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Perspectives in Medical Assistance in Dying (MAiD) amongst Indigenous Women, Two-Spirit, Transgender, and Gender-Diverse People in Canada:

An Exploratory Study

Native Women's
Association of Canada

L'Association des femmes
autochtones du Canada

Contents

I: Background

Within the context of Indigenous communities in Canada, Medical Assistance in Dying (MAiD) raises unique and critical questions. In 2016, Canada introduced MAiD as a legally authorized medical procedure that offers a peaceful and painless end to the lives of consenting adults who are facing grievous and irremediable medical conditions (Provincial Health Services Authority [PHSA], 2023). Eligibility for MAiD requires individuals to be at least 18 years of age, have access to publicly funded health care services in Canada, and provide voluntary, informed consent (Vancouver Coastal Health [VCH], 2023). Individuals seeking MAiD must be experiencing unbearable physical or mental suffering, however, their medical condition does not need to be terminal (VCH, 2023). The process involves a request form, two assessments, and placement into Track 1 (for foreseeable natural death) or Track 2 (for cases without this prognosis). Both tracks incorporate specific procedural safeguards, including witness presence, assessment periods, and expert consultations, ensuring an ethical and meticulous process (VCH, 2023; Health Law Institute, n.d.).

Amendments under Bill C-7, termed the "Medical Assistance in Dying (MAiD) Act," have significantly changed the MAiD process. These changes include the implementation of advance requests, expanded eligibility criteria, a two-track system, and enhanced safeguards (University of Toronto, 2021; Government of Canada [GoC], 2021b; GoC, 2023; GoC, 2024; Centre for Effective Practice, 2021). In 2023, 15,343 people in Canada received MAiD, accounting for 4.7% of all Canadian deaths with 5.96% of applications denied due to ineligibility (GoC, 2024). Some critics have raised concerns about the ease of access following the amendments. The potential negative impact on marginalized populations and apprehension towards allowing MAiD for individuals not facing terminal illnesses remain key issues (Honderich, 2023).

In response to these concerns, there is a growing conversation about the potential for coercion and the risk of devaluing lives in certain circumstances. The utilization of MAiD has been exponentially increasing since its introduction, which raises ethical questions about its compatibility with the healthcare system's commitment to promoting well-being (Cardus, 2023). While some advocate for an autonomy-centered approach to healthcare, others argue for a stance that challenges ableist assumptions and emphasizes the importance of increased health support, such as palliative care (Baril, 2022).

It is essential to acknowledge the multifaceted layers that impact attitudes toward end-of-life care, such as disparities in knowledge, socioeconomic status, and structural barriers within Canada's healthcare system (Berube et al., 2022). This includes observed imbalances among different socioeconomic, age, language, and family groups. For example, lower education levels and financial hardships are linked to lesser knowledge about end-of-life practices, raising concerns about potential inequities in accessing MAiD (Berube et al., 2022; Tran et al., 2022). Additionally, structural barriers, including systemic racism within Canada's healthcare system, pose significant obstacles to accessing MAiD, which particularly impacts Indigenous Peoples and those facing increased barriers to accessing end-of-life options (GoC, 2021a, 2022).

Addressing these challenges involves recognizing the diverse perspectives among Indigenous communities regarding MAiD and seeking guidance from Elders and spiritual leaders to ensure culturally sensitive practices (GoC, 2021a). The unique views of death within Indigenous communities underscore the need for a nuanced approach. Some individuals perceive medically assisted deaths as ceremony and view MAiD as a community-involved event, while others experience discomfort with MAiD due to historical, intergenerational, and contemporary trauma (Special Joint Committee on Medical Assistance in Dying [SJCoMAiD], 2023).

In existing literature, views and perspectives of MAiD within Indigenous communities have varied. Some Indigenous leaders and communities have expressed concerns that MAiD might be more accessible than obtaining essential resources that are crucial for quality of life (GoC, 2022). Similar worries have been echoed by Indigenous Elders and parliamentarians, who emphasized the importance of discouraging suicide and cautioned against broadening eligibility for assisted dying, as it may inadvertently send problematic messages (Brydon, 2016). Given the elevated rates of suicide among Indigenous youth, MAiD availability also raises concerns about the potential for misinformation. When the Government of Canada conducted roundtable MAiD engagement sessions in 2020, Indigenous individuals stressed the need for more health care services, including medical, mental health, and cultural safety training for health care providers (GoC, 2021a). This notion is particularly significant in remote communities where there are increased obstacles to palliative and end-of-life care provision. These include a lack of nursing staff, medical personnel, and psychologists, high turnover rates, insufficient programs and training opportunities, and decreased access to necessary narcotic medications (Hotson et al., 2004).

These initial perspectives highlight a complex interplay between culture, historical experiences, and contemporary challenges. MAiD availability further highlights the lack of comprehensive health care services, training, and resources in many communities. It is critical to engage Indigenous Peoples to address these intricate concerns while also addressing the need for culturally safe and enhanced health care provisions (SJCoMAiD, 2023).

Purpose of Study

To address challenges related to information, accessibility, and potential coercion in MAiD, the Native Women's Association of Canada (NWAC) held Sharing Circles across Turtle Island, Inuit Nunangat, and the Métis Homeland, exploring MAiD's impact on Indigenous Women, Two-Spirit, Transgender, and Gender-Diverse (W2STGD+) individuals. By amplifying Indigenous W2STGD+ voices, this project seeks to disseminate culturally relevant and trauma-informed perspectives and expand insights on MAiD's impact on Indigenous W2STGD+ communities. By discussing MAiD's shortcomings, exploring differing perspectives, and highlighting emerging solutions, findings will aim to provide valuable information to help bridge current knowledge gaps.

Aims and Goals

This project directly engaged 58 Indigenous W2STGD+ individuals and 39 MAiD practitioners to gather their perspectives on MAiD, its shortcomings, and potential solutions. The goal was to pinpoint gaps in the MAiD framework and deliver practical recommendations that specifically benefit Indigenous W2STGD+ individuals. By considering the unique perspectives and experiences of Indigenous W2STGD+ people concerning MAiD, knowledge will be disseminated to increase awareness and build capacity. Ultimately, this project seeks to expand the knowledge base of MAiD, enhance capacity, and develop tailored recommendations for governments, MAiD practitioners, community organizations, and researchers to better serve Indigenous W2STGD+ communities.

II: Methodology

A series of meaningful processes were implemented throughout the research project to ensure participant safety, cultural consideration, and person-centered facilitation. These methods included Culturally Relevant Gender-Based Analysis (CRGBA+), Free, Prior, Informed Consent (FPIC), an intersectionality lens, trauma-informed approaches, and Etuaptmunk – Two-Eyed Seeing Approach. These methodologies were also utilized to ground NWAC's work in the Truth and Reconciliation's Calls to Action.

In addition to these imperative methods, both quantitative and qualitative analyses were used to highlight key data and patterns in the research. Thematic analysis was chosen for the qualitative analysis because of its flexibility in identifying key trends, themes, and patterns in the data collected. The thematic analysis was also utilized to find key narratives and perspectives among the voices of Sharing Circle participants. Quantitative data was gathered through the surveys administered to MAiD Practitioners and Indigenous W2STGD+ individuals who attended the Sharing Circles. Qualitative data was collected from both the surveys and the in-person and virtual Sharing Circles.

Culturally Relevant Gender-Based Analysis Plus (CRGBA+)

NWAC aims to implement a distinctions-based CRGBA+ framework across all its initiatives to ensure the unique perspectives and experiences of First Nations, Métis, and Inuit Peoples are recognized (NWAC, 2020). This methodology serves as an essential tool to thoroughly examine and address the multifaceted impact of settler-colonialism on Indigenous W2STGD+ individuals specifically within the context of MAiD. This distinctions-based approach to CRGBA+ acknowledges that patriarchal histories and social norms have been imposed on Indigenous communities since European contact, recognizing the adverse effects on governance, family relations, and overall health and well-being. The framework also respects the unique cultural, historical, and spiritual contexts of diverse Indigenous communities (NWAC, 2020; Sanchez et al., 2020).

The CRGBA+ framework offers a reflective lens and thorough exploration of how various forms of colonialism intersect with gender to collectively influence the experiences of Indigenous W2STGD+ in relation to MAiD. It also explores how gender impacts the experiences of Indigenous W2STGD+ individuals who are facing complex challenges in particular healthcare and social contexts. This approach seeks to provide culturally relevant insights and recommendations tailored to enhance our understanding of the experiences and perspectives of W2STGD+ individuals regarding MAiD.

Free, Prior, Informed Consent (FPIC)

Following the guidance outlined in the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), this research was conducted with a commitment to implementing an FPIC model. FPIC is a fundamental research method for involving Indigenous Peoples and stands to prioritize their self-determination and autonomy (Institute for Human Rights and Business [IHRB], 2022). This approach acknowledges the importance of engaging with Indigenous communities on their terms, respecting their traditional knowledges, cultural practices, and land rights. This model requires researchers to obtain free, prior, and informed consent before initiating any research, to ensure that the research process is transparent, inclusive, and accessible (Food and Agriculture Organization of the United Nations, 2016; IHRB, 2022).

The FPIC process was instrumental in this project. In both virtual and in-person Sharing Circles, participants were provided with an Information and Consent letter (Appendix A) before participating in the Sharing Circle. This document provided a detailed overview of the topics to be discussed within the Sharing Circles, offering all participants the choice to disclose or withhold information at any time throughout the research process.

Intersectionality

This research project has been shaped significantly by an intersectionality framework, which provides a lens to acknowledge the intricate interconnections among social identities and categorizations (Tojer, 2018). Coined by Kimberlé Crenshaw in 1991, this framework illuminates the complex interplay between various forms of inequality, emphasizing their intertwined and compounded impact (Steinmetz, 2020). Indigenous Nations across Canada have vastly different identities, representing diverse histories, languages, cultural practices, and interactions with the land. Recognizing these intersectional differences is important to understand how individuals and communities navigate and confront layered experiences of discrimination. Utilizing an intersectional approach within this research allows for a deep exploration of the dynamics between hetero-patriarchy and settler colonialism, revealing how these systems manifest, and impact lived experiences (Carastathis, 2016). By integrating intersectionality, the research aims for a comprehensive understanding of the multifaceted dimensions of inequality and discrimination faced by Indigenous W2STGD+ individuals in the specific context of MAiD, fostering more inclusive and informed recommendations.

Trauma-Informed Approaches

A traumatic event can refer to a singular event, a past occurrence, or a long-standing pattern (CAMH, 2024). Approaching trauma through an Indigenous lens requires acknowledging that Indigenous W2STGD+ individuals may have experienced lived, vicarious, and/or intergenerational trauma, while also recognizing that Indigenous trauma cannot be separated from settler-colonialism. Trauma cannot be viewed solely as an individual experience but instead needs to be recognized as a collective, resilience-centred experience, that ultimately provides practical knowledge (Schiffer, 2019).

Researchers reflected on their intersectionality and positionality to engage with W2STGD+ individuals compassionately and respectfully. To reduce instances of re-traumatization, culturally relevant protocols were utilized, and gender diversity was considered to create more meaningful experiences and provide safer, inclusive environments. This project was conducted in collaboration with local Indigenous organizations to foster decolonial and supportive environments. By prioritizing a Trauma-Informed Approach, this research acknowledges the holistic connections between trauma and Indigenous Peoples, aiming to improve health outcomes for Indigenous W2STGD+ individuals in relation to MAiD legislation and responses.

Etuaptmumk – Two-Eyed Seeing Approach

Mi'kmaw Elder Albert Marshall defines Etuaptmumk or "Two-Eyed Seeing" as "to see from one eye with the strengths of Indigenous Ways of Knowing, and to see from the other eye with the strengths of Western ways of knowing, and to use both of these eyes together," (Barlett, Marshall & Marshall, 2012, p.335). In this study, NWAC applied Etuaptmumk by pairing Western methods with Indigenous Research methods, such as Sharing Circles and a qualitative thematic analysis. This collaborative approach enabled meaningful interpretations and actionable recommendations. Given the holistic impacts of health care, end-of-life care, and death care on Indigenous individuals and communities, integrating both Indigenous and Western Ways of Knowing is essential. Many participants in our Sharing Circles shared stories of both Indigenous healing and Western medical practices, fostering reciprocal learning and highlighting the nuanced differences in lived experience and ways of being. These shared practices emphasized the collaborative power of the research and the benefit of accessing dual healthcare systems (Peltier, 2018).

