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Racism Experiences of Urban Indigenous Women in Ontario, Canada: “We All Have That Story That Will Break Your Heart”

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Abstract

The objective of our mixed-methods research study was to present the discourse on racism experiences of Indigenous women living in two urban Canadian cities. A failure to recognize the impacts of racism on Indigenous women in Canada has emerged from the literature. Sharing circles, interviews, and a questionnaire including validated scales were used to collect data. The findings demonstrated that urban Indigenous women experience a number of racism events that span individual, collective and institutional, and cultural racism. The diversity of racist events was better captured in the questionnaire, whereas the roots of racism were understood more clearly in the qualitative findings to be an extension of historical colonial events to current day manifestations.

Keywords

racism, Indigenous women, determinant of health, Two-Eyed Seeing

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Racism Experiences of Urban Indigenous Women in Ontario, Canada: “We All Have That Story That Will Break Your Heart”

In Canada, First Nations, Métis and Inuit Peoples collectively referred to as the Indigenous Peoples of Canada are racialized groups having life experiences shaped by their Indigenous identity and the perceptions of such an identity by others (Poonwassie, 2006; Reading & Wien, 2009). This perception can be traced back to persisting colonial views and actions, and their intergenerational impact (Poonwassie, 2006; Reading & Wien, 2009). Historical and modern-day events have resulted in many Indigenous women experiencing trauma due to discrimination and structural barriers within legal, health, and education systems that affect their health and wellness, security, and self-actualization (Poonwassie, 2006; Reading & Wien, 2009). “Systemic discrimination reflects a pattern of behaviours, policies, or practices embedded in the structures of an organization creating or perpetuating disadvantages for racialized persons” (Ontario Human Rights Commission [OHRC], 2018, para. 2).

Achieving one’s full potential is difficult when basic needs are not satisfied, resources are inadequate and do not promote sustainable wellness, and chronic life stressors persist. Racism gives rise to these systemic and structural inequities experienced by Indigenous Peoples living in Canada and other countries (Browne & Fiske, 2001; Cunningham & Paradies, 2013). Racism has been defined as the beliefs, attitudes, arrangements, and acts held by or perpetuated by members of a race (i.e., characterized by physical traits, ancestry, genetics, or social relations) who accept as true that they possess specific characteristics or abilities that distinguish them as superior to another race or races (Clark, Anderson, Clark, & Williams, 1999; Hoyt, 2012; Paradies, Harris, & Anderson, 2008). This belief unfairly disadvantages racialized groups and advantages groups with power (Hoyt, 2012; Paradies et al., 2008). The invisibility of Indigenous cultures and knowledge systems, the visibility of negative stereotypes promoted through mainstream society, and the lack of knowledge about who Indigenous Peoples are fuels racism and discrimination in Canada (Goodman et al., 2017).

Research studies often fail to recognize the different systemic levels of racism experienced by Indigenous Peoples in Canada and internationally—for example Native Americans in the US, Maori in New Zealand, and Aboriginal and Torres Strait Islanders in Australia. Instead, studies largely focus on health service systems (Goodman et al., 2017; Green, 1995; Johnson et al., 2004; Neville, Awad, Brooks, Flores, & Bluemel, 2013; Phillips, 2011). A systematic review by Allan and Smylie (2015) described the pervasiveness of racism in health service systems that contribute to inequities in health service access and use and health status for Indigenous Peoples in Canada. First Nations women have described racism and invalidating encounters within mainstream health services (Browne & Fiske, 2001). Participants described having their health concerns dismissed or trivialized by nurses and doctors, at times even before being assessed (Browne & Fiske, 2001). Some women attributed this response to negative stereotypes. They also described service providers’ lack of regard for the women’s socio-economic challenges (e.g., charging for missed appointments, which may be due to factors such as the absence of public transportation on reserves). They also found that some women were reluctant to disclose concerning health symptoms, and others felt that they were not being listened to and should not speak up because, when they did, they were made to feel less knowledgeable or credible. They perceived that health care providers interpreted their reticence as passivity and viewed it negatively. Health care providers did not seem to understand that, for some, residential school experiences engrained in them that they should not question authority, while for others it was a sign of respect within the cultural

practice of consulting someone for assistance. Similarly, Indigenous mothers delayed accessing health services due to experiences of racism and discrimination, and the fear of child apprehension (Denison, Varcoe, & Browne, 2014). Indigenous women living in rural communities often have limited options for maternity care, which forces them to access mainstream birthing services (Varcoe, Brown, Calam, Harvey, & Tallio, 2013). Some birthing options included low-risk care by full- or part-time physicians with varied intrapartum skills. Women often had to give birth in nearby hospitals or health centres outside of their community or re-locate to an urban setting several weeks before delivery. In these settings, the women found being cared for by unfamiliar doctors who were often dismissive was distressing. Delivery options requiring travel were also often resource intensive and stressful without the support of family and community. The women felt that they had less control and fewer options in decision-making due to financial constraints. The destruction of traditional birthing practices through colonization, along with having few or no Elders with knowledge of cultural birthing customs, including Indigenous midwifery, hindered communities from passing on culture-specific birthing practices and teachings to the women (Varcoe et al., 2013).

In another study, Indigenous women completing breast cancer treatment believed that the absence of their traditional beliefs and recognition of Indigenous identity within health services made it difficult to address racism (Poudrier & Mac-Lean, 2009). In addition to Indigenous health seekers, Indigenous health service providers experience racism. Indigenous nurses in Atlantic Canada discussed the importance of understanding the interplay between race, racism, and the health service system. They believed that system-wide changes were needed to address the racism experienced by Indigenous nurses and patients (Vukic, Jesty, Mathews, & Etowa, 2012). They point to a lack of resources and policies to integrate cultural safety¹ into nursing training and practice, which made them afraid to speak up when they experienced or witnessed racism (Vukic et al., 2012). The deliberate and systematic erasure of Indigenous health and wellness practices and beliefs within health services has been critical in shaping racism (Denison et al., 2014; Varcoe et al., 2013; Vukic et al., 2012).

Similar to Canada, qualitative studies in the US have focused on health services use and access (Canales, 2004a; Canales, 2004b; Thackrah & Thompson, 2013; Vernon, 2007). Indigenous Peoples in the US are referred to as American Indian or Native American and we will use these terms to reflect the literature. A qualitative study of health service use and access by American Indian women living with HIV demonstrated a culture of treatment malpractice, poor treatment ethics, genderism, and racism (Vernon, 2007). An association between American Indian identity, health, and health service decision-making was shown to impact women's decisions about whether or not to access mammography and how to manage potential recurrences of breast cancer (Canales, 2004b; Canales & Geller, 2004). For example, their views on self-care and cultural practices influenced their decision to access cancer

¹ Cultural safety was developed as an outcome of nursing and midwifery education. Dr. Irihapeti M. Ramsden, a Ngai Tahupotiki and Rangitane (Maori of Aotearoa [New Zealand]) registered general and obstetric nurse in the 1960s, first conceptualized and defined the term. The concept of cultural safety asks: "How safe did the service recipient experience a service encounter in terms of being respected and assisted in having their cultural location, values, and preferences taken into account in the service encounter?" (Brascoupé & Waters, 2009, p. 9). Being culturally safe means going beyond cultural sensitivity and competency to include layers of commitment by a service provider, which includes self-reflection, taking a health advocacy role, and an awareness that the client has multiple realities that may conflict with a service providers' interventions (Brascoupé & Waters, 2009; Spence, 2001).

