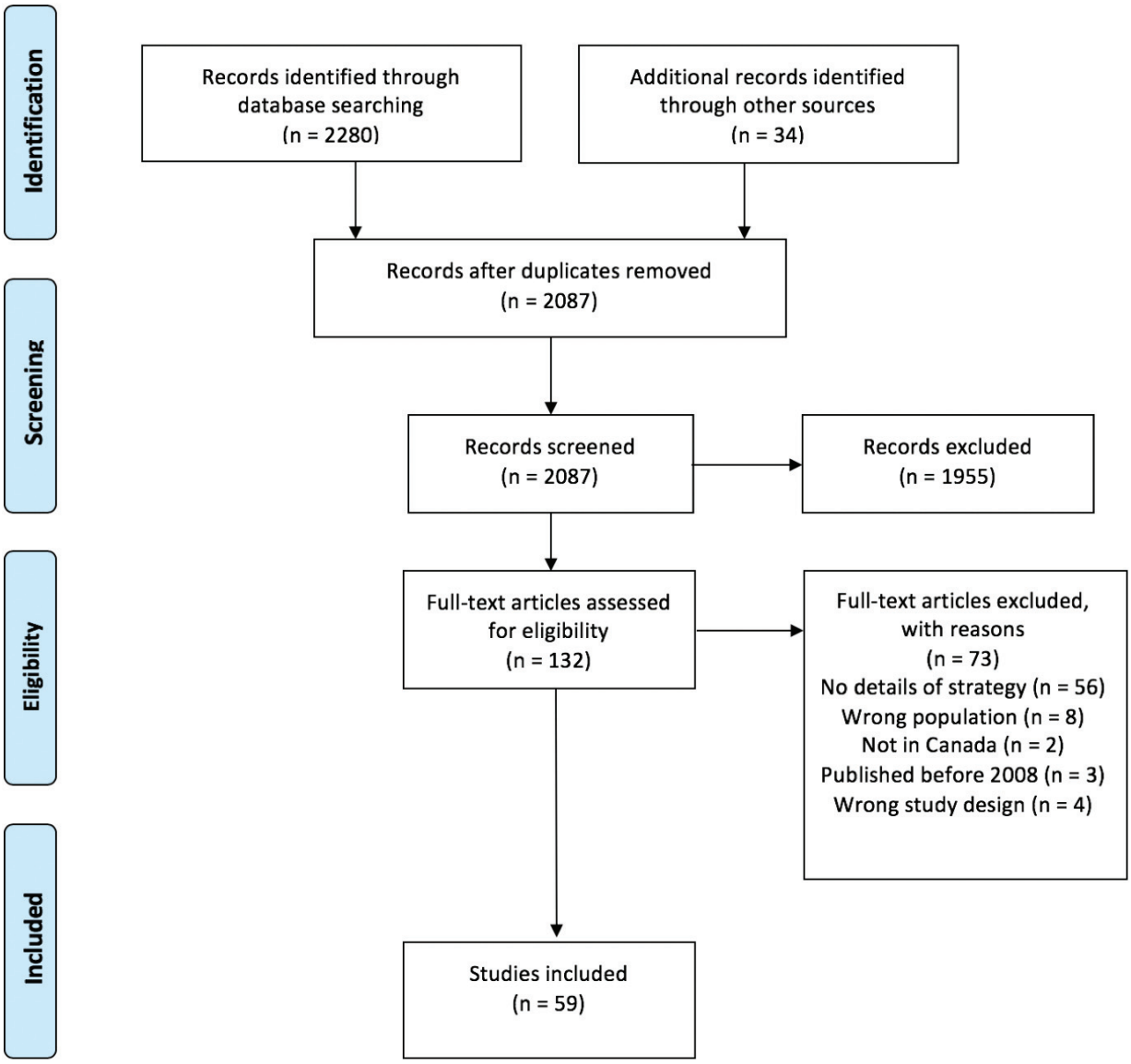

Figure 1 Selection of sources of evidence.

Overall Description of Articles

This section will present key findings regarding the literature types, distribution of articles by year, geographical locations, service settings, and types of healing strategies. See Appendix C for a full summary of extracted data.

Year of publication and literature type. Of the 59 articles included, about half (n = 29) were published between 2008 to 2013, with the remaining (n =28) being published between 2014

to 2018; two articles did not specify a year of publication. In terms of literature types, the majority were peer-reviewed journal articles (n = 41). This was followed by organizational publications (n = 15) and book chapters (n = 3).

Geographical location. The geographical locations of healing strategies refer to the regions where healing strategies were or will be implemented. As indicated in Figure 2, healing strategies were most frequently implemented in Ontario (n = 13), British Columbia (n = 8) and Manitoba (n = 5). While the majority of healing strategies were specific to one region, nine focused on multiple regions across Canada; among these, five were intended for Inuit Nunangat (ITK, 2008, 2013b, 2013a; Oliver et al., 2015; Pauktuutit, 2013, 2017). The remaining 12 healing strategies did not focus on a geographical location.

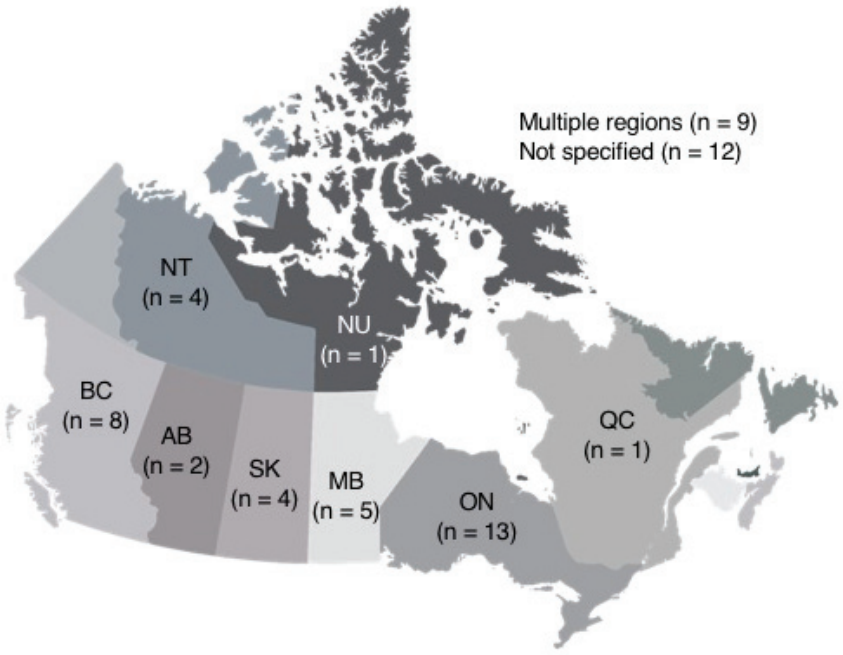

Figure 2 Geographical locations of included healing strategies.

Service setting. The service settings of healing strategies refer to the distinct areas of activity in which healing takes place. While there is no internationally agreed criterion of how to categorize service settings, the TRC (2015) Calls to Action provides useful guidance. In this document, the TRC put forward a wide range of calls targeting all levels of governments, institutions, and services in order to redress the legacy of residential schools. Individual calls to action were grouped into themes according to similarity in context, which is essentially the service setting as defined in this scoping review. As such, the TRC themes were extracted verbatim in this review to name the service settings of healing strategies, and the scope of service settings was defined by the specific calls to action under each TRC theme. As indicated in Figure 3, healing strategies included in this review were categorized into six service settings as per TRC Calls to Action: *Health* (n = 37), *Child Welfare* (n = 4), *Reconciliation* (n = 4), *Education* (n = 1), *Justice* (n = 1), and *Others* (n = 12).

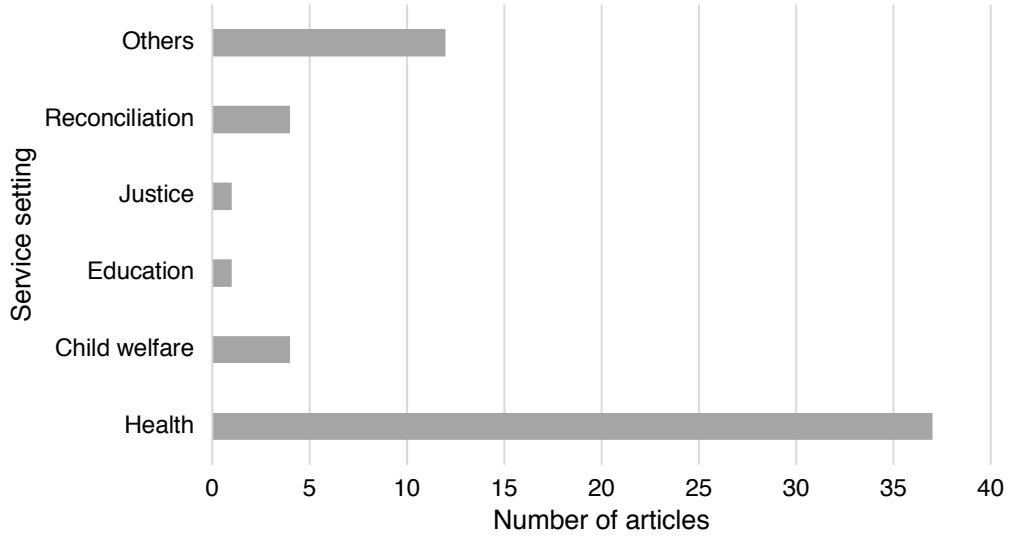

Figure 3 Service settings of included healing strategies.

The healing strategies within the setting of *Health* looked at various health indicators including: maternal health (Abbass-Dick et al., 2018; Jumah et al., 2017), mental health (Derrick,

2009; Healey, Noah, & Mearns, 2016; Maar et al., 2009; Maar & Shawande, 2010; McCabe, 2008; Reeves & Stewart, 2014), addictions (Dell, Chalmers, Dell, Sauve, & MacKinnon, 2008; Marsh, Cote-Meek, Young, Najavits, & Toulouse, 2016; Marsh, Marsh, Ozawagosh, & Ozawagosh, 2018), suicide (ITK, 2016; Wortzman, 2009), the availability of appropriate health services (Browne et al., 2016; Walker et al., 2010), residential school recovery programs (Archibald, Dewar, Reid, & Stevens, 2015; Gone, 2009, 2011; Pauktuutit, 2013; Waldram, 2008), land-based interventions (Dobson & Brazzoni, 2016; Kwanlin Dün First Nation Justice Department, 2010; Walsh, Danto, & Sommerfeld, 2018), traditional healing practices (T. Howell, Auger, Gomes, Brown, & Young Leon, 2016; Saskamoose, Bellegarde, Sutherland, Pete, & McKay-McNabb, 2017), school health (Tagalik, 2010) and oral health (ITK, 2013a).

Healing strategies related to *Child Welfare* centred around reducing the number of Indigenous children in out-of-home care through supporting fathers' engagement (Ball, 2013); fostering parents along with their children (Deane, Glass, Vystrcil-Spence, & Mignone, 2018); Aboriginal Infant Development Programs (Gerlach, Browne, & Greenwood, 2017); and a literature review on promising practices (Scott, 2013).

The service setting of *Reconciliation* included a National TRC Event (Gadoua, 2010), political pathways to healing (Mitchell, 2016), sport for development and peace (Hayhurst, Giles, & Wright, 2016), and social inclusion of Indigenous Peoples (Absolon, 2016). One strategy was classified under *Education* which works to foster healing through wholistic educational programming (Aguiar & Halseth, 2015). The service setting of *Justice* was identified in one strategy which presents a restorative program targeted at youth in need (Radu, House, & Pashagumskum, 2014).

Healing strategies that are out of the scope of the TRC Calls to Action were classified under *Others* (n = 12). Among these, six articles focused on the empowerment of Indigenous youth and women (Fanian, Young, Mantla, Daniels, & Chatwood, 2015; Goin & Mill, 2013; Goudreau et al., 2008; NWAC, n.d.-a; Petrucka et al., 2016; Recollet, Coholic, & Cote-Meek, 2009), four explored the research and partnership building process with Indigenous communities (C. M. Brooks & Poudrier, 2014; Castleden & Garvin, 2008; Finlay, Hardy, Morris, & Nagy, 2010; Isaak et al., 2010), one discussed homelessness prevention (Oelke, Thurston, & Turner, 2016), and one for violence prevention (NWAC, n.d.-b).

Types of healing strategies. Among the 59 articles, the majority (n = 24) described services and programs. Other major types of strategies were: policies and guidelines (n = 8), models and frameworks (n = 9), and Indigenous narratives and expert opinions (n = 7). The remaining 11 strategies included: e-Health resources (Abbass-Dick et al., 2018; Jongbloed et al., 2016), community-based research projects (C. M. Brooks & Poudrier, 2014; Castleden & Garvin, 2008; Edwards, Mitchell, Gibson, Martin, & Zoe-Martin, 2008; Isaak et al., 2010; Petrucka et al., 2016), toolkits (NWAC, n.d.-a, n.d.-b), an educational curriculum (Aguiar & Halseth, 2015), and a national TRC event for residential school survivors (Gadoua, 2010).

Characteristics of Healing Strategies

In the full-text review process some healing strategies were described in more than one article. For example, two journal articles included in this review reported on the same First Nation-controlled healing lodge on a Northern Algonquian reserve (Gone, 2009, 2011). Both articles were included for data extraction because they provided highly-relevant information on characteristics of the program. Specifically, Gone (2009) referred to the Medicine Wheel (which was extracted as a guiding principle) used consistently across therapeutic techniques, while Gone

(2011) gave examples of core activities (e.g., structured lectures, one-on-one counselling, field trips, cultural events and ceremonies; which were extracted as main components) that were included in the program. Both articles stated that all staff were of Indigenous ancestry, and that the Lodge was supervised by a board of directors appointed by the local chief and council (extracted as human resources). In light of this, it was decided that when the same healing strategy was presented in several related articles, the characteristics would be extracted across articles to fully describe the strategy. Technically, this treatment guaranteed that the same characteristics of a healing strategy were not extracted twice. As in the example mentioned above, "Indigenous staff" and "a board of directors appointed by the local chief and council" were recorded once in the charting table, although both articles referred to this characteristic related to human resources. Similarly, two journal articles authored by Marsh et al. (2016, 2018) described the same blended approach to treat intergenerational trauma and substance use disorders leading to a single extraction. The remaining articles included in the scoping review (n = 55) presented independent healing strategies. See Appendix D for extracted data on the characteristics (i.e., guiding principles, main components and human resources) of healing strategies included.

Guiding principles. In this scoping review, guiding principles were defined as the foundational values, concepts, and perspectives that guided the healing strategy. In the literature included, guiding principles have been described as approaches, models, key recommendations, priority areas, and traditional teachings originating from Indigenous cultures. Despite the differing expressions, guiding principles represent the overarching values and aspirations of the healing strategy (i.e., what is recognized as healing and how to approach healing). To extract data, guiding principles were recorded using verbatim words from included articles.

As indicated in Figure 4, nineteen guiding principles were identified in this scoping review, with the most frequent being *Honoring Cultures and Traditions* (n = 14). By revitalizing Indigenous languages and other local forms of wisdom, a strong cultural identity can be created and reinforced. The second most frequent principle is the *Medicine Wheel* (n = 12), an all-encompassing Indigenous philosophy that portrays a circle divided equally into four quadrants; which were often interpreted as the physical, mental, emotional and spiritual aspects of well-being. The third principle, *Strength-Based/Empowerment* (n = 12), was used as a fundamental approach to local capacity-building through shifting the focus away from deficits to the strengths of communities. Table 1 shows the different guiding principles identified in individual articles included.

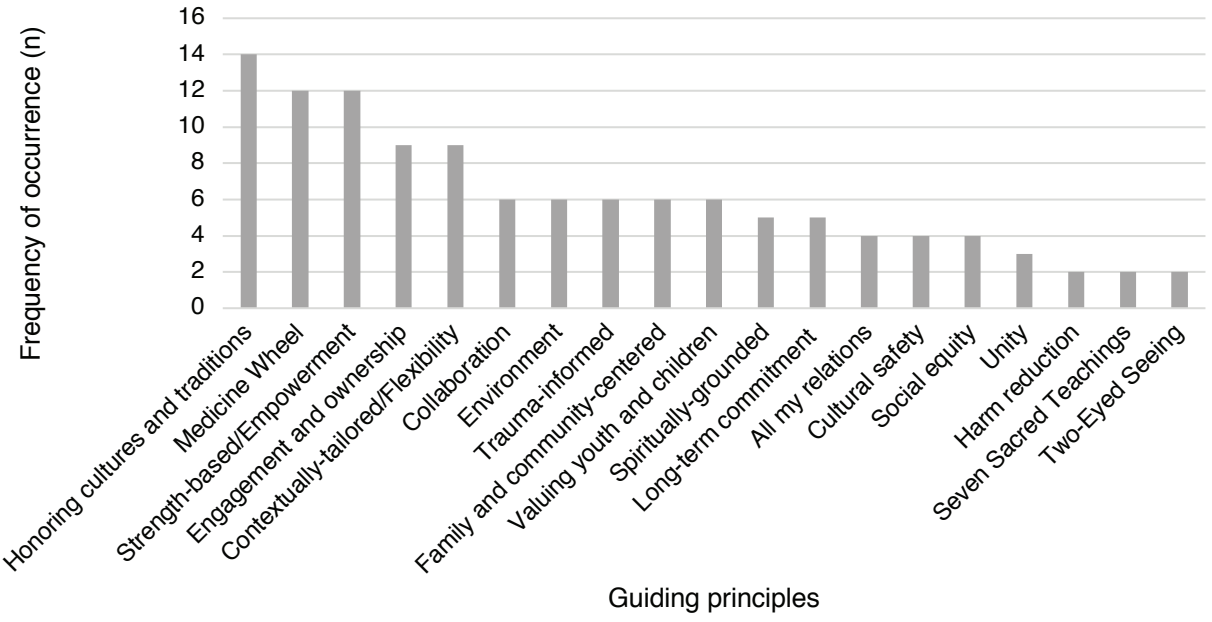

Figure 4 Guiding principles with frequency of occurrence in healing strategies included.