III: Methodological Tools

This exploratory study utilized a combination of qualitative and quantitative methodological tools. Two distinct surveys were developed and administered. One survey focused on MAiD practitioners, seeking their perspectives, experiences, and knowledge concerning MAiD procedures and processes in relation to Indigenous W2STGD+ individuals. The second survey was provided to Sharing Circle participants, to collect demographic data and understand their initial knowledge and opinions on MAiD. Additionally, nine Sharing Circles and one individual interview were conducted to gather qualitative data on Indigenous W2STGD+ participants' perspectives and experiences regarding MAiD.

MAiD Practitioners Survey

A 22-question survey (Appendix B) was developed to assess MAiD practitioners' training, familiarity with Indigenous-specific MAiD needs, and service provision challenges. The survey included quantitative and qualitative questions with respondents identifying their Indigenous identity, service location, specific roles, and knowledge of culturally safe care. The survey ran on SurveyMonkey from October 20, 2023, to January 24, 2024, and was open to all health care professionals (both Indigenous and non-Indigenous) who are involved in MAiD (e.g., physicians, nurse practitioners, pharmacists, mental health professionals). There were 39 responses; participants received a $25 NWAC Artisanelle gift card.

Pre-Sharing Circle Survey

A 20-question survey (Appendix C) was developed for participants of the MAiD Sharing Circles to assess awareness, perceptions, and experiences related to MAiD in Indigenous communities. Using a cross-sectional design, the survey combined quantitative and qualitative questions to examine service disparities, knowledge gaps, and accessibility issues. Participants completed the survey, administered online (through SurveyMonkey) or in-person (printed), prior to starting the Sharing Circles. There were 58 responses from participants across multiple provinces and territories.

Statistical Analyses of Surveys Data

The data for both surveys were imported independently into the program Statistical Package for the Social Sciences (SPSS) for analysis, with missing values, inconsistencies, and outliers addressed. Nominal and ordinal variables were coded, and categorical variables were recoded into binary groups for cross-tabulation. Descriptive statistics summarized demographic characteristics and assessed responses to the various survey questions. Means, standard deviations, and frequency distributions provided a dataset overview. Cross-tabulation using SPSS's Crosstabs function examined relationships between key categorical variables. The Chi-Square Test for Independence was performed to assess statistical associations. Independent samples t-tests were conducted and Welch's t-test was applied as needed. A p-value of <0.05 determined significance. Trends and patterns in the MAiD Practitioners Survey were further explored using frequency distributions, mean differences across respondents, and analyzing variations with SPSS's Explore and Compare Means functions.

Qualitative responses were analyzed thematically using NVivo software. Open-ended responses were coded inductively. NVivo's query functions ensured coding consistency, assessed word frequency, and visualized thematic relationships. The qualitative findings were integrated with statistical results to provide a comprehensive understanding of the survey responses.

Sharing Circles (In Person and Virtual)

Four in-person Sharing Circles were conducted at the following locations: one in Kirkland Lake (Ontario), one in Edmonton (Alberta), and two in Whitehorse (Yukon). Holding Sharing Circles in-person fostered a greater sense of community, allowing individuals to come together to share their perspectives and experiences related to MAiD. Similarly, the in-person format of these Sharing Circles provided a space for empathy, personal connections, and increased assistance from the research team, if needed.

Five virtual Sharing Circles were hosted for Saskatchewan, British Columbia, Nova Scotia, Newfoundland, and Prince Edward Island. Additionally, one virtual interview was performed with an Inuit Knowledge Keeper from Nunavut (currently residing in Ontario); this was included to offer an Inuit perspective on MAiD, as other Sharing Circles struggled to recruit Inuit participants. Virtual sessions also provided an opportunity for contributions from individuals who may have been unable to attend an in-person Sharing Circle.

NWAC collaborated with its Provincial and Territorial Membership Associations (PTMAs) and local organizations (when PTMAs were unavailable) to arrange logistics and recruit participants for the Sharing Circles. The Sharing Circle sought out diverse perspectives by recruiting from each of the Four Directions (North, South, East, West) in the country. Each of the virtual and in-person sessions lasted approximately one to two hours. During this time, participants completed the Pre-Sharing Circle Survey (Appendix C) and were briefed on the contents of the Information and Consent Letter (Appendix A), explaining the consent process and aftercare supports, as well as the research project's aims, goals, and desired outcomes. All Sharing Circles were opened and closed in a meaningful way. Whenever possible, an Indigenous Elder was present to provide their unique perspectives and holistically support other participants. The facilitator used a semi-structured format of asking questions, guided by the Sharing Circle Questions (Appendix D). The semi-structured format allowed for increased flexibility and exploration of the research topic. All sessions were audio-recorded via Zoom and transcribed through OtterAI. The generated transcriptions were cross-checked directly with the audio recordings and edited to ensure an accurate representation of the conversations.

Thematic Analysis of Sharing Circle Transcripts

NVivo was utilized to conduct a thematic analysis of the transcripts from the Sharing Circles and the individual interview. A contextualist epistemology approach was applied to balance essentialist and constructionist perspectives. This allowed participants' lived experiences, personal beliefs, and understandings to be contextualized with recognition of how broader structural forces (such as systemic inequities arising from colonization) impact personal narratives.

As this study is exploratory, data were analyzed with an open-coded inductive approach, allowing insights and patterns to emerge organically from participants' narratives. A combination of semantic and latent coding strategies ensured that both explicit and hidden contexts of participants' responses were thoroughly explored. Codes were developed off blocks of text rather than isolating individual words; this allowed for a more grounded and context-sensitive analysis that preserved the unique nuances of participants' reflections without decontextualizing or oversimplifying the data. As a result, responses were frequently double-coded and applied across multiple themes to accurately analyze the complex intersectionality of participants' experiences. After coding the 10 transcripts individually, the combined 1295 nodes were categorized into five higher-order themes, with 17 subthemes distributed throughout. Participant excerpts were edited in the results to remove any grammatical errors.

IV: Ethical Considerations

This research did not require ethics board approval, as it underwent an internal ethics review process by the funding entity, Indigenous Services Canada. However, it is essential to highlight that the research team is dedicated to employing a trauma-informed, culturally relevant, and consent-based approach. Participants provided ongoing informed consent throughout the research process.

Eligible Sharing Circle participants were ages 18+ and self-identified as being Indigenous W2STGD+. Participants were provided with an Information and Consent Letter (Appendix A) before completing the Pre-Sharing Circle survey (Appendix C). This document assured participants that their discussions would remain anonymous and confidential, and provided information about the research project including the intent, goals, and potential risks/benefits associated with their involvement. Additionally, it included contact information for various Indigenous Crisis Hotlines and the research team's contact information for any inquiries or concerns.

V: Results

MAiD Practitioners Survey: Quantitative Analysis

Prior to commencing the Sharing Circles, the MAiD Practitioners Survey (Appendix B) was completed by 39 individuals. Among respondents, 38.5% identified as family physicians, 33.3% as nurse practitioners, 7.7% as social workers, and 7.7% as mental health professionals, with 12.8% working in other health care roles (Figure 1.1). A majority (53.8%) identified as non-Indigenous, while 15.4% identified as First Nations, 17.9% as Métis, and 7.7% as Indigenous without specifying a group (Figure 1.2). In their workplace settings, 66.7% of respondents reported working alongside Indigenous health care staff, while 23.1% did not, and 7.7% were unsure.

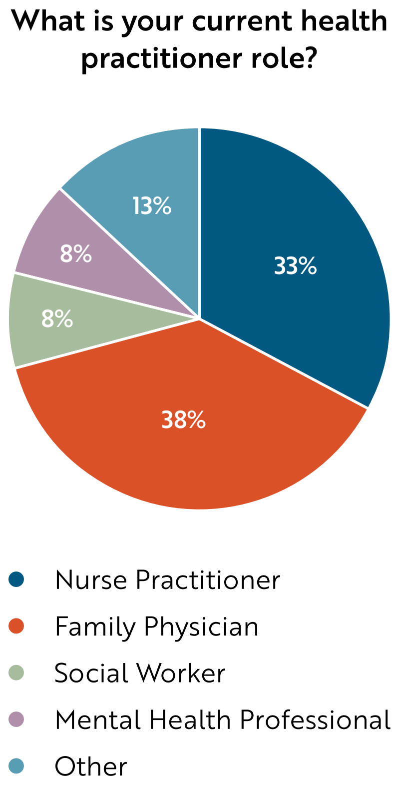


Figure 1.1 *Role of Health Care Practitioners*

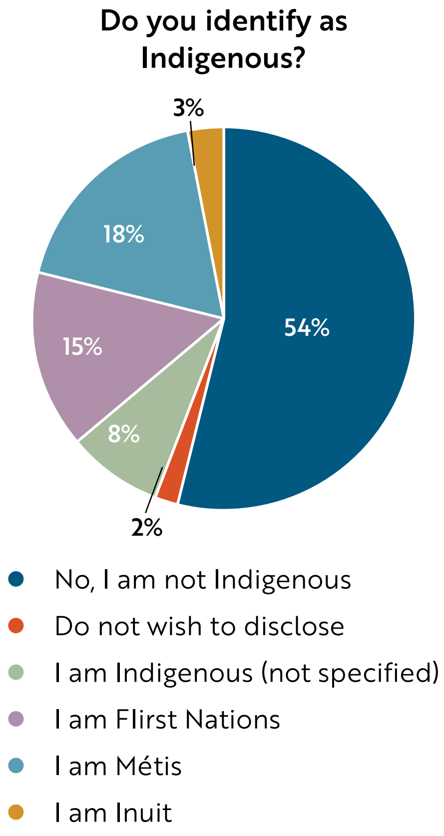


Figure 1.2 *Indigenous Identity of Respondents*

The majority of respondents (89.7%) had experience providing care to Indigenous patients (Figure 1.3), with the most common care settings including urban centres (28.2%) and off-reserve communities (25.9%), followed by on-reserve communities (17.6%), remote locations (17.6%), and fly-in communities (7.1%) (Figure 1.4). Despite this level of exposure, only 15.4% of respondents had received formal training specifically related to Indigenous MAiD services (Figure 1.5). Among those who had received training, Elder-led teachings and general Indigenous health education were the most frequently cited sources. When asked whether their training provided sufficient information on Indigenous MAiD needs, 64.1% of respondents stated that it did not (Figure 1.6). Challenges in providing MAiD to Indigenous patients with mental health or substance use issues were reported by 25.6% of respondents, while 41.0% had not encountered such challenges. Another 23.1% were unsure, reflecting uncertainty in assessing these issues.