screening and cancer treatment. In some cases, their connection to culture increased their health service options and, as such, they engaged in both cultural and mainstream approaches without dilemma. Self-care was also critical in their decision to make the most of resources available to them. However, for some women, belief in both systems brought about confusion about how and whether to engage in both approaches. There were women who were adamant that only cultural healing approaches were required because of their belief in teachings and the toxicity associated with mainstream treatments. Financing health care was also an issue for women without health insurance; some women did not access health services for any health issue, others took care of minor health problems on their own to avoid medical bills, and some women incurred costs when more serious health concerns arose. Experiences of discrimination including classism and racism, as well as the experiences of friends and family, contributed to mistrust of the health service system, which impacted whether women followed the advice of their service providers (Canales, 2004a; Canales, 2004b; Canales & Geller, 2004). Racism also negatively affected Indigenous professionals who work in health service. Racism and a lack of understanding of Native American cultural practices and values were among the barriers to the retention and recruitment of American Indian and Alaska Native students in social work programs (Cross, Day, Gogliotti, & Pung, 2013).

Experiences of racism among Indigenous Peoples in New Zealand and Australia have been studied in the health service system and more broadly in society. When referring to these populations, the terms from the cited studies will be used. Quantitative population-based studies among Aboriginal Australians described self-reported racial discrimination (27%, $n = 7,000$) in the past year (2008-2009) (Cunningham & Paradies, 2013). Among people reporting any racial discrimination, 41 percent had experienced racist events in public settings, 40 percent in legal settings, and 30 percent in work settings. Self-reported racial discrimination was more frequently reported by respondents who had experienced forced removal from their family as a child, indicated low trust based on the statement “most people can be trusted,” were unemployed, and had a university degree (Cunningham & Paradies, 2013, p. 4). Respondents indicating Indigenous identity and engaging in Indigenous cultural activities reported more frequent racial discrimination (Cunningham & Paradies, 2013). Similarly, the New Zealand Health Survey administered to Maori people demonstrated that racism was a determinant of health (Harris, Cormack, & Stanley, 2013). Maori people who, based on their appearance, were identified by others as being Maori-only or another non-European ethnicity, either alone or in combination with European ancestry, had worse self-rated health and higher exposure to racial discrimination than those classified as European-only (Harris et al., 2013). Qualitative studies have found that racism negatively impacts the mental health of Aboriginal Australians (Paradies & Cunningham, 2012a, 2012b), and their access to and use of health services (DiGiacomo et al., 2013). In addition, some research has shown that investments in changing aspects of the health service system were ineffective in improving cultural safety. For example, a midwifery training program integrating an Aboriginal culture unit was largely unsuccessful in changing racist attitudes among first year students (Thackrah & Thompson, 2013). For Maori nurses, incidents of institutional racism occurred during training when their Maori beliefs were marginalized, and, in nursing practice, they were expected to answer all culture-based questions and justify cultural safety training (Huria, Cuddy, Lacey, & Pitama, 2014). Interpersonal racism also occurred. For example, clients undervalued their clinical skill because they were Maori, and their cultural skills were often seen as ineffective in delivering health services (Huria et al., 2014).

Given the historical similarities between Canada, the US, Australia, and New Zealand with regards to colonization, processes of devaluing Indigenous cultures, and the current state of Indigenous People's health and wellness, it is incomprehensible why racism outside of health service systems has not been described as a determinant of health. The literature on racism towards Indigenous people is sparse in Canada compared to the US, and even more so compared to Australia and New Zealand. Our research aimed to describe perceived and experienced individual, collective and institutional, and cultural racism in all societal systems (including, but not limited to, health services) as stressors in the lives of Indigenous women from two urban cities in Ontario, Canada.

Methodology

Study Design

Our findings are from of a larger three-phase study entitled: Linking Social and Basic Science to Understand Stress as a Social Indicator for the Lived Experiences of Indigenous Women and a Biological Indicator for the Physiological Impact of Stress on HIV Pathogenesis. Phase 1 consisted of defining stress among Indigenous women living with and without HIV; discussing and measuring stressors, including HIV; and discussing stress management and stress biomarkers. Phase 2 involved piloting stress-reducing strategies, including culturally grounded approaches. The last phase, which is in progress, involves measuring stress through scales and stress biomarkers in women engaging in a culturally grounded stress-reducing intervention. This article presents Phase 1 findings where racism was frequently discussed as a stressor.

A convergent transformative mixed-method research design was used to describe the discourse on racism as a stressor. Our qualitative research question was: "Can you describe stressful life experiences?" Experiences pertaining to racism were captured. Our quantitative research question was: "What are participants' racism scores on validated scales?" We focused on the Index of Race-Related Stress (IRRS)— Brief Version (B) (IRRS-B) and the Perceptions of Racism Scale (PRS). Our mixed-methods research question was: "How do Indigenous women's experiences of racism in Canada support or contrast racism scores measured by validated scales?" In this design, qualitative and quantitative data are provided equal value, collected in parallel, analyzed separately, and then merged to gain greater insight into racism experiences than would be obtained by either data type separately (Creswell & Plano, 2011).

Our research process followed a Two-Eyed Seeing approach, which "refers to learning to see from one eye with the strengths of Indigenous ways of knowing and doing, and from the other eye with the strengths of Western ways of knowing and doing . . . and learning to use both these eyes together, for the benefit of all" (Bartlett, Marshall, & Marshall, 2012, p. 5; see also Martin, 2012). Two-Eyed Seeing is a guiding principle shaping in a meaningful way how we think about the work we are doing, as well as a way to approach communication by continuously evaluating our assumptions and values (Martin, 2012). It is important to note that Two-Eyed Seeing is not a research methodology (personal communication Elder Albert Marshall), but it has been difficult to define outside of this academic terminology. Over time, continuous assessment of Two-Eyed Seeing has led to an evolution in our understanding of it as a profound guiding principle. It encourages self-reflection and recognizes that knowledge, which is alive spiritually and physically, is transformative (personal communication Elder Albert Marshall). Each research team member may describe their experiences with Two-Eyed Seeing

differently, as such, what follows are a few examples to reflect these differences. Some have viewed Two-Eyed Seeing as a methodology that uses Western and Indigenous research methods together. Others engaged in Two-Eyed Seeing by holding meetings with leaders from Indigenous HIV/AIDS service organizations to ensure the potential study outcomes are impactful to Indigenous women through continuous engagement among research team members and study participants. Research processes needed to serve the dual purpose of data collection and healing as well. For example, sharing circles (described below as a data collection method) were held to enable healing, growth, and transformation for study participants and discussion facilitators. Two-Eyed Seeing emphasizes the transformative nature of knowledge and our individual and collective roles in this transformation. Community-based research principles were also followed to engage communities throughout all research phases (Israel, Schulz, Parker, & Becker, 1998). Our Indigenous stakeholders were asked to be research team members because of their national and provincial leadership roles in Indigenous health and HIV/AIDS research and services. From the project's conception, Indigenous stakeholders were involved in envisioning a three-phase research study. Indigenous community members were hired to work on the project to mentor other team members, recruit study participants, administer questionnaires, facilitate focus groups, and conduct interviews. All study members were asked to contribute to data analysis and to the preparation of this manuscript as co-authors.

