

INDIGENOUS HEALTH PRIMER

The Indigenous Health Writing Group of the Royal College
2019



ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA
COLLÈGE ROYAL
DES MÉDECINS ET CHIRURGIENS DU CANADA

Foreword

The following document is designed to provide key approaches, ideas and background knowledge for health care providers, learners and educators in caring for Indigenous Peoples. The primer was written and edited by Indigenous and non-Indigenous authors. Many of us are practising Indigenous physicians from a breadth of specialties. Each reference section is linked to detailed sources, the majority of which were created by Indigenous organizations. In addition to the theoretical and medical content, we aimed to include stories to illustrate the experiences of Indigenous Peoples in the health care system.

Quotes, testimonials, historical accounts and Indigenous physician perspectives are woven throughout the document as a way to honour Indigenous knowledge and ways of knowing, and also to promote self-reflection amongst readers. Ultimately, we hope to adapt the content of this primer into an interactive tool that includes videos, webinars and dynamic course materials. Whether you are a learner, teacher or practising professional, we hope that the *Indigenous Health Primer* will be an important resource on your journey to become a culturally safe provider for Indigenous patients, families and communities.

United Nations Declaration on the Rights of Indigenous Peoples. (2007).
Article 31.

1. Indigenous Peoples have the right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as the manifestations of their sciences, technologies and cultures, including human and genetic resources, seeds, medicines, knowledge of the properties of fauna and flora, oral traditions, literatures, designs, sports and traditional games and visual and performing arts. They also have the right to maintain, control, protect and develop their intellectual property over such cultural heritage, traditional knowledge, and traditional cultural expressions.

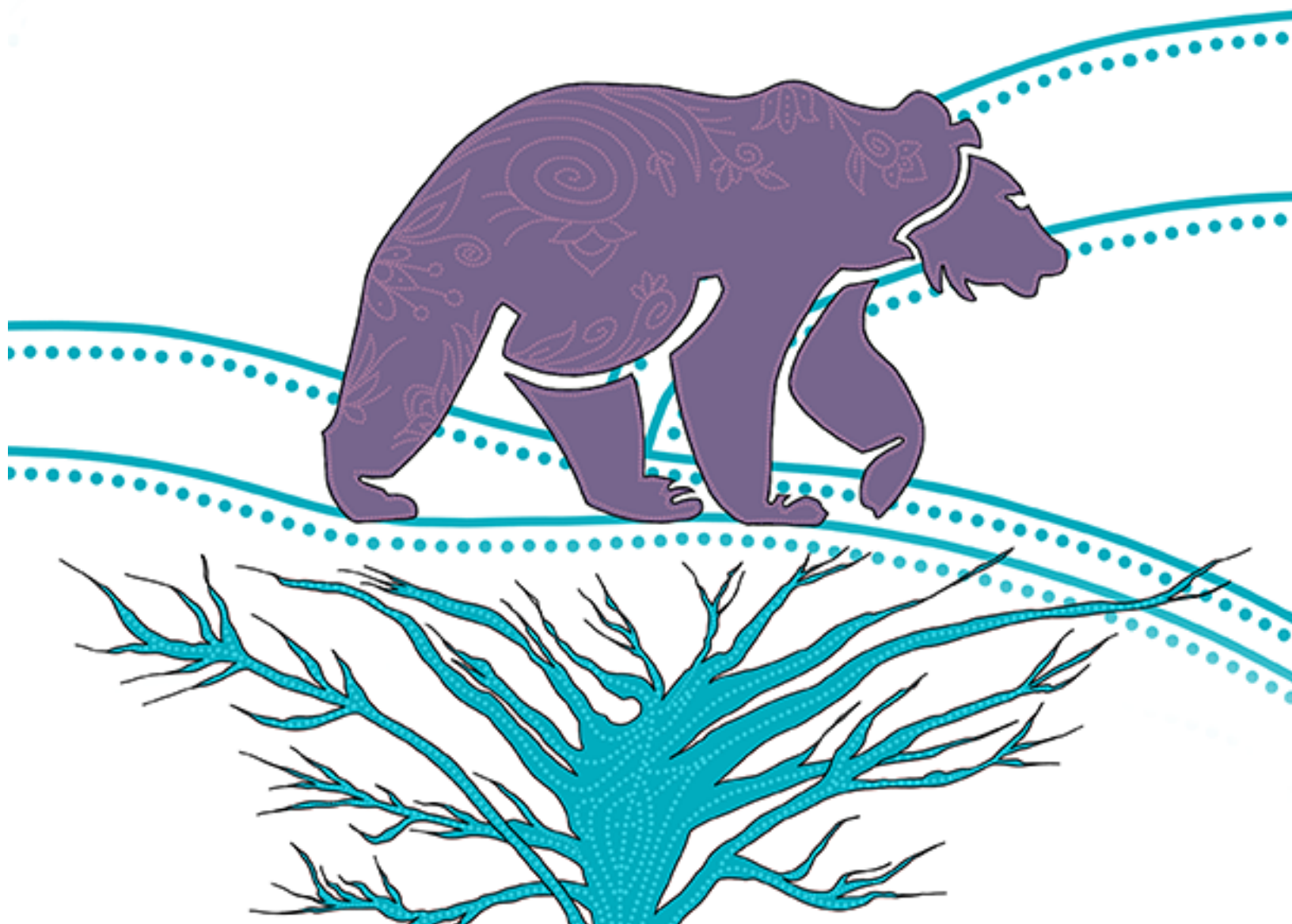
2. In conjunction with Indigenous Peoples, States shall take effective measures to recognize and protect the exercise of these rights.

Quote

“If you want to measure the effect of Canada’s racist and colonial policies toward Indigenous Peoples you only have to look at the fact that while Canada was recently

number one in the international quality of life indicator, Indigenous Peoples within its borders languished at number seventy-eight.”

Manuel, A. (2017). *The Reconciliation Manifesto Recovering the Land and Rebuilding the Economy*. James Lorimer & Co. Publishers. Toronto: ON, p. 78.



A word about language

The term Indigenous Peoples in this document refers to First Nations, Inuit and Métis Peoples in Canada collectively. It is important to recognize and respect these distinctions, where appropriate. “Indigenous” is gaining currency as the more recently preferred term by Indigenous Peoples, replacing the term “Aboriginal” (which is still acceptable and widely used in certain circles). Beyond these general terms, many Indigenous Peoples refer to themselves by their own Nation (e.g., Mi’kmaq, Haudenosaunee, Anishinaabe, Nisga’a, etc.).

The term “Indigenous” also refers to the original peoples of Turtle Island prior to colonization. Terms, names and styles continue to evolve. The language choices in this document are intended to mitigate colonial biases and respectfully reflect Indigenous experiences in health care.



Structure

The *Indigenous Health Primer* is organized into nine chapters, for quick reference, and is supported by more than 170 citations and links. Most chapters are structured in three segments:

- 1) a cited case study,
- 2) key topic areas under the chapter subject, and
- 3) references and links listed in alphabetical order.



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This document, along with more Indigenous health information, can be found at www.royalcollege.ca/indigenous.

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Chapter 1: Indigenous knowledge, science and rights

Case study

Genocide: The dismantling of Indigenous knowledge and human rights. (Truth and Reconciliation Commission of Canada, 2015).

The assault on Indigenous identity usually began the moment the child took the first step across the school's threshold. Braided hair (which often had spiritual significance) was cut, homemade traditional clothing was exchanged for a school uniform, Indigenous names were replaced with Euro-Canadian ones (and a number), and the freedom of life in their own communities was foregone for the regimen of an institution in which every activity from morning to night was scheduled. Males and females, and siblings, were separated, and, with some exceptions, parental visits were discouraged and controlled.

Hastily and cheaply built schools often had poor or non-existent sanitation and ventilation systems. With few infirmaries in which students with contagious diseases could be isolated, epidemics could quickly spread through a school with deadly results. Because schools were funded on a per capita basis, administrators often violated health guidelines and admitted children who were infected with such deadly and contagious diseases as tuberculosis. Often, parents were not informed if their children became sick, died, or ran away.

For most of the system's history, the federal government had no clear policy on discipline. Students were not only strapped and humiliated, but in some schools, they were also handcuffed, manacled, beaten, locked in cellars and other makeshift jails, or displayed in stocks. Overcrowding and a high student-staff ratio meant that even those children who were not subject to physical discipline grew up in an atmosphere of neglect.

"My ancestors resisted and survived what must have seemed like an apocalyptic reality of occupations and subjugation in a context where they had few choices. They resisted by simply surviving and being alive. They resisted by holding onto their stories. They resisted by taking the seeds of our culture and political systems and packing them away, so that one day another generation of Michi Saagiig Nishnaabeg might be able to plant them. I am sure of their resistance

because I am here today, living as a contemporary Michi Saagig Nishnaabeg woman. I am the evidence. Michi Saagiig Nishnaabeg people are the evidence. Now nearly two hundred years after surviving an attempted political and cultural genocide, it is the responsibility of my generation to plant and nurture those seeds and to make our ancestors proud” (Simpson, 2011:15).

Indigenous science

Indigenous science is a form of Indigenous knowledge. It refers to the science of Indigenous cultures. It is a way of seeing and knowing that is dynamic, holistic, intergenerational and time-tested. Indigenous science has existed for thousands of years, thus developing sophisticated modes of knowledge-transfer that have enabled its *survivance* (more than mere survival — it is a way of life that nourishes Indigenous ways of knowing).