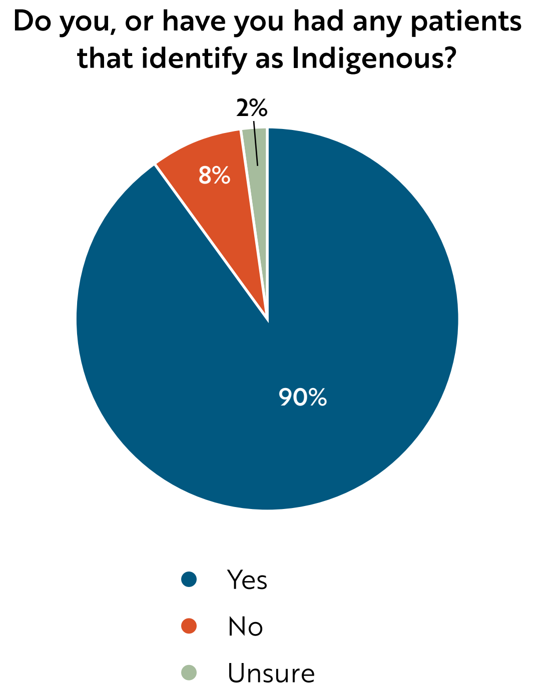


Figure 1.3 *Experience with Indigenous Patients*

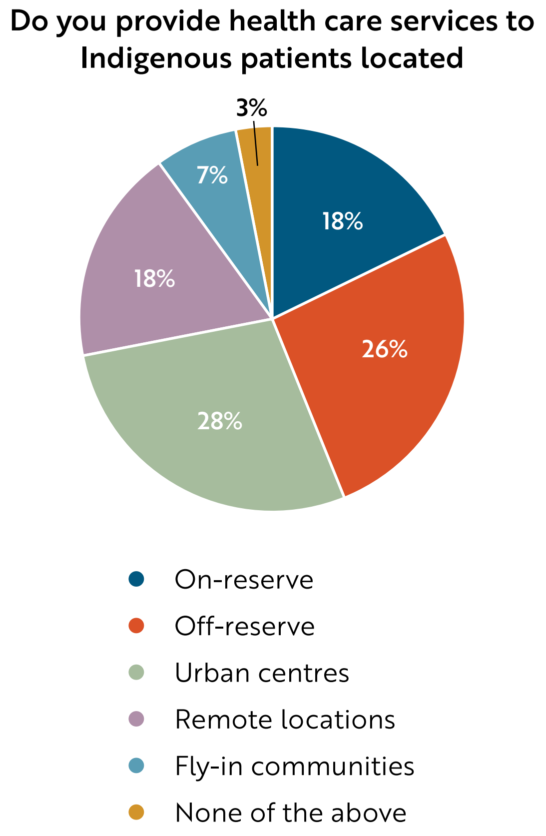


Figure 1.4 *Location Services are Provided to Indigenous Patients*

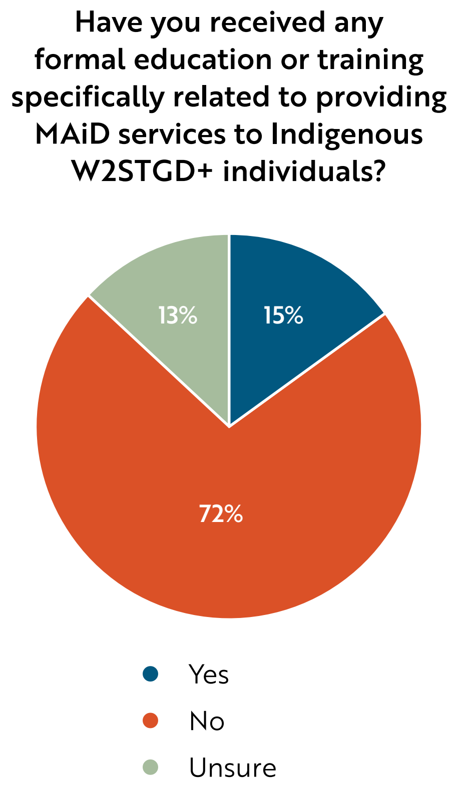


Figure 1.5 *Formal Education/Training for Providing MAiD Services to Indigenous W2STGD+ Patients*

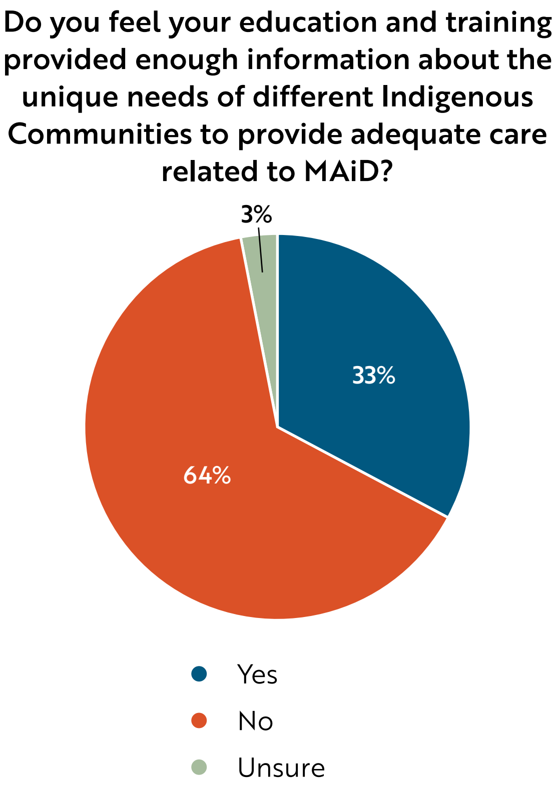


Figure 1.6 *Did Education/Training Provide Sufficient Information on Indigenous MAiD Needs*

The thematic analysis of qualitative responses identified key barriers to MAiD access for Indigenous W2STGD+ individuals, including systemic discrimination and healthcare mistrust (21.6%), lack of culturally safe services (24.3%), and limited access to information and care (24.3%). Additional concerns included stigma, psychological barriers, and social isolation. When asked about how they ensure culturally sensitive care for Indigenous patients receiving MAiD, respondents most frequently cited anti-racism and equal treatment (16%), cultural awareness and education (20%), and the integration of Indigenous practices (24%).

The quantitative analysis found no statistically significant relationships between training, familiarity, and reported challenges. Chi-square tests showed no association between receiving MAiD training and familiarity with Indigenous MAiD needs, nor between training and encountering challenges. Similarly, familiarity with Indigenous MAiD needs did not predict whether practitioners faced challenges. Independent samples t-tests found no significant difference in the number of challenges reported between trained and untrained practitioners ($t = 0.44$, $p = 0.6754$). Due to insufficient response variation, a t-test for familiarity and challenges could not be computed. Comparative analyses suggested that MAiD training increases familiarity with Indigenous-specific needs but does not reduce practitioner challenges. Among trained respondents, 78.3% reported familiarity with Indigenous MAiD needs, compared to 32.4% of those without training. However, trained practitioners were also more likely to report encountering challenges (73.9%) compared to those without training (27.1%). A similar trend was observed among those familiar with Indigenous MAiD needs, with 60.0% reporting challenges, versus 25.0% of those unfamiliar.

Chi-square tests showed no significant relationship between Indigenous identity and MAiD training, with 70.0% of both Indigenous and non-Indigenous respondents reporting they had not received formal training. Working with Indigenous colleagues also did not predict training likelihood ($\chi^2 = 0.31$, $p = 0.5775$), nor did providing care to Indigenous patients ($\chi^2 = 0.66$, $p = 0.4159$). Even among those who had participated in MAiD procedures, only 12.5% had received training, compared to 25.0% of those who had not ($\chi^2 = 0.11$, $p = 0.7398$). Inferential statistical tests, including independent samples t-tests and one-way ANOVA, reinforced these findings. A t-test comparing challenges reported by trained versus untrained practitioners found no significant difference ($t(38) = 0.44$, $p = 0.6754$). A one-way ANOVA also showed no significant differences in challenges based on training or familiarity ($F(39, 39) = 0.25$, $p = 0.6200$).

These findings highlight a critical gap in formal MAiD training on Indigenous-specific care. Despite working with Indigenous patients, most practitioners lacked formal training in culturally safe MAiD practices. Many reported only moderate or minimal familiarity with Indigenous MAiD needs, suggesting that exposure alone does not ensure competency. The lack of statistically significant links between training, familiarity, and reported challenges suggests that conventional training alone may be insufficient to address systemic barriers. The thematic analysis reinforces this, with respondents frequently citing discrimination, the lack of Indigenous-led services, and jurisdictional healthcare barriers as persistent obstacles. Additionally, nearly a quarter of respondents expressed uncertainty about challenges related to mental health and substance use, indicating gaps in confidence and preparedness. Notably, increased training and familiarity did not reduce reported challenges. Instead, greater awareness may highlight, rather than resolve, existing disparities. This aligns with broader research on cultural competency training, which suggests that while education raises awareness, it does not necessarily equip practitioners to navigate or dismantle structural inequities.

Pre-Sharing Circle: Quantitative Analysis

The Pre-Sharing Circle Survey (Appendix C) findings of 58 participants offered a range of perspectives on Medical Assistance in Dying (MAiD) grounded in personal, cultural, and community experiences. A significant portion of the sample identified as First Nations, status (81.97%), with the remainder being First Nations, non-status (8.20%), Métis (8.20%), and Inuit (1.64%) (Figure 2.1). Most participants identified as women (84.13%), with the remainder (15.87%) identifying as Two-Spirit, non-binary, or gender-diverse. Geographically, participants reflected a mix of urban and rural upbringings, with several indicating they had lived on reserve, in remote communities, or fly-in-only areas (Figure 2.2).

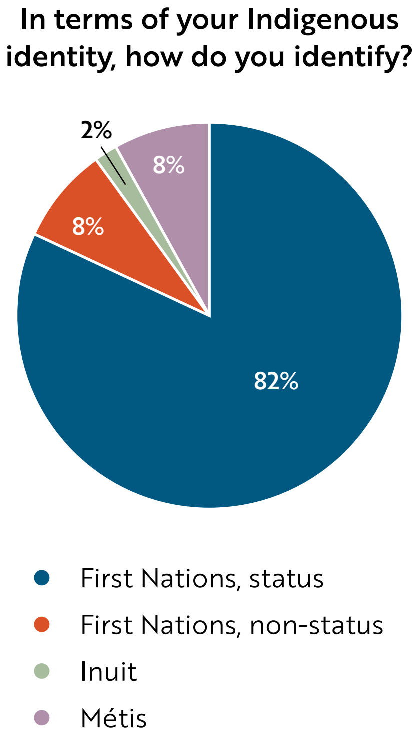


***Figure 2.1** Indigenous Identity of Participants*

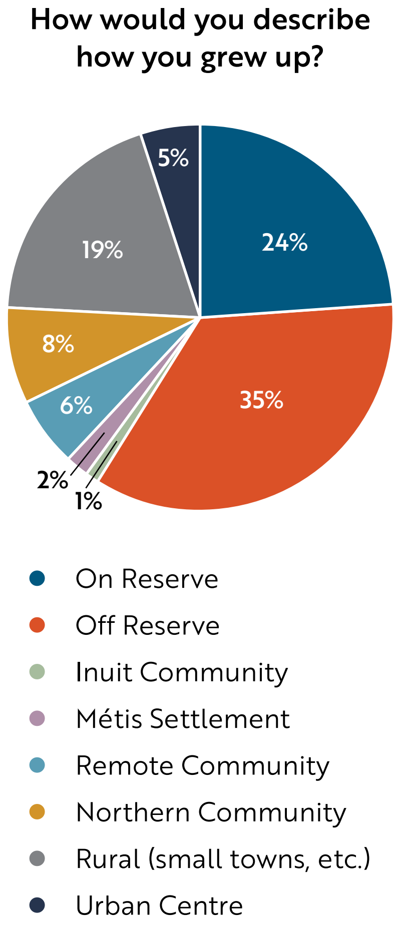


***Figure 2.2** Location Participants Grew Up*

Familiarity with MAiD (Figure 2.3) was strongly associated with efforts to seek out education or information. Among those who reported being "somewhat familiar" with MAiD, 60.7% had sought out additional education, while only 16.7% of those who were "not very familiar" reported doing the same (Figure 2.4). Similarly, respondents who were more familiar with MAiD were more likely to report having direct or indirect experience with it (Figure 2.5). For example, 89.3% of those who were "somewhat familiar" had personal or professional experience with MAiD, whereas all of those who were "not at all familiar" reported no experience. Of participants who sought further information and education on MAiD (27.59%), the internet or media, health care providers, and family or friends were the most utilized resources for learning (respectively) (Figure 2.6). A logistic regression model was used to explore whether demographic or experiential factors predicted the likelihood of having sought MAiD-related education. While no predictors reached statistical significance, respondents with greater familiarity had 2.67 times the odds of seeking out education, and those with direct experience had 1.84 times the odds of doing so.