Table 1 Guiding Principles Identified from Articles Included

	Honoring cultures and traditions	Medicine Wheel	Strength-based/Empowerment	Engagement and ownership	Contextually-tailored/Flexibility	Collaboration	Environment	Trauma-informed	Family and community-centered	Valuing youth and children	Spiritually-grounded	Long-term commitment	All my relations	Cultural safety	Social equity	Unity	Harm reduction	Seven Sacred Teachings	Two-Eyed Seeing	Number of guiding principles
(Abbass-Dick et al., 2018)																				0
(Absolon, 2016)		X																X		2
(Aguiar & Halseth, 2015)	X		X										X							3
(Archibald et al., 2015)																				0
(Ball, 2013)			X		X							X								3
(Browne et al., 2016)					X			X						X						3
(CAAN, 2010)	X			X	X					X							X			5
(Peltier, 2010)			X													X				2
(CAAN, 2009)	X	X		X					X							X				5
(C. M. Brooks & Poudrier, 2014)														X						1
(Castleden & Garvin, 2008)																				0
(Dell et al., 2008)									X		X									2
(Deane et al., 2018)																				0
(Derrick, 2009)									X	X	X		X							4
(Dobson & Brazzoni, 2016)	X						X				X		X							4
(Edwards et al., 2008)															X					1
(Fanian et al., 2015)	X		X	X						X										4
(Finlay et al., 2010)												X								1
(Gadoua, 2010)																				0
(Gerlach et al., 2017)					X			X	X					X						4
(Goin & Mill, 2013)		X																		1
(Gone, 2009, 2011)		X																		1
(Goudreau et al., 2008)		X																		1
(Hayhurst et al., 2016)																				0

	Honoring cultures and traditions	Medicine Wheel	Strength-based/Empowerment	Engagement and ownership	Contextually-tailored/Flexibility	Collaboration	Environment	Trauma-informed	Family and community-centered	Valuing youth and children	Spiritually-grounded	Long-term commitment	All my relations	Cultural safety	Social equity	Unity	Harm reduction	Seven Sacred Teachings	Two-Eyed Seeing	Number of guiding principles
(Healey et al., 2016)			X																	1
(T. Howell et al., 2016)		X																		1
(ITK, 2013b)	X			X	X	X				X					X					6
(ITK, 2013a)	X				X	X				X										4
(ITK, 2016)	X							X		X					X					4
(Isaak et al., 2010)				X																1
(Jongbloed et al., 2016)			X					X												2
(Jumah et al., 2017)			X		X							X								3
(Lys et al., 2016)																				0
(Maar et al., 2009)		X																		1
(Maar & Shawande, 2010)																				0
(Marsh et al., 2016, 2018)																			X	0
(McCabe, 2008)		X																		1
(Mitchell, 2016)	X						X	X							X	X				5
(NWAC, n.d.-a)																				0
(NWAC, n.d.-b)																				0
(Oelke et al., 2016)	X					X						X		X						4
(Oliver et al., 2015)			X																	1
(Pauktuutit, 2013)			X			X	X													3
(Pauktuutit, 2017)			X			X	X													3
(Petrucka et al., 2016)				X	X															2
(Radu et al., 2014)							X													1
(Recollet et al., 2009)																		X		1
(Reeves & Stewart, 2014)		X																		1
(Saskamoose et al., 2017)			X	X				X			X								X	4
(Scott, 2013)	X		X	X		X						X								5

	Honoring cultures and traditions	Medicine Wheel	Strength-based/Empowerment	Engagement and ownership	Contextually-tailored/Flexibility	Collaboration	Environment	Trauma-informed	Family and community-centered	Valuing youth and children	Spiritually-grounded	Long-term commitment	All my relations	Cultural safety	Social equity	Unity	Harm reduction	Seven Sacred Teachings	Two-Eyed Seeing	Number of guiding principles
(Smillie-Adjarkwa, 2009)	X						X				X						X			4
(Tagalik, 2010)	X												X							2
(Waldram, 2008)					X															1
(Walker et al., 2010)		X							X											2
(Walsh et al., 2018)																				0
(Wortzman, 2009)	X	X		X					X											4
(Kwanlin Dün First Nation Justice Department, 2010)		X																		1
Frequency of occurrence	14	12	12	9	9	6	6	6	6	6	5	5	4	4	4	3	2	2	2	

Main components. Nine core components were identified in the 59 articles included in this scoping review (Figure 5). The most frequent components were *Artistic Expression* (n = 16), which entail a broad range of activities such as singing, dancing, drumming, drawing, craft-making, photography and filming. *Ceremonies* were used in 15 articles, which included smudging, sweat lodges and other traditional rituals. *Games and Exercises* – in both traditional and modern forms – were conducted in 12 of the articles reviewed. These activities were often interactive in nature and involved body movements; examples included basketball, soccer and interactions with horses. *Cultural Teachings,* which involved storytelling and the offering of traditional knowledge by Elders, were described in 11 articles. Table 2 shows the different main components identified in individual articles included.

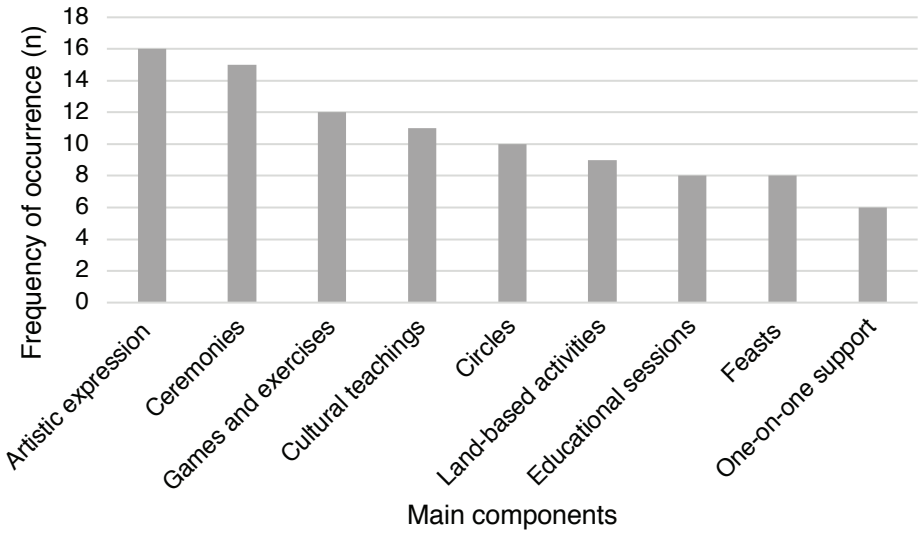

Figure 5 Main components with frequency of occurrence in healing strategies included.

Table 2 Main Components Identified from Articles Included

	Artistic expression	Ceremonies	Games and exercises	Cultural teachings	Circles	Land-based activities	Educational sessions	Feasts	One-on-one support	Number of main components
(Abbass-Dick et al., 2018)							X			1
(Absolon, 2016)										0
(Aguiar & Halseth, 2015)		X			X					2
(Archibald et al., 2015)	X	X	X				X			4
(Ball, 2013)										0
(Browne et al., 2016)										0
(CAAN, 2010)										0
(Peltier, 2010)										0
(CAAN, 2009)										0
(C. M. Brooks & Poudrier, 2014)	X				X					2
(Castleden & Garvin, 2008)	X							X		2
(Dell et al., 2008)			X							1
(Deane et al., 2018)							X			1
(Derrick, 2009)										0
(Dobson & Brazzoni, 2016)	X	X			X	X	X		X	6
(Edwards et al., 2008)							X			1
(Fanian et al., 2015)	X									1
(Finlay et al., 2010)										0
(Gadoua, 2010)	X	X	X		X					4
(Gerlach et al., 2017)										0
(Goin & Mill, 2013)		X		X		X				3
(Gone, 2009, 2011)		X				X	X		X	4
(Goudreau et al., 2008)	X									1
(Hayhurst et al., 2016)	X		X					X		3
(Healey et al., 2016)			X			X				2
(T. Howell et al., 2016)				X	X	X		X		4
(ITK, 2013b)										0
(ITK, 2013a)										0
(ITK, 2016)										0

	Artistic expression	Ceremonies	Games and exercises	Cultural teachings	Circles	Land-based activities	Educational sessions	Feasts	One-on-one support	Number of main components
(Isaak et al., 2010)								X		1
(Jongbloed et al., 2016)									X	1
(Jumah et al., 2017)										0
(Lys et al., 2016)	X						X			2
(Maar et al., 2009)										0
(Maar & Shawande, 2010)	X	X		X						3
(Marsh et al., 2016, 2018)	X	X			X			X		4
(McCabe, 2008)		X		X						2
(Mitchell, 2016)										0
(NWAC, n.d.-a)			X	X						2
(NWAC, n.d.-b)			X							1
(Oelke et al., 2016)										0
(Oliver et al., 2015)	X		X					X		3
(Pauktuutit, 2013)	X		X	X						3
(Pauktuutit, 2017)										0
(Petrucka et al., 2016)			X	X	X			X		4
(Radu et al., 2014)				X		X			X	3
(Recollet et al., 2009)	X	X	X	X				X		5
(Reeves & Stewart, 2014)		X		X						2
(Saskamoose et al., 2017)										0
(Scott, 2013)										0
(Smillie-Adjarkwa, 2009)		X		X					X	3
(Tagalik, 2010)										0
(Waldram, 2008)	X	X			X	X	X		X	6
(Walker et al., 2010)		X			X					2
(Walsh et al., 2018)						X				1
(Wortzman, 2009)										0
(Kwanlin Dün First Nation Justice Department, 2010)	X	X	X		X	X				5
Frequency of occurrence	16	15	12	11	10	9	8	8	6	

Human resources. The persons and organizations that contributed to the healing strategies in significant ways (e.g., conceptualization, development, implementation, etc.) are presented in Figure 6.

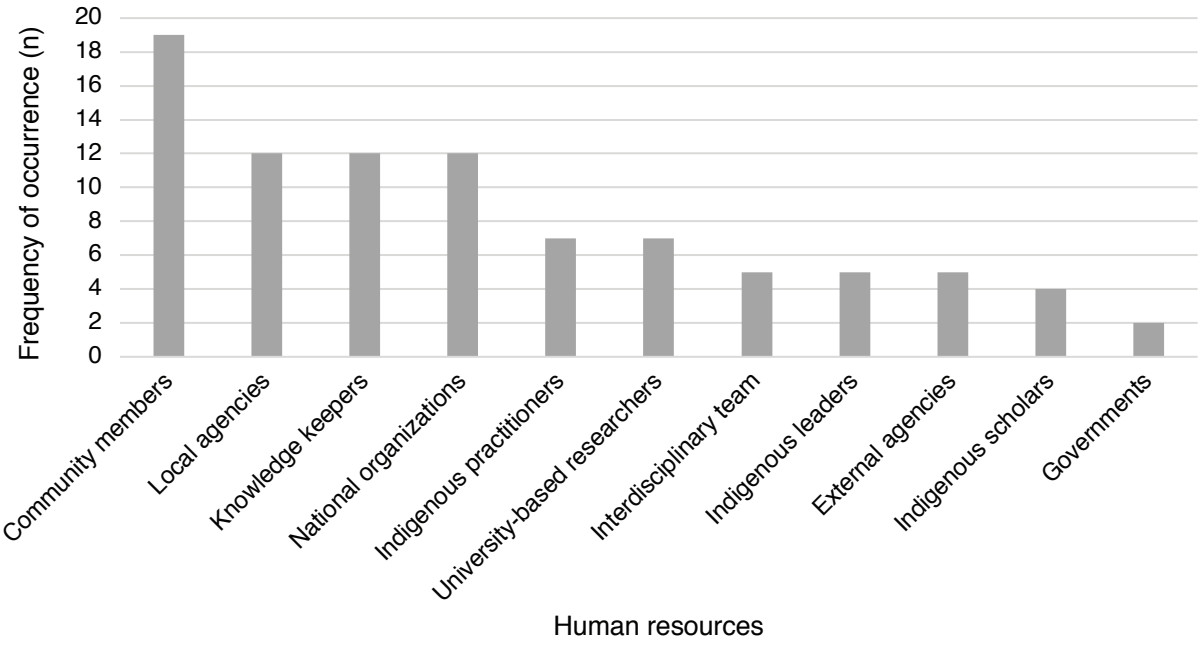

Figure 6 Human resources with frequency of occurrence in healing strategies included.

About one-third (n = 19) of healing strategies engaged *Community Members* who assumed a broad array of roles (e.g., volunteers, peer mentors, facilitators, and community-based researchers). Twelve healing strategies were executed in partnership with *Local Agencies* including health authorities, research centres, treatment lodges and other community-based stakeholders. Other frequently cited human resources were *Knowledge Keepers* (n = 12), such as Elders, traditional healers and other respected members in communities; and *National Organizations* (n = 12) advocating for Indigenous Peoples (e.g., NWAC, ITK, CAAN). See Table 3 for a summary of human resources utilized by included articles.

Table 3 Human Resources Identified from Articles Included

	Community members	Local agencies	Knowledge keepers	National organizations	Indigenous practitioners	University-based researchers	Interdisciplinary team	Indigenous leaders	External agencies	Indigenous scholars	Governments	Number of human resources
(Abbass-Dick et al., 2018)	X						X					2
(Absolon, 2016)										X		0
(Aguiar & Halseth, 2015)								X				1
(Archibald et al., 2015)					X							1
(Ball, 2013)	X											1
(Browne et al., 2016)		X				X						2
(CAAN, 2010)				X								1
(Peltier, 2010)	X			X								2
(CAAN, 2009)	X			X								2
(C. M. Brooks & Poudrier, 2014)	X	X				X						3
(Castleden & Garvin, 2008)	X					X						2
(Dell et al., 2008)			X						X			1
(Deane et al., 2018)		X										1
(Derrick, 2009)										X		0
(Dobson & Brazzoni, 2016)					X							1
(Edwards et al., 2008)	X								X			1
(Fanian et al., 2015)	X	X										2
(Finlay et al., 2010)	X					X	X		X			3
(Gadoua, 2010)				X								1
(Gerlach et al., 2017)			X		X			X				3
(Goin & Mill, 2013)	X											1
(Gone, 2009, 2011)					X			X				2
(Goudreau et al., 2008)	X											1
(Hayhurst et al., 2016)		X							X			1
(Healey et al., 2016)	X	X										2
(Howell et al., 2016)		X	X			X						3

	Community members	Local agencies	Knowledge keepers	National organizations	Indigenous practitioners	University-based researchers	Interdisciplinary team	Indigenous leaders	External agencies	Indigenous scholars	Governments	Number of human resources
(ITK, 2013b)				X								1
(ITK, 2013a)				X								1
(ITK, 2016)				X								1
(Isaak et al., 2010)	X	X				X						3
(Jongbloed et al., 2016)					X							1
(Jumah et al., 2017)		X				X					X	2
(Lys et al., 2016)	X											1
(Maar et al., 2009)			X				X					2
(Maar & Shawande, 2010)			X				X					2
(Marsh et al., 2016, 2018)			X		X					X		2
(McCabe, 2008)												0
(Mitchell, 2016)												0
(NWAC, n.d.-a)				X								1
(NWAC, n.d.-b)				X								1
(Oelke et al., 2016)												0
(Oliver et al., 2015)	X											1
(Pauktuutit, 2013)				X					X			1
(Pauktuutit, 2017)		X		X							X	2
(Petrucka et al., 2016)	X		X									2
(Radu et al., 2014)			X									1
(Recollet et al., 2009)		X								X		1
(Reeves & Stewart, 2014)			X		X							2
(Saskamoose et al., 2017)	X		X									2
(Scott, 2013)				X								1
(Smillie-Adjarkwa, 2009)												0
(Tagalik, 2010)												0
(Waldram, 2008)		X	X				X	X				4
(Walker et al., 2010)								X				1
(Walsh et al., 2018)	X		X									2

	Community members	Local agencies	Knowledge keepers	National organizations	Indigenous practitioners	University-based researchers	Interdisciplinary team	Indigenous leaders	External agencies	Indigenous scholars	Governments	Number of human resources
(Wortzman, 2009)												0
(Kwanlin Dün First Nation Justice Department, 2010)	X											1
Frequency of occurrence	19	12	12	12	7	7	5	5	5	4	2	

Culturally-Relevant Approaches

The second objective of this scoping review is to explore what approaches were used in the reviewed documents to improve the cultural relevance of healing strategies to local Indigenous contexts. Data were extracted from 30 primary research studies included in this scoping review. Other types of evidence – including text and opinion papers, policy documents, and discussion papers – were not applicable for this review question and therefore not extracted. Through thematic analysis (V. Braun & Clarke, 2006), extracted data on culturally-relevant approaches were synthesized into overarching themes according to similarity in meaning. Out of 30 primary studies extracted, eight approaches were utilized as summarized in Figure 7. See Appendix D for exemplar illustrations extracted from articles.