Despite this survivance, Indigenous Science has been devalued in the past by a Eurocentric worldview and institutions that have deemed it to be simplistic or primitive. Indigenous Science is place-based and therefore dependent on a deep connection and relationship to traditional lands and the natural world.

Anishinaabe Historian Brenda Child states “In Ojibwemowin, our language, the term for medicine is mashkiki or ‘strength of the earth.’ Medicine people approached the plant and medicinal knowledge in a meticulously systematic way, according to Frances Densmore, always emphasizing experiment and study. Like artists in their work, they were masterful observers of the natural world. They knew the exact time to harvest a multiplicity of plants, many of which had the most ephemeral season...Their work sustained the Ojibwe goal of *mino bimaddizi* [“the philosophy of a good life]” (Densmore, 2005).

Although Indigenous Nations in what is now referred to as Canada are incredibly diverse, they all share a common, earth-centred worldview. They also share a sense of deep interconnection and relationship with the land that differs from the dominant Eurocentric understanding.

“To the settler mind, land was property, real estate, or natural resources. But to our people, it was everything: identity, our connections to our ancestors, the home of non-human kinfolk, our pharmacy, our grocery store, our library, the source of everything that sustained us. Our lands were where our responsibility to the word was enacted, sacred ground. It belonged to itself; it was a gift, not a commodity, so it could never be bought or sold” (Kimmerer, 2013).

Indigenous self-determination in research

Worldview

“Research involving Aboriginal Peoples in Canada has been defined and carried out primarily by non-Aboriginal researchers. The approaches used have not generally reflected Indigenous worldviews, and the research has not necessarily benefited Aboriginal Peoples or communities. As a result, Aboriginal Peoples continue to regard research, particularly research originating outside their communities, with a certain apprehension or mistrust” (Government of Canada, 2018).

Ethical research that asserts the rights of Indigenous Peoples is addressed in the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2)* that is linked to in this chapter’s references.

The First Nations principles of OCAP®

As stated by the First Nations Information Governance Centre:

“The First Nations Principles of OCAP® represents a set of standards that establish how First Nations data should be collected, protected, used, or shared. They are the *de facto* standard for how to conduct research with First Nations. Standing for ownership, control, access and possession, OCAP® asserts that First Nations have control over data collection processes in their communities, and that they own and control how this information can be used” (First Nations Information Governance Centre, 2019).

The First Nations Information Governance Centre defines the standards that make up OCAP® as follows.

“**Ownership** refers to the relationship of First Nations to their cultural knowledge, data, and information. This principle states that a community or group owns information collectively in the same way that an individual owns his or her personal information.”

“**Control** affirms that First Nations, their communities, and representative bodies are within their rights in seeking to control over all aspects of research and information management processes that impact them. First Nations control of research can include all stages of a particular research project — from start to finish. The principle extends to the control of resources and review processes, the planning process, management of the information and so on.”

“**Access** refers to the fact that First Nations must have access to information and data about themselves and their communities regardless of where it is held. The principle of access also refers to the right of First Nations communities and organizations to manage and make decisions regarding access to their collective information. This may be achieved, in practice, through standardized, formal protocols.”

“**Possession.** While ownership identifies the relationship between a people and their information in principle, possession or stewardship is more concrete: it refers to the physical control of data. Possession is the mechanism by which ownership can be asserted and protected.”

Métis and Inuit frameworks for self-determination in research

As stated in the *University of Manitoba Framework for Research Engagement with First Nation, Métis, and Inuit Peoples* (2016):

“The Manitoba Métis Federation subscribes to the OCAS principles: Ownership, Control, Access and Stewardship. Ownership refers to the legal possession of something. Control refers to the power to make decisions about something and decide what should happen. Access refers to the right or opportunity to use something that will bring benefits. Stewardship speaks to issues of responsible planning and management of resources.

We have a responsibility to Métis to ensure that research that is completed is in their best interests, will result in positive changes in Métis health and health service delivery, and is done in as rigorous and ethical a manner as possible.

The Manitoba Inuit Association is committed to Inuit Qaujimajatuqangit. Inuit Qaujimajatuqangit is an Inuktitut phrase that is often translated as “Inuit traditional knowledge, Inuit traditional institutions or even Inuit traditional technology.” It comes from the root verb “qaujima” — meaning, “to know” — and can be literally translated as “that which has long been known by Inuit.” It is used to mean the integration of traditional culture of the Inuit into their modern governance structure, in order to combat disempowerment.”

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Chapter 2: Racism and anti-racism interventions

Case study

The tragic story of Brian Sinclair.

(Tomascik, Dignan, & Lavallée, 2018). In Arya, A.N., Piggott, T., the contributing authors and Canadian Scholars. 2018)

"There may have been some changes going on, but this is in no way an issue that has gone away and I don't think we can expect it to go away any time soon. Until people feel safe going to the hospital, we can't really say that very much substantial change has happened. It's terrible to remember that he actually died that way. I'd like to think that he passed away teaching us all something, teaching us that as human beings, we have become so insensitive to each other. The racism, the stereotyping, none of that has been addressed." – Cousin of Brian Sinclair (Malone, 2018).

Sometime in the waning hours of September 20, 2008, Mr. Brian Sinclair died in the waiting room of the emergency department of the Winnipeg Health Sciences Centre (WHSC). He was only 45. The medical cause of Brian's death was a treatable condition known as acute peritonitis — an infection from a blocked catheter that spread into his bloodstream causing shock.

His death did not come quickly. He obediently waited for 34 hours in the hospital waiting room in pain and discomfort before succumbing to sepsis. This tragedy occurred after he was admitted, triaged for medical attention and then subsequently forgotten until it was too late. He died before any medical intervention or human comforts were considered. He did not have an advocate and he passed away alone.

Brian did everything right in terms of seeking medical attention. He entered a community health clinic in Winnipeg, complaining of abdominal pain and being unable to relieve himself. An attending physician at the clinic immediately referred him to the WHSC for emergency treatment; within a span of about 40 minutes, he arrived at the emergency department by taxi with a referral letter from the primary care physician.

He was discovered dead in the waiting room a day and half after being admitted (Ignored to Death, 2017; Malone, 2018; Deal, 2013).

Did it matter that Brian was a broken man when he entered the system? In this circumstance, it did. He was homeless, a double amputee, wheelchair-dependent and he suffered from a range of chronic illnesses. He was also an Indigenous man. Indigenous health leaders and community members describe the death of Brian Sinclair as an extreme example of racism in the health care system.

The definition of racism

Racism includes the belief that one's own race is superior to another, as well as discrimination based on policy and outright hatred or intolerance (Reading, 2013a). Racism is shaped by the distribution of money, power and resources, which control the social determinants of health (Reading, 2013b).

Racism is an intractable issue. It is commonly described as structural, institutional or systematic. It translates into oppression through both interpersonal behaviours and through regulatory, social, political and economic policies in governments, public and private institutions (ERASE Racism, 2013).

Medical education is not immune. In fact, its "hidden curriculum" can reinforce traditional power structures and Eurocentric worldviews that may perpetuate racist behaviours. Racism appears in many forms within medicine and leads to negative health effects for individuals, families and communities (Tomascik, Dignan & Lavallée, 2018).

The roots of racism in Canada

"The real cause of our profound distress is of course, that we do not have power over any land or resources in our Aboriginal and treaty territory except for the 0.2 per cent of our territories that has been designated as reserve lands. We have no access to our own Aboriginal and treaty lands to build a sustainable economy for our peoples, so we look stupid and primitive. The settlers who have access and control over 99.8 per cent of our territory always look smart and civilized" (Manuel & Derrickson, 2017).

"Colonialism is a process with a long history...and values in Canada have been informed by the colonial foundation of the nation. The present health of Indigenous Peoples is impacted by these colonial foundations, which have

resulted in the displacement and marginalization of Indigenous communities... and the perpetuation of discriminatory or stereotyped ideas about what it means to be Indigenous”(Reading, 2013a).

Canada’s colonial legacy continues to adversely affect the health and well-being of Indigenous populations. Most of the country’s colonial policies were originally designed to access natural resources located on Indigenous lands. This gradually perpetuated total control over every aspect of the lives of Indigenous Peoples.

Colonialism equals racism

The *British North America (BNA) Act*, passed in 1867, defined health services for settlers as provincial jurisdiction and health services for Indigenous people as federal jurisdiction, creating ambiguity that remains today. The *BNA Act* marked the end of the Nation-to-Nation relationship, and preceded the *Indian Act* of 1876, which facilitated an era of colonization and cultural assimilation (Moss & Gardner-O’Toole, 1991).

The *Indian Act* created a federal structure that exerts control over Indigenous lands, languages, and cultural practices and has shaped persisting health and social inequities (Loppie et al., 2014). The effects of the *Indian Act* are far reaching and have an impact on health and the social, economic, and political aspects of well-being (Reading & Wein, 2009; Coates, 2008). The *Indian Act* imposed

- religious and education systems,
- formal ownership of lands,
- permanent settlement on reserve lands,
- foreign systems of government, and
- encouraged Indigenous people to relinquish their status and Treaty rights (Richmond & Cook, 2016).