Sampling and Study Population

We followed purposive criterion sampling. Flyers were used to recruit study participants. Research assistants and community partners also assisted in recruiting participants through introducing the study in a safe space. Safe spaces were created by including reflections of Indigeneity (e.g., cultural activities were practiced and Indigenous staff with diverse identities were present), using private rooms, and not permitting any violence, including discrimination. Eligible participants were: (a) cis- or trans-women; (b) First Nation, Métis, or Inuk; (c) aged 18 or over; and (d) could read and/or write in French or English and (e) from Toronto or Thunder Bay, Ontario. Both cities were selected because one of the community partners has sites in both cities, and we have Indigenous and non-Indigenous research team members who live and conduct Indigenous health research in Toronto and Thunder Bay. It is important to note that Thunder Bay has the highest proportion of Indigenous people in Canada (Statistics Canada, 2017b) and has been reported to have the highest rates of hate crimes in Canada (Statistics Canada, 2017a). Women living with and without HIV were recruited. Our study was reviewed by the Women's College Research Institute Ethics Review Board, Toronto, Ontario. Participants provided verbal and written informed consent prior to beginning study procedures.

Data Collection

All study participants completed an interviewer-administered questionnaire and were asked to participate in sharing circles or interviews; a third of the participants accepted. Sharing circles were held separately for women living with HIV and one-on-one interviews were also conducted for those requesting more confidentiality and privacy.

Quantitative data was collected from 90 women (30 women living with and 60 without HIV) using a socio-demographic questionnaire and two racism scales. The sample size was selected to ensure subsequent phases of the project were feasible. Stress related to racism was measured with the IRRS-B

(Utsey, 1999; Utsey & Ponterotto, 1996). The IRRS-B is a 22-item multidimensional scale of four subscales (cultural, collective, institutional, and individual). Cultural racism reflects experiences of one's culture being denigrated or maligned. Collective racism includes the organized efforts of White people to restrict the rights of ethnic minorities. Institutional racism is embedded in the discriminatory policies and practices of a given institution. Individual racism measures racism on an interpersonal level. Each item is rated on a 5-point scale ranging from 0 to 88 where 0 indicates *this has never happened to me* and 4 indicates *this happened and I was extremely upset* (Utsey, 1999; Utsey & Ponterotto, 1996). High total scores representing global racism indicate greater experiences of racism. The scale's strong psychometric properties have been assessed in African American women and the authors have stated it can be adapted to other non-White populations (Greb et al., 2012; Utsey, 1999; Utsey & Ponterotto, 1996). We calculated a Cronbach's alpha of 0.90 for global racism. The Cronbach alphas were: 0.83 for cultural, 0.82 for individual, and 0.89 for the collective and institutional racism domains. The PRS was used to assess racism from health service providers and society in general (Green, 1995). Racism perceptions are divided into affective, behavioural, and cognitive categories and measured using a 20-item scale rating. Participants rated each item on a 4-point scale with 1 indicating *strongly agree* and 4 *strongly disagree* (Green, 1995). The score ranges from 20 to 80 with high scores indicating stronger perceptions of racism. The scale was developed to assess racism perceptions by African American women and its psychometric properties were strong (Greb et al., 2012; Green, 1995). We calculated a Cronbach's alpha of 0.75. In order to maintain rigor in the quantitative data analysis, the scales selected have been evaluated for their psychometric properties in women (Greb et al., 2012; Green, 1995; Utsey, 1999; Utsey & Ponterotto, 1996).

Qualitative data was collected through in-depth semi-structured interviews and sharing circles, with interviews lasting one and a half hours and sharing circles lasting two hours. Sharing circles engage women in discussions similar to focus groups, but with ceremony and other Indigenous practices determined by a Knowledge Keeper (Lavallee, 2009; Rothe, Ozegovic, & Carroll, 2009). Four circles were held. Two were with HIV-negative women ($n = 6$ and $n = 11$, respectively) and two were with women living with HIV ($n = 4$ and $n = 2$, respectively). Seven interviews were held with women living with HIV. Our study yielded 11 transcripts (277 pages). The sample size was based on data saturation and suggested sizes from the literature (Creswell, 1998; Weiss, 1994).

Data Analysis

For the quantitative data analysis, baseline socio-demographic characteristics were presented as frequencies and proportions for categorical variables. The p values for the comparisons between women living with HIV and without HIV were determined using the Fischer's exact test. Rows with frequencies less than five were suppressed. Medians and interquartile ranges (IQR) described continuous variables and the p values for the comparisons between each group of women were calculated using the Wilcoxon rank test. For all scales, items were summed and presented as continuous and p values calculated for the comparisons between each group of women for each racism category using Wilcoxon rank test. We conducted linear regression analysis to calculate unadjusted estimates (UE) and adjusted estimates (AE) along with 95% confidence intervals (CI) to identify covariates of the IRSS-B domains. Significant covariates ($p < 0.1$) in the unadjusted models and the a priori variables: HIV, age, and income (Cunningham & Paradies, 2013) were candidates for multiple regression analysis. Statistical analyses were performed using SAS Statistical Software (Version 9.4).

For qualitative data, discussions were audio-recorded and transcribed with personal identifying information removed, while information relevant to experiences of racism was preserved. The data were analyzed through thematic analysis (Braun & Clarke, 2006). Multiple coders finalized and re-evaluated the themes to establish reliability of the qualitative strand. A validity check of the Phase 1 findings was conducted in Phase 2 through sharing circles. One sharing circle was conducted for study participants living with HIV, and another for HIV-negative women, generating two transcripts.

Data Integration

The quantitative data from the IRRS-B and the qualitative data from the sharing circles and interviews were compared and integrated (Li, Marquart, & Zercher, 2000). This form of integration reflects triangulation for corroboration between the sets of data (Creswell & Plano, 2011; O’Cathain, Murphy, & Nicholl, 2010). IRRS-B cultural, individual, and collective and institutional racism domains were used to categorize themes. The percentage of individuals experiencing racist events from each domain was also described. Also, covariates identified in the regression analysis were compared and contrasted to the themes and keywords from the qualitative data.

Results

Participant Characteristics

Of the 90 women (including trans women, $n < 5$) enrolled in the study, 60 women were HIV-negative and 30 were living with HIV. We did not conduct a separate analysis for the trans women because of the small sample size, which raises confidentiality issues and makes it difficult to conduct descriptive statistical analyses. The median age at interview was 40 [IQR: 29 - 46] for HIV-negative women and 42 [IQR: 38 - 49] for women living with HIV. Overall, 92 percent ($n = 55$) of HIV-negative women and 73 percent ($n = 22$) of women living with HIV identified as First Nations ($p = 0.02$). Participant characteristics are summarized in Table 1.

Quantitative Analysis: IRRS-B and PRS

Out of the 90 women who were asked to complete the IRRS-B scale, 83 (92%) responded to all questions. Of the 60 HIV-negative women, two women did not complete any of the questions so they were excluded from the analysis. Five women did not complete all of the questions: two women had seven missing questions, one had three, and two had one missing question. The 30 women living with HIV completed all of the questions. IRRS-B scores were imputed for unanswered questions by calculating the mean value of non-missing answers. The median IRRS-B score for HIV-negative women was 55.5 [IQR: 42.9 - 71.2] and 50.0 [IQR: 40.5 - 56.5] for women living with HIV ($p = 0.08$; Table 2).