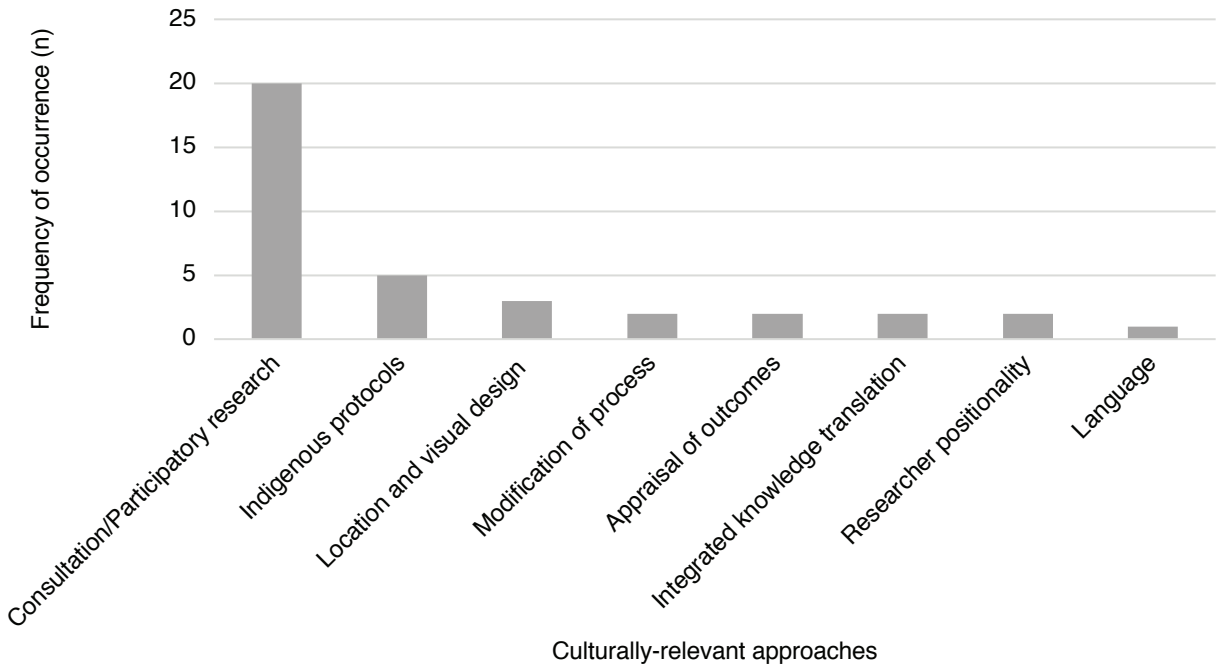

Figure 7 Culturally-relevant approaches with frequency of occurrence in healing strategies included.

The majority of studies (n = 20) employed *Consultation/Participatory Research* in various forms. A common practice reported was the establishment of Indigenous Advisory Committees; for example, the research project by Oliver et al. (2015) was "guided by our National Youth Peer Advisory Committee, which met both by teleconference and in person to provide recommendations, strategies and direction for the project and its workshops" (p. 908). Members of the Advisory Committees were diverse, often from multi-disciplinary and cross-sectoral backgrounds, with Elders being most frequently included. The Cedar Project Partnership, for instance, represented "an independent body of Indigenous Elders, health and social service experts, researchers, and elected leaders [that] governs the entire research process" (Jongbloed et al., 2016, p. 3). Overall, the studies aimed to balance power differentials and seek

active participation of communities from the inception, in an effort to produce knowledge that is mutually beneficial (Castleden & Garvin, 2008; Isaak et al., 2010).

The respect of *Indigenous Protocols* was reported in five primary studies. These included the manner in which research was initiated, and often involved collaborating with Elders to ceremoniously open and close the project; and to provide ongoing guidance in between. Other ways to start a respectful partnership included a sweat lodge for research team members at the beginning of the study (Castleden & Garvin, 2008; Isaak et al., 2010), and receiving a Spirit name for the study from a knowledge keeper (Oelke et al., 2016). Consistent with local traditions, tobaccos were offered as a sacred gift to participants in several studies to bind the commitment of all partners (Reeves & Stewart, 2014).

Table 4 Culturally-Relevant Approaches Identified from Articles Included

	Consultation/Participatory research	Indigenous protocols	Location and visual design	Modification of process	Appraisal of outcomes	Integrated KT	Researcher positionality	Language	Number of approaches
(Abbass-Dick et al., 2018)	X		X						2
(Archibald et al., 2015)			X						1
(Browne et al., 2016)	X								1
(C. M. Brooks & Poudrier, 2014)				X		X			2
(Castleden & Garvin, 2008)	X			X					2
(Edwards et al., 2008)	X							X	1
(Fanian et al., 2015)	X								1
(Gerlach et al., 2017)									0
(Goin & Mill, 2013)	X								1
(Gone, 2009, 2011)					X				1
(Goudreau et al., 2008)	X	X							2
(Hayhurst et al., 2016)	X								1
(Healey et al., 2016)	X						X		1
(T. Howell et al., 2016)	X	X							2
(Isaak et al., 2010)	X								1
(Jongbloed et al., 2016)	X				X	X			3
(Lys et al., 2016)									0
(Maar et al., 2009)	X								1
(Maar & Shawande, 2010)	X								1
(Marsh et al., 2016, 2018)	X								1
(Oelke et al., 2016)	X	X							2
(Oliver et al., 2015)	X	X							2
(Petrucka et al., 2016)	X								1
(Recollet et al., 2009)	X		X				X		2
(Reeves & Stewart, 2014)		X							1
(Waldram, 2008)	X								1
(Walsh et al., 2018)									0
Frequency of occurrence	20	5	3	2	2	2	2	1	

Summary

This scoping review included 59 articles for data extraction. About two-thirds were journal articles, and nearly half of the articles reviewed were published within the last five years (i.e., 2014 and onward). The healing strategies were most frequently implemented in Ontario, British Columbia and Manitoba. In terms of service setting, the majority of strategies belonged to the health sector which included mainstream treatment modalities as well as community-based healing initiatives. As for the types of healing strategies, services and programs were the most predominant, followed by models and frameworks; policies and guidelines; and Indigenous narratives and expert opinions in comparable numbers.

Out of 59 articles included, the most frequent guiding principles were identified as *Honoring Cultures and Traditions*, the *Medicine Wheel*, and *Strength-Based/Empowerment*. The most widely used core components were *Artistic Expression*; *Ceremonies*; *Games and Exercises.* The majority of strategies engaged *Community Members* in various positions. Other important human resources included *Local Agencies* and *Knowledge Keepers.*

To identify culturally-relevant approaches in the research process, 30 primary research studies were extracted. In total, eight approaches emerged from the literature with the most popular being Consultation/*Participatory Research* and respecting *Indigenous Protocols.*

Chapter Five: Discussion

This chapter will begin by providing a substantive discussion of the results of the scoping review, with a focus on the characteristics of healing strategies (guiding principles, main components, human resources) and culturally-relevant approaches. This chapter will then discuss the strengths and limitations of the scoping review, in looking to summarize what it adds to the current knowledge base as well as the important work that it lays ahead. Lastly, this chapter will return to the *IQ* framework – including four *maligait* and six *piqujarjuat* – which will be used to inform future research about culturally-relevant cervical cancer care for Inuit communities.

Scoping Review Results

This scoping review identified and described Indigenous healing strategies in Canada. Findings from this review suggest that the characteristics of healing strategies were, when viewed individually, extensive and highly heterogeneous; but interrelated upon closer examination which, as a whole, underscore a decolonizing approach. As explained by the National Inquiry of MMIWG (2019), "[a] decolonizing approach aims to resist and undo the forces of colonialism and to re-establish Indigenous Nationhood. It is rooted in Indigenous values, philosophies, and knowledge systems. It is a way of doing things differently that challenges the colonial influence we live under by making space for marginalized Indigenous perspectives. The National Inquiry's decolonizing approach also acknowledges the rightful power and place of Indigenous women and girls." (p. 56) Essentially, three tenets can be identified from this statement:

- Upholding Indigenous knowledge;
- Respecting Indigenous rights to self-determination; and
- Recognizing Indigenous resilience and agency.

The above tenets have been consistently referred to in Indigenous health literature as promising pathways to decolonization. As such, this section will use the three tenets of a decolonizing approach to guide discussions around the guiding principles, main components, human resources and culturally-relevant approaches identified from the scoping review. Examples will be given that illustrate the relationship between and among findings when possible. Although some might argue that findings should be examined separately for ease of reading, the interconnected nature of findings determines that it would make more sense to consider them collectively in moving from resilience to revitalization, to self-determination, and ultimately, to wellness and healing.

Upholding Indigenous knowledge. The strong resurgence of Indigenous cultures and languages, both nationally and internationally, has revealed the richness of Indigenous knowledge that has been historically excluded from Eurocentric paradigms. Scholars often discuss what constitutes Indigenous knowledge, in seeking to understand a cognitive system with its own epistemology, philosophy, and scientific and logical validity (M. Battiste, 2002). The immense diversity within the Indigenous population in Canada means that Indigenous knowledge cannot be defined by a generic label; rather, it is a transcultural knowledge that embraces the contexts of about five percent of the Canadian population (M. Battiste, 2002; Statistics Canada, 2017). The extensiveness of Indigenous knowledge was reflected in a wide range of guiding principles identified in this scoping review, many of which were rooted in local forms of wisdom. Examples include the *Medicine Wheel*, *All My Relations*, *Seven Sacred Teachings*, as well as *Two-Eyed Seeing*. Interestingly, all principles described above have a First Nations origin. Despite the growing inquiry into Inuit knowledge (e.g., the *IQ* framework), this scoping review did not identify any strategy that utilize Inuit-specific guiding principles. The

lack of Inuit representation may be attributed to the fact that significantly less research has been done with Inuit compared to First Nations peoples in Canada. The same is true for Metis, whose historical and cultural distinctiveness is reported to be obscured by pan-Indigenous generalizations (Evans et al., 2012).

While there is much diversity among Indigenous cultures, classic concepts in Indigenous knowledge suggest that everything is interconnected: mind, body, spirit, and emotions; all of equal significance to achieving optimal health (Little Bear, 2000). As further elaborated upon by Battiste and Henderson (2000), "Indigenous peoples regard all products of the human mind and heart as interrelated within Indigenous knowledge. They assert that all knowledge flows from the same source: the relationships between global flux that needs to be renewed, the people's kinship with the spirit world". (p. 43) The wholistic worldview that situates the person in a web of harmonious relationships is, to the amazement of many practitioners and researchers, strikingly similar to modern aspirations in the area of health promotion (Goudreau et al., 2008; Wortzman, 2009). Health promotion is characterized by population health approaches that work with people to build capacity and take action on determinants of health which are often beyond the control of individuals (Diem & Moyer, 2015; World Health Organization, n.d.). Its explicit focus on the entire population is in line with the finding that Indigenous healing should be *Family and Community-Centred*. For service providers, a community-wide approach would be embodied in group activities and community events such as *Feasts, Games and Exercises,* and various forms of *Circles*. Schoshone Scholar Larry Murillo (2004) commented on the healing effects of talking circles, for example, through storytelling, speaking from the heart, and community integration. The rebuilding of intergenerational connections that were once disrupted by residential schools is

essential to the health and wellness of Indigenous communities today (Richmond & Ross, 2008; Waddell, Robinson, & Crawford, 2017).

In addition to interconnectedness, spirituality has also been considered as a fundamental difference between experiential, *Spiritually-Grounded* Indigenous knowledge and scientifically-based Western paradigms. Fleming and Ledogar (2008) argued that Indigenous spirituality extends beyond the term spirituality in general usage – "one's relationship with a particular faith tradition or doctrine about a divine other or supernatural power" (p. 49) – to include spiritual activities that vary from one tribe or band to another. Indigenous spirituality typically involves ritualistic modalities such as "sacred circles", a form of many *Circles* that were identified as a main component in this scoping review; as well as a broad range of *Ceremonies* and *Artistic Expression* that include the sweat lodge, smudging, drumming, and powwow dancing. As Waldram (2014) pointed out, Indigenous spirituality plays a pivotal role in healing by speaking not only to religious contentment, but also to a shared identity across nations that brings people in *Unity* (Kirmayer et al., 2003).

For researchers and health care providers, how to move forward with incorporating spirituality into Indigenous healing then becomes a central question. Findings of this scoping review suggest that *Indigenous Protocols* must be followed, in consultation with *Knowledge Keepers* in the community such as Elders and Traditional Healers. Métis psychologist Glen McCabe (2008) described the deep meaning of burning tobacco for Indigenous Peoples, which establishes a mutual commitment between the healer and the client. The offering of tobacco as symbol of positive working relationship between researchers and community members was used in several studies included in this review (See Goudreau et al., 2008; Reeves & Stewart, 2014). The choice of location where healing takes place is also worthy of consideration; situating the

healing work somewhere with historical significance (e.g., the first TRC National Event was held at The Forks, a traditional gathering point for Indigenous groups in Manitoba for over 6,000 years; Gadoua, 2010) and visual elements of Indigenous cultures appeared to be a popular choice (i.e., *Location and Visual Design*).

The central role of Indigenous knowledge in improving health and wellness has been acknowledged in both national and international literature. In Canada, these include the many reports authored by the Royal Commission on Aboriginal Peoples (Library and Archives Canada, 2016), which eloquently summarized the value of Indigenous medicinal knowledge. In the international arena, the Principles and Guidelines for the Protection of the Heritage of Indigenous People were ratified by the United Nations in the 1990s (M. Battiste, 2002); the effective protection of Indigenous knowledge has since then become an international binding standard in a variety of policy sectors and academic disciplines. The reclamation of languages and cultures has been posited by many Indigenous scholars as a specific "medicine" to colonial traumas, and "zones of refuge that are immune to the reaches of imperialism and globalization" (Alfred & Corntassel, 2005, p. 605). However, the importance of cultural preservation and renewal should not deflect attention from the ongoing marginalization of Indigenous Peoples enacted through legislation and socio-economic oppression (Kirmayer et al., 2003), which will be discussed in further detail next.

Respecting Indigenous rights to self-determination. In accounting for the alarming health disparities experienced by Indigenous Peoples, it is critical to consider how colonial policies, both historical and present-day, work to exclude Indigenous Peoples socially, geographically and economically. The Indian Act, for example, has been instrumental in limiting access to federally-funded health services for Indigenous Peoples by enforcing an artificial

definition of who can be recognized as an "Indian" (Allan & Smylie, 2015). The state-constructed framing of Indigenous identities was designed to undermine the power of self-determination, which, in turn, cut across a broad spectrum of social determinants such as education, income, and relationship to traditional lands (e.g., the reserve systems that restricted traditional subsistence activities). If Canada is to embrace multiculturalism, race-based legislations such as the Indian Act must change, and the discriminatory treatment of Indigenous Peoples must change. As findings of this scoping review suggest, the improvement of *Social Equity* will be an important vehicle for countering the aftermath of colonization through sustainable social and economic developments. These include adequate access to housing and community infrastructure, health care and educational systems, employment opportunities and, according to the wholistic Indigenous worldviews, the protection of *Environment* on traditional lands (Reading & Wien, 2012).

Increasingly, Indigenous Peoples across Canada are calling for greater control over environmental management and resource decisions on their homelands. In looking seven generations into the future, Indigenous Peoples are highly aware of the risks of environmental degradation and contamination to the very existence of Indigenous nationhood (Richmond & Ross, 2009). Activities that threaten the integrity of the ecological environment have been met with resistance and solidarity from coast to coast to coast (e.g., the Mi'kmaq opposition to the Alton Gas project in Nova Scotia). A direct advancement is that more governments and organizations begin to seek Indigenous consultation regarding the development of traditional territories. The United Nations Declaration on the Rights of Indigenous Peoples clearly supports the collective rights to traditional lands, as well as the inclusion of Indigenous knowledge in sustainable development (United Nations General Assembly, 2007). In Canada, historical treaties

and modern-day land claim agreements further commit the Crown to the legal responsibility of obtaining free, prior, and informed consent from Indigenous communities regarding any activity on or near ancestral lands (Mitchell, 2016). That being said, many Indigenous Peoples continue to experience unequal participation in decision-making over land issues; as there is no binding mechanism to ensure follow-through on the part of governments and corporations (Black & McBean, 2016). This limiting factor should be addressed through political avenues nationally and internationally so that the support for Indigenous self-determination is no longer mere lip service from colonial entities that lack a true will for change (Black & McBean, 2016; Mitchell, 2016).