The measures enacted through the *Indian Act* were aimed at assimilating Indigenous people into the mainstream Canadian culture against their wills (Sinclair, 2015). These colonial structures created systemic policy that caused health inequities by failing to assert the self-determination of Indigenous Peoples and their sovereignty (Allan & Smylie, 2015).

Although there have been many amendments to the *Indian Act* over the years, its legal structure of perpetuating state dominance continues today in different forms. Indian agents, once employed to enforce the *Act*, have since been

replaced by Band Councils as the only legitimate governing structure by the federal government.

One of the most harmful weapons used by the federal government to perpetrate cultural genocide on Indigenous Peoples was the residential school system. The legacy of the residential school system (1884 – 1996) continues to affect the health of its survivors, their families and communities today. The system, which lasted for the better part of Canada’s nationhood, was designed exclusively to assimilate Indigenous children, some as young as toddlers, into Canadian society by removing them from their communities and attempting to destroy their cultural and familial ties. Parents who did not comply with the apprehension of children were subject to fines or incarceration. Physical, emotional and sexual abuse, deprivation, humiliation and social isolation were often employed as an attempt to break the Indigenous child. The Truth and Reconciliation Commission (2015) estimates that 6,000 children may have died in school custody — so many that the schools and government stopped recording the deaths. The trauma suffered by these survivors has led to tremendous suffering that is passed on to families and communities. Post-traumatic stress response is common in Indigenous people who survived the residential school system. Subsequent generations experience post-traumatic stress response as intergenerational trauma (Mitchell & Maracle, 2005).

The shocking facts about the residential school system’s racist posture speak for themselves (Aboriginal Healing Foundation, 2007):

- There are approximately 75,000 former students currently alive; these people represent more than one out of 20 Indigenous people in Canada whose continued suffering from residential schools affects family, community and culture — and therefore the greater Indigenous Peoples in this country.
- Assimilation was forced on these people against their will and cultural genocide was a government sanctioned policy and church doctrine; many children were forcibly removed and taken great distances away from their families and communities.
- Residential schools continued as recently as 1996; they are not artifacts from the 1800s or early twentieth century. Many of its victims are relatively young and parents and grandparents who were students lost the ability to develop healthy social behaviours and role model nurturing parenting skills. Generations are affected. This historical trauma is recent and therefore its impact on the Indigenous people has not been diluted with time. In many cases, healing interventions have not had time to take effect.

- The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders defines a traumatic stressor as, “an event that comprises actual or threatened death or serious injury, or alternative threats to an individual’s well-being, as well as learning about the unexpected or violent death, serious harm, or threat of death or injury of a close associate or family member” (Bombay, Matheson & Anisman, 2009).
- Protracted or severe stressors related to residential school experiences may contribute to heart disease, high blood pressure, stroke, diabetes, and exacerbation of immunologically related illnesses and neurodegenerative disorders. In addition, they may precipitate mental disorders such as depression, post-traumatic stress disorder and substance use disorders (Tomascik, Dignan & Lavallée, 2018).

The wide spectrum of racism

According to the Ontario Human Rights Commission (OHRC), racism occurs in several forms. The following list of racist behaviours may be practised by institutions and individuals alike:

- **Prejudice and overt bias** manifest themselves in hostility, hate, prejudgment and bigotry towards a person or group that is different in culture, ethnicity, gender, sexual orientation, social status, beliefs, religion and age. Brian Sinclair may have experienced prejudice because he was a homeless Indigenous man.
- **Stereotyping** attributes or imprints false, negative or derogatory characteristics to all members of a group, either on purpose or unknowingly due to misinformation, ignorance and misconceptions. Stereotyping is sometimes fueled by strongly held beliefs. These false generalizations do not distinguish the unique characteristics of a person and are applied generously because of the person’s association with a culture, population, community or experience. Was Brian Sinclair seen through the lens of negative stereotypes commonly attributed to Indigenous people?
- **Racial profiling** is defined by the OHRC as “any action undertaken for reasons of safety, security or public protection that relies on stereotypes about race, colour, ethnicity, ancestry, religion or place of origin rather than on reasonable suspicion, to single out an individual for greater scrutiny or different treatment.” Of note, racial profiling manifests itself in racial comments, altered (negative or non-interventionist) behaviours and

deviations from normal or professional practice. Brian Sinclair certainly experienced these manifestations.

- **Racial discrimination** is a form of racism. It includes any action that has the effect of singling out persons based on their race, and imposing burdens on them and not on others, or withholding or limiting access to benefits available to other members of society (OHRC, n.d.).
- **Oppression** is a particularly virulent form of racism. It is about a dominant population brandishing power over, and subduing, a smaller or racialized group. It flaunts superiority by creating inferiority. The justice system presents an excellent example of an oppressive institution in Canada that reflects a racist culture, where power of a dominant society is wielded against a racialized minority population. To emphasize this point, Manitoba's Indigenous people represent 12 per cent of the population and yet more than half of the inmates in Manitoba's jails are Indigenous; Indigenous people are more than twice as likely as non-Indigenous people to be incarcerated in the province. The magnitude of these figures is more or less reflected in other jurisdictions across the country (Aboriginal Justice Implementation System, 2013; Statistics Canada, 2009).
- **The hidden curriculum in medical education** can be harmful to Indigenous patients, medical students, residents and clinicians. It is defined as a set of influences that function at the level of organizational structure and culture that affect learning, teaching and clinical practice. The Association of Faculties of Medicine of Canada states that "the hidden curriculum often supports hierarchies of clinical domains or gives one group advantages over another." All forms of racism can appear in the hidden curriculum, which is buttressed by cultural dominance and traditional power structures (Association of Faculties of Medicine of Canada, 2009).

Breaking racist behaviour

Solutions start with understanding the historical roots of racism and colonialism, how they grow, where racism takes place and what are its detrimental effects on Indigenous patients. Challenging its existence, no matter how benign or lethal its consequences appear for survivors or perpetrators, takes honest self-reflection and the courage to speak up and change the health care system. By applying principled interventions based on Indigenous health values, health care can become culturally safe and free of racism (Tomascik, Dignan & Lavallée, 2018).

Conclusions

Indigenous people in Canada are impacted by higher rates of poor health, largely related to racism and the ongoing practices of colonialism. The Brian Sinclair story exemplifies how multiple forms of racism can have devastating effects on the health of Indigenous patients. While the effects of racism can be difficult to measure, it is a major determinant of health which can have similar or greater effects on health, happiness and wellbeing than commonly considered social determinants of health such as housing, education and employment. When physicians and other health care providers begin to understand the impact of colonial violence and racism on their Indigenous patients, they will be better equipped to reflect on their own behaviours and can work to heal its damage.

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Chapter 3: The Importance of trauma-informed care

Trauma

A traumatic event involves an experience, or multiple experiences, that overwhelm an individual's ability to cope or integrate the ideas and emotions involved in that experience. Traumatic experiences may be experienced early in life (e.g., child abuse, neglect, witnessing violence, or disrupted attachment) or later during the life course (e.g., due to violence, accidents, sudden and unexpected loss, or other life events that are out of an individual's control) [Klinik Community Health Centre, 2013]. Individuals with Adverse Childhood Experiences (ACEs) adapt and thrive. These experiences may cause increased allostatic load, inflammation, addiction, mental health issues, cardiovascular disease, respiratory disease, and cancer (Felitti et al., 1998; Felitti & Anda, 2010; Keeshin, Cronholm & Strawn, 2012).

Historical trauma

Indigenous Peoples, across what is now referred to as Canada, have survived the federal government's many attempts at cultural assimilation (Aboriginal Healing Foundation, 2003). Indigenous Peoples have survived multiple forms of genocide, including: physical genocide, committed through mass and targeted killings; biological genocide through destroying the reproductive capacity of groups of people; and cultural genocide through destruction of structures and practices, seizing land, banning languages, persecuting spiritual leaders and forbidding spiritual practices (Makokis & Greenwood, 2017). This has resulted in historical trauma, which has been described as cumulative emotional and psychological wounding over one's lifespan and across generations, emanating from massive group trauma experiences (Yellow Horse Brave Heart, 2003).

Testimonies at Truth and Reconciliation Commission of Canada (TRC) hearings verified that mental and emotional pain endures for numerous people who experienced traumatic events in residential schools. These experiences, in addition to missionaries undermining the role of Elders and Healers in the healing process, necessitate a trauma-informed approach to care (Assembly of First Nations & Health Canada, 2015; TRC, 2012). Understanding

intergenerational trauma enhances the capacity of health care providers to be compassionate and collaborative, to view behaviour within a larger context, challenge belief systems and attitudes that adversely affect patients, and create safer environments.

Colonization continues to result in intergenerational transmission of varied degrees of post-traumatic stress, higher rates of ill-health, systematic violence and sexual exploitation against Indigenous Peoples. This is illustrated by the life-threatening, gender-based violence Indigenous women and girls face due to systemic gendered racism and patriarchy (Kubik, Bourassa & Hampton, 2009; Native Women’s Association of Canada, 2010, 2015; Inter-American Commission on Human Rights, 2014; National Council of Welfare, 2007).

Colonial science and medicine

Paternalistic medical research practices of the federal government, as well as political and legal structures of inequality and oppression, have resulted in severe harm to Indigenous Peoples. Examples of this severe mistreatment include

- coerced sterilization and abortions,
- compulsory and segregated hospitalization,
- experimentation without consent,
- biological warfare,
- forced starvation, and
- destruction of Indigenous food security (Mosby, 2013; Martin (Nisga’a – Gitanyow) & Walia, 2019).