Table 1. Characteristics of Study Participants and Group Comparisons by HIV Status

| | | All (<i>n</i> = 90) | Without HIV (<i>n</i> = 60) | With HIV (<i>n</i> = 30) | |
|---------------------------------|-------------------------------------|-------------------------|------------------------------------|------------------------------|-------------|
| | | <i>n</i> (%) | <i>n</i> (%) | <i>n</i> (%) | <i>p</i> |
| Age at interview | ≤ 35 years | 31 (33) | 26 (44) | 5 (17) | 0.03 |
| | 36 - 45 years | 28 (30) | 15 (25) | 13 (43) | |
| | > 45 years | 30 (37) | 18 (30) | 12 (40) | |
| Indigenous group | First Nations | 77 (86) | 55 (92) | 22 (73) | 0.02 |
| | Inuit, Métis, or other | 13 (14) | 5 (8) | 8 (27) | |
| Education | Grade 1 - 8 | <i>n</i> (10) | <i>n</i> (7) | <i>n</i> (17) | 0.13 |
| | Grade 9 - 12/13 | 45 (51) | 28 (47) | 17 (57) | |
| | Some college or university | 35 (39) | 27 (45) | 8 (27) | |
| Employment | Employed | <i>n</i> (22) | <i>n</i> (27) | <i>n</i> (13) | 0.15 |
| | Unemployed | 70 (78) | 44 (73) | 26 (87) | |
| Annual income | ≤ \$20,000 | 70 (80) | 46 (79) | 24 (83) | 0.70 |
| | > \$20,000 | 17 (20) | 12 (21) | 5 (17) | |
| Living status | Alone | 28 (31) | 13 (22) | 15 (50) | 0.01 |
| | Family, friend, or partner | 46 (51) | 33 (55) | 13 (43) | |
| | No permanent residence ^a | <i>n</i> (18) | <i>n</i> (23) | <i>n</i> (7) | |
| Sexual orientation | Heterosexual | 68 (76) | 46 (78) | 22 (73) | 0.63 |
| | Bisexual or two-spirit ^b | 21 (24) | 13 (22) | 8 (27) | |
| Cultural or spiritual practices | No | 34 (40) | 26 (43) | 14 (47) | 0.76 |
| | Yes | 51 (60) | 34 (57) | 16 (53) | |
| Marijuana use | No | 39 (44) | 28 (47) | 11 (37) | 0.21 |
| | ≤ 2 joints/day | 30 (34) | 21 (36) | 9 (30) | |
| | > 2 joints/day | 20 (22) | 10 (17) | 10 (33) | |
| Injection drug use | Never | 41 (48) | 34 (58) | 7 (25) | 0.01 |
| | ≤ 1 month ago | 16 (19) | 9 (16) | 7 (25) | |
| | ≥ 1 year ago | 29 (34) | 15 (26) | 14 (50) | |

Table 1. Characteristics of Study Participants (continued)

| | | All (<i>n</i> = 90) | Without HIV (<i>n</i> = 60) | With HIV (<i>n</i> = 30) | |
|-------------------------------------|---------------------|-------------------------|------------------------------------|------------------------------|----------|
| | | <i>n</i> (%) | <i>n</i> (%) | <i>n</i> (%) | <i>p</i> |
| Other illicit drug use ^c | Never | 21 (33) | 14 (33) | 7 (33) | 0.91 |
| | ≤ 1 month ago | 22 (35) | 14 (33) | 8 (38) | |
| | ≥ 1 year ago | 20 (32) | 14 (33) | 6 (29) | |
| Alcohol use (past 30 days) | Never | 28 (31) | 19 (32) | 9 (30) | 0.66 |
| | 1 - 7 times a week | 25 (28) | 18 (31) | 7 (23) | |
| | 1 - 3 times a month | 36 (40) | 22 (37) | 14 (47) | |
| Co-morbidities | Hepatitis C | 21 (28) | 9 (18) | 12 (52) | <0.01 |
| | Depression | 52 (70) | 36 (70) | 16 (70) | 0.93 |
| | Anxiety | 52 (70) | 36 (70) | 16 (70) | 0.93 |
| | Other ^d | 34 (46) | 26 (51) | 8 (35) | 0.19 |

Note. *n* = value suppressed because the frequency in the category is less than 5. Statistical comparisons between HIV status groups were calculated using Fischer's exact test for categorical variables and the Wilcoxon rank test for continuous variables.

^aNo permanent residence includes living in supportive housing, shelter, or temporarily with family, a partner, a friend, or a roommate. ^bTwo-spirit was an answer to the "other, please specify" option for sexual orientation. Two-spirit refers to the gender of Indigenous people carrying a male and female spirit who historically were visionaries, healers, and medicine people. Although contemporary practice is to consider two-spirit as a gender, some people occasionally use it to describe their sexual identity (Robinson, 2017). ^cOther illicit drug use includes smoking, inhaling, or orally taking drugs. ^dOther co-morbidities includes bipolar disorder, asthma, cancer, diabetes, hypertension, or post-traumatic stress disorder.

Table 2. Overview of Racism Scale Scores

| | All | Without HIV | With HIV | <i>p</i> |
|---------------------------------------|--------------------|--------------------|--------------------|--------------|
| | Median (IQR) | Median (IQR) | Median (IQR) | |
| Perceptions of Racism Scale (PRS) | 45.0 (40.0 - 49.5) | 44.5 (40.0 - 48.0) | 47.5 (41.0 - 50.0) | 0.08 |
| Index of Race-Related Stress (IRRS-B) | | | | |
| Individual racism | 15.0 (10.0 - 20.0) | 15.0 (10.0 - 20.2) | 14.5 (9.0 - 20.0) | 0.53 |
| Collective and institutional racism | 14.0 (9.0 - 19.8) | 13.0 (8.8 - 19.2) | 14.0 (9.0 - 22.0) | 0.38 |
| Cultural racism | 24.5 (19.0 - 32.8) | 28.5 (21.0 - 34.0) | 22.0 (18.8 - 27.2) | 0.003 |
| Global racism | 51.0 (42.0 - 68.5) | 55.5 (42.9 - 71.2) | 50.0 (40.5 - 56.5) | 0.08 |

Note. IRRS-B scores range between 0 and 88 where high scores indicate greater experiences of racism. PRS scores range from 20 to 80 where high scores indicate higher perceptions of racism.

The individual racism domain score was 15.0 [IQR: 10.0 - 20.2] and 14.5 [IQR: 9.0 - 20.0] for women living without and with HIV, respectively ($p = 0.53$). The collective and institutional racism domain score was 13.0 [IQR: 8.8 - 19.2] and 14.0 [IQR: 9.0 - 22.0] for women living without and with HIV, respectively ($p = 0.38$). The cultural racism score was 28.5 [IQR: 21.0 - 34.0] for HIV-negative women and 22.0 [IQR: 18.8 - 27.2] for women living with HIV ($p = 0.003$). All women experienced at least one racist event, which resulted in at least one item on the IRRS-B scale having a score greater than 0 (Table not shown).