In the contemporary context of Indigenous healing, decolonization can only hope to succeed if Indigenous Peoples possess greater control over future endeavours in the best service of their communities. To meet the prerequisite demands a pause on the part of non-Indigenous populations to applaud and learn from *Indigenous Leaders*: the Elders, front-line community workers, and people with lived experience of community realities (Iwama, Marshall, Marshall, & Bartlett, 2009; National Inquiry into MMIWG, 2019). These people are great assets as their perspectives are firmly based in local contexts where they were born and raised. As such, *Indigenous Leaders* must be encouraged to speak up in the critical discussion around healing and bring their solutions to the table. To make space for Indigenous-led solutions requires researchers, clinicians and policy-makers to "listen, wait and be prepared to follow as well as lead" so that a mutual obligation to shared goals can be fulfilled (Iwama et al., 2009, p. 6).

Just as the gaps in health did not occur overnight, meaningful changes require a *Long-Term Commitment* from all parts of the society in creating opportunities for Indigenous Peoples to gain strengths (Scott, 2013). New *Collaboration* between and among professions, disciplines

and services need to be forged in the journey of co-learning. As identified in this scoping review, increasing numbers of *Local* and *External Agencies*, *National Organizations*, *Governments,* and *University-Based Researchers* have entered the dialogue. For settler populations who aspire to become genuine allies, the promises to Indigenous communities must be formalized through stable funding (Oelke et al., 2016) and *Contextually-Tailored*/*Flexibility* (in) programing (Browne et al., 2016). In clinical practice, *Flexibility* means going above and beyond daily routines and broker resources to meet community preferences (e.g., incorporating *Land-Based Activities* and *Cultural Teachings* in addition to mainstream treatment methods). When it comes to research, it means being open-minded and allowing communities to lead. As exemplified in several studies included in this scoping review, much effort has been directed at modifying classic research methodologies (i.e., *Modification of Process*; Castleden & Garvin, 2008); identifying appropriate outcomes through an Indigenous lens (i.e., *Appraisal of Outcomes*; Jongbloed et al., 2016); and disseminating knowledge in a meaningful way to the community (i.e., *Integrated Knowledge Translation*; Brooks & Poudrier, 2014). While the principle of *Flexibility* was executed in different ways, a continuous adaptation to community needs and priorities is a hallmark of the studies described above. It is the strong obligation for change, as well as willingness to commit resources in unprecedented ways that form the building blocks of transformative healing strategies which, over time, will eventually lead to collective well-being of Indigenous Peoples.

Recognizing Indigenous resilience and agency. What characterized diverse healing strategies included in this scoping review is the passionate belief in the resilience of Indigenous Peoples. This is evident in the principle of *Strength-Based/Empowerment* which promotes a sense of worth and confidence in community members to make important decisions that affect

their everyday lives. For too long, the dominant discourses in Canada and other settler-colonial nations have served to reinforce racist stereotypes about Indigenous Peoples as deviant (Browne & Smye, 2002; de Leeuw, Greenwood, & Cameron, 2010; Tang & Browne, 2008). These assumptions have normalized a series of paternalistic policies and inequitable treatment that automatically image the settler population as necessary agents of care, protection and improvement for the Indigenous Peoples' own good (de Leeuw et al., 2010). The best evidence against such myth is the thriving Indigenous population worldwide, and their resistance to colonialism and forced assimilations despite great odds. Rather than seeing themselves portrayed as powerless and dispossessed, Indigenous Peoples are increasingly calling for stories told about them and by them, from Indigenous points of view (Kirmayer et al., 2011). For both Indigenous and settler communities, there is a high premium on taking full advantage of the obvious agency of Indigenous Peoples who envision their collective representations in ways that valorize strengths and capacities (Scott, 2013). The rethinking of Indigenous identity through culturally-based *Language*; that of how, who, what, and why narratives are configured, provides a platform for Canadian society to achieve comprehensive decolonization.

Within Indigenous communities, *Empowerment* entails shifting the power dynamics that historically exist between researchers and community members. Among primary studies included in this review, formal attempts to decolonize healing inquiry were demonstrated through *Consultation/Participatory Research*. This was evident in the formation of Indigenous advisory committees and working groups (Abbass-Dick et al., 2018; Browne et al., 2016; Edwards et al., 2008; Fanian et al., 2015; Goin & Mill, 2013; T. Howell et al., 2016; Isaak et al., 2010; Jongbloed et al., 2016; Maar et al., 2009; Maar & Shawande, 2010; Marsh et al., 2018, 2016; Oliver et al., 2015), and community-based participatory research (CBPR) such as photovoice (C.

M. Brooks & Poudrier, 2014; Castleden & Garvin, 2008). Such an inclusive model affirms the teachings of four Rs – respect, reciprocity, responsibility, and relevance (Kirkness & Barnhardt cited in Howell et al., 2016); and is in keeping with a *Strength-Based* focus on the potential and expertise within communities. It was observed that in addition to being active participants in research, *Community Members* assumed a wide range of roles including volunteers (Walsh et al., 2018), peer mentors (Healey et al., 2016; Lys et al., 2016), facilitators (Archibald et al., 2015; Fanian et al., 2015; Marsh et al., 2016, 2018), liaison (Isaak et al., 2010), and community-based researchers (Castleden & Garvin, 2008; Edwards et al., 2008); all with the intention to become co-leaders of project. Their extensive participation created conditions for Indigenous communities to own all phases of research; that is, to ensure communities were engaged in taking *Ownership* of the development, implementation and evaluation of programs as well as reporting and application of research products (Tagalik, 2010). Researchers who wish to work with Indigenous communities should use recognized ethical frameworks that include the OCAP™ (ownership, control, access, and possession; First Nations Information Governance Centre, n.d.), the Canadian Institutes of Health Research (CIHR) Guidelines for Health Research Involving Aboriginal People (CIHR cited in Isaak et al., 2010), and community-specific protocols (Wilson et al., 2013).

Given the primacy of relationship within a CBPR framework, a discussion on *Researcher Positionality* is critical. The once popular "safari-scholar" approach has been increasingly criticized and the concern of being "researched to death" is shared by many Indigenous people (Isaak et al., 2010). The hard truth that many past research efforts were imposed on communities, and that participants rarely received any credit or benefit for their contribution, became the context of communities' suspicions toward "outside" researchers (Gerlach et al., 2017). To

overcome mistrust requires a deepened reflection on researcher's place of privilege, which was built through centuries of assimilation and cultural oppression. Naturally, the rebuilding of right relationships will be based on trust and will demand time (Pyrch and Castillo cited in Isaak et al., 2010). Findings of this scoping review encourage researchers to locate themselves in relation to the Indigenous people they are working with, and to be transparent in their motives in taking an interest in particular communities (Absolon, 2016; Derrick, 2009; Healey et al., 2016; McCabe, 2008; Recollet et al., 2009). The guiding principle of *Cultural Safety* is pertinent to such discussion because it shifts attention away from ethno-cultural differences to power relations that continue to shape policies and practices in the public sector (Baba, 2013; Smye & Browne, 2002). In determining cultural safety, the views and experiences of the recipients of strategies must be put at the forefront (Gerlach et al., 2017) – which again links back to the centrality of Indigenous perspectives, the inherent right to self-determination, and people's capacity in creating transformative changes.

Strengths and Limitations

This scoping review was guided by the rigorous and transparent JBI approach to scoping reviews. A systematic search of literature was conducted in seven electronic databases (including two grey literature databases), ten governmental and organizational websites, and two peer-reviewed journals with a focus on Indigenous health. In order to emphasize healing instead of deficits, the search terms were carefully chosen which, on the one hand, highlight resilience and wellness, and on the other hand, capture the broader contexts of colonization and historical trauma. A wide range of literature emerged from diverse academic disciplines including nursing, social work, psychology, medicine, sociology, education, anthropology, and environmental

science. Publications by Indigenous organizations such as AHF, Pauktuutit, and NWAC formed the majority of Indigenous representation within this scoping review.

Although every effort was made to include Indigenous perspectives, relatively few articles were authored by Indigenous scholars, health practitioners or front-line community workers (Absolon, 2016; Derrick, 2009; Goudreau et al., 2008; Healey et al., 2016; McCabe, 2008; Recollet et al., 2009). In particular, there is a paucity of literature about Inuit or Metis. Of the 59 articles included, only six were Inuit-specific and there was none for Metis. This identifies a clear gap in literature and more research should be conducted with these populations in the future.

Given the broadness and complexity of Indigenous healing, the time frame available for completing this review was limited (from the submission of protocol in July 2018 to the writing of this thesis in July 2019). This informed the decision to exclude theses and dissertations, as it was impractical to review such extensive documents within a short period of time. A further limitation is that the inclusion was restricted to literature written in the English language. It is possible that some healing strategies in Canada have been described in French and Indigenous languages, or in forms other than written documents. Traditionally, the cultural knowledge of Indigenous Peoples has been renewed through oral traditions, artworks, songs, and ceremonies. These local forms of wisdom were not represented in this scoping review because there is no currently available method to synthesize them with other evidence documented in writing. Future work should be directed at making knowledge synthesis more integrative so that researchers and knowledge users are able to tap into richer sources of Indigenous healing.

Lastly, the exclusion of healing strategies outside of Canada may have limited the international relevancy of this scoping review. Although Indigenous Peoples around the world

share a number of common predicaments, more focused discussions are needed to inform policies and practices in different nations.

Implications for Research

The initial conceptualization of this scoping review stemmed from the critical need to build evidence toward culturally-relevant cervical cancer care for Inuit communities. Understanding what "works" for healing from diverse Indigenous experiences, while recognizing Inuit distinctiveness, remains foundational to achieving this goal. To this end, further analysis is needed to unravel the relationship between Inuit culture and the characteristics of Indigenous healing strategies identified from this review. Specifically, the *IQ* framework will be used as a reference point for illustrating the alignment of Inuit ways of knowing and findings of the scoping review (i.e., guiding principles, main components, human resources and culturally-relevant approaches). The conceptual mapping was inspired by Chatwood et al.(2017) who used a similar process to compare Indigenous values identified in their research with those in national documents. See Table 5 for details.

Table 5 Alignment of *IQ* Framework and Scoping Review Findings

Maligait	***Piqujarjuat***	**Guiding Principles**	**Main Components**	**Human Resources**	**Culturally-Relevant Approaches**
Working together for the common good	*Pijitsirniq* (Service to others and leadership) *Piliriqatigiingniq* (Collaborative relationships)	Collaboration Family and community-centred Long-term commitment Social equity Unity Two-Eyed Seeing			Researcher positionality
Respecting all living things	*Avatimik Kamattiarniq* (Environmental stewardship)	Environment Spiritually-grounded All my relations	Artistic expression Ceremonies Games and exercises Cultural teachings Circles Land-based activities Educational sessions Feasts One-on-one support	Community members Local agencies Knowledge keepers National organizations University-based researchers Interdisciplinary team Indigenous leaders External agencies Indigenous scholars Governments	-
Maintaining harmony and balance	*Aajiiqatigiingniq* (Consensus decision-making)	Engagement and ownership Seven Sacred Teachings			Consultation/Participatory research Indigenous protocols
Continually planning and preparing for the future	*Pilimmaksarniq* (Skills and knowledge acquisition) *Qanuqtuurunnarniq* (Being innovative and resourceful)	Honoring cultures and traditions Strength-based/Empowerment Contextually-tailored/Flexibility Valuing youth and children			Modification of process Appraisal of outcomes Integrated knowledge translation
-	-	Trauma-informed Cultural safety Harm reduction	-	-	Location and visual design Language

As is evident in Table 5, the majority of findings from this scoping review align well with the laws and principles of *IQ.* It should be noted, however, such organization of concepts is not final or definitive. Since *IQ* represents the living knowledge of Inuit, it holds out the very possibility that its meaning varies from person to person. As people interpret *IQ* differently, the mapping of scoping review findings may change as well. In Table 5, a few guiding principles and culturally-relevant approaches fell outside of the *IQ* framework. This becomes less concerning given the highly interrelated nature between and among findings from this review; other reviewers may be able to make sense of those findings within the laws and principles of *IQ*. The evolving body of Inuit knowledge ensures multiple possibilities of mapping, which in turn enhances coherence of this research.

This scoping review set out to lay a solid foundation for future research about the development of culturally-relevant cervical cancer care for Inuit communities. Based on findings from the scoping review, the following implications are proposed:

- Forming an Inuit cervical cancer prevention working group that includes representatives from women and families, Knowledge Keepers, community health nurses and representatives, provincial and territorial public health agencies, Inuit organizations and other stakeholders;
- Identify and support community members with the talent and passion to become helpers, mentors, and leaders in sexual health promotion and engage them as co-researchers;
- Strengthen the capacity of Inuit communities by providing research training and technical support in grant application, data collection and analysis;

- Build connections with regional and national data agencies to aggregate Inuit-specific data on HPV infection and cervical cancer rates throughout Inuit Nunangat;
- Consult the working group in determining culturally-relevant outcome indicators of Inuit sexual health and wellness;
- Involve Elders in the development of educational materials in English, French and Inuktitut for women and girls, two-spirited people, men and boys, as well as older adults to promote awareness of HPV and cervical cancer;
- Find creative ways to deliver awareness campaigns that include land-based activities (e.g., hunting and harvesting) and Inuit artistic expressions (e.g., throat singing, drum dancing, and sewing);
- Provide ongoing cultural competency training for health care providers, community-based researchers and other front-line workers to promote awareness of the links between colonialism, unresolved trauma, violence, substance abuse and high-risk sexual behaviours;
- Work in partnership with all areas of service delivery – including but not limited to child care, housing and transitional homes, local employers, food services, and mental health and substance abuse treatment programs – to ensure that the basic and immediate needs of women are addressed;
- Invest in the recruitment and training of Inuktitut-speaking health care providers throughout Inuit homelands.

Chapter Six: Conclusion

The purpose of this thesis was to undertake a JBI scoping review of Indigenous healing strategies in Canada including both peer-reviewed and grey literature and to create a platform for future research about culturally-relevant cervical cancer care for Inuit communities. The review identified a wide range of characteristics pertaining to existing healing strategies, as well as culturally-relevant approaches that have been used in primary research. Although the findings are extensive and heterogenous, consistent trends are evident regarding the long-term vision of decolonization, which the Canadian society can hope to accomplish through: upholding Indigenous knowledge, respecting Indigenous rights to self-determination, and recognizing Indigenous resilience and agency. The findings from this scoping review also demonstrated a high level of alignment with *IQ*, the living and evolving knowledge of Inuit passed from generation to generation. Since time immemorial, the laws and principles of *IQ* enabled Inuit to find strength in an unforgiving Arctic environment that is further complicated by Canada's colonial legacy. In the contemporary context, *IQ* continues to offer much-needed lessons about how to exist in harmony and balance in order to ensure the wholistic wellness of people. These teachings hold deep meanings for all members of Canada in advancing the process of truth and reconciliation.

This thesis ends where it began: The incredible strengths and resilience of Inuit and other Indigenous Peoples in Canada must be acknowledged and built upon, on their own terms. Despite the long way ahead for achieving wellness, the key is to engage communities in the critical discussion and continue to seek their expertise. It is time for the people to lead.