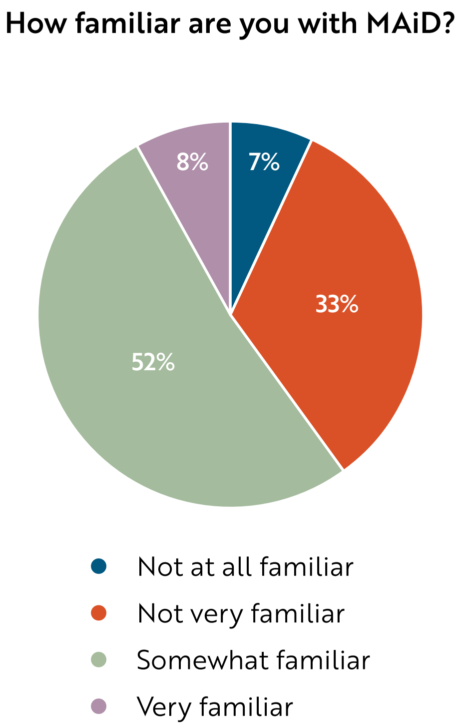


Figure 2.3 *Familiarity with MAiD*

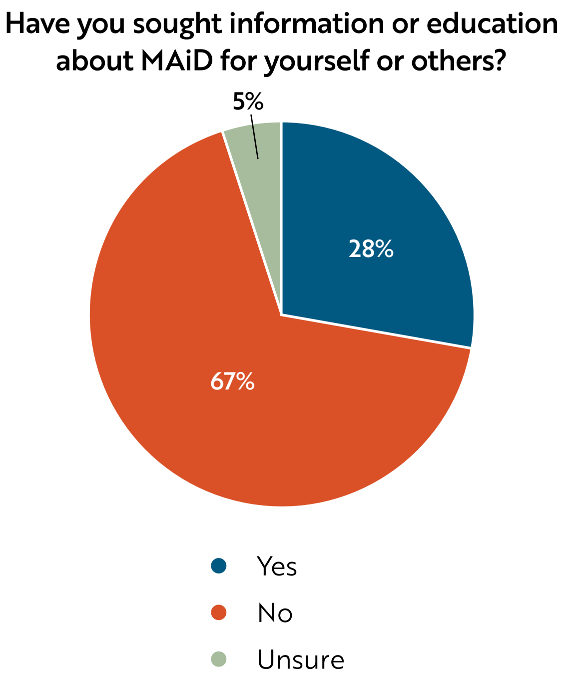


Figure 2.4 *Sought Information or Education on MAiD*

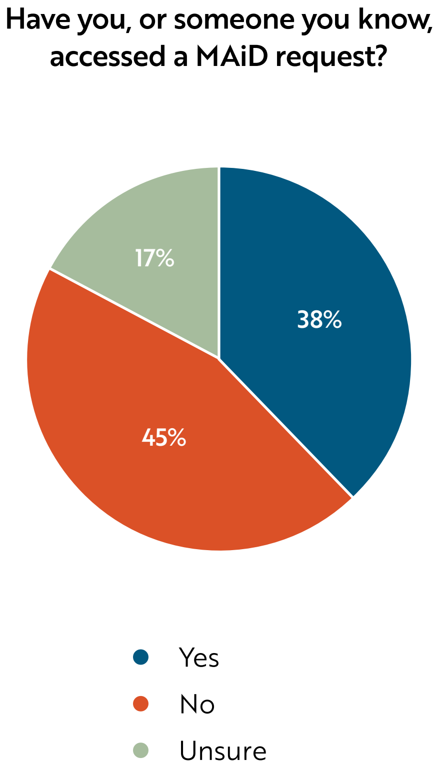


Figure 2.5 *Direct or Indirect Experience with MAiD Requests*

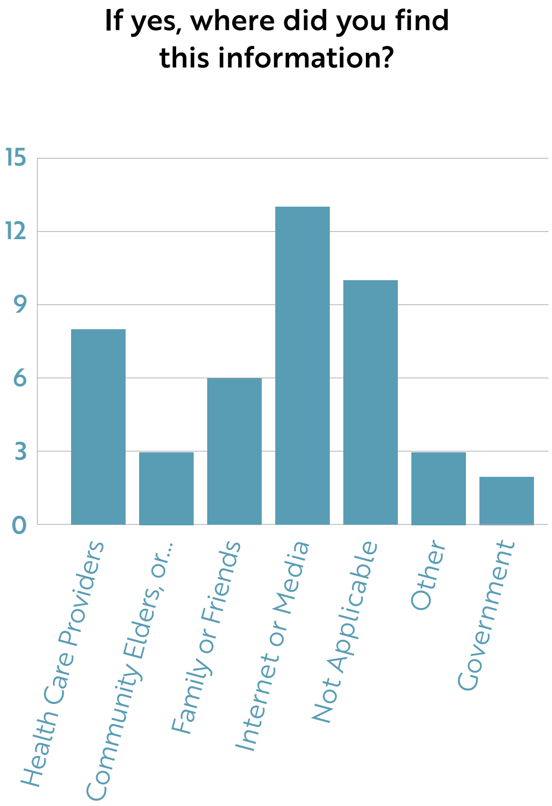


Figure 2.6 *Sources of MAiD Information or Education*

When asked if they believe there is enough MAiD awareness in their communities, the majority (86.21%) of participants said "no", while the remainder (13.79%) were unsure (Figure 2.7). Not a single respondent selected "yes" indicating a unanimous perception that awareness is insufficient. This finding remained consistent across all levels of familiarity with MAiD and was confirmed through chi-square testing ($\chi^2 = 38.07$, $p < 0.00000001$). Even among those who reported being "very familiar" with MAiD, all respondents agreed that more awareness is needed. There was no significant association between the source of information about MAiD (e.g., online platforms, health care providers, or social networks) and perceptions of awareness, suggesting that gaps in understanding are systemic rather than tied to a single information channel.

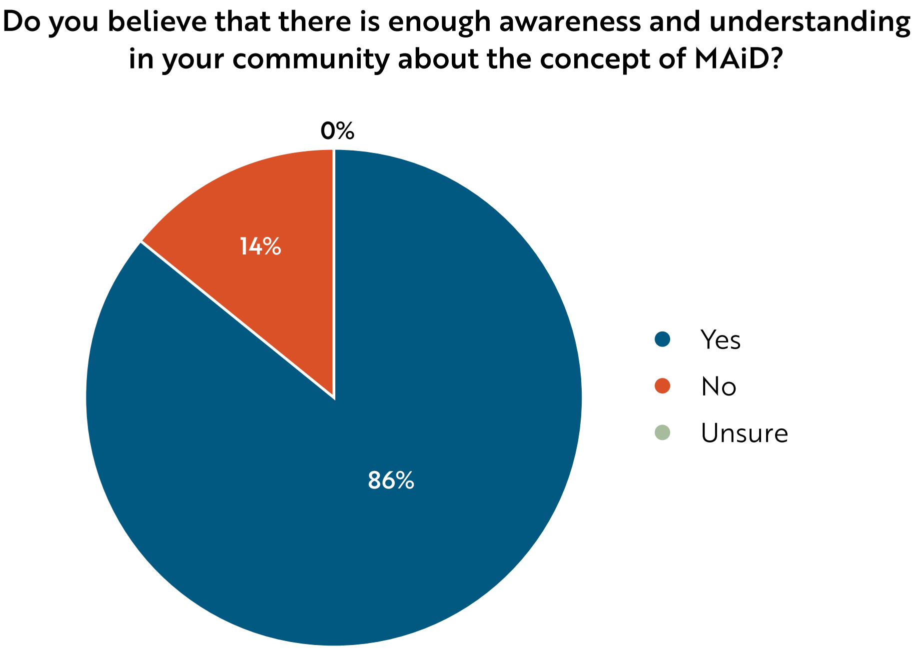
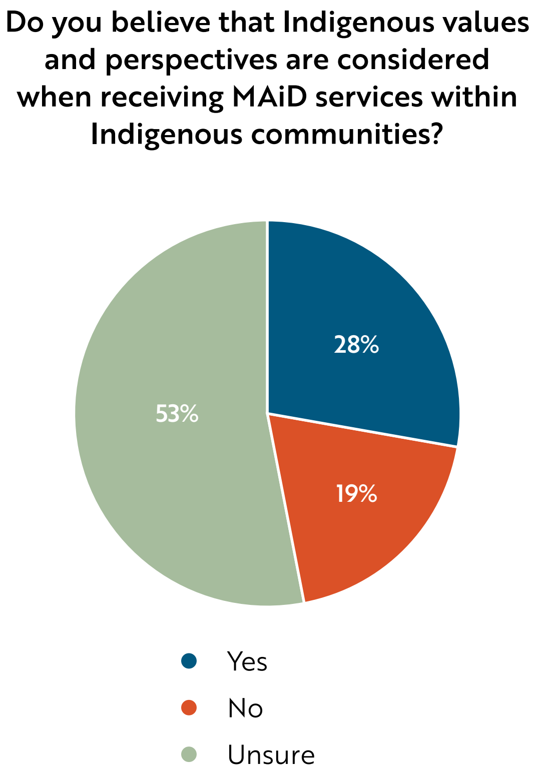


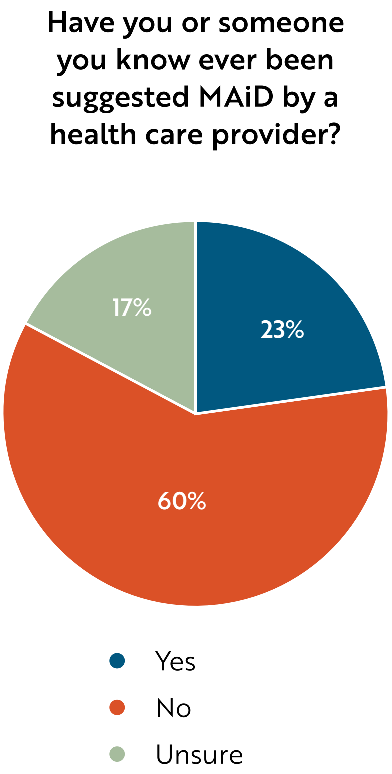
Figure 2.7 *Is There Enough MAiD Awareness and Understanding in Their Community?*

Perceptions of whether Indigenous values and perspectives are considered in MAiD services were mixed. Only 27.6% of respondents believed that Indigenous values and perspectives are considered, while the majority (53.45%) were unsure and the remainder (18.97%) said no, they are not (Figure 2.8). Those who had sought out education were more likely to believe that Indigenous values and perspectives were being considered (47.1%) than those who had not (22.3%), suggesting that learning more may help identify existing areas of inclusion. Participants who believed that Indigenous values and perspectives are not considered in MAiD were more likely to report that MAiD had been suggested to them or to someone they knew by a health care provider (Figure 2.9). This difference (39.2% vs. 61.5%) may reflect a disconnect between culturally safe communication and the way MAiD is introduced in clinical contexts.



Do you believe that Indigenous values and perspectives are considered when receiving MAiD services within Indigenous communities?

Figure 2.8 *Perceived Inclusion of Indigenous Values and Perspectives in MAiD Services*



Have you or someone you know ever been suggested MAiD by a health care provider?

Figure 2.9 *Experience with MAiD Being Suggested by a Health Care Provider*

Geographic background also shaped participant experiences. Respondents who grew up in rural or reserve communities were significantly more likely to report facing challenges related to MAiD access (F=6.83, p=0.013), reinforcing structural end-of-life care inequities. In addition, age was significantly associated with having sought out education or information about MAiD (F=5.74, p=0.007), with younger respondents more likely to have done so. However, this increased access to information did not correspond with increased confidence in the system or reduced perception of barriers. No significant relationships were found between familiarity, education, experience, or perceived challenges and respondents' Indigenous identity, gender identity, or region once categories were collapsed to preserve statistical power.

The thematic analysis of qualitative responses further reinforced the survey's findings. Participants consistently emphasized the importance of cultural safety, ceremonial continuity, and respect for community-based knowledge in MAiD and end-of-life care (Figure 2.10). Many called for the integration of traditional practices, including smudging, singing, and involvement of Elders or Knowledge Keepers throughout the death and dying process. Respondents highlighted the need for deep listening, the recognition of intergenerational trauma, and the right to die in a way that honours one's spiritual and cultural identity. While themes did not explicitly focus on health care practitioner tools or competencies, they pointed to a broader structural issue: that MAiD, as it is currently understood and delivered, remains fundamentally disconnected from many Indigenous Worldviews.


What is important for health care providers to know about MAiD or end-of-life services in Indigenous communities?

Figure 2.10 *Key Considerations for Health Care Providers: Indigenous MAiD and End-of-Life Care*

The absence of respondents reporting sufficient awareness highlights gaps in education, jurisdictional barriers, and limited culturally safe services. Across the survey, there was an alignment between higher levels of familiarity and increased efforts to engage with MAiD information, but this did not appear to reduce the perception of barriers. In fact, those with greater familiarity were often more likely to recognize systemic gaps. Even when Indigenous individuals were aware of MAiD, systemic barriers still limited access to timely and culturally safe end-of-life resources. Geographic disparities further highlighted challenges around delivering culturally safe health education and health care access. Rural and remote respondents reported greater gaps, which illuminates how geography intersects with systemic injustices to produce unique forms of marginalization at end-of-life. Communities that emphasized family involvement and traditional ceremonies in end-of-life care reported fewer discussions about MAiD with health care providers, reflecting cultural differences in decision-making. Further, respondents who felt Indigenous values and perspectives were not considered were more likely to have had MAiD suggested to them by a health care provider, raising concerns about whether health care providers are introducing MAiD in a way that respects Indigenous values and perspectives.