Of the 90 women completing the PRS, 88 (98%) completed some or all of the questions. The majority of women, 78 (87%) responded to all questions. Of the 60 HIV-negative women, two did not complete any questions and were excluded from the analysis. Among the 58 remaining women, 10 had less than complete data. One woman had nine missing questions, one had five, two had two, and six had one question missing. Of the 30 women living with HIV, 28 completed all questions and two had one missing question each. PRS scores were imputed for missing questions as previously described. The median PRS score for HIV-negative women was 44.5 [IQR: 40.0 - 48.0] and 47.5 [IQR: 41.0 - 50.0] for women living with HIV ($p = 0.08$; Table 2). All women had at least one perceived racism experience (Table not shown).

Linear Regression Analysis

The variable associated with individual racism, injection drug use equal to or more than one year ago (UE 2.91, 95% CI: 0.13 - 5.70), was not significant after adjustment (Table 3). Correlates associated with collective and institutional racism (injection drug use ≥ 1 year ago, UE 5.03, 95% CI: 2.05 - 8.01) and cultural racism (HIV-negative, UE 5.32, 95% CI: 1.86 - 8.78) remained significant after adjustment (injection drug use ≥ 1 year, AE 3.64, 95% CI: 0.21 - 7.06; HIV-negative, AE 5.23, 95% CI: 0.96 - 9.50).

Table 3. Unadjusted (UE) and Adjusted Linear Regression Estimates (AE) of Variables Associated with Individual, Collective and Institutional, and Cultural Racism

| | | Individual | | Collective and Institutional | | Cultural | |
|--|----------------|---|---|---|--|---|---|
| | | UE | AE | UE | AE | UE | AE |
| | | (95% CI) | (95% CI) | (95% CI) | (95% CI) | (95% CI) | (95% CI) |
| | | <i>p</i> | <i>p</i> | <i>p</i> | <i>p</i> | <i>p</i> | <i>p</i> |
| HIV (<i>ref.</i> = Positive) | Negative | 0.83 (-1.77, 3.43) <i>p</i> = 0.53 | 1.72 (-1.33, 4.77) <i>p</i> = 0.26 | -1.26 (-4.13, 1.61) <i>p</i> = 0.38 | -0.29 (-3.70, 3.12) <i>p</i> = 0.86 | 5.32 (1.86, 8.78) <i>p</i> = 0.003 | 5.23 (0.96, 9.50) <i>p</i> = 0.02 |
| Cultural practices (<i>ref.</i> = No) | Yes | 2.31 (-0.14, 4.75) <i>p</i> = 0.06 | 1.62 (-1.00, 4.24) <i>p</i> = 0.22 | 2.03 (-0.69, 4.76) <i>p</i> = 0.14 | 2.26 (-0.67, 5.19) <i>p</i> = 0.13 | 1.92 (-1.53, 5.39) <i>p</i> = 0.27 | 1.03 (-2.64, 4.70) <i>p</i> = 0.58 |
| Marijuana use (<i>ref.</i> = No) | ≤ 2 joints/day | 2.19 (-0.59, 4.07) <i>p</i> = 0.12 | 2.08 (-0.91, 5.08) <i>p</i> = 0.17 | 2.57 (-0.53, 5.67) <i>p</i> = 0.10 | 2.42 (-0.93, 5.76) <i>p</i> = 0.15 | 3.60 (-0.29, 7.50) <i>p</i> = 0.07 | 4.04 (-0.15, 8.22) <i>p</i> = 0.06 |
| | > 2 joints/day | -1.20 (-4.31, 1.92) <i>p</i> = 0.45 | -1.68 (-5.28, 1.92) <i>p</i> = 0.35 | -0.40 (-3.87, 3.08) <i>p</i> = 0.82 | -0.11 (-4.14, 3.91) <i>p</i> = 0.96 | -0.52 (-4.89, 3.84) <i>p</i> = 0.81 | -0.90 (-5.94, 4.14) <i>p</i> = 0.72 |
| Injection drug use (<i>ref.</i> = Never) | ≤ 1 month ago | 2.94 (-0.43, 6.32) <i>p</i> = 0.09 | 1.41 (-2.26, 5.07) <i>p</i> = 0.44 | 3.05 (-0.56, 6.66) <i>p</i> = 0.10 | 2.13 (-1.96, 6.23) <i>p</i> = 0.30 | 1.71 (-3.12, 6.54) <i>p</i> = 0.48 | 1.58 (-3.55, 6.72) <i>p</i> = 0.54 |
| | ≥ 1 year ago | 2.91 (0.13, 5.70) <i>p</i> = 0.04 | 2.09 (-0.98, 5.16) <i>p</i> = 0.18 | 5.03 (2.05, 8.01) <i>p</i> = 0.001 | 3.64 (0.21, 7.06) <i>p</i> = 0.04 | 1.78 (-2.20, 5.77) <i>p</i> = 0.38 | 1.63 (-2.67, 5.92) <i>p</i> = 0.45 |

Table 3. Unadjusted (UE) and Adjusted Linear Regression Estimates (AE) of Variables Associated with Individual, Collective and Institutional, and Cultural Racism (continued)

| | | Individual | | Collective and Institutional | | Cultural | |
|---------------------------------------|------------|--|--|--|--|--|--|
| | | UE | AE | UE | AE | UE | AE |
| | | (95% CI) | (95% CI) | (95% CI) | (95% CI) | (95% CI) | (95% CI) |
| | | <i>p</i> | <i>p</i> | <i>p</i> | <i>p</i> | <i>p</i> | <i>p</i> |
| Co-morbidities (<i>ref.</i> = No) | Depression | 1.91 (-0.91, 4.72) <i>p</i> = 0.18 | 1.47 (-1.43, 4.38) <i>P</i> = 0.31 | 1.99 (-1.24, 5.22) <i>p</i> = 0.22 | 1.48 (-1.76, 4.72) <i>p</i> = 0.36 | 3.89 (-0.12, 7.90) <i>p</i> = 0.06 | 2.96 (-1.10, 7.02) <i>p</i> = 0.15 |
| | Anxiety | 1.61 (-1.22, 4.44) <i>p</i> = 0.26 | 1.29 (-1.56, 4.14) <i>p</i> = 0.37 | 2.93 (-0.26, 6.11) <i>p</i> = 0.07 | 2.91 (-0.27, 6.09) <i>p</i> = 0.07 | 2.21 (-1.86, 6.30) <i>p</i> = 0.28 | 1.67 (-2.31, 5.66) <i>p</i> = 0.40 |

Note. Unadjusted models included HIV status, age at interview, Indigenous group, income, sexual orientation, cultural practices, marijuana use, injection drug use, other illicit drug use, alcohol use last 30 days, and co-morbidities. Variables of interest (HIV, age at interview, and income) and those with a *p* value < 0.1 in the unadjusted models were included in the adjusted model. Education, employment, and living status were not included in the analysis due to small sample sizes (< 5) in some categories. Statistically significant values are in bold.

Qualitative Analysis: Sharing Circles and Interviews

Several themes around racism concerning past and current events were described. Past events were directly linked to colonial activities and policies such as the Sixties Scoop, the Indian Act, and Indian Residential Schools. Current events related to the inherited outcomes of colonialism that focused on inadequate health services, socio-economic insecurity, negative stereotypes and judgements, and a lack of recognition of Indigenous knowledge systems. We further categorized and described these racism events based on the IRRS-B domains.

Individual racism. The individual racism domain assessed racism on an interpersonal level. While shopping, one woman described being treated like a thief by a store employee:

And then going shopping, people just watching you. And I'm like, one day I said, listen, I'm going into Aisle 5 right now, if somebody wants to follow me.