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Appendix A Final Search Strategies and Results

Sociological Abstracts: 1685 results on December 5th 2018

(MAINSUBJECT.EXACT("Eskimos") [Soc Abs] OR MAINSUBJECT.EXACT("American Indians") [Soc Abs] OR MAINSUBJECT.EXACT("North American Cultural Groups" [Soc Abs] OR MAINSUBJECT.EXACT("Indigenous Populations" [Soc Abs] OR aboriginal OR (first PRE/1 nation*) OR (native NEAR/1 canadian*) OR indigenous OR inuit OR metis OR Algonquin OR Athabaskan OR Anishinabek OR Chipewyan OR Cree OR Dene OR Innu OR Montagnais OR Inuktitut OR Inuvialuit OR Mi'kmaq OR Oji-Cree OR Ojibway)
AND
(canada OR canadian OR newfoundland OR labrador OR "nova scotia" OR "new brunswick" OR "prince edward island" OR Quebec OR ontario OR manitoba OR saskatchewan OR alberta OR "british columbia" OR yukon OR "northwest territories" OR Nunavut OR "atlantic Canada" OR "atlantic provinces" OR "prairie provinces" OR maritimes OR "maritime provinces" OR Arctic OR "Canadian Arctic" OR Subarctic OR "Inuit Nunangat" OR Inuvialuit OR Nunatsiavut OR Nunavut OR Nunavik OR northern OR western OR urban)
AND
(MAINSUBJECT.EXACT("Culture") OR MAINSUBJECT.EXACT("Well Being") OR MAINSUBJECT.EXACT("Cultural Pluralism") OR MAINSUBJECT.EXACT("Cultural Identity") OR MAINSUBJECT.EXACT("Culture") OR MAINSUBJECT.EXACT("Cultural Values") OR MAINSUBJECT.EXACT("Health Education") OR MAINSUBJECT.EXACT("Health Problems") OR MAINSUBJECT.EXACT("Knowledge") OR MAINSUBJECT.EXACT("Resilience") OR "strength based" OR strength* OR ((trauma* OR cultur*) NEAR/2 inform*) OR resilien* OR health OR wellness OR wellbeing OR "well being" OR healing OR wholeness OR balance OR harmony)
AND
(MAINSUBJECT.EXACT("Posttraumatic Stress Disorder") [Soc Abs] OR MAINSUBJECT.EXACT("Trauma") [Soc Abs] OR MAINSUBJECT.EXACT("Colonialism") [Soc Abs] OR MAINSUBJECT.EXACT("Racism") [Soc Abs] OR MAINSUBJECT.EXACT("Oppression") OR MAINSUBJECT.EXACT("Decolonization") OR MAINSUBJECT.EXACT("Racial Relations") OR MAINSUBJECT.EXACT("Cultural Conflict") OR (historic* OR cultur* OR coloni* OR generation* OR intergeneration*) NEAR/3 trauma*)

Academic Search Premier: 111 results on December 5th 2018

(DE "NATIVE Americans" [Acad Search Prem] OR DE "ALGONQUIANS (North American people)" [Acad Search Prem] OR DE "ATHAPASCANS (North American people)" [Acad Search Prem] OR DE "CADDOANS (North American peoples)" [Acad Search Prem] OR DE "CALIFORNIA Indians (North American people)" [Acad Search Prem] OR DE "ESKIMOS" [Acad Search Prem] OR DE "FIRST Nations" [Acad Search Prem] OR DE "GREAT Basin peoples (North American peoples)" [Acad Search Prem] OR DE "IROQUOIANS (North American peoples)" [Acad Search Prem] OR DE "MASSAWOMECK (North American people)" [Acad Search Prem] OR DE "METIS" [Acad Search Prem] OR DE "MONONGAHELA (North American people)" [Acad Search Prem] OR DE "MOUND-builders" [Acad Search Prem] OR DE "NATIVE American Mormons" [Acad Search Prem] OR DE "NATIVE American actors" [Acad Search Prem] OR DE "NATIVE American children" [Acad Search Prem] OR DE

"NATIVE American dancers" [Acad Search Prem] OR DE "NATIVE American directors" [Acad Search Prem] OR DE "NATIVE American freemasons" [Acad Search Prem] OR DE "NATIVE American men" [Acad Search Prem] OR DE "NATIVE American musicians" [Acad Search Prem] OR DE "NATIVE American students" [Acad Search Prem] OR DE "NATIVE American teachers" [Acad Search Prem] OR DE "NATIVE American women" [Acad Search Prem] OR DE "NATIVE American youth" [Acad Search Prem] OR DE "NATIVE Americans in the motion picture industry" [Acad Search Prem] OR DE "NATIVE Americans in the performing arts" [Acad Search Prem] OR DE "NATIVE Americans with disabilities" [Acad Search Prem] OR DE "OFF-reservation Indians (Native Americans)" [Acad Search Prem] OR DE "OLDER Native Americans" [Acad Search Prem] OR DE "PACIFIC Northwest peoples (North American peoples)" [Acad Search Prem] OR DE "PAN-Indianism" [Acad Search Prem] OR DE "PLAINS peoples (North American peoples)" [Acad Search Prem] OR DE "RESERVATION Indians (Native Americans)" [Acad Search Prem] OR DE "SOUTHWEST Indians (North American peoples)" [Acad Search Prem] OR DE "SUBARCTIC peoples (North Americans)" [Acad Search Prem] OR DE "TWO-spirit people" [Acad Search Prem] OR DE "UTO-Aztecan peoples (North American peoples)" [Acad Search Prem] OR DE "WOODLAND peoples (North American peoples)" [Acad Search Prem] OR DE "INDIGENOUS peoples of the Americas"[Acad Search Prem] OR aboriginal OR (first PRE/1 nation*) OR (native NEAR/1 canadian*) OR indigenous OR inuit OR metis OR Algonquin OR Athabaskan OR Anishinabek OR Chipewyan OR Cree OR Dene OR Innu OR Montagnais OR Inuktitut OR Inuvialuit OR Mi’kmaq OR Oji-Cree OR Ojibway)
AND
(canada OR canadian OR newfoundland OR labrador OR "nova scotia" OR "new brunswick" OR "prince edward island" OR Quebec OR ontario OR manitoba OR saskatchewan OR alberta OR "british columbia" OR yukon OR "northwest territories" OR Nunavut OR "atlantic Canada" OR "atlantic provinces" OR "prairie provinces" OR maritimes OR "maritime provinces" OR Arctic OR "Canadian Arctic" OR Subarctic OR "Inuit Nunangat" OR Inuvialuit OR Nunatsiavut OR Nunavut OR Nunavik OR northern OR western OR urban)
AND
DE "WELL-being" [Acad Search Prem] OR DE "SUBJECTIVE well-being (Psychology)" [Acad Search Prem] OR DE "RESILIENCE (Personality trait)" [Acad Search Prem] OR DE "RESILIENCE (Personality trait) in children" [Acad Search Prem] OR "strength based” OR strength* OR ((trauma* OR cultur*) NEAR/2 inform*) OR resilien* OR health OR wellness OR wellbeing OR "well being" OR healing OR wholeness OR balance OR harmony)
AND
DE "EMOTIONAL trauma" [Acad Search Prem] OR DE "HISTORICAL trauma" [Acad Search Prem] OR DE "POST-traumatic stress disorder" [Acad Search Prem] OR DE "BATTERED woman syndrome" [Acad Search Prem] OR DE "POST-traumatic stress disorder in children" [Acad Search Prem] OR DE "RAPE trauma syndrome" [Acad Search Prem] OR ((historic* OR cultur* OR coloni* OR generation* OR intergeneration*) NEAR/3 trauma*)

CINAHL: 61 results on December 5th 2018
(MH "Eskimos" OR MH "Native Americans" OR aboriginal OR (first PRE/1 nation*) OR (native NEAR/1 canadian*) OR indigenous OR inuit OR metis OR Algonquin OR Athabaskan OR Anishinabek OR Chipewyan OR Cree OR Dene OR Innu OR Montagnais OR Inuktitut OR Inuvialuit OR Mi’kmaq OR Oji-Cree OR Ojibway)

AND
(MH "Canada+" OR canada OR canadian OR newfoundland OR labrador OR "nova scotia" OR "new brunswick" OR "prince edward island" OR Quebec OR ontario OR manitoba OR saskatchewan OR alberta OR "british columbia" OR yukon OR "northwest territories" OR Nunavut OR "atlantic Canada" OR "atlantic provinces" OR "prairie provinces" OR maritimes OR "maritime provinces" OR Arctic OR "Canadian Arctic" OR Subarctic OR "Inuit Nunangat" OR Inuvialuit OR Nunatsiavut OR Nunavut OR Nunavik OR northern OR western OR urban)
AND
(MH "Wellness" OR MH "Psychological Well-Being" OR MH "Hardiness" OR "strength based" OR strength* OR ((trauma* OR cultur*) NEAR/2 inform*) OR resilien* OR health OR wellness OR wellbeing OR "well being" OR healing OR wholeness OR balance OR harmony)
AND
(MH "Stress Disorders, Post-Traumatic" OR (historic* OR cultur* OR coloni* OR generation* OR intergeneration*) NEAR/3 trauma*)

PsycINFO: 232 results on December 5th 2018
(DE "American Indians" OR DE "Inuit" OR DE "Indigenous Populations" OR aboriginal OR (first PRE/1 nation*) OR (native NEAR/1 canadian*) OR indigenous OR inuit OR metis OR Algonquin OR Athabaskan OR Anishinabek OR Chipewyan OR Cree OR Dene OR Innu OR Montagnais OR Inuktitut OR Inuvialuit OR Mi'kmaq OR Oji-Cree OR Ojibway)
AND
(canada OR canadian OR newfoundland OR labrador OR "nova scotia" OR "new brunswick" OR "prince edward island" OR Quebec OR ontario OR manitoba OR saskatchewan OR alberta OR "british columbia" OR yukon OR "northwest territories" OR Nunavut OR "atlantic Canada" OR "atlantic provinces" OR "prairie provinces" OR maritimes OR "maritime provinces" OR Arctic OR "Canadian Arctic" OR Subarctic OR "Inuit Nunangat" OR Inuvialuit OR Nunatsiavut OR Nunavut OR Nunavik OR northern OR western OR urban)
AND
(DE "Well Being" OR DE "Resilience (Psychological)" OR "strength based" OR strength* OR ((trauma* OR cultur*) NEAR/2 inform*) OR resilien* OR health OR wellness OR wellbeing OR "well being" OR healing OR wholeness OR balance OR harmony)
AND
(DE "Emotional Trauma" OR DE "Post-Traumatic Stress" OR DE "Posttraumatic Stress Disorder" OR DE "Complex PTSD" OR DE "DESNOS" OR DE "Trauma" OR (historic* OR cultur* OR coloni* OR generation* OR intergeneration*) NEAR/3 trauma*)

MEDLINE: 191 results on December 5th 2018
(exp American Native Continental Ancestry Group/ OR aboriginal OR (first PRE/1 nation*) OR (native NEAR/1 canadian*) OR indigenous OR inuit OR metis OR Algonquin OR Athabaskan OR Anishinabek OR Chipewyan OR Cree OR Dene OR Innu OR Montagnais OR Inuktitut OR Inuvialuit OR Mi'kmaq OR Oji-Cree OR Ojibway)
AND
(exp CANADA/ OR canada OR canadian OR newfoundland OR labrador OR "nova scotia" OR "new brunswick" OR "prince edward island" OR Quebec OR ontario OR manitoba OR saskatchewan OR alberta OR "british columbia" OR yukon OR "northwest territories" OR Nunavut OR "atlantic Canada" OR "atlantic provinces" OR "prairie provinces" OR maritimes

OR "maritime provinces" OR Arctic OR "Canadian Arctic" OR Subarctic OR "Inuit Nunangat" OR Inuvialuit OR Nunatsiavut OR Nunavut OR Nunavik OR northern OR western OR urban)
AND
(exp CULTURE/ OR exp Health Education/ OR exp Resilience, Psychological/ OR "strength based" OR strength* OR ((trauma* OR cultur*) NEAR/2 inform*) OR resilien* OR health OR wellness OR wellbeing OR "well being" OR healing OR wholeness OR balance OR harmony)
AND
(exp Stress Disorders, Traumatic/ OR exp Colonialism/ OR (historic* OR cultur* OR coloni* OR generation* OR intergeneration*) NEAR/3 trauma*)

iPortal: 12 results on February 18th 2019
Website: https://iportal.usask.ca
Keywords used: Healing, Canada
Filters applied: Peer-reviewed articles, E-book chapters and oral traditions
Reference of articles included: (Deane et al., 2018)**(**Dell et al., 2008**)**(Dobson & Brazzoni, 2016)(McCabe, 2008)(Radu et al., 2014)(Smillie-Adjarkwa, 2009)(Wortzman, 2009)(Edwards et al., 2008)(Goin & Mill, 2013)(Maar et al., 2009)(Recollet et al., 2009)(Gone, 2011)

Canadian Electronic Library: No results on February 18th 2019
Website: https://www-deslibris-ca.ezproxy.library.dal.ca/en-us/search-results.aspx#sort=dateadded-desc
Keywords used: Healing, Canada
Reference of articles included: None

Health Canada: No results on February 18th 2019
Website: https://www.canada.ca/en/health-canada.html
Method for searching: Entered keywords in the website search bar; searched through the menu/titles on homepage
Keywords used: Indigenous, Aboriginal, health, wellness, healing, strategy, service, program, policy, guideline, model, framework
Reference of articles included: None

Public Health Agency of Canada: No results on February 18th 2019
Website: https://www.canada.ca/en/public-health.html
Method for searching: Entered keywords in the website search bar; searched through the menu titles on homepage
Keywords used: Indigenous, Aboriginal, health, wellness, healing, strategy, service, program, policy, guideline, model, framework
Reference of articles included: None

Indigenous and Northern Affairs Canada: No results on February 18th 2019
Website: https://www.aadnc-aandc.gc.ca/eng/1100100010002/1100100010021
Method for searching: Entered keywords in the website search bar; searched through the menu titles on homepage
Keywords used: Indigenous, Aboriginal, health, wellness, healing, strategy, service, program, policy, guideline, model, framework

Reference of articles included: None

National Collaborating Centre for Aboriginal Health: Four results on February 18th 2019
Website: https://www.nccah-ccnsa.ca/en/
Method for searching: Entered keywords in the website search bar; searched through the menu titles on homepage
Keywords used: Indigenous, Aboriginal, health, wellness, healing, strategy, service, program, policy, guideline, model, framework
Reference of articles included: (Aguiar & Halseth, 2015)(Tagalik, 2010)(Scott, 2013)(Gerlach et al., 2017)

Aboriginal Healing Foundation: One result on February 18th 2019
Website: http://www.ahf.ca
Method for Searching: Searched through the menu titles on homepage (search bar not available)
Keywords Used: N/A
Reference of articles included: (Waldram, 2008)

Native Women's Association of Canada: Two results on February 18th 2019
Website: https://www.nwac.ca
Method for Searching: Entered keywords in the website search bar; searched through the menu titles on homepage
Keywords Used: Indigenous, Aboriginal, health, wellness, healing, strategy, service, program, policy, guideline, model, framework
Reference of articles included: (Native Women's Association of Canada, n.d.-b, n.d.-a)

Quebec Native Women: No results on February 18th 2019
Website: https://www.faq-qnw.org/en/
Method for Searching: Searched through the menu titles on homepage (search bar not available)
Keywords Used: N/A
Reference of articles included: None

Canadian Aboriginal AIDS Network: Three results on February 18th 2019
Website: https://caan.ca/en
Method for Searching: Searched through the menu titles on homepage (search bar not available)
Reference of articles included: (CAAN, 2009, 2010)(Peltier, 2010)

Pauktuutit Inuit Women of Canada: Two results on February 18th 2019
Website: https://www.pauktuutit.ca
Method for Searching: Searched through the menu titles on homepage (search bar not available)
Keywords Used: N/A
Reference of articles included: (Pauktuutit, 2013, 2017)

Inuit Tapiriit Kanatami: Three results on February 18th 2019
Website: https://www.itk.ca
Method for Searching: entered keywords in the website search bar; searched through the menu titles on homepage
Keywords Used: Indigenous, Aboriginal, health, wellness, healing, strategy, service, program, policy, guideline, model, framework
Reference of articles included: (ITK, 2013b, 2013a, 2016)

Handsearching of key journals: Six results on February 20th 2019
Method for Searching: Entered keywords in the website search bar
Keywords Used: Indigenous, Aboriginal, health, wellness, healing, strategy, service, program, policy, guideline, model, framework
Reference of articles included: (Fanian et al., 2015)(Goudreau et al., 2008)(D. Howell et al., 2014)(Maar & Shawande, 2010)(Petrucka et al., 2016)(Walker et al., 2010)

Handsearching of reference lists of included articles: One result on May 9th 2019
(Kwanlin Dün First Nation Justice Department, 2010)

Appendix B Articles Excluded with Reasons

Exclusion Criteria: No details of strategy
Articles excluded: (Ansloos, 2015)(Ashworth, 2018)(Ball, 2009)(Ball, 2010)(Barker, Goodman, & DeBeck, 2017)(Bingham, Leo, Zhang, Montaner, & Shannon, 2014)(Bombay, Matheson, & Anisman, 2014b)(Bombay, Matheson, & Anisman, 2014a)(Bombay, 2015)(Bombay, Matheson, & Anisman, 2017)(Boyer, 2017)(Braun, Browne, Ka'opua, Kim, & Mokuau, 2014)(L. A. Brooks, Darroch, & Giles, 2013)(Brown, McPherson, Peterson, Newman, & Cranmer, 2012)(Browne, 2017)(Cameron, Carmargo Plazas, Salas, Bourque Bearskin, & Hungler, 2014)(Carmen Rodríguez de, 2010)(Cassell, 2016)(Castleden, Garvin, & Nation, 2009)(Charles & DeGagné, 2013)(Cindy Smithers & Mandawe, 2017)(Coburn, 2016)(Crawford, 2014)(Czyzewski, 2011b)(Czyzewski, 2011a)(Danto & Walsh, 2017)(Dionne & Nixon, 2014) (Douglas, 2010)(Eggertson, 2014, 2016)(Gesink, Whiskeyjack, Suntjens, Mihic, & McGilvery, 2016)(Gone, 2013)(Goodman et al., 2017)(Gray, 2016)(Hanson, 2016)(Hatala, Desjardins, & Bombay, 2016)(Hill, 2017)(Isaak et al., 2015)(Kirmayer, Dandeneau, Marshall, Phillips, & Williamson, 2011)(Kirmayer, Gone, & Moses, 2014)(Klingspohn, 2018)(Kral, 2012)(MacDonald, 2014)(Marsh, Coholic, Cote-Meek, & Najavits, 2015)(Marsh, Cote-Meek, Toulouse, Najavits, & Young, 2015)(McGuire-Adams & Giles, 2018)(McNichols, 2017)(Mehl-Madrona, 2006)(Menzies, 2008)(Nutton & Fast, 2015)(Park, 2016)(Richardson, 2012)(Robbins & Dewar, 2011)(Thibeault, 2011)(Wakewich, Wood, Davey, Laframboise, & Zehbe, 2016)(Waldram, 2014)