In sum, findings underscore disparities in MAiD awareness, Indigenous inclusion, and access, particularly in rural and remote Indigenous communities. The Pre-Sharing Circle Survey data revealed education alone does not sufficiently address the cultural, geographic, and jurisdictional barriers faced by Indigenous Individuals considering or encountering MAiD. Broader, intersectional systemic issues fail to offer culturally grounded, community-led, or meaningfully accessible MAiD services to Indigenous People.

Virtual and In-Person Sharing Circles: Qualitative Thematic Analysis

Five themes (with 2-5 subthemes each) emerged to guide the reflexive thematic analysis (Appendix E). The interconnection between themes and subthemes is described below.

Theme 1: Cultural Perspectives, Teachings and Traditions in End-of-Life Care

Perspectives and Teachings on Life and Death

Sharing personal beliefs and traditional teachings about the significance of life and death was important for participants to situate their perspectives on dying. Understanding death as a natural and inevitable part of life gave some a sense of harmony, peace, and acceptance. There was a strong reflection on the spiritual interconnection of birth and death, frequently framed through circular and cyclical lenses. Many participants detailed how our energy (or spirit) comes from the Spirit World to walk a human journey; at death, your ancestors descend to guide you “home” to the Spirit World. Traditional language around death and dying was mentioned, with one Elder explaining the Cree word ‘nakataskwew’ which means ‘going ahead’:

> “The part about dying, we don’t have that in our languages. In my language, we say it’s ‘going ahead’ and when they ‘go ahead’, my mother and my father have left me footprints for me to follow when it is my turn to go.” (Elder, PEI)

The concept of a place to return and reconnect to ancestors helped many participants frame death through a positive lens.

> “When a child is born into this world, we all celebrate. We’re happy, right? Because that person becomes with his spirit. Then the people in the Spirit World must be mourning. We mourn when a person crosses over, and their ancestors in this Spirit World are celebrating a life there, born into their world.” (Elder, BC)

Another traditional teaching that arose was the concept of “willing oneself to die”. Many stories described Elders choosing their time to die, either by walking off onto the land or remaining behind alone. One participant discussed it as a personal end-of-life plan and two others presented it in passing as a teaching. Some participants also applied this concept in relation to MAiD.

> “In Inuit culture...all people will themselves to die without being assisted.” (Inuit Knowledge Keeper, ON)

> "These people make that decision to walk out on the ice or take a long walk into the woods...That’s where that Indigenous person is taking the decision for end-of-life into their own hands...I think MAID is just an extension of that” (Participant, PEI)

Traditional Medicines, Ceremonies, and Cultural Practices at End-of-Life

Ceremonial practices during the death and dying process (including songs, prayers, drumming, rattles, and medicines) were frequently referenced. The importance of holistic support, addressing their physical, mental, emotional, and spiritual needs, was discussed, with others emphasizing how ceremony connects the person to the Spirit World.

> “As soon as one of our people are getting ready to pass over, make sure that [there] are songs, drumming, and singing... [Without this] their spirit will get lost in that other world and their ancestors can’t find them.” (Elder, BC)

Many participants highlighted the significance of smudging while others referenced the diverse uses of plant medicines. These ranged from various methods of reducing suffering during the dying process to post-mortem cedar baths for purification. One participant mentioned how expressing grief through wailing (alongside family members) is medicine itself. The support of family and community during death and grief was frequently highlighted, along with the traditional roles of death doulas.

> “I learned about the role of Two-Spirit and one of the jobs was being a death doula. Just like they helped with births and were midwives, we also had death doulas to help with death.” (Elder, SK)

Others mentioned different ways communities support family members after the death of loved ones. Celebrations of life and feasts were broadly mentioned. Ultimately, the importance of recognizing the variation in end-of-life ceremonies, medicines, and cultural practices was emphasized by a participant:

> “There are so many different things that First Nations practice. Even from the same community, different families will do things [differently]. So being mindful and respectful in how people do things, [and] that you don’t just assume that everybody does things the way you would do them.” (Participant, YT)

Reclaiming Knowledge and Traditions Around Death and Dying

Sharing traditional teachings and practices was often associated with gaps in knowledge transfer across generations due to colonization. The impacts of colonization on traditional practices led many participants to express sadness over lost teachings and regret not learning from Elders while they were alive. They stressed the urgent need to reclaim their knowledge and traditions while questioning how to do so.

> “We have lost so much from the colonial war against us. How do we recover that knowledge and those ways and not mix them up with the colonial ways or the Christian ways?... I’m trying to go back to pre-colonial views about death.” (Elder, SK)

There was a strong desire for increased gathering and dissemination of information. Ideas included engaging Elders, re-enacting protocols, and reviving death doula training. Some suggested research and government support but emphasized avoiding a pan-Indigenous methodology. One participant from SK explained that the government ‘should do an in-depth study with [multiple] Elders [from] each tribe to learn their practices”, allowing each treaty territory to share its diverse cultural knowledge around death and dying. Despite recognizing the generational gap in knowledge, there was still optimism that knowledge could be revived and reformed.

Theme 2: Navigating Healthcare Barriers, Inequities, and Support in End-of-Life Care

Systemic Inequities and Barriers to Healthcare Access

The intersectional systemic and social inequities Indigenous communities experience frequently arose in conversations. Participants shared about disproportionately high suicide rates in their communities and concerns around increasing physical health issues (such as diabetes, cancer, and COVID-19). The impact of the opioid drug poisoning crisis was repeatedly discussed along with how addictions, overdoses, and housing needs are ignored through a lack of funding and services.

> "We're overrepresented in every negative aspect in Canada: foster care, sexual abuse, violence, prison, trauma, suicide rate, homelessness, and that all affects everything, your health, your mental health. We are disproportionately affected by that as Indigenous people." (Participant, AB)

Participants mentioned distrust towards the government and the lack of integration of Indigenous knowledge into healthcare policies. Some found navigating different levels of health governance confusing, while others shared frustrations over refused funding for care. When accessing health care services, the most common barrier was the lack of resources and support. For example, some participants detailed personal experiences of traveling great distances (by car or air) to receive basic care. This impact on timely diagnosis and treatment was a significant concern. Participants urgently advocated for increased resources in rural, remote, and Northern communities. This was further contextualized when discussing MAiD:

> "The Inuit, First Nations people of Canada weren't consulted when they first made it along. They're doing the consultations right now. The Indigenous leaders did express their concern: you're offering this service, and we don't have the resources to [give] the treatment." (Participant, ON)

Improper Treatment, Biases, and Power Dynamics with Health Care Providers

Bias, prejudice, discrimination, and racism by health care providers were a reoccurring theme when discussing MAiD. Some participants analyzed this on a macro level through Canada's history, medical school education, and inherent biases of non-Indigenous people.

> "A lot of non-Indigenous people have varying levels of inherent bias and depending on where you are and what community you're coming from, the medical community is not very welcoming to some Indigenous people. We've seen some of that in the news recently." (Participant, PEI)

Many participants related these concepts to power dynamics in healthcare, mentioning fears of authority, and feeling rushed, unheard, vulnerable, spoken down to, and blamed. Some also discussed power dynamics with Western health care providers through systemic lenses.

> "The doctor advises something, and Inuk will say yes without asking any questions because they feel the doctors know what they're doing, or the social services. Because they're white people and we've been taught white people are more educated - which is a bunch of bull!" (Inuit Knowledge Keeper, ON)
>
> "I've seen my mother and my grandmother, my aunties, give their power away to doctors. Everybody has. How many pills and how many things that they take because the doctor said so? 'We can't travel because the doctor said so' and the doctor decides their whole life... All the labels, the diagnosis." (Elder, SK)

Experiences of biases, racism, and power dynamics were naturally coupled with personal stories of receiving improper treatment. Communication issues were frequently flagged as problematic, including lack of information, derogatory remarks, and failure to accommodate language needs by not providing interpreters. Many participants were frustrated by inadequate care, including lack of urgency, misdiagnosis/ late diagnosis, and outright neglect.

The Role of Family and Community in End-of-Life Care

All sessions discussed how family and community provide support for those who are dying. Many emphasized the importance of extended family being present 24/7 at hospitals (or hospice/ palliative care facilities). Some faced challenges, including advocating for visitation, bridging language gaps, and stepping in for neglected care.

> "I stayed with my friend [in the hospital]. Her niece and I went and asked [the staff]: 'Can I get a wash basin? Can I get some soap?' Because there was an infection that started to ooze...not to leave her in filth." (Participant, BC)

Participants shared similar sentiments about providing home-based care, acknowledging its challenges while expressing gratitude for the privilege. Some emphasized positive sentiments around being present during the dying process.

> "There is that empowerment of 'we're going to keep you out of pain but we're going to still be here every day of every second that we can'... That was a special gift that was given to our families." (Participant, AB)

Participants spoke about grief in navigating end-of-life care and the challenges of watching their loved one's health deteriorate. While many participants emphasized the importance of family support at end-of-life, others reflected on those who experience isolation when dying. One participant expressed concerns about their own end-of-life support:

> "Our family systems are so broken. Before we were able to care for people as a family, everybody pitched in. I come from a broken family system. My sisters are not going to come, and they weren't there for my kid's birth. They're not going to be there when I die. Who's going to be there for me?" (Participant, AB)

Community also played a meaningful role in end-of-life care through supporting those dying in hospitals by sending singers for ceremonies, bringing cultural foods, and witnessing final wishes. Many emphasized the importance and interconnection of communities and families supporting each other throughout the process.

Addressing Gaps in Culturally Safe and Community-Based End-of-Life Services

A strong theme that emerged from discussions on community roles in end-of-life care was the need for more community-based services. Many expressed frustrations with the limited resources available in their communities.

> "Over 430 patients that are without family and friends, and it's just the two of them [on the Aboriginal Liaison Team] trying to navigate that every day.... Are you kidding? Two people?!" (Participant, AB)

The desire for community-based care services, such as hospice, palliative care, or home-based support, was a key focus for participants. Many preferred these options over hospital care. This sentiment was further amplified when discussing fly-in-and-out community experiences with end-of-life. One Elder shared detailed accounts of Elders being removed from their communities to receive care in a major city. Experiences of homesickness, loneliness (not seeing family for years before dying), cultural disconnect, and mistreatment were all underscored. They urgently advocated for needing community-based resources to support the dying.

> "Nobody visits them. They're being fed vegetables - they're meat eaters! They don't have their own food. They don't have an interpreter...I wish there was a way where they can send them home with enough funding to have somebody look after them for 24 hours... But there's no funding to care for these people that want to stay in community." (Inuit Knowledge Keeper, ON)

Other participants echoed the importance of having more Indigenous People involved in end-of-life care processes. As one Elder explained,

> "Bringing that care into the communities is to educate the personnel from these communities… and this being an educated part that's offered in a training program that's specific for Indigenous People, and that it can only come from Indigenous People." (Elder, PEI)

Recommendations for improving cultural safety included addressing issues like the inability to smudge in facilities and improving interactions between health care providers and families. Increased communication and empathy from providers were key themes, with recommendations for plain language use (and consideration/accommodation of language barriers), properly explaining treatments, engaging families in discussions, and creating empathic connections.

> "Having a nurse or even a doctor just bring in some water and just remind us that we're still here having a human experience… helping to make that connection from the medical team." (Participant, BC)
>
> "It's hard for them to look somebody in the eyes and to say, 'what can I do for you? What would you like? How do you see this playing out?' To actually engage. (Participant, YT)

Participants stressed that health care providers must accept their traditional knowledge and practices, with suggestions to expand cultural education. Finally, some proposed creating opportunities for health care providers to learn directly from Indigenous communities.

Theme 3: Preparation, Autonomy, and Decision-Making at End-of-Life

Planning and Preparing for End-of-Life Decisions

Discussions of MAiD prompted reflections on the importance of end-of-life planning. Participants shared stories of individuals who lost their capacity to consent, leaving difficult medical decisions to others. The idea of "your future being in the hands of others" was viewed as deeply unsettling. Without early, uncomfortable conversations, families faced the burden of making difficult decisions.