Another woman described harassment and violence as a consequence of being Indigenous:

When I was growing up, I got beat a lot from other kids just because of how I looked. I didn't look like the other kids. I used to get picked on, especially, more in the summertime when I got really dark.

Individual perceived racism was lower when surrounded by individuals that were also non-White:

Yeah 'cause I live around lots of Black people, lots of Latinos and I feel like nobody bothers me anyway because I'm Native, but let's say I was living in [location] or [location], I would be really stereotyped, really bothered and probably not even served as much as I am down there.

It is important to acknowledge that some participants also expressed anger or discriminatory attitudes toward individuals presenting as White and non-White. The participants perceived that these individuals felt superior to Indigenous people.

Collective and institutional racism: The collective and institutional racism domain is a combined measure of racism. Institutional racism is embedded in the policies and practices of a given institution. Collective racism reflected the organized efforts of White people to restrict the rights of Indigenous people. A major concern for participants was housing security. Overcoming barriers to secure housing seemed to be insurmountable, as was employment security. Feelings of anger, frustration, and worry were common. Below are quotes from four individuals:

I've gone looking for housing, and because of who I am, an Aboriginal, they say, "Oh, we just gave the apartment away." And meanwhile I go back and they say, "Still apartment available, vacancy available." And that pisses me off . . .

Right now, I'm kind of angry about it because one day I went to 10 different buildings and 10 different doors were slammed in my face. Yeah, and that really angered me.

[Referring to finding a home because the participant will soon be homeless.] Yeah, a nice little house or an apartment. That stresses me out because a lot of landlords or owners have so much racism towards Aboriginals or Inuit, Métis, all nations, and are racist towards us. This is what stresses me out is to find a home, to find a home or an apartment to try to live alone and not get stressed out by other issues that we're going through.

When you're out looking for work and you're competing against younger women and, in particular White younger women, there's a lot of judgement.

Racism in the health service setting was also described. One woman explained how she felt ignored:

I was at the doctor's office, I dislocated my arm, and they kept putting my chart down, and my son was waiting for me at home, at his place, and it was like, oh my god, my son is waiting for me, why are these people putting my chart down to the bottom? I've been waiting like everybody else, how come they keep putting my chart down? That pissed me off. I put my arm back into place and I walked out. That's crazy, I shouldn't have had to do that.

Although some experiences can be considered perceived racism, many discussions highlighted overt racist experiences, particularly for cultural racism.

Cultural racism. Cultural racism describes experiences in which one's culture is denigrated or maligned and believed to be inferior to other cultures by both individuals and institutions. The quotes below focused on experiences related to the Sixties Scoop, Indian Act, Indian Residential Schools, and the outcomes of colonization. The quote below described the invisibility of some Indigenous people in the city and how acknowledgement can assist them by being perceived as valuable and estimable. The undertone of the discussion alluded to their lower perceived worth compared to members of the dominant society. Strategies to move on from racist events were also described:

Just being an Aboriginal woman, especially in Canada, I've never experienced racism or anything like that . . . I noticed it. Well, maybe as a little kid. I grew up in a White community because I was part of the Sixties Scoop and got adopted by a White family. So I was discriminated earlier, but it didn't really bother me too much because of how I grew up and what I experienced. I learned to shut down. I learned to shut down and not deal with nothing. So if anything did happen to me, I just took that attitude. And then when I came here and I seen what was happening with the Natives and how they were treated. And one of the teachings I got from the Elder he said, "You know what? When you see your brother and sister on the street, acknowledge them even if they're lying on the ground or they're drunk, acknowledge them." I don't care. I acknowledge all the time. You never walk by them and act like they don't exist because that's what's been happening for our whole existence that we don't exist. And if you acknowledge everybody, then it makes that person say, "Hey, I am somebody." And I do this to help people because it helps me.

Stories similar to the one above about being adopted and placed in non-Indigenous families or being removed and placed in foster care were common. The Sixties Scoop, a widespread policy in Canada of removing Indigenous children from their families and communities and placing them with non-Indigenous families, was discontinued in the mid-eighties and contributed to the loss of cultural

knowledge and cultural practices within communities and families. It also exposed many Indigenous children to abuse and violence. One woman recounted how she was not only removed from her family, but also how her mother lost her Indian Status² by marrying a White man:

I was put into care very young, having a father that was Scottish and Aboriginal, a mother that was Aboriginal, and him being military and her [Indian] Status being taken and us being taken.

Another woman alluded to culture loss due to her grandmother attending an Indian Residential School. Throughout much of Canada's history, Indigenous teachings and cultural practices were outlawed and were not valued for their role in Indigenous Peoples' wellbeing:

There's a lot of things like from my past that I need to forgive myself or others for and I feel like that has uhmm I guess created a loss in some ways of my culture because I'm just getting back into a lot of traditional stuff and because my life was impacted by my grandmother going to residential school so we missed out on a lot of traditional teachings.

Participants expressed their distrust of children's aid societies, and their belief that children's aid societies implement a different set of rules for Indigenous mothers than for White mothers. These concerns are expressed in the following quotation:

She still has her kids, she's White and she still has her [expletive] kids, excuse my language. It just set me right off, thinking, she's been an ongoing addict for like seven years. These children all look like under the age of eight, she had three, she still had them.

Finally, Indigenous women recognized that when they were not treated as if they were invisible, they were working to undo the negative stereotypes about Indigenous women. The lack of knowledge about Indigenous Peoples and their knowledge systems in mainstream society has allowed negative beliefs about Indigenous women to persist. Many settlers, as well as some Indigenous people, are ignorant of the important roles, including as mothers and bearers of children, many Indigenous women once held in their communities:

[Being the ideal mother] I was too busy trying to be perfect because all I had heard was that Native women were whores and drunks so I went out of my way to make sure my children were well dressed and I did whatever I had to do to make sure they got what they wanted, but I didn't do things the right way you know teaching and stuff like that so I screwed up a lot as a mother . . . When I see kids doing normal things and even though the kids don't look happy, they're going to soccer and the moms are driving them. Mother is present . . . To get over something you have to be able to forgive yourself. Right? I did so many things with my children I can't forgive. My children say, "Mom don't worry about it."

² The term *Status Indian* refers to a First Nations individual who is registered with the federal government or a band that has signed a treaty with the Crown. First Nations women were discriminated against by having their Indian Status removed if they married a man without Indian Status, which also resulted in their descendants losing their Status. This process occurred from 1951 to 1985.

Another woman recounted how as a young child any behaviour deemed unacceptable, referred to as “stupid things,” was due to her Indigenous ancestry, whereas her European ancestry was associated with “good things”:

My foster mother used to put me down all the time, if I did what like she called stupid things, that was the Indian in me and, when I did really good things, that was the French in me.

Data Integration

The qualitative and quantitative data strands were integrated. Individual racism from the qualitative data included experiences of being harassed and abused. A greater diversity of racist events were reflected in the quantitative IRRS-B data. Overall, 73 percent of the women living with and 78 percent living without HIV stated that they had been treated with a lack of respect in multiple spaces (e.g., store, restaurant), which included being treated like they did not belong, were not intelligent enough to understand information, and could not afford certain items.