“We could always find food out in the country. We never went to the hospital or white coat doctors. If we had a toothache, we would pull the teeth out. If we got cut, our dad would squeeze our skin shut and tape it together. But then my older sister got sick. I was six years old at the time. My mom and dad took my sister to the doctors in the city. They moved us all to the city. I believe my parents signed some papers at the hospital that they could not understand. The doctors cut off her hair. They said it was a brain tumour and they were going to do brain surgery three or four times. My sister only came home a bit. I feel it was brain testing and they used her as a guinea pig. The last time they took her in, when I was eight years old; they would not let us inside the hospital. We had to stand outside on the grass. Why didn’t they let us in? And I don’t think there were brain surgeries

going on in the 1960s in that small town. I really believe the medical profession murdered my sister.” – Veronica (Martin & Walia, 2019).

Trauma is a public health issue that impacts every health care service system in Canada. As individuals with experiences of trauma are at risk of being re-traumatized in health care settings, it is important that health care providers understand trauma, are able to recognize symptoms of trauma, and acknowledge their role in supporting recovery (Klinik Community Health Centre, 2013).

Trauma-informed care

Trauma-informed care, now referred to as trauma and violence-informed care, is an organizational structure and treatment framework that increases the safety of health care by understanding, identifying and responding to the effects of trauma. Providers consider the possibility that each individual they engage with may have experienced trauma and prioritize their safety, choice, control and empowerment. This universal precaution ensures the care provided minimizes the risk of re-traumatizing patients and contributes to support and healing (Public Health Agency of Canada, 2018; Canadian Centre on Substance Abuse, 2014; Assembly of First Nations & Health Canada, 2015).

Trauma-informed care improves health care providers’ understanding of the needs of Indigenous patients affected by trauma. It also empowers them to support healing based on compassion (Assembly of First Nations & Health Canada, 2015). The goal of trauma-informed care approaches is to minimize harm to patients and provide care in a welcoming and appropriate manner. This differs from trauma-specific services, which focus on treating trauma through therapeutic interventions (Klinik Community Health Centre, 2013; Harris & Fallot, 2001; Public Health Agency of Canada, 2018).

Trauma-informed providers and organizations:

- acknowledge the widespread impacts of trauma and understand potential paths for healing;
- recognize the signs and symptoms of trauma in clients, staff and other providers;
- understand the variety of coping mechanisms used to manage trauma;
- recognize that people follow different pathways to healing; and

- respond by integrating knowledge about trauma into policies, procedures, practices and settings (Klinic Community Health Centre, 2013).

Trauma-informed care in medicine

Purkey, Patel & Phillips (2018) identified five principles of trauma-informed care to guide clinicians in caring for patients:

- trauma awareness and acknowledgment (bear witness to the patient’s experience of trauma);
- safety and trustworthiness (help patients feel they are in a safe space and recognize their need for physical and emotional safety);
- choice, control and collaboration (include patients in the healing process);
- strengths-based and skills-building care (believe in the patient’s strength and resilience); and
- cultural, historical and gender issues (incorporate processes that are sensitive to a patient’s culture, ethnicity, and personal and social identity).

Raja and colleagues (2015) found that trauma-informed health care consists of two major domains: universal trauma precautions and trauma-specific care. Table 1 outlines the suggestions they provide for how health care providers can implement trauma-informed care.

Table 1: Suggestions for implementing trauma-informed care in patient care (Raja et al., 2015).

| Principle of trauma-informed care | Suggestions for practice |
|---|---|
| Patient-centered communication and care | <ul style="list-style-type: none"> • Ask every patient what can be done to make them more comfortable during the appointment. • Prior to physical examination, present a brief summary of what parts of the body will be involved, allow the patient to ask questions, and let the patient know there will also be time available to ask questions afterward. • Give the option of shifting an item of clothing out of the way rather than putting on a gown when an entire area does not need to be visualized. • Patients who are anxious in the supine position may feel more comfortable if offered a pillow for their backs. • Offer the option of a mirror to see procedures or examinations that are out of the patient’s visual field. |

- If patient nonverbal behavior indicates a moderate to high level of anxiety, conduct further anxiety assessment and offer patient ways to “signal” distress either verbally or via by raising their hand (e.g., signaling anxiety during a Papanicolaou smear).

| | |
|--|---|
| Understanding the health effects of trauma | <ul style="list-style-type: none"> • Understand that maladaptive coping (e.g., smoking, problematic substance use, overeating, and high-risk sexual behavior) may be related to trauma history. • Understand that the maladaptive coping behaviors have adverse health effects. • Engage with patients in a collaborative, non-judgmental fashion when discussing health behavior change. |
| Interprofessional collaboration | <ul style="list-style-type: none"> • Maintain a list of referral sources across disciplines for patients who disclose a trauma history. • Keep referral and educational material on trauma readily available to all patients in the waiting room. • Engage in interprofessional collaboration to ensure continuity of care. |
| Understanding your own history and reactions | <ul style="list-style-type: none"> • Reflect on your own trauma history (if applicable) and how it may influence patient interactions. • Learn the signs of professional burnout and vicarious traumatization, and prioritize good self-care. |
| Screening | <ul style="list-style-type: none"> • Examine your specialty, setting, and level of long-term interaction with patients. • Decide if you will screen for current trauma (e.g., current domestic violence) or a history of traumatic events. • Consider if screenings will be face-to-face or self-report. • Use a framing statement prior to the trauma screen. • Provide all staff with communication skills training about how to discuss a positive trauma screening with a patient. |

Conclusions

The systematic attempt to assimilate Indigenous Peoples necessitates the need for a trauma-informed workforce that is trained to address the impacts of multi-generational trauma (Assembly of First Nations & Health Canada, 2015). Many traumatic experiences violate an individual’s bodily integrity and therefore may adversely impact physical health and mental health (Havig, 2008; Thoits, 2010) and attitudes concerning medical care (Morse et al., 2012; Raja et al., 2015). Medical examinations can feel invasive, especially if they require touching the patient’s body, asking sensitive questions or delivering uncomfortable treatments (Tello, 2018; Raja et al., 2015). As patients with experiences of trauma may be triggered by these practices (Raja, 2012), it is important that health care providers

understand the prevalence and health effects of trauma, and implement universal trauma precautions that include strong patient-centered communication and care (Raja et al., 2015; Tello, 2018).

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Chapter 4: The history and continuum of cultural safety

Case study

Winnipeg Case Study of Health and Social Services.
(Allard, Lithman, O'Neill, & Sinclair, 1992).

On November 2, 1980, a surgeon at St. Boniface Hospital in Winnipeg inserted two glass beads into the ends of a suture after a lung biopsy on a 52-year-old Cree woman from Shamattawa in northern Manitoba. (The description of the number of beads inserted varies; some media reports say dozens, while the inquiry report says two). The surgeon claimed he had joked with the patient about inserting these beads prior to the surgery. He indicated in the subsequent inquiry that he had meant to communicate his respect for the patient's beadwork abilities. He claimed to have used another Cree male patient in the hospital as an interpreter, although this individual denied any knowledge of a discussion about beads. The patient, who did not speak English, claimed no such consent was obtained and was embarrassed and angry after wondering why hospital staff was laughing when looking at her surgical area (the sutures were located below her right armpit in an area she could not see without the aid of a mirror).

Ongoing discrimination against First Nations children

The ongoing inequity in access to health and social services by First Nations children has been documented by the First Nations Child and Family Caring Society of Canada (FNCFCSC), the Canadian Paediatric Society, the Assembly of First Nations and the United Nations Children's Fund Canada, to name a few (FNCFCSC, 2018a; Sinha & Wong, 2015; CBC, 2017). Jordan's Principle ensures that First Nations children can access all public health services when they need them. The Canadian Human Rights Tribunal ruled (2016) that the federally run First Nations health care system is discriminatory as it fails to provide services to First Nations children that are comparable to those offered provincially to other children. As of February 2018, the tribunal has issued four remedial, non-compliance orders as a result of delayed implementation of Jordan's Principle (FNCFCSC, 2018a, 2018b; Sinha & Wong, 2015).

The Sixties Scoop, a practice to forcibly take Indigenous children from their families, involved over 11,000 children with Indian status and many other Indigenous children who were adopted or placed in foster care between 1960 and 1990. Alarming, the number of Indigenous children with status who were apprehended into the child welfare system rose by 71.5 per cent from 1995 to 2001 (National Council of Welfare, 2007). These practices, in addition to the residential school system, disrupted the roles, values and traditions of the children removed from their homes and communities.

The Canadian Human Rights Tribunal also ruled that the federal government discriminated against Indigenous children by under-funding child welfare services. Indigenous children account for approximately half of all children in care. Most of the approximately 14,200 Indigenous children in care are subjected to a provincially run child welfare system (Tasker, 2017). The continued discrimination against Indigenous children subjected to such government care systems is reminiscent of historical practices that resulted in children being apprehended — either by the residential school system or to be adopted by non-Indigenous families, become Crown wards or placed in permanent care settings during the Sixties Scoop.