Exclusion Criteria: Wrong population
Articles excluded: (Beavis et al., 2015)(Boksa, Joober, & Kirmayer, 2015)(Browne et al., 2018)(Fraser, 2018)(Hampton et al., 2011)(Hojjati et al., 2018)(Weinberg, 2018)(Wilson et al., 2013)

Exclusion Criteria: Not in Canada
Articles excluded: (Barlowe & Thompson, 2009)(Wexler et al., 2016)

Exclusion Criteria: Published before 2008
Articles excluded: (Borrows, 2000) (Hibbard, 2001) (Heaslip, 2003)

Exclusion Criteria: Wrong study design
Articles excluded: (Dutton, 2010)(Gauld, 2009)(Gordon, 2014)(Reeves, 2013)

Appendix C Overall Description of Articles Included

Table C1 Extracted Data on Literature Type, Geographical Location, Service Setting and Type of Strategy

Author	Literature type	Geographical location	Service setting	Type of strategy				
				Services and programs	Polices and guidelines	Models and frameworks	Indigenous narratives and expert opinions	Others (specify)
(Abbass-Dick et al., 2018)	Journal article	ON	Health					eHealth Breastfeeding Resource
(Absolon, 2016)	Journal article	N/A	Reconciliation				The framework of wholistic and ethical social inclusion	
(Aguiar & Halseth, 2015)	Organizational publication	AB	Education					Blue Quills First Nations College (BQFNC) curriculum and programming
(Archibald et al., 2015)	Journal article	BC	Health	A five-day residential art therapy workshop called "Honouring Your Grief"				
(Ball, 2013)	Book chapter	N/A	Child welfare				Five key strategies for supporting fathers involvement	
(Browne et al., 2016)	Journal article	BC	Health			The framework of Equity-Oriented Primary Health Care with Indigenous People		
(CAAN, 2010)	Organizational publication	N/A	Health		The National Aboriginal Youth Strategy on HIV and AIDS in Canada for First Nations, Inuit and Métis youth from 2010 to 2015 (NAYSHAC)			

Author	Literature type	Geographical location	Service setting	Type of strategy				
				Services and programs	Polices and guidelines	Models and frameworks	Indigenous narratives and expert opinions	Others (specify)
(Peltier, 2010)	Organizational publication	N/A	Health		Environments of Nurturing Safety (EONS): Aboriginal Women in Canada: Five Year Strategy on HIV and AIDS			
(CAAN, 2009)	Organizational publication	N/A	Health		Aboriginal Strategy on HIV/AIDS in Canada II (ASHAC II) for First Nations, Inuit and Métis Peoples from 2009 to 2014			
(C. M. Brooks & Poudrier, 2014)	Journal article	SK	Others: Research					Research methods: photovoice
(Castleden & Garvin, 2008)	Journal article	BC	Others: Research					Research methods: photovoice
(Dell et al., 2008)	Journal article	SK	Health	Equine Assisted Learning (EAL) at the White Buffalo Youth Inhalant Treatment Centre				
(Deane et al., 2018)	Journal article	MB	Child welfare	This Live-In Family Enhancement (LIFE) program				
(Derrick, 2009)	Book chapter	N/A	Health				A Clinical Systemic Therapy Model	
(Dobson & Brazzoni, 2016)	Journal article	BC	Health	Carrier Sekani Family Services, Addiction Recovery Cultural Healing Program				

Author	Literature type	Geographical location	Service setting	Type of strategy				
				Services and programs	Polices and guidelines	Models and frameworks	Indigenous narratives and expert opinions	Others (specify)
(Edwards et al., 2008)	Journal article	NT	Health					Healing Wind Strategy: a community-led health research
(Fanian et al., 2015)	Journal article	NT	Others: Youth development	The Ko`ts'i`ıhtł a (''We Light the Fire'') project was a 5-day creative arts and music workshop				
(Finlay et al., 2010)	Journal article	ON	Health			Mamow Sha-way-gi-kay-win, the North-South Partnership for Children		
(Gadoua, 2010)	Journal article	MB	Reconciliation					TRC National Event in Winnipeg
(Gerlach et al., 2017)	Journal article	BC	Child welfare	Aboriginal Infant Development Program (AIDP)				
(Goin & Mill, 2013)	Journal article	AB	Health			A model of key components of resilience		
(Gone, 2009, 2011)	Journal article	MB	Health	the outpatient ''counseling'' program				
(Goudreau et al., 2008)	Journal article	ON	Others: Women empowerment			Aboriginal Women's Handrumming (AWHD) Circle of Life Framework		
(Hayhurst et al., 2016)	Journal article	BC	Reconciliation	Because We Are Girls Group				
(Healey et al., 2016)	Journal article	NU	Health			The Eight Ujarait/Rocks Model for Youth Wellness Interventions		
(T. Howell et al., 2016)	Journal article	BC	Health	Seven holistic health circles				
(ITK, 2013b)	Organizational publication	Inuit Nunangat	Health		Inuit-specific TB Action Plan			
(ITK, 2013a)	Organizational publication	Inuit Nunangat	Health		Inuit Oral Health Action Plan			

Author	Literature type	Geographical location	Service setting	Type of strategy				
				Services and programs	Polices and guidelines	Models and frameworks	Indigenous narratives and expert opinions	Others (specify)
(ITK, 2016)	Organizational publication	Inuit Nunangat	Health		National Inuit Suicide Prevention Strategy (NISPS)			
(Isaak et al., 2010)	Journal article	MB	Others: Research					The research project titled "From risk factors to culturally sensitive interventions: A programmatic approach to Aboriginal suicide"
(Jongbloed et al., 2016)	Journal article	BC	Health					The Cedar Project WelTel mHealth intervention: a structured mobile-phone initiative
(Jumah et al., 2017)	Journal article	ON	Health		Consensus statements developed by workshop participants involved in the care of substance-involved pregnant and parenting women			
(Lys et al., 2016)	Journal article	NT	Health	Fostering Open eXpression among Youth (FOXY): seven workshops				
(Maar et al., 2009)	Journal article	ON	Health			The Knaw Chi Ge Win collaborative mental health service model		
(Maar & Shawande, 2010)	Journal article	ON	Health	Traditional healing services at Noojmowin Teg Health Access Centre				

Author	Literature type	Geographical location	Service setting	Type of strategy				
				Services and programs	Polices and guidelines	Models and frameworks	Indigenous narratives and expert opinions	Others (specify)
(Marsh et al., 2016, 2018)	Journal article	ON	Health	The Indigenous Healing and Seeking Safety (IHSS) sharing circles				
(McCabe, 2008)	Journal article	N/A	Health				A discussion of the meaning of the personal integrated inner body, mind, emotions and spirit dialogue from an Aboriginal perspective	
(Mitchell, 2016)	Book chapter	N/A	Reconciliation				Six political pathways to Indigenous health and wellness	
(NWAC, n.d.-a)	Organizational publication	N/A	Others: Women empowerment					The Honouring Indigenous Women Toolkit: an educational resource
(NWAC, n.d.-b)	Organizational publication	N/A	Others: Violence prevention					Project PEACE Workbook
(Oelke et al., 2016)	Journal article	MB, SK, AB, BC	Others: Homelessness prevention			The best practice framework for homeless services for Aboriginal Peoples		
(Oliver et al., 2015)	Journal article	ON, QC, BC, PEI	Health	Six different Indigenous community workshops to create artistic pieces				
(Pauktuutit Inuit Women of Canada, 2013)	Organizational publication	Inuit Nunangat	Health	A Community Story workshop				
(Pauktuutit Inuit Women of Canada, 2017)	Organizational publication	Inuit Nunangat	Health		Tavva: National Inuit Sexual Health Strategy			

Author	Literature type	Geographical location	Service setting	Type of strategy				
				Services and programs	Polices and guidelines	Models and frameworks	Indigenous narratives and expert opinions	Others (specify)
(Petrucka et al., 2016)	Journal article	SK	Others: Youth development					The Positive Leadership, Legacy, Lifestyles, Attitudes, and Activities for Aboriginal Youth (PL3A3Y) research project
(Radu et al., 2014)	Journal article	QC	Justice	The Chisasibi land-based healing program				
(Recollet et al., 2009)	Journal article	ON	Others: Women empowerment	Holistic arts-based group				
(Reeves & Stewart, 2014)	Journal article	ON	Health	Anishnawbe Health Toronto				
(Saskamoose et al., 2017)	Journal article	SK	Health			Indigenous Cultural Responsiveness Theory (ICRT): a working theoretical model		
(Scott, 2013)	Organizational publication	MB, BC, ON, SK	Child welfare	Neah Kee Papa; Healthy Children, Healthy Futures Program; Creating Working Partnerships That Really Work; KidsFirst Program; Working Together to Help One Another				
(Smillie-Adjarkwa, 2009)	Journal article	ON	Health				Traditional Healing methods work for Aboriginal people who are overcoming addictions	
(Tagalik, 2010)	Organizational publication	N/A	Health			Indigenous School Health Framework		

Author	Literature type	Geographical location	Service setting	Type of strategy				
				Services and programs	Polices and guidelines	Models and frameworks	Indigenous narratives and expert opinions	Others (specify)
(Waldram, 2008)	Organizational publication	NB, BC, NU, MB, SK	Health	Five AHF-funded healing programs				
(Walker et al., 2010)	Journal article	ON	Health	Traditional Healing, Medicines, Foods and Supports (THMFS) program				
(Walsh et al., 2018)	Journal article	ON	Health	Project George				
(Wortzman, 2009)	Journal article	N/A	Health				Recommendations that could guide the development of future mental health promotion programs	
(Kwanlin Dün First Nation Justice Department, 2010)	Organizational publication	NT	Health	Caring for the Circle Within Program				

Appendix D Extracted Data on Characteristics and Culturally-Relevant Approaches

Table D1 Full Description of Guiding Principles, Main Components, and Human Resources for Included Healing Strategies

Articles	Characteristics of Indigenous healing strategy		
	Guiding principles	Main Components	Human resources
(Abbass-Dick et al., 2018)	Not specified	(1) why breastfeed, (2) how to breastfeed, (3) the early days, (4) supporting mom (including the role of the father/partner and other coparents), (5) common concerns, (6) getting help, and (7) everyday life.	1) The original generic resource (website) was created by a team of experts, which included health care professionals, a lactation consultant, education specialist, website developer, graphic designer, and animator. Feedback was sought from 2) Indigenous mothers, and 3) health care providers who were involved in providing breastfeeding education or support services to Indigenous families.
(Absolon, 2016)	Four Directions of Medicine Wheel; Seven Sacred Teachings	N/A	The author is an Anishinaabekwe (Ojibwe woman) and a member of Flying Post First Nation which is in Northern Ontario, Canada.
(Aguiar & Halseth, 2015)	Other foundational elements that guide the everyday work at BQFNC include: implementing circular processes based firmly on spirituality; incorporating Elders and other traditional and local forms of wisdom; utilizing strength-based perspectives and approaches; mindfully employing empowering strategies; incorporating humor; engaging in storytelling; practicing role modeling; incorporating collective leadership practices; practicing ethical relations with all other life forms; and honoring the contributions and experiences of others, including Aboriginal ancestors.	the role of culture, the use of circular processes (aka sharing circles), and the incorporation of ceremony.	A First Nation controlled institution; BQFNC is governed by seven appointed Board members, each representing one of the seven local First Nations communities
(Archibald et al., 2015)	Not specified	1) centring exercise, finger painting exercise, boundaries exercises 2) presentation about attachment theory 3) create something related to their early years, making wrapped dolls, a container to represent the self, poetry 4) a cleansing/healing ceremony, prayer	The workshop was co-facilitated by a registered art therapist (female), and a trauma counsellor at the centre (male); both are from Nanoose. The therapists and participants shared a common cultural background and a common history as First Nation people living in British Columbia
(Ball, 2013)	1) Patience: the need for policy reforms and systemic program solutions within a postcolonial, social justice agenda that requires a long-term commitment. 2) Positive Media Images of Indigenous Fathers: there is a need for media that show men assuming roles as positively involved fathers 3) Program Supports for Fathers: rep-esenting the particular needs, goals, and circumstances of fathers 4) Paternity Registration; 5) Policy Reforms	N/A	An Indigenous team based mainly in communities that partnered in doing the study recruited 80 Indigenous father participants

Articles	Characteristics of Indigenous healing strategy		
	Guiding principles	Main Components	Human resources
(Browne et al., 2016)	culturally safe care, trauma- and violence-informed care, and contextually tailored care	N/A	This four-year study was conducted in partnership with two urban Aboriginal health centres located in two inner cities in Canada. The research team was guided by an Indigenous community advisory committee (CAC) including leaders in Indigenous health services, patient representatives, and people recognized as Indigenous Elders.
(CAAN, 2010)	NAYSHAC Values Youthful Perspectives, Greater & Meaningful Involvement, Harm Reduction, Confidentiality, Open minds, Dialogue, Multiple Good Approaches, Human Rights, Role Models, Knowledgeable, Culture & Traditions	N/A	This strategy was developed in direct consultation with the National Aboriginal Youth Council on HIV and AIDS (NAYCHA). NAYCHA is comprised of youth perspectives from all three distinctive groups of First Nations, Métis, and Inuit. We also represent a mix of urban/rural, on/off reserve, and region/territory specific youth. This strategy was also developed with participants at the Canadian Aboriginal AIDS Network's AGM.
(Peltier, 2010)	EONS – Guiding Principles: Aboriginal women are diverse but can demonstrate unity amongst each other to benefit their children, themselves, and the communities in which they live. Aboriginal women are nurturers, healers, and keepers of women's knowledge and keepers of culture and must honour these gifts in how they work with each other, their children, and their communities. Aboriginal women are resourceful, flexible, and responsible for themselves, their children, and their communities and for these reasons are self-determined in their work for and with each other.	N/A	EONS was developed in consultation with a diverse group of approximately 300 Aboriginal women from communities and regions across Canada.

Articles	Characteristics of Indigenous healing strategy		
	Guiding principles	Main Components	Human resources
(CAAN, 2009)	ASHAC Guiding Principles • Change is possible and must occur. • Honour the "Statement on the Meaningful Engagement of Aboriginal People"3 and the "Greater Involvement of People Living with HIV (GIPA) Principle". • Respectfully accepting that HIV/AIDS exists in the Aboriginal community will reduce stigma and discrimination. • Act with the pride and dignity that Aboriginal heritage demands, respecting and honouring all Aboriginal beliefs, practices and customs. • First Nation, Inuit and Métis peoples have diverse, rich histories and strong cultural foundations to ground our actions and guide our hearts. • Demonstrate unity amongst all Aboriginal peoples regardless of where they reside and without distinctions between Status and Non-Status First Nations, Métis or Inuit peoples. • Integrate the wholistic Aboriginal worldview engaging the mental, physical, emotional and spiritual aspects of a person. • Honour, respect and connect with family, the community and the whole population consistent with our family-based cultures. • Mentorship is an effective approach for demonstrating opportunities, supporting someone to invest in their life and contributing towards sustainability for the Aboriginal HIV/AIDS movement. • Recognize we have inherent rights which guarantee good health and well-being as Aboriginal Peoples. • The strategy supports initiatives at the national, regional, provincial and local levels.	N/A	The Canadian Aboriginal AIDS Network (CAAN) The Aboriginal Strategy on HIV/AIDS II was developed in direct consultation with 140 people.
(C. M. Brooks & Poudrier, 2014)	A culturally safe lens	Photovoice process: *focus groups *photography *one-on-one interviews *a sharing circle for the women and a community workshop where the women shared their stories and pictures with community breast cancer stakeholders and community policy makers.	Through this research, the participants, researchers, and community partners participated (in a self-reflexive way) to create a new understanding of Aboriginal women survivors' lives through collaboration.