Collective and institutional racism was reflected in the qualitative and quantitative data. Racist events linked to employment and housing were found in both strands; in contrast to health services, which was reflected in the qualitative data only. However, questions around health services were not specifically asked. Key words captured in the quantitative data related to persons of authority (e.g., police, employers) treating Indigenous females poorly. Diverse racist events were captured through the quantitative data with 65 percent of women living with and without HIV having been assaulted or threatened with violence, denied opportunities, and/or told they should accept crimes as part of being Indigenous.

In assessing cultural racism, the qualitative data was supported by the quantitative data. Cultural racism was the most salient form of racism experienced. Stereotypes and associated behaviours regarding Indigenous ethnicity and Indigenous female identity were described in the qualitative data. The data focused on the intergenerational impact of the Sixties Scoop, Indian Act, and Indian Residential Schools. A greater diversity of key words were captured in the quantitative data, including how society portrayed Indigenous Peoples and the judgement associated with this portrayal. Cultural racism was described by 70 percent and 86 percent of the women living with and without HIV, respectively. Although HIV-negative women had a higher frequency of cultural racism, similar racism themes were identified in the qualitative data for both groups of participants.

The PRS is a single-dimensional racism measure useful for assessing perceptions of racism in health services (Green, 1995). Given the limited accounts of racist events in health services in the qualitative data, we did not complete a comparison with the PRS items.

Discussion

We found that Indigenous women experience challenges in securing socio-economic stability and are frequently exposed to interpersonal racism. The intergenerational impact of colonialism through cultural racism has a crucial impact on these women’s life stories as they navigate systemic barriers. Racism research regarding Indigenous women in Canada has largely focused on health status, particularly health service access, through qualitative research (Allan & Smylie, 2015; Browne, 2017;

Browne & Fiske, 2001; Denison et al., 2014; Poudrier & Mac-Lean, 2009; Varcoe et al., 2013; Vukic et al., 2012). There has been limited use of quantitative research tools, such as validated racism scales. A mixed methods research approach for describing racist events experienced by Indigenous women in Thunder Bay and Toronto, Ontario, has enabled us to explore racism in different contexts. In an effort to engage in meaningful discussions about racist events, a scale describing multiple acts of racial discrimination has been valuable in providing a broader representation of these experiences. The scale also highlighted experiences of racism that were not reported during qualitative discussions. In contrast, the qualitative data provided context for the women's experiences of racism, which was linked to colonialism and policies that define and control Indigenous populations in Canada.

Individual racism, which is also called interpersonal racism, has largely been neglected in the literature as part of the discourse on what perpetuates inequities at the macro level. A study showed that chronic and persistent everyday exposure to negative race-based treatment adversely impacted physical health even more so than overt acts of discrimination (Williams, Yu, Jackson, & Anderson, 1997). More recently, a study with Aboriginal Australians showed that racially based treatment was not different when adjusting for sex, employment, or education status, suggesting racism was part of their daily interactions (Larson, Gillies, Howard, & Coffin, 2007). This was similar to findings for African Americans who also experienced daily interpersonal racism (Barnes et al., 2004; Deitch et al., 2004). Larson et al. (2007) stated that physical health was associated with interpersonal racism and cautioned that measures of chronic racism, not acute racism, were more consistently associated with health. A study with a Cree First Nation community showed that interpersonal racism was associated with diagnoses of depression after adjusting for confounders, and the odds of having depression increased with more incidences of interpersonal racism (Janzen et al., 2017). A study in Kettle and Stony Point First Nation, Ontario, determined that perceived stress was positively associated with interpersonal racism, which was modestly impacted by cultural resilience (Spence, Wells, Graham, & George, 2016). In our study, most participants reported poor health outcomes, but we did not find associations between health outcomes or health behaviours, including cultural practices, with individual racism. Our sample size may not have allowed us to assess small but meaningful differences, even if our population was homogenous in terms of their characteristics, with the exception of HIV diagnosis. We did not investigate an exhaustive list of health behaviours and outcomes or do a longitudinal analysis. We only captured racism experiences through respondents' recollection of events. As such, measuring experiences of chronic racism and health status at a single point in time may not lead to the same findings as repeatedly measuring racism over time and observing associated variations in health. Individual racism experienced within relationships or communications between people can be captured in the other IRRS-B domains, particularly collective and institutional racism. Racism at the micro-level would be more limited in its impact or more challenging to perpetuate if racist beliefs were not ingrained in and supported by the macro-level. For example, interpersonal racism is perpetuated by health service providers who dismiss Indigenous Peoples' chronic pain because of racial stereotypes that say Indigenous people misuse pain medication, for example. In the absence of institution-wide policies on cultural safety training, institutional racism enables these stereotypes to persist.

Institutional and collective racism often focuses on differences in socio-economic status between groups, which is consistent with some of the discourse in our study. We focused on exploring racism within an Indigenous context, not in comparison to other racialized groupings, so we cannot say how Indigenous people's experiences compare to other racial minority groups. Racist events discussed in the sharing

circles and interviews were largely related to housing and employment. The validity check discussions further emphasized racism as a barrier to achieving socio-economic stability. In the qualitative component of our study, accessing health services was only mentioned once. This may be because our questions did not focus specifically on health service systems or were too broad, or it could be that health service systems were not the most pressing concern for the participants. Alternatively, the lack of discussion on this topic during sharing circles could be because participants may have mainly elaborated and built on topics discussed by other participants, and the issue of health services was not raised. It is important to note that perceived racism was high in the PRS, which measures racism experiences in health services. The literature suggests that racism experiences largely occur in hospital settings, a finding which has been supported in the case of First Nations women (Browne & Fiske, 2001; Shah, Gunraj, & Hux, 2003; Wood & Kerr, 2006). Another topic not discussed in our sharing circles was injection drug use and its impact on accessing services or attaining socio-economic stability. Our linear regression analysis showed that past injection drug use (at least a year ago) was associated with collective and institutional racism, and our descriptive table showed a higher frequency of injection drug use among study participants living with HIV. Injection drug use may have been avoided as a topic because of stigma related to it and the socio-economic challenges it can generate. It may also have been a past activity that they wanted to leave in the past.

From a qualitative perspective, themes around cultural racism were not different for women living with and without HIV. Unlike the IRSS-B cultural racism items, the qualitative data captured the depth of the women's racism experiences, including the systematic and systemic devaluation of Indigenous cultures in Canada. However, cultural racism in the IRSS-B was statistically significant for HIV-negative Indigenous women compared to women living with HIV. It may be that women living with HIV were being discriminated against for other reasons (e.g., injection drugs use, co-morbidities) that may have a profound effect on their lives. A study suggested that being Indigenous, using illicit substances, and living in poverty were associated with stereotypes and stigmas that shaped Indigenous Peoples' negative interactions with health service providers (Goodman et al., 2017). Goodman et al. (2017) also highlighted the exclusion of Indigenous healing approaches and the lack of historical knowledge about the roots of Indigenous health inequities within health service settings as significant in shaping cultural racism. Cultural racism, in turn, contributed to Indigenous people avoiding or having invalidating health service encounters. Our study further suggests that HIV-negative women may be more likely to be racially socialized, a process through which people come to identify as a member of a particular racial group. As a result, they may have developed higher levels of cultural pride, but may also see their community as having less strength. In either case, HIV-negative women have been found to be more likely to perceive racial discrimination (Boykin & Toms, 1985).