In addition to discriminatory child welfare and health care systems, the lack of culturally safe health care in Canada has resulted in Indigenous women and girls being coerced into tubal ligations following childbirth (Boyer & Bartlett, 2017). In response, there is a pending class action lawsuit against physicians, regional health authorities, the province of Saskatchewan and the Government of Canada for sterilization procedures that were performed without proper consent. The United Nations Committee Against Torture has also called for Canada to end forced or coerced sterilization of Indigenous women and girls (2018).

The history of cultural safety

Cultural safety was developed in the 1980s from the work of Irihapeti Ramsden, a New Zealand Māori nurse and writer. It was first introduced into nursing education curriculum in 1990 by the Nursing Council of New Zealand. This was done in response to the Māori peoples' discontent with the lack of adequate or appropriate health care, which was consistent with their cultural health needs (Ramsden, 1990; Richardson, 2010; National Aboriginal Health Organization [NAHO], 2006). The theory of cultural safety, which upholds self-determination and decolonization, was developed as an organizing concept to educate nurses

on the need for attitudinal changes and an awareness of their power in health care relationships with Māori patients (Ramsden, 1992; NAHO, 2006).

Description of cultural safety

The definition of cultural safety, in the Canadian context, continues to be redefined (Yeung, 2016). Cultural safety is focused on social justice and the proper use of power in the delivery of health care. It is based on understanding power differentials in the health care system and serves as a concept for guiding an analysis of power in every relationship of difference (Hart-Wasekeesikaw, 2009; Ramsden, 2002).

This patient-centered approach encourages self-reflection among health care practitioners, which is a skill that is fundamental to the patient-physician relationship (Indigenous Physician's Association of Canada [IPAC] & the Association of Faculties of Medicine of Canada, 2009). Addressing inequities through the concept of cultural safety reveals the social, political and historical contexts of health care. It also affords health care practitioners the opportunity to contemplate concepts like racism, discrimination and prejudice (Hart-Wasekeesikaw, 2009).

The continuum of cultural safety begins with cultural awareness (the acknowledgement of difference), then cultural sensitivity (which focuses on respecting that difference), cultural competence (which focuses on a provider's skills and attitudes) and ends with cultural safety (Wabano Centre for Aboriginal Health, 2014).

Cultural safety extends cultural sensitivity by

- analyzing power imbalances, institutional discrimination, colonization and relationships with colonizers, as applicable to the delivery of health services;
- requiring an examination of how personal biases, authority, privilege and territorial history can influence the bicultural patient and provider relationship; and
- relying on both self-reflection and critical reflection (Bourassa, McElhaney & Oleson, 2016; NAHO, 2006).

Culturally safe practice

Initially, culturally safe practice requires the health care practitioner to engage in ongoing reflexivity and analysis of how power/knowledge structures contribute to

the power differential within the bicultural patient–provider relationship. This is followed by practices that challenge stereotypes, address inequities and facilitate self-determination with Indigenous patients (Richardson, 2010; Lavallée et al., 2009). Providers are tasked with examining the social determinants of health and the impact colonization continues to have on Indigenous people, both through legislation and policy (Yeung, 2016).

The patient-provider relationship is redefined through culturally safe practice, which promotes a shared power paradigm where the patient is understood to be a powerful and valuable member of the relationship (Yeung, 2016; Brascoupé & Waters, 2009). Culturally safe care empowers people by reinforcing the value and validity of each person’s knowledge and reality (NAHO, 2006). In practice, cultural safety promotes the integration of holistic approaches to health, Indigenous control of services and equitable access to health care (Bourassa, McElhaney & Oleson, 2016).

Culturally safe practice is based on respectful engagement that is conducive to patients identifying paths to well-being (Health Council of Canada, 2012). While ensuring cultural safety is the responsibility of the provider, culturally safe care is identified and experienced by the Indigenous patient (Ramsden, 2002).

In addition to informing clinical practice, cultural safety serves as a moral discourse for informing policy analysis of systemic issues. These include colonial-based racism and the impact of mainstream health policies on Indigenous Peoples’ health (Yeung, 2016). The political commitment to equity in health care that is inherent in cultural safety is required to address health inequities between Indigenous and non-Indigenous people (Darroch et al, 2016).

CanMEDS Framework

The CanMEDS Framework identifies and describes the abilities that physicians require to deliver effective health care. These abilities are grouped thematically under seven “Roles” that competent physicians integrate into their practices. The Royal College, in partnership with the Indigenous Health Committee of the Royal College, mapped Indigenous health values against each CanMEDS Role to guide culturally safe interventions (Royal College, 2018).

Figure 1: Mapping Indigenous health values as interpreted through the CanMEDS Framework

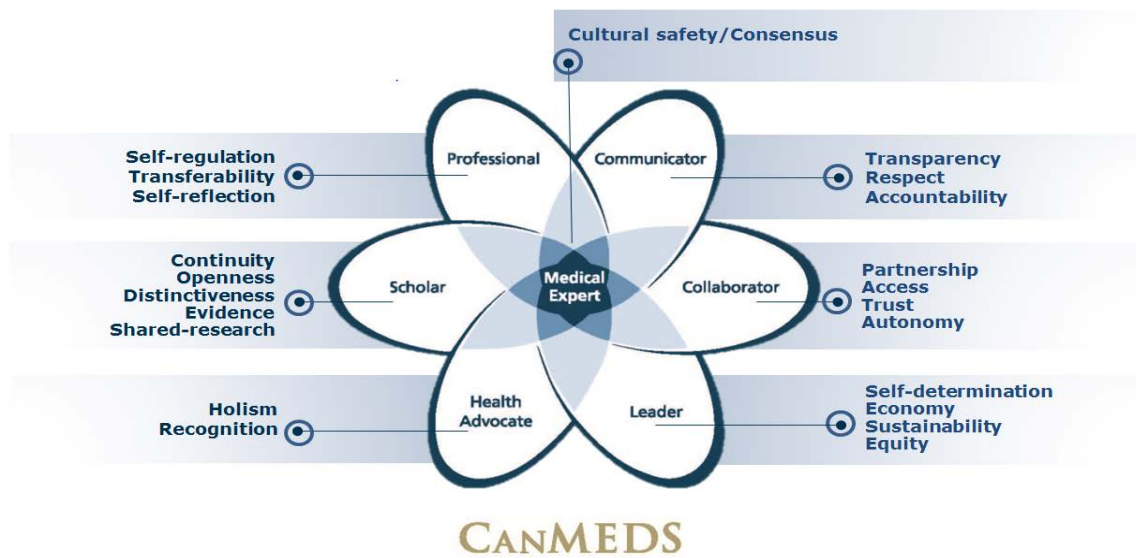


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Conclusions

The Health Council of Canada (2012) found that Indigenous participants did not favour using, and many are not seeking, mainstream health services due to experiences of stereotyping, discrimination, racism and being minimized, judged or ignored. Health care institutions that do not provide culturally safe care alienate Indigenous people from obtaining health services, thereby contributing to poorer health outcomes (Di Lallo, 2014).

The Health Council of Canada formulated descriptions of cultural safety and culturally safe care based on previous research (IPAC & Royal College, 2009a; IPAC & the Association of Faculties of Medicine of Canada, 2009; IPAC & Royal College, 2009b; NAHO, 2008):

Cultural safety is

- an outcome, defined and experienced by those who receive the service — they feel safe;
- based on respectful engagement that can help patients find paths to well-being;
- based on understanding the power differentials inherent in health service delivery, the institutional discrimination, and the need to fix these inequities through education and system change; and

- requires acknowledgement that we are all bearers of culture — there is self-reflection about one’s own attitudes, beliefs, assumptions and values.

Culturally safe care

- involves building trust with Indigenous patients and recognizing the role of socioeconomic conditions, history and politics in health;
- requires communicating respect for a patient’s beliefs, behaviours and values; and
- ensures the client or patient is a partner in decision-making.

Culturally safe practice requires critical thinking and self-reflection — a teachable skill — that enables health care practitioners to better understand upstream barriers (e.g. structural racism, discriminatory laws, historical legacies, uneven distribution of economic opportunities, etc.) and their connection to the downstream effects influencing the health and healing of those defined as under threat (Royal College, 2013).

Ongoing discrimination against Indigenous children showcases the individual and systemic consequences of racism. It also displays the desperate need for culturally safe health care in Canada. Health care professionals can contribute to systemic change by familiarizing themselves with Jordan’s Principle and advocating for its full implementation. The provision of equitable services for Indigenous children requires pediatricians, family physicians and other health care practitioners to systematically identify cases involving jurisdictional disputes and efficiently link them to Jordan's Principle processes. Further, health care practitioners are able to use resources and administrative discretion to document gaps and disparities. They can also identify ways to aggregate information across cases, departments and institutions, and respect self-determination (Sinha & Wong, 2015).

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Chapter 5: Indigenous health values and principles

Case study

(Truth and Reconciliation Commission Calls to Action in Health, 2015).

- “We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous federal government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.”
- “We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.”
- “In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.”
- “We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.”
- “We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.”

- “We call upon all levels of government to: i. Increase the number of Aboriginal professionals working in the health-care field. ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities. iii. Provide cultural competency training for all healthcare professionals.”
- “We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.”

Development of the *Indigenous Health Values and Principles Statement*

The *Indigenous Health Values and Principles Statement* was first introduced by the Royal College on July 4, 2013, to complement anti-racism teachings. Building on the intrinsic CanMEDS Roles identified in the Royal College’s *CanMEDS 2015 Physician Competency Framework*, and responding to the Truth and Reconciliation Commission of Canada’s Calls to Action, the values and principles outlined in the second edition of the document (released in 2019) represent a foundation to underpin concrete actions in medical education, professional development and culturally safe practices (Royal College, 2019). These measures will help redress disparities and inequities in the delivery of quality health care.