Articles	Characteristics of Indigenous healing strategy		
	Guiding principles	Main Components	Human resources
(Castleden & Garvin, 2008)	Not specified	1) a short training session regarding the ethical and technical use of the provided 27-exposure disposable camera. 2) Participants returned completed cameras, the research team developed the film, and semi-structured interviews were held 3) At the conclusion of each interview, participants were also asked to comment on the Photovoice process itself 4) provide updates to the community via a newsletter and a series of monthly pot- luck dinners	Huu-ay-aht elected and hereditary leaders agreed to embark on a CBPR partnership with a PhD student from a Canadian University. The elected Huu-ay-aht Council immediately appointed an Advisory Committee consisting of one elected Councillor, one hereditary Chief, and one experienced community re- searcher. Two community researchers were also trained and employed on the project.
(Dell et al., 2008)	YSAC's Culture-Based Model of Resiliency The model focuses on assisting youth in uncovering their inner spirit and strengthening their spirit by drawing on available community resources.	horse-focused exercises	counselors, Elders, and EAL facilitators from the Cartier Equine Learning Center
(Deane et al., 2018)	Not specified	attachment-based parenting training, anger management training, substance abuse relapse prevention, employment assistance, help with nutrition and budgeting, support with issues at school or daycare	An Indigenous agency in Manitoba, Metis Child, Family, and Community Services
(Derrick, 2009)	1. It is spiritually centered 2. It is child based 3. It is female led 4. It processes information by asking "What is true?" 5. All life forms are accepted as equal in value 6. Roles bring direction, accountability, and responsibility to all relationships 7. The primary goal is to become self-aware and self-disciplined 8. Relationships are the primary focus 9. The family is the primary building block of the community	N/A	The author is a registered marriage and family therapist of Mohawk ancestry
(Dobson & Brazzoni, 2016)	spirit, circle, harmony and balance, all my relations, kindness and respect, path of life continuum, earth connection, language	smudging; a morning talking circle; psychosocial education such as healthy relationships and relapse prevention; ongoing one on one sessions with an addiction counsellor or the mental health therapist; a variety of cultural activities along with staff (harvesting, craft making, sweat lodge ceremonies).	The program's core staff includes four addiction counsellors, one mental health professional, and one cultural worker. The majority of CSFS staff are Carrier First Nations. All treatment staff are trained in contemporary addiction and mental health intervention.
(Edwards et al., 2008)	This study combined the Tłįchǫ integrative perspective (inclusive of education and social services under the health umbrella) with an ecological framework.	1) Training workshops for CBRs 2) A research survey on sexual health attitudes and behaviours 3) Development of strategic plan	1) Community Advisory Committee: Elders, health service personnel, and TCSA staff members 2) The Community-based Researchers (CBRs): employed as Community Health Assistants. 3) CIETcanada: provide technical resources and training as part of the re-search process.

Articles	Characteristics of Indigenous healing strategy		
	Guiding principles	Main Components	Human resources
(Fanian et al., 2015)	a. Community-based b. Youth-friendly c. Strengths-based approach d. Rooted in Tłı̨cho values and traditions e. Respect and creating safe spaces f. Ownership, control, access and possession (OCAP)	1) a diverse set of artistic activities, which included spoken word, sound production and design, film, photo- graphy, multimedia arts, jewellery making and visual arts. 2) arranging for youth participants to display and discuss their work at the upcoming Tłı̨cho CART's Annual Youth Conference, community- friendly version of this report to share with Tłı̨cho communities "	The project was hosted by the Tłı̨cho Community Action Research Team (CART) in Behchoko CART is guided by the Healing Wind Advisory Committee, a committee of Elders and com- munity representatives. The Tłı̨cho CART recruited Indigenous facilitators to deliver the programming, 3 of the 5 facilitators were Tłı̨cho and from Behchoko
(Finlay et al., 2010)	1) Long Term Commitment 2) Awareness 3) Non-Partisan Approach	N/A	1) Volunteer assessment teams (comprised of experts in areas such as mental health; child and youth care; justice; economic development; and, housing and infrastructure) 2) A research consortium of 15 academics and researchers from four Universities across Ontario 3) southern supports including funding agencies, volunteers, training resources and donations. 4) First Nations community members
(Gadoua, 2010)	N/A	Sharing circles; information sessions about residential school history and its impact; movie screenings, plays, exhibitions, and an academic conference on the residential schools' legacy; ceremonies; daily meditations; throat singing, games, drum dancing and singing; Inuktitut lessons and sewing demonstrations.	the Canadian Truth and Reconciliation Commission (TRC)
(Gerlach et al., 2017)	1) Understanding the context of caregivers' suspicions: their history and ongoing involvement with child welfare authorities was often linked with their concerns and suspicions 2) Working hard to gain caregivers' trust: spending extensive amounts of time fostering relationships often over the course of many months or even years 3) Reflecting on our 'place of privilege': Taking into consideration how one's social and historical positioning, life experiences and taken-for-granted assumptions impact the care being provided is central to cultural safety 4) Nurturing relationships between families and Elders 5) Offering choices is 'a big deal', i.e., flexibility of program delivery 6) Supporting the whole family, i.e., responsive to caregivers' immediate concerns and priorities 7) Resisting what's taken-for-granted, i.e., adapt routine practices	N/A	1) AIDPs workers (8/18 have Indigenous ancestry) 2) The Elders (3 women and 1 man) 3) The three women administrative leaders (1/3 have Indigenous ancestry)

Articles	Characteristics of Indigenous healing strategy		
	Guiding principles	Main Components	Human resources
(Goin & Mill, 2013)	The Medicine Wheel	1) keeping busy and having a routine; 2) spending time with nature; 3) humour and laughter 4) hang onto early teachings of parents and grandparents 5) prayers and ceremonies 6) reaching out to families and friends	Ten Aboriginal women who had lost loved ones to suicide were interviewed twice. The research was guided by a community advisory committee (CAC) composed of community women and an Elder
(Gone, 2009, 2011)	The Medicine Wheel	1) structured ‘‘lectures’’—usually accompanied by associated therapeutic activities—for 2–4 h on four evenings per week, 2) one-on-one counseling by appointment as desired. 3) Additional therapeutic activities included coordinated field trips, sponsored cultural events, or participation in ceremonies. 4) community education and outreach activities	The entire staff at the lodge identified as Aboriginal, and most were citizens of the local tribal community (or ‘‘Band’’). The supervisory board of directors was appointed by the local chief and council.
(Goudreau et al., 2008)	Circle of Life model, commonly referred to as the Medicine Wheel	handrumming	Members of the Waabishki Mkwaa Singers as an invitation to become both co-researchers and participants in the study.
(Hayhurst et al., 2016)	Not specified	1) competitive sport opportunities, particularly basketball and soccer 2) cultural, social, and physical activities, which include hip-pop, archery, Pow Wow dancing 3) ‘West Coast nights’—social evenings where community members get together to enjoy food and participate in cultural activities.	1) the Vancouver Aboriginal Friendship Centre Society (VAFCS) - a non-governmental organization 2) VAFCS’ recreation programs are supported by a grant from Nike’s N7 Fund started by Sam McCracken in 1997—a Nike executive from the Fort Peck Sioux Tribe
(Healey et al., 2016)	The study followed an Indigenous research framework based on Inuit philosophy called the *Piliriqatigiiniiq* (i.e., the development of skills through effort and practice—a critical concept in understanding Inuit ways of knowing) Partnership Model for Community Health Research	visiting elders; helping clean their community by picking up garbage; volunteering at the animal shelter, thrift shop, or soup kitchen; or baking and giving food to someone in need. the practice of Inuit games and traditional activities, such as hunting, harvesting fish, hiking, berry picking, egg picking, cleaning and caring for the campsite, etc., which naturally involve body movement.	1) This study was conducted by the Qaujigiartiit Health Research Centre, an independent community research centre that was formed by Nunavummiut. 2) Community members were consulted in a series of open dialogue sessions 3) Youth mentors or peer leaders were encouraged to join the intervention leadership team, acting as role models and supporting the intervention’s implementation.

Articles	Characteristics of Indigenous healing strategy		
	Guiding principles	Main Components	Human resources
(T. Howell et al., 2016)	Musqueam worldview of *nə̓ c̓ aʔmat tə šxwqweləwən ct* (one heart, one mind) and *xwna:mstəm* (witness) *tə slaχen* (medicines) (listen to the medicine) The principles of coming together as one heart, one mind, by listening to the medicine and ancestors through the cultural teachings, to each other, and to all our relations would begin a return to being of good mind, good heart, good spirit, and good body.	talking circles, teachings of Elders and traditional healers, medicinal walk, making medicinal tea blends, a healthy meal and time to socialize	This research project was developed in partnership between an academic institution and a health authority 1) We formed an Aboriginal Health Working Group (AHWG), which consisted of approximately 15 Aboriginal Elders and/or community members. The AHWG is a diverse group representing many different nations from across Canada. 2) We also hired a cultural consultant to guide us through the cultural nuances and protocols involved in implementing the program and establishing relationships with all those involved. 3) A different Aboriginal Elder or traditional healer facilitated each of these life practices. 4) We also attempted to have gender balance, so most of the health circles were co-facilitated.
(ITK, 2013b)	• Involvement of Inuit and Inuit communities; • Respect for Inuit values, language, knowledge, culture, and the historical context of TB in Inuit Nunangat; • Commitment to health equity for Inuit, and recognition that this will require both biomedical interventions and improvements to the social determinants of health in Inuit Nunangat; • Valuing youth perspectives and the potential for youth to lead and champion meaningful change; • Appreciation of the importance of tailoring TB prevention and control approaches to meet the needs of Inuit rather than vice-versa; • Transparency and accountability; • Collaboration.	N/A	ITK has collaborated with the Inuit Public Health Task Group (IPHTG), a sub-committee of ITK's National Inuit Committee on Health (NICoH), to develop and implement a coordinated plan to reduce incidence rates of TB disease across Inuit Nunangat.
(ITK, 2013a)	Principles 1. Respect for Inuit values, language, knowledge and culture. 2. Equitable access to quality dental services across Inuit Nunangat. 3. Solutions and actions that are Inuit-specific and work within the geography, climate and isolated conditions of Inuit communities and hamlets. 4. Communication that includes collaboration and partnerships across jurisdictions and with other stakeholder groups. 5. The place to start is with the children.	N/A	ITK has collaborated with two subcommittees of the National Inuit Committee on Health (NICoH), the Inuit Non-Insured Health Benefits Working Group and the Inuit Public Health Task Group, to develop the Inuit Oral Health Action Plan.
(ITK, 2016)	Six priority areas (1) creating social equity (2) creating cultural continuity (3) nurturing healthy Inuit children from birth (4) ensuring access to a continuum of mental wellness services for Inuit (5) healing unresolved trauma and grief (6) mobilizing Inuit knowledge for resilience and suicide prevention	N/A	Contributions made by the Inuit Tapiriit Kanatami (ITK) Board of Directors, the National Inuit Committee on Health, the Alianait Inuit Mental Wellness Advisory Committee, and the National Inuit Youth Council.

Articles	Characteristics of Indigenous healing strategy		
	Guiding principles	Main Components	Human resources
(Isaak et al., 2010)	Principles 1) Health researchers, medical professionals, mental health and social workers, and policy makers must be aware of the cultural and personal environment of First Nations people in the context of suicide. 2) Those who live and work in these First Nations communities must be involved in the development of the research project as well as any planned suicide prevention and intervention strategies.	1) consulted several key research groups who had worked with Aboriginal communities in the United States and Australia 2) Visiting and community meals: relationship building, informal introduction of research project 2) 2-day meeting for advisory councils which include a half-day suicide awareness training called safeTALK 3) Annual meetings between the university and community research team and other members of the Swampy Cree communities	This project is a collaborative partnership between a group of researchers at the University of Manitoba and members of Cree Nation Tribal Health. 1) A First Nation member hired as project facilitator 2) community liaisons employed In each community 3) Community advisory councils developed within each Swampy Cree community
(Jongbloed et al., 2016)	our paradigm is to acknowledge grief and historical trauma while building on young Indigenous peoples' strengths.	Weekly two-way text messaging	1) The Cedar Project Partnership, an independent body of Indigenous Elders, health and social service experts, researchers, and elected leaders, governs the entire research process. 2) Cedar Case Managers include Indigenous and non- Indigenous nurses and Cedar Project staff members who have extensive frontline outreach experience
(Jumah et al., 2017)	1) Clinical practice guidelines that are relevant to rural and remote settings 2) Improved transitions in care 3) Facilitated access to buprenorphine 4) Increased focus on postpartum care for mother, baby and family 5) Long-term, stable funding for addiction and mental health programs 6) Incorporation of an Indigenous worldview – Building on strengths and increasing local capacity within First Nations communities	N/A	Participant representation came from eight First Nations organizations, two universities, one community college, two regional public health units, six district hospitals, four community groups, the Northwest Local Health Integration Network (LHIN), Health Canada, and the College of Physicians and Surgeons of Ontario.
(Lys et al., 2016)	Not specified	The content areas for each 1–2 hour session include: 1. Birds and the bees: create visual word maps related to sexual health topics. 2. Question box 3. Student-led sex education 4. Myth versus truth 5. Body mapping: Using arts-based techniques, such as drawing and painting 6. Healthy relationship charades: non-verbal role playing 7. Role playing	FOXY Executive Director (Lys C), as well as other facilitators and adolescent peer leaders on staff at FOXY will conduct the intervention in schools where FOXY has been invited. All facilitators and peer leaders have expertise in sexual health education and arts-based HIV prevention.

Articles	Characteristics of Indigenous healing strategy		
	Guiding principles	Main Components	Human resources
(Maar et al., 2009)	An holistic Aboriginal framework that acknowledges the physical, mental, emotional, and spiritual aspects of health as well as historical, socioeconomic and cultural influences	Not specified	1) The Knaw Chi Ge Win Team, i.e. the core mental health team with expertise in psychology, mental health nursing, long-term care, social work and traditional Aboriginal medicine and healing 2) Coordination with other Care Providers in the Region, e.g. primary care physicians, First Nations Community- based para-professionals 3) Collaboration with Visiting Consultants, e.g. traditional healer, psychiatrist
(Maar & Shawande, 2010)	Not specified	Learning opportunities at the centre have included Anishinabe life cycle teachings, language classes, storytelling, workshops, and participating in Aboriginal ceremonies, dancing workshops and helping with traditional healing sessions.	1) traditional healers 2) the interdisciplinary mental health team includes a case manager, a psychologist, a mental health nurse, two social workers, a program assistant, and the traditional coordinator
(Marsh et al., 2016, 2018)	Two-Eyed Seeing	sweat lodge ceremonies; smudging; drumming; sharing circles; sacred bundle; traditional healers; Elder teachings; feast	the Elders, an Aboriginal advisory group, and Aboriginal scholars and clinicians (also called cultural informants) were consulted throughout the entire research process. 1) Two Indigenous health-care workers and one student to co-facilitate sharing circles 2) The sweat lodge ceremonies were conducted by two Elders
(McCabe, 2008)	The Medicine Wheel	The Medicine Wheel, burning tobacco, the sweat lodge and story-telling	Not specified
(Mitchell, 2016)	1) self-determination and decolonization 2) social policy: The improvement of social, economic, and environmental living conditions 3) protection of territory and environmental protection: Historical treaties and modern-day land claim agreements, environmental protections, and the right to free prior and informed consent regarding development on traditional territories must be honoured 4) resilience and resurgence: to develop national and international partnerships between Indigenous populations 5) reconciliation and reparation: to promote awareness and public education about the Indian residential school system and its impact 6) revitalization: reclaiming languages and Indigenous concepts	N/A	Not specified

Articles	Characteristics of Indigenous healing strategy		
	Guiding principles	Main Components	Human resources
(NWAC, n.d.-a)	Not specified	• A Strong Diverse Nation • Traditional Roles of Women • Defining Respect and Honour • Cleaning the Lens • Wolf Cub Story • Valuing Yourself • Mindfulness Activity • Sustainability in Culture • Some Traditions and Teachings • Two-Spirit and LGBTQ+ in Traditional Indigenous Culture • Empowerment Word Search Activity • Indigenous Innovations • Inquiry into Missing and Murdered Indigenous Women, Girls and Gender Diverse People (MMIWGGD) • Be Safe, Be Wise, Be Aware • Affirmation Activity: I am, I can and I will • Moving Forward	The Honouring Indigenous Women Project is an initiative by the Native Women's Association of Canada (NWAC).
(NWAC, n.d.-b)	Not specified	1) Presence of Self and Setting Goals: mindfulness activity, goal setting 2) Encouraging Strength and Resilience: resilience plan 3) Accessing Services and Supports: building my support bundle, how to use a community services guide 4) Community as a Safety Net: identify my support network 5) Engaging in Culture: write, cut and glue activities to workbook	NWAC
(Oelke et al., 2016)	1) Ensuring cultural safety, 2) fostering partnerships among agencies 3) implementing Aboriginal governance 4) ensuring adequate and sustainable funding 5) equitable employment of Aboriginal staff 6) incorporating cultural reconnection 7) undertaking research and evaluation to guide policy and practices related to homelessness among Aboriginal peoples	N/A	Not specified
(Oliver et al., 2015)	Our approach is grounded in a strengths-based understanding that Indigenous young people are strong, resilient and talented.	1) technical skills building and art-making 2) interactive games and activities 3) Sunday evening community feasts and public gatherings 4) filmed and created short videos about the process for each community.	1) Youth coordinators hired, trained and supported in each community 2) Community-member artists were hired to facilitate the artistic components