Internalized racism was not explicitly measured in the scales, but it was captured in the participants' comments regarding stereotypes. Some participants appeared to have internalized negative racial stereotypes as a result of the individual racism and institutional and collective racism they experienced (Wyatt et al., 2003). These internalized stereotypes may also cause adverse mental health outcomes, including low self-esteem, depression, and hostility (Wyatt et al., 2003). In our study, women reported poor mental health outcomes (see also Benoit et al., 2016) but, in our analysis, we did not examine pathways between mental health outcomes and forms of racial discrimination.

Racism impacts individual and community development, including the social position and acceptance of individuals in their communities and society; opportunities for self-determination in achieving socio-economic stability and health and wellness; and freedom of cultural expression. Clark et al. (1999) noted that inter- and intra-ethnic group racism are significant stressors for African Americans that may exert significant influence on wellbeing (Clark et al., 1999). If racism is a stressor, then biopsychosocial sequelae and coping responses may in part contribute to inequitable health outcome status. Thus, for Indigenous Peoples, racism as a stressor and its expression while living with chronic and acute stressful life experiences also needs consideration as an immediate biological determinant of health. Racism is a learned behaviour that is passed down through social stereotypes; as such, it is a determinant of health that we can collectively work to eliminate for the improvement of Indigenous Peoples' and other racialized groups' health.

There are other considerations that we did not include in our data interpretation. Some of the racist events were layered with other simultaneously occurring events; therefore, at times, events could have been categorized differently. We categorized events via the general message of the event, group discussions, and co-author feedback. Intersecting identities, although not discussed in our manuscript, were mentioned by multiple women, and the discrimination that accompanies some of those identities did contribute to the different layers in the racist events. Goodman et al. (2017) showed that Indigenous Peoples' intersecting identities (i.e., race, socio-economic status, and substance use) shaped their health service experiences, and racialized stereotypes influenced health service provider perceptions (Goodman et al., 2017). Therefore, intersecting identities that are associated with negative labels may have similarly impacted, for example, housing security. In our study, intersecting identities included gender (e.g., trans woman, two-spirited) and sexual identities (e.g., bisexual, gay), living in poverty with socio-economic barriers, being a sex worker, being a substance user (including alcohol consumption), and being judged for these past or present statuses. HIV stigma was described by many women living with HIV, and HIV testing was stigmatizing for those not living with HIV. Interestingly, whether or not the women had control over their identities, they still carried the weight of changing the discourse around these identities for Indigenous women. We could have applied the intersectionality concept to our study. In Crenshaw's (1989) essay, intersectionality described a situation and an experience, a view on complexity and marginalization, and finally a solution to the challenges experienced by Black women. She strived for increased awareness and attention to Black women's lives and experiences. Intersectionality could also put a spotlight on Indigenous women's lives and experiences. Another important factor in our study is that women's relationships were defined by the labels and identities they held. For example, mothers could be viewed as providers and teachers and being an *Indigenous* mother placed emphasis on their Indigenous identity, which speaks to a relationship with culture. Although these associations were positive, they could still be as burdensome as the negative stereotypes because achieving and maintaining these identities does not always leave room for setbacks.

Our study had several limitations. The socio-demographic characteristics were not generalizable; they specifically speak to women who experience several forms of discrimination and access urban resource centres and organizations for Indigenous Peoples or Indigenous women. A high percentage of our participants were First Nations, and Indigenous groupings may influence the types of racist events experienced. Also, qualitative data and the demographics do not display the full range of variables that may reflect the women's strengths. Moreover, our quantitative findings reflect a cross-sectional analysis, which does not allow for cause-and-effect conclusions to be drawn. Finally, our sample size was small

($n = 90$), which meant that some frequencies could not be reported, and it limited the types of analysis we could complete and which variables could be included in our regression analysis.

Conclusions

Our findings will contribute to the ongoing dialogue between Indigenous women and the service providers who engage with them, as well as the broader communities in which they live. It is important to note that, given that differences were observed between women living with and without HIV, further work is required to understand the impact of cultural racism. The data indicates that racism is a determinant of health: It is incumbent that systems beyond health services respond. It has been suggested that to address racism we must eliminate the term “race” in order to subsequently eliminate racial categorization. In contrast, others have suggested that possessing a strong racial identity and awareness of racism could shield individuals from the adverse effects of racism on health (Boykin & Toms, 1985; Harrell, 2000). This is reflected in our earlier discussion concerning the possibility that HIV negative women who were racially socialized and had high levels of cultural pride, or who saw the strength of being Indigenous as low, being more likely to perceive racial discrimination. Eliminating racial ideologies may be a near impossibility as these ideas have existed long before 1876 (i.e., establishment of the Indian Act in Canada), and will likely continue to exist for the foreseeable future. In the meantime, it is crucial to address discriminatory laws, policies, and practices that adversely affect Indigenous Peoples. Current strategies to confront racism in Canada respond to the Truth and Reconciliation Commission of Canada’s (TRC, 2015) *Calls to Action*, many of which require long-term strategies and huge investments that support and promote Indigenous worldviews. Our study focuses on numerous situations (e.g., housing, employment, violence, assault, child apprehension, and adoption), which makes it difficult to focus on a single policy to challenge, shift, develop, or even critique. However, drawing on Reading (2014), we argue that it is critical that those in social policy development roles across these areas detail policy processes aimed at addressing Indigenous racism more broadly. In Reading’s (2014) report on Indigenous racism, she described three anti-racist social models that could be useful in developing policies that attempt to address Indigenous racism (Allport, 1954; Duckitt, 2001; Guerin, 2003). These include the contact hypothesis, racial socialization, and racial decategorization (Allport, 1954; Duckitt, 2001; Guerin, 2003; Reading, 2014). The contact hypothesis aims to increase engagement between Indigenous and non-Indigenous persons to work towards common goals. The expectation is that they will eventually come to understand, or at the very least appreciate, each other’s perspectives (Allport, 1954). Guerin’s (2003) definition of racial socialization, which differs from the one described by Boykin and Toms (1985), involves being able to identify and understand experiences of racism as well as respond to racist events in ways that are commensurate with its seriousness. This may be achieved through inter-cultural education strategies including anti-racism, anti-oppression, cross-cultural, cultural competency, or cultural safety training for decision-makers and the general population through their employment or education. Racial decategorization is a process by which individuals come together, form connections, and create a category based on a shared identity; this leads to altered beliefs about race-based stereotypes (Duckitt, 2001). The latter may be achieved when working together to achieve common goals (i.e., contact hypothesis) and through cultural training (i.e., racial socialization) prior to beginning the work. In addition, a Mi’kmaq guiding principle, Two-Eyed Seeing, implores us to be open to multiple perspectives in order to obtain the most beneficial outcomes for those involved (Bartlett et al., 2012). This perspective involves a life-long reflective learning process that could be used to address racism. Opportunities for increased

conversations about racism have also been shown to reduce the potential for miscommunications and racial tensions (Devine & Vasquez, 1998; Reading, 2014). Social media might play a role in opening such conversations to a wider audience, but a strategy would be needed to determine the impact of this method. There is evidence to suggest that subtle non-confrontational messaging delivered by respected individuals is effective against racism (Donovan & Leivers, 1993). Finally, addressing racism requires multiple policy-based strategies that permeate a range of institutions (e.g., housing, health services). To implement these policies, it is necessary to increase exposure to and reach of Indigenous worldviews at different system levels.

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