To ensure that Indigenous perspectives are aptly reflected in these values and principles, the Indigenous Health Committee of the Royal College, which predominantly comprises Indigenous physicians and scholars, guided their development. The document was informed by literature that is focused on the application of values and principles to advance Indigenous health, as well as key informant interviews conducted with Indigenous stakeholders and health care educators. This document builds on past work by the Indigenous Physicians Association of Canada and the Association of Faculties of Medicine of Canada, among others, in developing core competencies in medical education specific to Indigenous health.

Indigenous health values and principles embodied in the CanMEDS Roles

CanMEDS is a framework for improving patient care by enhancing physician training. Its main purposes are to define the necessary competencies for all areas of medical practice, and to provide a comprehensive foundation for medical education and practice in Canada. Indigenous health principles bridge the seven CanMEDS Roles with 23 Indigenous health values. They promote anti-racism education to bring about culturally safe actions.

The overarching Indigenous health principle that captures the essence of the culturally safe health care practitioner, as embodied in the CanMEDS Roles, is as follows:

“The health care of an Indigenous person reflects the dimensions of quality for patient-centred care that resonates with the culture and values of that person in all stages of his/her life. Culturally safe practices, reflexivity and anti-racism interventions should always be demonstrated by the physician, including empathy, open-mindedness and understanding of how colonialism deliberately excludes Indigeneity, and how the determinants of health contribute to the patient’s health status and fall short in meeting it. The Path to First Nations Information Governance articulates the decision-making process that recognizes the value of Indigenous Peoples’ self-determination through the principles of ownership, control, access and possession, and the benefits of making unencumbered and informed choices to promote health sustainability and equity (Royal College of Physicians and Surgeons of Canada, 2018).”

Mapping Indigenous health values as interpreted through the CanMEDS Framework

| CanMEDS ROLES | INDIGENOUS HEALTH VALUES | INDIGENOUS HEALTH PRINCIPLES |
|----------------|---|--|
| Medical Expert | <ul style="list-style-type: none"> • Cultural safety • Consensus | <p>The culturally safe physician is a complete health care practitioner who embraces Indigenous knowledge/science, understands and accepts that racism exists and how historical/intergenerational trauma affects the health and well-being of the Indigenous patient, and takes steps to foster anti-racism interventions.</p> |
| Communicator | <ul style="list-style-type: none"> • Transparency • Respect • Accountability | <p>The culturally safe physician communicates in clear, honest and respectful dialogue about health matters, and sees a mutual responsibility between him/her and the Indigenous patient/community for achieving shared health outcomes.</p> |
| Collaborator | <ul style="list-style-type: none"> • Partnership • Access • Trust • Autonomy | <p>The culturally safe physician recognizes that the Indigenous patient-physician relationship is sacrosanct and without hierarchy or dominance; this partnership fosters access to health care, and the resources necessary for health and wellness of the person, family and community. It also facilitates the physician's ability to work effectively with community institutions to help the patient.</p> |
| Leader | <ul style="list-style-type: none"> • Self-determination • Economy • Sustainability • Equity | <p>The culturally safe physician is equipped with the tools, knowledge, education and experience to achieve the highest form of evidence-informed professional competencies, while practising with cultural humility, fostering an environment of cultural safety and</p> |

CanMEDS ROLES

INDIGENOUS HEALTH VALUES

INDIGENOUS HEALTH PRINCIPLES

Health Advocate

- Holism
- Recognition

proactively pursuing anti-racism interventions.

The culturally safe physician embraces Indigenous identity as the platform that promotes holistic health and encourages active participation of Indigenous people, in concert with physicians and other health care professionals, as “agents of change for health.”

Scholar

- Continuity
- Openness
- Distinctiveness
- Evidence
- Shared-research

The culturally safe physician understands that Indigenous health is an integral component of medical research, education, training and practice, and that this research is based on evidence from empirical sources, critical appraisal of relevant material beneficial to patients, leading Indigenous and non-Indigenous practices and lifelong learning that can be adapted to serve Indigenous patients. Reflective practice grows a physician’s skills in the collaborative patient-physician relationship.

Professional

- Self-regulation
- Transferability
- Self-reflection

The culturally safe physician is committed to the well-being of Indigenous patients, their families, communities and cultures through ethical behaviours, compassion, integrity, respect and a commitment to clinical competencies that engender health of Indigenous people.

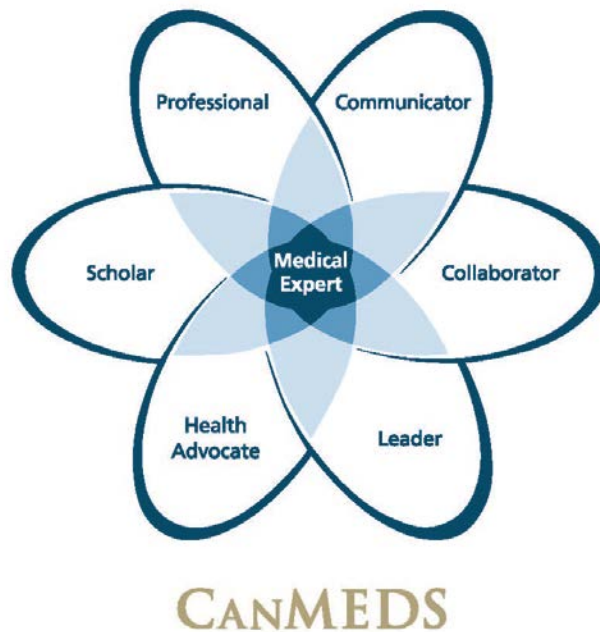


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Conclusions

The *Indigenous Health Values and Principles Statement* maps Indigenous health values and principles onto the CanMEDS Roles. CanMEDS Roles represent excellent directives to structure values and principles into categories physicians understand. They also provide a bridge to understand Indigenous community needs and current practices. The correlation of values with a given CanMEDS Role could be debated, and some possibly moved within the CanMEDS Framework, but the most important result is integration of the set of values. The collection is based on empirical evidence, as well as deliberations with Royal College Council, the Royal College directorate of specialty education, the Indigenous Health Committee of the Royal College and organizations that successfully promote Indigenous health.

Racism is unacceptable in medical education and practice. It is hoped that the *Indigenous Health Values and Principles Statement* will foster reflexivity and trigger anti-racism interventions to preclude oppression and eliminate racism in the health care system.

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Chapter 6: Legislation and policies — how they affect Indigenous people and how they are connected to the social determinants of health

Case study 6a

Leaders of racism and the people they harm

Quotes from Prime Minister of Canada Sir John A. MacDonald (Indigenous Corporate Training Inc., 2016).

“When the school is on the reserve, the child lives with its parents, who are savages, and though he may learn to read and write, his habits and training mode of thought are Indian. He is simply a savage who can read and write. It has been strongly impressed upon myself, as head of the Department, that Indian children should be withdrawn as much as possible from the parental influence, and the only way to do that would be to put them in central training industrial schools where they will acquire the habits and modes of thought of white men.”



The interior of a classroom of St. Joseph's Residential School in Cross Lake, Manitoba. 1951. (UNIVERSITY OF MANITOBA / CANADIAN PRESS)

“The great aim of our legislation system and assimilate the Indian people in all respects with the other inhabitants of the Dominion as speedily as they are fit to change.”

“We have been pampering and coaxing the Indians; that we must take a new course, we must vindicate the position of the white man, we must teach the Indians what law is; we must not pauperise them, as they say we have been doing.”

Quote from Duncan Campbell Scott, career civil servant and architect of the residential school system (Rheault, 2011).

“I want to get rid of the Indian problem. I do not think as a matter of fact, that this country ought to continually protect a class of people who are able to stand alone. That is my whole point. Our object is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic, and there is no Indian question, and no Indian department, that is the whole object of this Bill.”

Quote from Chief Dan George, July 1, 1967 (APTN National News, 2017).

“When I fought to protect my land and my home, I was called a savage. When I neither understood nor welcomed his way of life, I was called lazy. When I tried to rule my people, I was stripped of my authority.”

Quotes from residential school survivors. (Toronto Star, 2015).

“Too many Canadians know little or nothing about the deep historical roots of these conflicts. This lack of knowledge has serious consequences for First Nations, Inuit and Métis peoples and for Canada.”

“From 1958, when it first opened, until 1979, there was never a year in which Grollier Hall in Inuvik did not employ at least one dormitory supervisor who would later be convicted for sexually abusing students.”

“Indian Affairs officials often tried to portray these rates (of death) as simply the price that Aboriginal people had to pay as part of the process of becoming civilized. In reality, these rates were the price they paid for being colonized.”

“There was no effort to record the number of students who died. It will be critical for the National Centre for Truth and Reconciliation to obtain all records related to the deaths of residential school students.”

“I wanted to be white so bad, and the worst thing I ever did was I was ashamed of my mother, that honourable woman, because she couldn't speak English.”