Articles	Characteristics of Indigenous healing strategy		
	Guiding principles	Main Components	Human resources
(Pauktuutit Inuit Women of Canada, 2013)	1. Pilirigarigiinngniq—Working together for the common good) 2. Avatikmik Kamattiarniq—Environmental wellness 3. Pijittsirarniq—Service to others and leadership 4. Pilimmaksarniq—Empowerment 5. Qanuqtuurunnarniq—Resourcefulness and adaptability 6. Aajiiqatigiinngniq—Cooperation and consensus	1) physical and/or cultural activity (throat singing, traditional drumming, Arctic sports, etc.) 2) roundtable discussion and note taking 3) fun games to build teamwork 4) traditional stories told by local people 5) art-making and sharing	The workshop outlined in this document was developed and piloted jointly by Pauktuutit and BluePrintForLife, a private social work agency that promotes Healing Through Hip-Hop workshops for youth.
(Pauktuutit Inuit Women of Canada, 2017)	Pijitsirniq: Service to others and leadership Aajiiqatigiinniq: Cooperation and consensus Pilimmaksarniq: Empowerment Piliriqatigiinniq: Working together for the common good Qanuqtuurunnarniq: Being innovative and resourceful Avatittinnik Kamatsiarniq: Environmental wellness	N/A	Pauktuutit Inuit Women of Canada, Canadian Inuit HIV/AIDS Network, Inuit Regions, Urban Inuit Organizations, National Organizations/Partner Organizations, different levels of governments
(Petrucka et al., 2016)	1) The emphasis of PL3 A3Y was that these youth were actively engaged as capable and essential partners 2) This research was further situated within wise practices, which are inclusive, locally relevant, sustainable, respectful, flexible, pragmatic, and encompassing of all worldviews, and which consider historical, societal, cultural, and environmental factors.	community feast, learning circles, storytelling, reflection, traditional gaming	1) community Elders (both male and female) 2) a community Research Coordinator 3) a student research team (comprising six youth between 16 and 19 years of age)
(Radu et al., 2014)	The program promotes personal, family and community wellness from a perspective rooted in iiyiyiu pimaatisiiwin (Cree way of life). The Cree way of life, or iiyiyiu pimaatisiiwin, reflects the ways in which individuals interact with the land and, more specifically, harvesting activities, including the activities of hunting, fishing, trapping, gathering plants and berries, cutting wood for personal use and other related activities which are central to life in the bush.	lectures given by Elder, bush activity (hunting, fishing, trapping - depending on the season), group discussions, one-on-one counselling, storytelling	Elders, program coordinator, camp helper
(Recollet et al., 2009)	The Seven Grandfather teachings and the Seven Concepts of Respect, Honesty, Bravery, Humility, Love, Wisdom and Truth.	making dream collages, learning to meditate and use guided imagery, drawing, consciousness writing, cultural/spiritual teachings, smudging ceremony, feast	The group was facilitated by the first author who is an Aboriginal woman from the Six Nations community. we worked in partnership with the Shkagamik-Kwe Health Centre
(Reeves & Stewart, 2014)	AHT counsellors incorporate the medicine wheel teaching into many aspects of therapy.	This facility offers traditional teachings, ceremonies, and access to Elders and traditional healers as well as mainstream Western mental health services.	Traditional healers/medicine people, traditional counsellors, Elder

Articles	Characteristics of Indigenous healing strategy		
	Guiding principles	Main Components	Human resources
(Saskamoose et al., 2017)	a. Trauma-informed, b. Strengths-based, c. Community engaged, and d. Spiritually grounded. Concept 1. Middle Ground: Ermine's Ethical Space Concept 2. Two-Eyed Seeing Concept 3. Neurodecolonization Concept 4. Snowshoe and Starblanket's Protective Factors of Culture-Based Healing	N/A	1) Federation of Sovereign Indigenous Nations (FSIN, previously known as the Federation of Saskatchewan Indian Nations) 2) Community participants included men, women, and youth from a broad array of First Nations communities. 3) Cultural "experts": Elders, ceremonialists, medicine people or herbalists, and helpers from the various tribes and linguistic groups.
(Scott, 2013)	· Leadership and commitment; · Community engagement, empowerment and ownership; · Client and strengths-based focus; · Reinforcing aboriginal cultures; · Holistic services; · Building relationship and welcoming environments; and, · Strong teams in healthy work environments.	N/A	National Aboriginal organizations and their regional affiliates
(Smillie-Adjarkwa, 2009)	Uncritical attitude, sharing, humble presentation, happiness, honour Elders, silence, tribal values, simplicity, tradition, spiritual values, learning from Elders, few rules, mysticism, smallness, natural medicine, unity with nature, accept others as they are	Strategies to promote "healing," such as residential treatment programs (based on a variety of treatment models), one-on-one therapeutic counselling programs, personal growth workshops, retreats and traditional ceremonies such as Sweat Lodges, healing ceremonies, fasting, prayers and the application of traditional teachings are used in treatment programs.	Not specified
(Tagalik, 2010)	1) Interconnectedness and Relationship 2) Cultural identity and worldview 3) Self-reliance and collective ownership	N/A	Not specified
(Waldram, 2008)	Hence, what we discovered is the inherent need for flexibility, eclecticism, and diversity in treatment approaches. From the use of the Medicine Wheel to New Age and popular cultural therapeutic modalities, we found that these programs operate freely to meet the variable needs of their clients. These programs have borrowed liberally from biomedical and psychotherapeutic treatment paradigms and have integrated these with Aboriginal paradigms.	traditional dancing and drumming talking circles nature walks, day trips, seasonal camps storytelling ceremonies and rituals (e.g., smudging, blessing rites, tobacco offerings, pipe ceremonies, sweat lodge rituals, and the shaking tent) group work one-on-one counselling lectures/seminars	1) Aboriginality: there are always some Aboriginal staff, and often a primarily Aboriginal board of directors. 2) culturally and professionally varied treatment staff: Elders working alongside university-trained psychologists and social workers. 3) local treatment centres/lodges
(Walker et al., 2010)	Medicine Wheel Community and family	1) interpreter service 2) smudging and sweat lodge ceremonies 3) healing circles 4) traditional medicines 5) traditional foods	1) Proportional representation of directors: 2/3 Anishinabe, 1/3 non-Native 2) Elders council made up of Elders from the communities who are fluent in English and the native language.

Articles	Characteristics of Indigenous healing strategy		
	Guiding principles	Main Components	Human resources
(Walsh et al., 2018)	Not specified	1) transfer of specific knowledge and skills (hunting, fishing, trapping, camping) 2) team work 3) relationships with facilitators and other participants 4) program participants' involvement in decision-making 5) involvement of Elders 6) combined traditional practices and new outdoor activities	run by volunteers and guided by the experience of Elders
(Wortzman, 2009)	1) mental health promotion programs targeting youth suicide should be addressed from biological, psychological, sociocultural, and spiritual perspectives; 2) locally-initiated, owned, and accountable; 3) responsible for the entire community; 4) monitored and evaluated using appropriate methods and on an ongoing basis; 5) rooted in Aboriginal culture; and 6) facilitated in a manner that encourages participants to have a voice in program development, implementation, and evaluation.	N/A	Not specified
(Kwanlin Dün First Nation Justice Department, 2010)	Medicine Wheel	1) hunting, fishing, harvesting traditional medicines, cooking gopher, and butchering and drying meat. 2) beading, singing, and making drums and knives 3) sharing circles 4) smudging ceremony 5) exercise: Stepping into the Circle Within	For many months, a steering committee of 13 Kwanlin Dün community members and staff met to help develop program ideas that would achieve the mission of the pilot program.

Table D2 Full Description of Culturally Relevant Approaches in Primary Studies Included

Theme 1: Participatory Research	
Article	Extracted Data
(Abbass-Dick et al., 2018)	Eleven mothers and nine committee members were recruited for this participatory design study to ensure members of the target population were included in all phases of the study and that the resource would meet the needs of the target population as they defined them. Participants in all phases completed a consent form before participating in the study activities. Mothers and advisory committee members were compensated for their participation in each phase of the study. p. 482
(Browne et al., 2016)	The research team was guided by an Indigenous community advisory committee (CAC) including leaders in Indigenous health services, patient representatives, and people recognized as Indigenous Elders. p. 3
(Castleden & Garvin, 2008)	The work reported here evaluates the use of Photovoice, a CBPR method that uses participant-employed photography and dialogue to create social change. p. 1393 The elected Huu- ay-aht Council immediately appointed an Advisory Committee consisting of one elected Councillor, one hereditary Chief, and one experienced community researcher. p. 1396
(Edwards et al., 2008)	A committee of Elders, health service personnel, and TCSA staff members and a preliminary intervention program were in place prior to the initiation of the research. p. 114
(Fanian et al., 2015)	CART is guided by the Healing Wind Advisory Committee, a committee of Elders and community representatives. p. 2
(Goin & Mill, 2013)	A participatory action research design (PAR) using a qualitative approach was used for the study. The research was guided by a community advisory committee (CAC) composed of community women and an Elder (Figure 1). The committee were consulted prior to and throughout the research process, from the development of the research question to the dissemination of results. p. 487
(Goudreau et al., 2008)	The Indigenous research methodology created for this study encouraged Aboriginal women hand drummers to share their stories, build on their strengths, and generate knowledge in a way that was familiar to them, by fully engaging them in the research process. p. 75
(Hayhurst et al., 2016)	This study used a transnational approach to postcolonial feminist participatory action research (TPFPAR). In brief, the participatory element in action research invokes agency and the active role that traditionally marginalized groups (e.g. Indigenous young women) can play in contributing to the discourses and practices of development (McEwan, 2009). In essence, PAR practices invert 'who constructs research questions, designs, methods, interpretations, and products, as well as who engages in surveillance' (Fine et al., 2008, p. 161). p. 554
(Healey et al., 2016)	Themes from the literature review were presented to community members, parents, elders, youth, and youth workers for comment in a series of community consultations/ open dialogue sessions. The model was developed by the authors and validated by a subset of community members from the open dialogues who agreed to be contacted again for this purpose. p. 96
(T. Howell et al., 2016)	Aboriginal Health Working Group (AHWG), which consisted of approximately 15 Aboriginal Elders and/or community members who are experts in Aboriginal healthcare knowledge and practices. p. 115
(Isaak et al., 2010)	community-based participatory action research (PAR) project that equally engages the community in the research process from its inception and provides control over the research. Community advisory councils have been developed within each Swampy Cree community. p. 261
(Jongbloed et al., 2016)	The Cedar Project Partnership, an independent body of Indigenous Elders, health and social service experts, researchers, and elected leaders, governs the entire research process. p. 3
(Maar et al., 2009)	We used a participatory action approach; as such, the project was designed to be highly collaborative, relevant and empowering for stakeholders. A steering commit- tee consisting of Aboriginal elders, community members and local decision makers was formed to oversee the research process. p. 2
(Maar & Shawande, 2010)	The guidelines were developed at the inception of the program, using Aboriginal research methods to consult with Elders, people with traditional knowledge and practitioners of traditional healing in the seven local First Nations to determine how traditional healing in a clinical setting should occur in the region. Similar to consultations on this issue held elsewhere, there was not always immediate consensus. The process took several years to complete and was supported by a traditional advisory working group of Elders who provided ongoing guidance and direction on contentious issues. p. 21
(Marsh et al., 2016, 2018)	Indigenous research frameworks, methodologies, and approaches were applied throughout the entirety of this project. These included: • The application of Two-Eyed Seeing; • Consultation and collaboration with Elders; • The establishment of an Aboriginal advisory group; • The incorporation of Indigenous traditional healing practices p. 5
(Oelke et al., 2016)	We worked with an urban Aboriginal organization, the Aboriginal Friendship Centre of Calgary, to ensure that the study addressed the principles of community engagement, collaborative participation, and ownership. p.3
(Oliver et al., 2015)	We were also guided by our National Youth Peer Advisory Committee, which met both by teleconference and in person to provide recommendations, strategies and direction for the project and its workshops. p. 908
(Petrucka et al., 2016)	The methodology used for PL3 A3Y was a community-based participatory research (CBPR) approach. This method employs a collaborative approach to investigation that engages participants as equals in all phases of the research process. Such a model is focused on knowledge gathering as well as action to address pressing community issues. The assumption is that people are knowledgeable about their environments and are capable of developing more awareness by becoming full participants in the research process. It was imperative to recognize and address challenges related to working with youth as co-researchers. p. 181
(Recollet et al., 2009)	The facilitator consulted with one Native Elder and the Traditional Coordinator for information concerning traditional Ojibway knowledge/spirituality. p. 176

(Waldram, 2008)	Consultations were held with members of the Community Health and Wellness Board for the initial approval for the project and were followed by the community's ethics approval. Upon completion of the research stage, the preliminary results were reported back to the board. p. 15
Theme 2: Indigenous Protocols	
Article	Extracted Data
(Goudreau et al., 2008)	Consistent with the traditions of the area where the study was carried out, as the primary researcher, I offered traditional tobacco to members of the Waabishki Mkwaa Singers as an invitation to become both co-researchers and participants in the study. p. 75
(T. Howell et al., 2016)	We also ensured that we followed land-based protocols by inviting Elders from the local Coast Salish Peoples of Musqueam and Squamish. p. 115
(Oelke et al., 2016)	Throughout the project, we consulted with an Elder who held a sweat lodge ceremony for research team members at the beginning of the study. p. 3
(Oliver et al., 2015)	Elders helped to ceremoniously open and close sessions and remained available throughout as supports. p. 909
(Reeves & Stewart, 2014)	Following Indigenous inquiry protocols, this study was guided by Anishnawbe Elders, the researchers were rooted in the community of study (both were employed at the agency), the researchers attended sweat lodge ceremonies throughout the research study, and the study received a Spirit name from a traditional healer, among other protocols. The project concept was developed with the mental health staff, and the agency's research agreement was adhered to. Traditional healers and managers at the agency were respectfully approached with the sacred gift of tobacco, in accordance with local protocols. p. 62-63
Theme 3: Location and Visual Design	
Article	Extracted Data
(Abbass-Dick et al., 2018)	The medicine wheel colors used, birch bark background, and culturally relevant photos p. 486
(Recollet et al., 2009)	The following factors helped to establish a personally and culturally safe healing environment: x The workshop was held in a respected residential healing centre that is administered and staffed by Aboriginal people and located on reserve; x The physical design of the centre includes cultural imagery, a traditional healing pond, a spiritual room, and a sweat lodge; x Participants had access to an Elder-in-residence; x The workshop facilitators are skilled therapists who live and work in the communities surrounding the centre; x The healing centre operates by incorporating the traditions of the territory (Coast Salish) alongside effective healing traditions from other Aboriginal cultures (i.e., a sweat lodge) and the Western world (art therapy). p. 11
(Recollet et al., 2009)	Situating the group within the health centre was crucial to the overall process and success of the project. p. 176
Theme 4: Modification of Process	
Article	Extracted Data
(C. M. Brooks & Poudrier, 2014)	As researchers, we learned the importance of listening to what the women needed in the research process. Picture taking was a personal journey and this could not be rushed. This meant that our own research timelines were modified, ethics amended, and data collection coincided with relationship building. We were reminded of the importance in qualitative research for researchers to be learners and listeners, not experts. p. 39
(Castleden & Garvin, 2008)	Modifying photovoice: a feedback loop, prolonged immersion in the field, not actively recruiting Elders due to mobility issues, Individual interviews happen soon after photos were taken instead of group discussion at the end, comment on all photos rather than the best. p. 1401
Theme 4: Appraisal of Outcomes	
Article	Extracted Data
(Gone, 2009, 2011)	- the proposed remedy for the disorder in question: Indigenous healing moves beyond clinical concerns toward strong Aboriginal identification, cultural reclamation, spiritual wellbeing, and purposeful living - the nature of the evidence required for the appraisal of therapeutic outcomes: formal assessment of Indigenous therapeutic interventions may be met with resistance p. 758-759 in Gone-2009"
(Jongbloed et al., 2016)	The Cedar Project Partnership, an independent body of Indigenous Elders, health and social service experts, researchers, and elected leaders, governs the entire research process. p. 3
Theme 4: Integrated Knowledge Translation	
Article	Extracted Data
(C. M. Brooks & Poudrier, 2014)	The final two stages of the research involved a sharing circle for the women and a community workshop where the women shared their stories and pictures with community breast cancer stake- holders and community policy makers. p. 37
(Jongbloed et al., 2016)	Findings will be shared through ceremony with Indigenous partners. p. 9
Theme 4: Researcher Positionality	
Article	Extracted Data
(Healey et al., 2016)	Two of the authors of this paper are from Nunavut and were considered older youth at the time of the development of this study. The third author was also a Nunavut resident whose children and partner are from Iqaluit. p. 95

(Recollet et al., 2009)	The group was facilitated by the first author who is an Aboriginal woman from the Six Nations community. The facilitator was in her final year of undergraduate social work study in a Native Human Services program. p. 175
Theme 4: Language	
Article	Extracted Data
(Edwards et al., 2008)	"The Tłįchǫ have a history of colonization and missionaries had a strong influence on their language. During those years, new words were introduced to the Tłįchǫ language to refer to sexuality and many of these had negative images and connotations in Tłįchǫ. The CBRs found this handicapped the survey process in the Tłįchǫ language, and thus developed alternative terms and phrases to make discussions around STIs less value-laden and judgmental." p. 120