> "People are asked in the hospital whether they want to pull the plug because that person is brain dead and the machine is keeping them alive now. That's no longer life. But people are staying alive on machines and the family is asked to make a decision about that person because they didn't have that conversation before." (Elder, Saskatchewan)

This discussion underscored the necessity of families having open conversations about their end-of-life wishes. Although some participants acknowledged the emotional difficulty of these discussions, they agreed that being prepared is essential.

> “Where are you on the spectrum? Do you want to continue on till you hit a certain point? Have all those discussions before you’re in the moment. When everybody can just sit comfortably and have that cup of coffee or whatever. Just sit and talk when you're not in the emotional turmoil of the time.” (Participant, PEI)

Many participants found peace of mind in accepting death as inevitable and planned accordingly. They discussed having personal directives, signing Do-Not-Resuscitate (DNR) orders, registering as organ donors, creating wills, and pre-paying funeral arrangements. Some participants further reflected on how end-of-life planning intersects with MAiD, expressing positive opinions on its integration into the process.

> “It’s really something amazing when you can plan how you’re going to go out and who you’d like to be there... It’s such a very, very courageous thing to do.” (Participant, NL)

Honouring Autonomy and the Right to Choose

Participants frequently accentuated the importance of choice in end-of -life decisions when discussing MAiD. Many saw it as an individualized decision that must be respected, often describing it as “dying with dignity”. Some felt it allows for grace and peace in one’s final moments. While Participants discussed the contentious nature of MAiD, they also underscored the right to choose in comparison to other topics.

> “It’s an expansion of choice. I think it’s fantastic. It’s so similar to something like an abortion, [the] choice might not be right for you but there’s somebody else out there who it might be okay for. And you need to respect that person’s right to choose.” (Participant, SK)

Reflecting on their own end-of-life preferences, some participants wished it was available for family members who suffered in the past. Many expressed an appreciation for having the option available for both themselves and their communities. Personal stories were shared to highlight the challenges of navigating loved ones’ end-of-life choices. Family dynamics, differences of opinions, and emotions often made respecting end-of-life choices more difficult, reinforcing the need for open conversations in advance.

> “I became his voice because he told me. It wasn’t easy because [my] family all had their opinions. This is what mattered, it was what my father wanted. And I’ll honour you by saying: ‘Okay, I may not have agreed with it, but I will honour you and I will stand up and be your voice when you can’t be your voice’.” (Participant, YT)

Overall, participants strongly emphasized the importance of respecting and supporting the wishes of others, regardless of personal opinions. MAiD was seen as an important option in end-of-life decision-making.

Theme 4: Complex Ethical, Cultural, and Emotional Dimensions of MAiD

Personal Experiences and Understandings of MAiD

Participants had varying levels of awareness about MAiD, some only recently learned about it while others have known for years. Working in healthcare, word of mouth, media, documentaries, radio, and new sources were cited for discovering MAiD. Many shared experiences of family members and friends who chose MAiD.

> "Was my dad able to die with dignity? If I didn't know about it, he'd probably still be alive and he'd be miserable and he'd hate us all. He absolutely would. And I am so grateful for it." (Participant, AB)

A few participants had professional experience with MAiD, while others spoke about community members who chose MAiD. One participant recalled their community's support:

> "The whole community came out. Her option was her birthday...they all sang happy birthday to her and then she died on that day. I was expecting some backlash or negativity - there may have been, but I didn't hear anything...It was just a choice that she made, and all the community honoured it." (Participant, SK)

MAiD was largely viewed as a valuable option for terminal illnesses, often situating it as ending pain and suffering. Those with personal connections to MAiD expressed strong positive sentiments towards MAiD as an end-of-life option.

Navigating Religious, Cultural, and Spiritual Beliefs Around MAiD

Many participants explored MAiD through religious, cultural, and spiritual perspectives. A couple of participants grappled with whether MAiD was a sin under Catholicism, while others saw Catholic beliefs as harmful colonial conditioning. Cultural perceptions were divided. Participants with negative feelings towards MAiD often referenced cultural stigmas towards acknowledging death and MAiD's proximity to suicide as driving factors in their opinions.

> "I'm not even comfortable talking about it because it's just another suicide as far as I'm concerned...In my cultural background, we don't like to talk about death and helping people to die. Helping them, it's like you're a murderer." (Inuit Knowledge Keeper, ON)

Some participants emphasized the Creator's role in choosing when you die and not "engineering the process" of Mother Nature. The journey to the Spirit World was also a concern, with some participants unsure if MAiD would cause a spirit to remain in limbo.

> "I wonder, if we're going to be doing this assisted death, what if the timing's not right and therefore that spirit doesn't make it to where it's supposed to go?" (Participant, AB)

Others reconciled MAiD with cultural beliefs, distinguishing it from suicide and likening it to traditional teachings like "willing" oneself to die. One participant saw self-determination as central, believing that views restricting MAiD are inherently colonial. While some feared the Creator's reactions to MAiD, others emphasized the Creator as non-judgmental.

> "When your life journey is done, that's when you die. But that doesn't mean that you can't be the person who decides this is the time. The Creator is giving me the option to end my life in a way that I feel is the way it should be ended." (Participant, SK)

Recognizing MAiD as a personal choice, participants acknowledged the significant role religious, cultural, and spiritual beliefs play in decision-making.

Concerns with Consent, Safeguards, and Medical Oversight Processes

Participants raised concerns about the complexity of the MAiD, pointing to bureaucratic "red tape" delays and lengthy assessments as barriers. A key issue was the requirement to provide consent both at the start of the application and again at the time MAiD is administered. This leaves some individuals ineligible due to declining capacity. Dementia was a frequent concern, with participants advocating for the ability to provide advanced consent in these circumstances.

> "The laws have to change…. It's too bad you couldn't say 'Yeah I want MAiD when I'm no longer able to talk or when I'm no longer able to take care of myself'. They have to have the capacity so they may be doing it 2-3 years ahead of time when they really would want it." (Participant, NS)

Participants also briefly discussed the need for stronger safeguards and suggested patient advocates could help ensure informed, mediated decision-making. Concerns around loopholes, the potential for patients to recover, and health care providers' biases were all mentioned. Some worried about inconsistencies in how health care providers approach MAiD, ranging from refusing patients' wishes for MAiD to fears that MAiD would be readily suggested.

> "You often hear about the oath that the doctors had to take …Do no harm. What happens now if your practitioner is still of the old-school thinking? (Participant, BC)
>
> "If somebody told me about that MAiD, I would feel like oh, you just want me to hurry up and die. That's how I would feel." (Participant, NS)

These reflections underscored the delicate balance between autonomy and protection, and the importance of creating a system that supports consent, clarity, and trust.

Ethical Oppositions and Varied Perspectives on MAiD for Mental Health

Most participants approached MAiD with nuanced concerns and openness. However, when mental health eligibility for MAiD arose in discussions, there were many strong objections. Feelings of shock, fear, and disappointment were shared, especially given the high rates of mental illness in Indigenous communities.

> "It's insane because you're surrounded by a community that's at risk. You see people around you suffer every day. You bury your cousins, you bury your aunties. And then this is a solution that they give you? It's sickening. It's disappointing." (Participant, AB)

Participants strongly urged that housing, addictions supports, gender-affirming care, and accessible mental health services must first be addressed, as these are driving factors influencing mental health. They worried about the vulnerability of individuals with mental health issues and questioned how informed and supported those decisions could truly be.

> "Given that we have a lack of resources when it comes to mental health in our province, I wonder sometimes about something being so available to somebody who's at such a vulnerable point in their life." (Participant, NL)

Alternatively, some participants acknowledged the complexity of the issue, questioning whether MAiD for mental health could present a more peaceful, less invasive, and less traumatic alternative to suicide. They discussed the role of safeguards and robust counselling in MAiD applications as supporting those in need.

> "It's not to end pain, it's to end suffering, and suffering comes in so many different forms. Going through the counselling process, for my family member, if that was available when they were thinking of suicide...maybe there would have been a different end. Or maybe not. I mean, it would have been their decision at the end, whichever way it was." (Participant, PEI)

Integrating Cultural and Emotional Supports for Individuals and Families

Participants heavily emphasized the need for culturally safe spaces and respectful healthcare interactions. They called for stronger collaboration between health care services and Indigenous organizations, to ensure culturally grounded supports, such as Elders, Indigenous Health Liaisons, counsellors, medicines, and ceremonies, are available to those who want them.

While these cultural supports were seen as vital, participants said they should remain optional, not mandatory, to avoid placing undue emotional burden on Elders.

> “There’s only so much we can expect our Elders to do because it's a big decision… especially with our Elders when they're so close to that time of their life. It can also be hard for them as well.” (Participant, PEI)

There was also strong advocacy for grief counselling. Overall, most participants highlighted ongoing cultural and emotional support for both the patients and their families/communities as a necessary addition to MAiD processes.

> “Making sure that the family and community of the person is taken care of and look[ed] after in a good way. Not just, it happens and then all of those resources dissipate.” (Participant, NS)

Theme 5: Need for Awareness, Education, and Community Conversations on MAiD

Need for MAiD Awareness and Information

Participants consistently expressed a strong need for more education on MAiD, regardless of existing knowledge. Some had never heard of MAiD, while others felt they were only beginning to understand it. Most participants highlighted a lack of awareness in their communities, which contributed to misinformation, stigma, and fear.

> “There’s a lack of awareness and therefore, a bit of stigma… broader education… would help reduce the stigma.” (Participant, NL)

> “We as communities, tend to shun. People tend to be afraid to ask questions if someone’s doing MAiD…it’s taboo or is scary.” (Participant, NS)

Participants called for reputable, accessible information through websites, television commercials, and posters or pamphlets in health care settings. They had questions about eligibility criteria, the application process, and who the governing bodies were. Overall, participants emphasized the critical importance of ongoing awareness and engagement in MAiD’s implementation.

> “I believe that we have a very strong obligation to be part of these processes that are coming in from the colonial perspective, as Indigenous People. We must be aware. We must be knowledgeable…We must be part of this in order to either support…or to protect the next seven generations.” (Elder, PEI)

Promoting Community Conversation on MAiD and End-of-Life

Expanding on the need for awareness and information, many participants expressed the importance of bringing these conversations into their communities. While death is often avoided as a topic, some highlighted the healing power of speaking about it openly.

> “It’s a piece of clay that we all need to get our hands on and start [working] through that molding…. It stops that fear of passing away and it becomes a place of intention.” (Participant, YT)

Participants explored many ideas for facilitating these conversations, including collaborating with researchers, speakers, health care providers, and local health authorities, as well as cultural options such as round tables, sacred circle training/teachings, and Elders' weekends. One Elder emphasized the need for respectful, mindful, and community-specific:

> “It most definitely needs to be done with full respect and protocol… Just walking in with this kind of information could be an explosive topic…so the educational part, the knowledge sharing, and the demographics…the language, all that would be a priority.” (Elder, PEI)

These conversations were viewed as essential for preparing communities for informed, end of life decision-making, while also exploring how Indigenous culture could be integrated into MAiD processes.

> “The older generation they kind of want[s] to stick to our old ways, but our new generation needs to [do new things]. That’s where maybe MAiD comes in. It’s combining our Indigenous culture and creating the concept [of] ‘how should the Indigenous MAiD process look?’”. (Participant, ON)

Evolving Youth Education and Awareness of MAiD

Participants discussed how to navigate the topic with youth, emphasizing the need for trusted, credible sources. Concerns were raised about social media spreading misinformation, with some suggesting MAiD education should be integrated into school curriculums.

> “I would rather my child hear that from school… It’s better off to have it included in the curriculum…A lot better than hearing it and searching up for themselves and being ill-informed.” (Participant, NL)

Participants expressed mixed feelings on what age is appropriate for this education. Many agreed that the teenage years (highschool) would be best. Others believed children should receive transparent communication if they presented the topic.

> "We're not saying that they're going to use it. We're just going to say, there's this option.... At least they are aware that is there and it's a choice." (Participant, PEI)

They recognized potential backlash, comparing it to debates over sex education, Pride celebrations, and religious holidays. Still, they emphasized that avoiding the topic only deepens the taboo. They recognized that "knowledge is power" and that youth education will eventually change and evolve. They believed that eventually, MAiD would become normalized in society.