Key messages

- Legislation and policies related to Indigenous people in Canada were created with the intention to assimilate Indigenous people.
- The policies and laws, based entirely on race alone, resulted in cultural, social and economic disruption.
- Jurisdiction regarding health care delivery for Indigenous people is complex and often misunderstood.
- Current inequities in health and well-being experienced by Indigenous people are the result of these dismissive and oppressive policies and laws, which continue in some forms in our present day.

Understanding legislation and policies can be overwhelming but, put simply, there are two fundamental areas of legislation and policies that affect the lives of all Indigenous Peoples in Canada:

1. the set of laws and policies that were originally designed to assimilate Indigenous people, and
2. a second set of laws that dictate the level of government that is responsible for health care delivery to Indigenous people.

These laws and policies are often misunderstood as providing Indigenous people with preferential treatment. In reality, however, they have contributed to poverty, and social and cultural disruption. The end result: inequities in the health and well-being of Indigenous people that we see today.

The relationship between the federal government and Indigenous people was not always this way. When one looks at how this relationship began, one can find agreements made by autonomous players who were on equal footing. This is often referred to as the Nation-to-Nation relationship. However, over time the Indigenous population began to dwindle as a result of disease, famine and war. At that time, the creation of dismissive and oppressive policies began and efforts were made to rid the government of the so-called “Indian problem.”

Assimilation policies

It is essential that all health care providers understand that legislation and policies related to Indigenous Peoples are rooted in racism. They were designed to rid Canada of First Nations, Inuit and Métis via the systematic control of culture and independence. The federal government has at its disposal broad

constitutional powers that are rooted in colonial dominance. The University of British Columbia (2009) lists legislative articles that are key drivers affecting (both directly and indirectly) health and health care of Indigenous people in Canada.

These include

- the *Indian Act* and its equally invasive components like Indian status, bands, *Bill C-31* and enfranchisement;
- reserves, as this system was created by the government in an attempt to limit Indigenous Peoples' movement and free up land for arriving settlers;
- the residential school system refers to an extensive school system set up by the federal government and administered by churches that purported to educate Indigenous children by removing them from their families and home communities, forbidding them to acknowledge their Indigenous heritage, and indoctrinating them into Euro-Canadian and Christian ways of living to assimilate them into mainstream Canadian society. The last residential school closed its doors in 1996. The damaging and traumatic impacts of the residential school system continues to have lasting legacies on residential school survivors, their families and communities;
- the Sixties Scoop refers to the widespread removal of Indigenous children from their families and home communities. Although it is commonly known as the Sixties Scoop, widespread "adopting-out" of Indigenous children is still prevalent today;
- the Royal Proclamation of 1763 is perhaps the first colonial policy to mention Indigenous Peoples in what would become Canada. The Proclamation continues to influence policy and Indigenous rights discourse today;
- the 1969 White Paper was a policy the federal government proposed but later dropped due to widespread resistance from Indigenous Peoples and organizations across Canada; and
- Section 35 of the *Constitution Act* (1982) that represents the inclusion of Indigenous Peoples in the Canadian constitution, after much lobbying on the part of Indigenous activists and political organizations.

Jurisdiction over health care delivery

Case study 6b Jordan's story

(First Nations Child and Family Caring Society of Canada, 2014).

"Jordan River Anderson was a First Nations child from Norway Cree House Nation in Manitoba. Born in 1999 with complex medical needs that could not be treated on-reserve, he spent more than two years in a hospital in Winnipeg before doctors agreed that he could leave the hospital to be cared for in a family home. However, because of jurisdictional disputes within and between the federal and provincial governments over who would pay costs for in-home care, Jordan spent over two more years unnecessarily in hospital before he tragically died in 2005. He was five years-old and had never spent a day in a family home."

Jordan's death resulted in the creation of "Jordan's Principle." It is a child-first principle calling on the government of first contact to ensure Indigenous children can access public services on the same terms as other children; it prevents red tape and jurisdictional disputes.

Canada has a unique and complex legislative framework for delivery of health services to First Nations and Inuit people. It is done via the First Nations and Inuit Health Branch (FNIHB) which is administered by the federal government department of Indigenous Services Canada. The legislative roots of this federal responsibility can be traced back to the *British North America Act* (Lavoie et al., 2011). FNIHB provides limited health services to those living on-reserve, such as nursing and physician services. The federal government also administers the Non-Insured Health Benefit program (NIHB) for a variety of benefits, such as some medications and some dental services/device and vision care. These services and benefits only apply to eligible First Nations and Inuit people. The health care delivery, services and benefits afforded to those receiving services from FNIHB have been criticized as adversely affecting the health and care of Indigenous people.

Attempts towards different self-governance models in different areas of the country further complicate the picture of health care service delivery to Indigenous people in Canada. Lavoie and colleagues (2011) describe this as a

“patchwork of policies, legislation and relationships.” Such service delivery models fall into two broad categories: cross-jurisdictional coordination mechanisms and intergovernmental health authorities.

An example of cross-jurisdictional models includes Ontario’s Aboriginal Health and Wellness Strategy (AHWS), which was developed in 1994. The AHWS is managed by a Joint Management Committee consisting of two representatives from each of the eight Aboriginal umbrella organizations in Ontario, as well as several government ministries and departments. This model is typical across Canada where a committee of Indigenous and government representatives maps out health care services in the province or territory. On the other hand, intergovernmental health authorities are often extensions of provincial health care systems and funded by provincial and federal governments. Their genesis comes from federal/provincial partnerships or self-government agreements. An example of this is the unique health care structures that emerged as a result of the James Bay and Northern Quebec Agreement to serve the health care needs of Nunavik Inuit and the James Bay Cree (Lavoie et al., 2011).

The complexity of the jurisdictional responsibilities over health care between the federal/provincial/territorial governments can make the system difficult for individuals to navigate and for health care providers to know how to advocate. An extreme example of this jurisdictional complexity was brought to the fore in the case of Jordan River Anderson, who as a result of a rare neuromuscular disorder spent his life in hospital due to a jurisdictional dispute between the federal and provincial governments regarding who was responsible for paying for his homecare services. Jordan’s Principle resulted from a private members motion designed to prevent this from occurring again (Reading & Wien, 2009).

Nevertheless, the rights to self-governance and self-determination and Treaty rights have significant roles to play in making improvements in health care service delivery for Indigenous people. “In addition, the focus of resources must be on enhancing the health of communities through addressing various social determinants of health, rather than merely dealing with diseases. In order to be successful, such a change must find its way into the federal, provincial and territorial health legislation and policy frameworks. To do so, the adoption of a national umbrella Indigenous health policy may be required” (Lavoie et al., 2011). Ensuring health care institutions are free of racism and discrimination is essential to ensuring culturally safe health care delivery.

Indian status and Non-Insured Health Benefits

The Non-Insured Health Benefit program (NIHB) is a national program that provides coverage to eligible First Nations and Inuit for a specified range of medically necessary items and services. Benefits may cover dental care, eye care, medical equipment, drugs, counselling and transportation.

First Nations and Inuit Peoples in Canada are subjected to an archaic and bureaucratic form of identification for the purpose of receiving NIHB coverage from the federal government. The application process to receive Indian status cards and documentation for proof of Indigenous “distinction” is a perfect example of subjugation based in racist policy. In some jurisdictions, First Nations Health Authorities provide the health benefits; in others, the province, territory or federal government is responsible.

It is important to point out that Métis and non-status First Nations people face additional challenges in accessing health care because they are not recognized within the governance structure. A 2016 Supreme Court ruling stated the term “Indian” in the *Constitution Act* of 1867 applies to Métis and non-status Indians. This ruling does not bestow “status” but it does allocate federal responsibility for ensuring similar rights for Métis as those bestowed on eligible First Nations and Inuit people. It is clear that proving nationality and Indigenous identity is a de-humanizing exercise for First Peoples.

How Non-Insured Health Benefits coverage works

- 1) Eligibility as a First Nations person must be in a registry of status Indians under the *Indian Act*; Inuit people must be recognized by an Inuit Land Claim Organization.
- 2) Patients enroll directly into the NIHB program by filling out an application and ensuring that requisite documentation is attached.
- 3) In some cases, providers bill the NIHB program directly. In others, patients pay up front for services and recover payment from the NIHB. Co-pay private insurance or other provincial/territorial programs may also supplement coverage.

How legislation is connected to the social determinants of health

Social determinants of health include legislation and government policies, particularly as they relate to Indigenous status. The World Health Organization (2008) defines the social determinants of health as “the conditions in which people are born, grow, live, work and age.” They are the economic, social, political and infrastructural conditions that affect health.

Indigenous-specific determinants of health — such as colonialism, racism, social exclusion and undermining self-determination — are the precursors (distal determinants) to several other more downstream (proximal determinants) (Reading & Wien, 2009). Government policies designed to assimilate Indigenous people acted via each of these determinants of health. The resultant legislation and policies continue to affect the health outcomes of Indigenous people and the quality of their physical, emotional, mental and spiritual health. This is echoed in the United Nations Human Development Index where First Nations people in Canada ranked 68th in the world on dimensions such as poverty, income, housing and education — all of which are known, important determinants of health (Reading & Wien, 2009).

The understanding of how government legislation and policies can affect health has gained popular acceptance in recent years. Furthermore, the importance of healthy public policy has been positioned as a process whereby inadvertent health effects should be mitigated (World Health Organization, 1988). Legislation and policies are important interventions to close the gap in health disparities. Such legislation and policies not only include improvements to health care service access, but also address more upstream determinants of health. In particular, self-determination has been identified as essential to improving the health of Indigenous people (Assembly, 2007).