> "You're growing up with a generation who are going to have this as an option. It'll be something that more people have access to, just like any other kind of medical health care choice... That's going to become a normalized option." (Participant, SK)

VI: Limitations

This study had several limitations. First, the small sample sizes of both the MAiD Practitioners Survey (39 participants) and the Pre-Sharing Circle survey (58 participants) limit the generalizability of the findings. Most (75.85%) of Sharing Circle participants were over 40 years of age, limiting the representation of younger adults' perspectives on MAiD. Further, the vast majority (90.17%) of Sharing Circle participants identified as First Nations (both status and non-status), narrowing the applicability of these results as Métis and Inuit perspectives were not proportionately represented. The findings further highlight disparities between urban and rural/remote respondents, yet the sample size may not have been large enough to fully explore regional differences. This study also did not include Sharing Circles in the Northwest Territories, Nunavut, Manitoba, Quebec, and New Brunswick (due to various timing and capacity constraints), furthering knowledge gaps around MAiD in these regions. Given these factors, a larger sample that proportionately recruits by age, Indigenous identity, and location could provide a more representative understanding of perspectives on Indigenous MAiD services in future research.

Second, the MAiD Practitioner Survey primarily included family physicians and nurse practitioners, with fewer social workers and mental health professionals. This imbalance may not fully reflect the perspectives of those working in holistic or community-based care models. No significant statistical links were found between training, familiarity, and challenges, suggesting that key factors influencing Indigenous MAiD care may not have been captured. The impact of training (for health care providers) also remains unclear because while it increased familiarity with Indigenous MAiD needs, it did not reduce reported challenges. This raises questions about whether existing training programs effectively address systemic barriers. Additionally, both surveys relied on self-assessments of familiarity, training, and challenges, which may introduce bias, as participants could overestimate or underestimate their knowledge and experiences.

Third, this study may have attracted more participants with strong opinions on MAiD or Indigenous healthcare, potentially biasing the results. Further, participants for the MAiD Practitioners Survey were recruited through NWAC's social media channels, which may overlap respondents with other NWAC projects. Familiarity and experience with NWAC could introduce biased perspectives; recruiting through social media also limits the reach and diversity of respondents to those who regularly access the internet and use those channels of information sharing. Initially, there we 66 recorded competitions of the survey but upon further inspection of the data, 27 of those were fraudulent/automated accounts, leaving 39 valid responses. Future projects would require additional measures to prevent these responses. Further, recruitment for the Sharing Circles was performed by PTMAs and local organizations, with many citing challenges recruiting participants who felt comfortable discussing the subject matter. This highlights the importance of creating safe spaces for sharing diverse perspectives, as this could limit the representation of various opinions (including stronger, more oppositional views) towards MAiD.

Fourth, participation for this study was limited by language and accessibility (to technology, the internet, and physical spaces). The MAiD Practitioner Survey, Pre-Sharing Circle Survey, and Sharing Circle discussions were all conducted in English. The MAiD Practitioner Survey and virtual Sharing Circles required access to internet-connected devices and the ability to navigate SurveyMonkey. The virtual Sharing Circles necessitated reliable internet connection to attend a 2-hour Zoom meeting. In-person Sharing Circles were often conducted in proximity to urban centres, presenting potential barriers of distance and transportation for rural participants. This was further compounded by funding constraints, which did not support participants' travel from rural areas to urban centres for the Sharing Circles. This limited the representation of diverse rural/remote community locations.

Finally, jurisdictional barriers were not fully examined. Although the study acknowledges systemic discrimination and policy barriers, it does not deeply analyze jurisdictional issues (e.g., federal vs. provincial healthcare responsibilities) that may impact MAiD access for Indigenous communities. Addressing these limitations will be crucial for future research.

VII: Recommendations

To ensure equitable access to MAiD services for Indigenous W2STGD+ individuals, the following actions are recommended:

1. Indigenous-Led MAiD Education and Training

- Shift from general cultural competency training to Indigenous-led educational programs centered on experiential learning, community-driven approaches, and Indigenous perspectives on end-of-life care.
- Integrate training on the historical contexts affecting Indigenous healthcare experiences, Indigenous-led palliative models, and gender-affirming care.
- Provide mentorship opportunities with Indigenous health care providers and incorporate case studies and hands-on learning.

2. Systemic and Policy Reforms

- Remove jurisdictional barriers and implement policies that improve end-of-life care and MAiD accessibility in rural and remote Indigenous communities.
- Increase funding for Indigenous-led end-of-life care and MAiD services; expand culturally affirming supports.
- Require healthcare institutions to embed Indigenous perspectives within MAiD policies and adopt trauma-informed, anti-racist approaches.

3. Community Engagement and Awareness

- Establish partnerships with Indigenous communities, Knowledge Keepers, and health care providers to co-develop culturally appropriate MAiD frameworks.
- Conduct community-driven, culturally safe outreach to increase awareness and understanding of MAiD in Indigenous and non-urban communities.
  - ↳ Recognize the sensitivity and complexity of MAiD; vastly different cultural beliefs, practices, and experiences that impact different communities’ comfort around the topic.
  - ↳ Ask for permission before promoting MAiD information and awareness in Indigenous communities; ensure that materials and methods are respectful and honour Indigenous perspectives.
  - ↳ Collaborate with community Elders to facilitate the delivery of MAiD information in a manner that is culturally meaningful and grounded.

4. Culturally Safe MAiD Discussions and Care

- Ensure healthcare providers approach MAiD conversations with cultural humility, respecting Indigenous values, traditions, and spiritual practices.
    - ↳ Reduce experiences of fear and difficulties navigating bureaucracy by collaborating with local Indigenous organizations to offer support and access to Indigenous cultural practices (such as prayers, smudging, use of medicines, ceremonies, etc.).
- Integrate Indigenous-led palliative care models to ensure holistic, community-driven, culturally appropriate end-of-life care provision.
- Expand infrastructure and availability of end-of-life and MAiD services in communities to improve accessibility while maintaining cultural safety.

5. Research and Policy Development

- Purposefully engage rural and remote Métis and Inuit communities to expand understandings of the unique cultural and geographical considerations for providing MAiD services.
- Conduct studies to assess the effectiveness of Indigenous-led MAiD training and systemic policy reforms.
- Work with Indigenous leaders and policymakers to dismantle structural barriers and uphold Indigenous self-determination in MAiD policymaking.

By implementing these recommendations, healthcare institutions and policymakers can work toward a more inclusive, culturally safe, and accessible MAiD framework that respects and integrates Indigenous perspectives on end-of-life care.

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Appendix A: Consent Letter for Sharing Circles

Title of Project: Perspectives in Medical Assistance in Dying (MAiD) amongst Indigenous Women, Two-Spirit, Transgender, and Gender-Diverse People in Canada: An Exploratory Study.

Introduction

You are invited to participate in a Sharing Circle with the Native Women's Association of Canada. This project aims to explore the challenges, experiences, and viewpoints of Indigenous Women, Two-Spirit, Transgender, and Gender Diverse (W2STGD+) people across Canada regarding MAiD. Your participation involves completing one survey (online or in-person) and participating in one Sharing Circle.

Background

Funded by Indigenous Services Canada, this project emphasizes the crucial role of Indigenous W2STGD+ voices in shaping discussions about MAiD. Discussions will be centred on accessibility, knowledge, and support needs to inform resources and policy recommendations.

NWAC aims to develop tailored resources that aid health system decision-makers in formulating policies, programs, and initiatives to address concerns and perspectives of Indigenous W2STGD+ individuals within the context of MAiD. The final report will amplify participants' recommendations and direct them toward government officials, health care practitioners, MAiD providers, and academic institutions. This resource will offer vital information, fostering awareness of health care priorities and community concerns at various levels.

Purpose of the Project

This project is part of a larger, multi-year initiative led by Health Canada to collaborate with Indigenous partners and inform MAiD policy and implementation, and overall end-of-life care policy. As a partner with Indigenous Services Canada and Health Canada, NWAC is committed to respectfully leading community engagement across Canada. Additionally, this project will also contribute to future funding initiatives that aim to support critical areas like mental health and addictions within Indigenous communities, especially as they intersect with MAiD.

A survey (completed virtually or in-person) before the Sharing Circles will gather individual demographics, perspectives, and insights related to MAiD. This will be followed by virtual and in-person Sharing Circles with Indigenous W2STGD+ Individuals across Turtle Island and Inuit Nunangat, in partnership with provincial and territorial membership associations and other community-based organizations to ensure engagements are accessible and regionally representative. By sharing your lived experiences, you will help determine the research, services and resource needed for MAiD within Indigenous communities.

Based on the insights gathered, NWAC will develop a summary report to be sent to Indigenous Services Canada and published on the NWAC website. The report will highlight findings from these engagements, including recommendations for moving forward, and will be available in both English and French. Additionally, an academic article will also be developed and published to reach academic institutions.

Your Participation

This project received approval from Indigenous Services Canada through its internal ethics review process. Your participation is entirely voluntary. NWAC recognizes that participating in the Sharing Circle discussions, particularly on the topic of MAiD, may present challenges. NWAC is committed to ensure that all participants across Turtle Island and Inuit Nunangat feel safe, comfortable, and free to share their experiences and thoughts without fear of judgement.

Your contribution to this project holds significant weight in shaping recommendations and policies that address the impact of MAiD on Indigenous communities. By sharing your insights, you will have a meaningful opportunity to influence future actions and services. Additionally, participation offers a chance to connect with others who share similar concerns and experiences, fostering a sense of community and support.

Potential Risks

It is important to acknowledge the potential risks associated with participation. Engaging in conversations on death and dying, and your choices around end-of-life car may evoke strong emotions or trigger personal memories and experiences. While NWAC is committed to fostering a safe and respectful environment, you may encounter differing perspectives or opinions that could be emotionally challenging. Crisis support resources are available should you need them. Your input is invaluable, and we are deeply grateful for your willingness to be a part of this important endeavour.

What is being collected?
We will be asking you to share your experiences, knowledge, and insight regarding MAiD and its impact on you and your community. Some of the topics discussed will include your personal experiences with MAiD, the challenges you or your community have faced related to MAiD, the support, resources, or services you believe are needed, any concerns you may have, and your recommendations concerning MAiD and its implementation. This may involve conversations about healthcare system experiences that relate to MAiD, which may bring up distressing emotions. Please seek support or take time at any point.

Your participation will remain anonymous, and anything shared will be kept confidential. Your name and identifiers will not be shared or used with anyone outside of the project team or recorded in any reports.

What happens to the information I provide?
The Sharing Circle session will be recorded and transcribed using Zoom. After the session, all documents and notes will be anonymized immediately and securely stored, with only the research team having access to the information. Once the final reports are written and new programming has been developed and implemented, all notes and information will be destroyed. All participants will have access to the final report once it is published.

How is this information being shared?
The information we receive during the Sharing Circle sessions will be anonymized and handled only by the NWAC project team to develop recommendations about Indigenous-specific views and priorities regarding MAiD. NWAC, Health Canada and Indigenous Services Canada are committed to respecting Indigenous data sovereignty by ensuring that the organization and use of data fully aligns with OCAP Principles of data Ownership, Control, Access, and Possession. The information generated from this project may be shared on the NWAC website, social media platforms, in peer-reviewed journals, and in presentations. The final report will be sent to the funder, Indigenous Services Canada. None of your personal or identifying information will be shared.

What if I change my mind and no longer want to participate?
In the event, that you, as a participant feel uncomfortable or uncertain about what you shared during the Sharing Circle session and/or the survey, and no longer wish to have it included in the session notes or project, you have the option to withdraw. Participants are free to leave the Sharing Circle at any time. You can decide if what you shared before leaving can be used in this project, whether specific parts are included, or if none of it is included. Please notify us of your decision either during the session by informing the facilitator or later via email.

Resources

Crisis Lines

Métis Crisis Line is a service of Métis Nation British Columbia.
Call **1-833-MétisBC (1-833-638-4722).**

Hope for Wellness Help Line offers immediate mental health counselling and crisis intervention by phone or online chat. Call toll-free **1-855-242-3310** or start a confidential chat with a counsellor at hopeforwellness.ca.

Services are offered in: Ojibway, Cree, Inuktitut, English and French

Talk 4 Healing is a service for Indigenous women in Ontario.

Call 1-855-554-4325 or start a confidential chat at beendigen.com/programs/talk4healing

Services are offered in: Ojibway, Oji-Cree, Cree, Algonquin, Inuktitut, Mohawk, Oneida, Odawa, Potawatomi, Micmac, Blackfoot, Anishinaabe, Moose Cree, Swampy Cree and English

Kamatsiaqtut Nunavut Helpline provides anonymous and confidential telephone counselling for northerners in crisis.

Call **1-800-265-3333**

Services are offered in: Inuktitut, English and French

Indian Residential Schools Resolution Health Support Program provides cultural and emotional support, and mental health counselling services to Survivors of Indian Residential Schools and the families of former students.

Please contact the Indigenous Services Canada regional office in your province or territory (or, for those in British Columbia, the First Nations Health Authority (FNHA) to access services through the Resolution Health Support Program.

Appendix B: MAiD Practitioners Survey

Disclaimer and Consent

Indigenous Services Canada funds this project. The purpose of this project is to gather essential data regarding the views and education of MAiD practitioners concerning Indigenous Women, Two-Spirit, Transgender and Gender-Diverse (W2STGD+) individuals' experiences with Medical Assistance in Dying (MAiD). The insights collected will inform recommendation for improving the quality and cultural competence of MAiD practices when working with Indigenous communities. Survey responses will remain entirely anonymous.

We kindly ask you for your candid and honest responses, as the accuracy and depth of your insights are pivotal in shaping our recommendations. The NWAC team acknowledges the dedication of allies who strive to ensure that Indigenous patients and clients are treated with the respect, dignity, and culturally affirming care they deserve. For those who do not identify as Indigenous and/or have not experienced health-related discrimination in the past based on race, ethnicity, or heritage, the risks associated with this survey are minimal. However, it's important to note that discussions regarding MAiD may evoke strong emotions or trigger personal memories and experiences.

The NWAC team greatly appreciates the commitment of MAiD practitioners and their teams to provide the best possible care and support. As a token of our appreciation, the first forty individuals who complete the survey will receive an honorarium of $25 to Native Women's Association of Canada shop Artisanelle, which will be sent by mail.

1. What is your current health practitioner role?

○ Family Physician
○ Nurse Practitioner
○ Pharmacist
○ Mental Health Professional
○ Social Worker
○ Other (please specify):
____

2. Do you Identify as Indigenous?

○ Yes, I identify as:
○ No, I am not Indigenous.
○ Do not wish to disclose.

3. Do you work alongside health care practitioner staff who identify as Indigenous?

○ Yes ○ No ○ Unsure

4. Do you have, or have you had any patients that identify as Indigenous?

○ Yes ○ No ○ Unsure

5. Do you provide health care services to Indigenous patients located (select as many as needed):

○ On-reserve
○ Off-reserve
○ Urban centres
○ Remote locations
○ Fly-in communities

6. On which territory do you provide health services:

7. What is your postal code? This information will help us better understand the geographic distribution of our participants.

8. Does your health team provide Indigenous specific services for Indigenous patients?

○ Yes ○ No ○ Unsure

9. Have you participated in MAiD procedures as part of End-of-Life Care within the past 5 years?

○ Yes ○ No ○ Unsure

10. Which of the following MAiD services do you provide or are involved in? (Select all that apply)

○ Referrals to MAiD providers
○ Acting as a witness during the MAiD procedure
○ Conducting consultations with patients considering MAiD
○ Administering medication for MAiD
○ Assessing eligibility for MAiD
○ Emotional and Psychological Support
○ Bereavement Support
○ Other (please specify): ______________________

11. Are you familiar with the unique cultural and health care needs of Indigenous Women, Two-Spirit, transgender, and gender-diverse (W2STGD+) individuals in the context of MAiD?

○ Extremely familiar
○ Very familiar
○ Somewhat familiar
○ Not so familiar
○ Not at all familiar
○ Unsure

12. In your opinion, what specific challenges or barriers might Indigenous W2STGD+ individuals face in accessing MAiD services?

13. How do you ensure culturally sensitive, and affirming care for Indigenous W2STGD+ individuals when providing MAiD services?

14. Have you received any formal education or training specifically related to providing MAiD services to Indigenous W2STGD+ individuals?

○ Yes ○ No ○ Unsure

15. If yes, please briefly describe the content and duration of this education or training.

16. Do you feel your education and training provided enough information about the unique needs of different Indigenous Communities to provide adequate care related to MAiD?

○ Yes ○ No ○ Unsure

17. What additional education or training do you believe would be beneficial for health care practitioners regarding MAiD services for Indigenous W2STGD+ individuals?

18. In your experience in providing MAiD services, have you encountered any specific challenges or consideration when providing MAiD services to Indigenous individuals who also have mental health or substance use issues?

○ Yes ○ No ○ Unsure

19. If yes, please briefly describe the challenges or considerations.

20. Do you have any additional comments, suggestions, or experiences you would like to share regarding MAiD services for Indigenous W2STGD+ individuals?

21. Would you like the Native Women's Association of Canada (NWAC) to send you training, resources, and information that come from this research project? If so, please provide your email address below:

22. If you are in the first forty individuals to complete the survey, would you like to receive your honorarium of a $25 gift card to Native Women's Association of Canada shop Artisanelle? If so, please provide a mailing address below:

Appendix C: Pre-Sharing Circle Participant Survey

Disclaimer and Consent

The purpose of this survey is to gather the perspectives and experiences of Indigenous Women, Two-Spirit, Transgender and Gender-Diverse (W2STGD+) individuals with Medical Assistance in Dying (MAiD).

Content Warning: This survey discusses sensitive topics related to Medical Assistance in Dying (MAiD) and End-of-Life care within Indigenous communities. It may touch on experiences and perspectives that could be emotionally distressing or triggering for some individuals. Please be aware of the potentially difficult nature of the content before proceeding with this survey.

You may choose to skip any question you do not wish to answer. The survey is 22 questions long and could take you about 15-20 minutes to complete. No ethics board approval is required for this survey as the project was already approved by Indigenous Services Canada and their internal ethics review, however, we do ask you access the Survey Consent Form to ensure you are aware of the risks and benefits of the survey. All surveys will be submitted anonymously, meaning we will not know who completed the survey. If you complete a survey in person, we will put the survey in an envelope and review the information later. All information you provide is confidential, meaning no names or identifying information will be used.

Section One: Demographic

1. In terms of your Indigenous identity, how do you identify (Click all that apply)

- ○ First Nations, Status
- ○ First Nations, Non-Status
- ○ Inuit
- ○ Métis
- ○ I also identify as: (specify below) :

____

2. How do you identify in terms of your gender? (Click all that apply)

- ○ Two-Spirit
- ○ Woman
- ○ Man
- ○ Transgender
- ○ Non-binary or Gender Diverse
- ○ I wish to use other words to describe my gender (write below)

____

3. What is your current age?

- ○ 18-25
- ○ 26-30
- ○ 31-39
- ○ 40-49
- ○ 50-59
- ○ 60-69
- ○ 70-79
- ○ 80-85
- ○ Over 85

4. Which province or territory do you currently live in?

- ○ Alberta
- ○ British Columbia
- ○ Quebec
- ○ Manitoba
- ○ New Brunswick
- ○ Newfoundland and Labrador
- ○ Northwest Territories
- ○ Nova Scotia
- ○ Nunavut
- ○ Ontario
- ○ Prince Edward Island
- ○ Saskatchewan
- ○ Yukon

5. How would you describe where you grew up? (Select all that apply)

- ○ On reserve
- ○ Off reserve
- ○ Inuit community
- ○ Métis settlement
- ○ Remote
- ○ North
- ○ Rural (small towns etc.)
- ○ Urban Centre
- ○ Not applicable

6. What Traditional Territory do you currently have the honour of living on?

Section Two: MAiD and End-of-Life Care:

7. When did you first hear about Medical Assistance in Dying (MAiD)?

- ○ Less than 1 year ago
- ○ 1-2 years ago
- ○ 2-5 years ago
- ○ More than 5 years ago
- ○ I can't remember.

8. How familiar are you with MAiD?

- ○ Very familiar
- ○ Somewhat familiar
- ○ Not very familiar
- ○ Not familiar at all

9. Which, if any Western End-of-Life services have you encountered or are aware of? [check all that apply]:

- ○ Palliative Care
- ○ Hospice Care
- ○ Long-term Care
- ○ Medical Assistance in Dying (MAiD)
- ○ None
- ○ Other (write below)

____

10. **In your community, what End-of-Life resources are available?**

- ○ Palliative Care
- ○ Hospice Care
- ○ Long-term Care
- ○ Medical Assistance in Dying (MAiD)
- ○ None
- ○ Other (write below)

____

11. **What cultural practices or ceremonies in your community play a vital role in End-of-Life care?**

12. **Do you believe that Indigenous values and perspectives are considered when receiving MAiD services within Indigenous communities?**

○ Yes ○ No ○ Unsure

13. **Have you, or someone you know, accessed a MAiD request?**

○ Yes ○ No ○ Unsure

14. **Have you sought information or education about MAiD for yourself or others?**

○ Yes ○ No ○ Unsure

15. **If yes, where did you find this information or education?**

- ○ Health care providers
- ○ Community Elders or Leaders
- ○ Family or friends
- ○ Internet or media
- ○ Other (please specify)

____

16. **Have you or someone you know ever been suggested MAiD by a health care provider?**

○ Yes ○ No ○ Unsure

17. **Have you or someone you know personally faced challenges related to MAiD or End-of-Life care?**

○ Yes ○ No ○ Unsure

18. **Do you believe that there is enough awareness and understanding within your community about the concept of MAiD?**

○ Yes ○ No ○ Unsure

19. If no, what areas of MAiD do you believe require more public awareness or education within your community?

○ Process and regulations
○ Cultural considerations
○ Availability
○ Other (please specify) ______________________

20. What is important for health care providers to know about MAiD or End-of-Life services in Indigenous Communities?

21. Would you be willing to provide feedback on the final report and recommendations developed from this survey and Sharing Circle?

○ Yes
○ No.
○ Maybe, please send me more information

22. If yes, or if you'd like more information, please share your contact email.

Appendix D: Sharing Circle Questions

Content Warning & Disclaimer

This Sharing Circle discusses sensitive topics related to Medical Assistance in Dying (MAiD) within Indigenous communities, including knowledge, awareness, accessibility, racism, and discrimination. The discussion may involve emotionally challenging or triggering subjects. Additionally, we want to inform you that an Elder will be present for support and guidance during this session.

Please be aware of the potentially difficult nature of the content before participating in this Sharing Circle. If you find any aspect of the discussion distressing or if you require support during or after the session, please don't hesitate to reach out to the Elder, who is here to offer guidance and assistance. Your participation is voluntary, and you are not required to respond to any questions that make you uncomfortable.

Contextual Understanding (~20 minutes):

1. **When did you first hear of Medical Assistance in Dying (MAiD) and what was your initial reaction?**

2. **Have you or anyone you know looked for information about MAiD? Where did you find it?**
    a. Did the information about MAiD provide a comprehensive understanding, or were there gaps in the information available?

Defining Perspectives (~25 minutes):

3. **What do you think about MAiD? Is it a good or bad thing for your community? Why?**
    a. What factors or experiences shape this opinion?

4. **Are there any Indigenous beliefs and teachings that influence how you see MAiD?**

Accessibility and Challenges (~20 minutes):

5. **Do you have access to MAiD services or end-of-life resources within your community?**
   a. If yes, what types of resources are available?
   b. What resources do you think are missing/lacking?

6. **Have you or someone you know faced any problems or challenges when accessing MAiD resources or other end-of-life care options?**

7. **What kind of support or resources do you think would be most beneficial for Indigenous communities when discussing or considering MAiD?**

Cultural Integration and Training (~20 minutes):

8. **What changes do you think should happen to make sure MAiD respects and integrates Indigenous cultural values and perspectives on end-of-life decisions?**
   a. What measures or approaches do you think could be created to ensure that MAiD practitioners are more culturally sensitive and respectful when working within Indigenous communities?

9. **Should MAiD practitioners get specific cultural training to better understand and respect Indigenous perspectives on death and dying?**
   a. What might this training look like?

Impact and Future Perspectives (20 minutes):

10. **How do you think the acceptance or rejection of MAiD within Indigenous communities today might influence future generations?**

11. **Are there aspects of MAiD that you think people in your community should know more about?**

Native Women's
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