Figure 1: Race as a social determinant of health. Government legislation and policies rooted in racism are important upstream (or distal) determinants of health for Indigenous people.



Case study 6c

The Indigenous cancer journey and how it is impacted by the social determinants of health

(Jason Pennington, MD, FRCSC, 2019)

Cancer is a loaded word to most people/communities, but possibly more so in Indigenous society.

Cancer is a state in which certain cells grow out of control with the possibility of disrupting the body's anatomic and physiologic functions. This process can be quite indolent or rapidly progress. Treatments range from watchful waiting to complicated multidisciplinary approaches. Prognosis can range from near-certain cure to purely palliative options.

The Indigenous cancer journey starts with prevention and screening, followed by diagnosis, medical work-up and treatment. It culminates in

survivorship and/or palliation, and sometimes death. Once a diagnosis of cancer is made, it remains a part of that patient's life forever. This impacts the person, their family and community. The impacts may be physical, mental, emotional and/or spiritual.

The social determinants of health follow the Indigenous medicine wheel. They are holistic and involve not only the patient, but their family, community, environment and much more. They can be proximal, intermediate or distant. The proximal ones may be the easiest to understand and solve but, without addressing the distal determinants, it is impossible to truly address their impact on wellness, including the Indigenous cancer journey.

What is the burden of disease associated with cancer on Indigenous Peoples? With decreased life expectancy and higher rates of chronic disease and mental illness, Indigenous communities may not focus on cancer as a significant concern. This is not borne out by the data.

Studies performed by Chiefs of Ontario and Cancer Care Ontario (2017) demonstrate a steady increase in cancer incidence among First Nations Ontarians. In fact, cancer incidence overall in Indigenous Ontarians is almost equal to that of non-First Nations Ontarians; among males, it has surpassed the non-First Nations Ontario incidence. The top three cancers are the same in both groups: prostate, lung and colon for males, and breast, lung and colon for females. For First Nations Ontarians, the cancer incidence is higher for lung and colon and lower for breast and prostate, than rates among their non-First Nations counterparts.

The more worrisome findings from those studies come with respect to outcomes. Both mortality and five-year survival rates are worse for the top three cancers in First Nations males and females when compared to the Ontario average. These worse outcomes are also documented in Indigenous populations in other jurisdictions across Canada and around the world. Explanations can generally be linked back to the social determinants of health.

In many forms of cancer, the stage of the cancer at the time of diagnosis has a great impact on prognosis. Risk factors and screening have an important impact on the stage at the time of diagnosis. For example, both First Nations and Métis patients living in Ontario have a greater

number of risk factors for cancer, including smoking, poor diet, obesity and sedentary lifestyle.

Similarly, First Nations and Métis individuals in Ontario have been shown to be less up-to-date with their cancer screening. Screening is definitely affected by the social determinants of health. Proximal social determinants of health, such as the cycle of lower education, unemployment and poverty, all lead to conditions that make cancer screening more difficult and a lower priority for patients. Furthermore, a later diagnosis generally leads to more advanced disease and a worse prognosis, which makes a successful treatment and cure less likely. These poor outcomes can reaffirm a community's fear and sense of futility around cancer and its treatment.

The proximal social determinants of health not only impact cancer prevention and screening, but all aspects of the Indigenous cancer journey. A diagnosis of cancer is only the start of a complicated lifelong journey that may involve many investigations and various modalities of treatment. The path from diagnosis to treatment or palliative, may involve surgery, chemotherapy, radiation and novel treatment modalities. All of these have risks and side effects that are difficult for English- or French-speaking, college-educated individuals to comprehend. Many may require travel to regional centres, time off work and other interventions that have innumerable impacts on "normal" daily life. Consider how poverty, limited higher education, language barriers and unemployment all add to the difficulties of undergoing cancer treatment.

The intermediate social determinants of health can have an even greater impact on the Indigenous cancer journey. Inconsistent and incongruent flow of care between federal and provincial providers, and inconsistent resources within Indigenous communities, often make it difficult to provide quality care close to home and family. Another intermediate social determinant of health is the disruption of environmental stewardship and pollution of traditional water, land, plants, fish and meat. These changes in the environment can increase exposure to carcinogenic contaminants. Furthermore, they make participating in a healthier traditional lifestyle and diet less possible.

On a deeper level, the distal social determinants of health are the true barriers to high quality care for Indigenous patients. The history of

colonization and its resultant actions undermine the self-determination that is necessary to develop truly healthy therapeutic relationships and attain equitable outcomes for Indigenous patients with cancer.

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Chapter 7: Indigenous health policy

Health policy and structural racism

The persistent health inequities between Indigenous and non-Indigenous people in Canada highlight the need to evaluate the impact of federal policy on the wellness of Indigenous people (Coates, 2008). Structural racism is rooted in policies and political actions that create and/or reinforce discrimination against a racialized group. In Canada, structural racism is expressed against Indigenous Peoples chiefly through the *Indian Act* (Loppie et al., 2014) and severely inadequate approaches for addressing the social determinants of Indigenous health (Reading & Wien, 2009). A history of isolationist and assimilationist policies have significantly infringed on the rights of Indigenous Peoples, resulting in legislation that has removed their sovereignty (Moss & Gardner-O'Toole, 1991).

The *Indian Act*

The *British North America (BNA) Act*, which was passed in 1867, defined health services for settlers as provincial jurisdiction and health services for Indigenous Peoples as federal jurisdiction. This created ambiguity that remains today. The *BNA Act* marked the end of the Nation-to-Nation relationship; it preceded the *Indian Act* of 1876, which facilitated an era of colonization and cultural assimilation (Moss & Gardner-O'Toole, 1991; Reading & Wein, 2009; National Collaborating Centre for Aboriginal Health, 2013).

The *Indian Act* created a federal structure that exerts control over Indigenous lands, languages and cultural practices; it has shaped persisting health and social inequities (Loppie et al., 2014). The effects of the *Indian Act* are far-reaching and impact health, and the social, economic and political aspects of well-being (Reading & Wein, 2009; Coates, 2008).

The *Indian Act* imposed

- religious and education systems,
- formal ownership of lands,
- permanent settlement on reserve lands,

- foreign systems of government, and
- encouraged Indigenous people to relinquish their status and Treaty rights (Richmond & Cook, 2016).

The measures enacted through the *Indian Act* were aimed at assimilating Indigenous people into the mainstream Canadian culture against their wills (Sinclair, 2015). These colonial structures created systemic policy that caused health inequities by failing to recognize the self-determination of Indigenous Peoples and their sovereignty (Allan & Smylie, 2015).

Structural racism was also expressed at the institutional level through the residential school system, which attempted to assimilate Indigenous children. Tragically, these schools aimed to “kill the Indian in the child” (Miller, 2004, p.35). Children were punished for speaking their mother tongue (Nagy & Sehdev, 2012) and often experienced neglect, abuse, poor diet and disease exposure (MacDonald & Hudson, 2012).

Structural racism is also present within the health care system, where there may be racist policies and stereotypes. When these policies and perceptions intersect, it sometimes results in discrimination against Indigenous people. Racism within the health care system, as discussed in previous chapters, leads to poor health outcomes (Loppie et al., 2014).

Consequences of structural racism

Most of the Indigenous languages that were once spoken across what is now referred to as Canada are endangered. This is a result of historical laws and policies that limited their use (e.g. Anti-Potlatch Laws, enacted from 1885 to 1951, which banned various Indigenous ceremonies). These profound human rights violations were aimed at eliminating Indigenous languages, cultural practices and identities as distinct peoples. Due to the resilience of Indigenous Peoples, the actions of the federal government and churches did not rid Indigenous languages completely; however, they did significantly reduce their use. If these languages are not preserved, the cultural identity and nationhood inherent within them will be lost (Sinclair, 2015; Galley, 2016; Norris, 2007; Jacob et al., 2015).

Prior to European contact, Indigenous people relied on a variety of ways to organize and operate (e.g. oral traditions, wampum belts and Potlatch ceremonies). As a consequence of the jurisdictional power and control of settlers, the significance of these practices and traditions has not been respected. Consequently, these practices and traditions have been ignored or legally

suppressed while the federal government attempted to impose assimilation (Moss & Gardner-O'Toole, 1991).

Health policy continues to demonstrate widespread neglect and a lack of political will to improve access to health care for Indigenous people. Inadequate health care services in some First Nations communities have raised concerns about the failure of the government to ensure that service providers are competent, that health care facilities are safe and that communities are properly consulted (Office of the Auditor General of Canada, 2015). Successive governments have racially discriminated against Indigenous Peoples by investing less in the social and economic development of Indigenous communities than in others (Musto, 1990).

The provision of health care for Indigenous Peoples is complex and fails to address the health care needs of all Indigenous Peoples. It also results in jurisdictional disputes over payment for health care services, which negatively impacts access to care (Lavoie et al., 2011).

Self-determination

Indigenous communities are best positioned to identify their health priorities and deliver their health care services (Lavoie et al., 2011). There is great promise in community self-determination over health care and community-led research as advocacy for policy reform (Richmond & Cook, 2016). It has been recommended that a new *act* is required to recognize Indigenous Nations as jurisdictions, thereby affirming Indigenous Peoples' inherent rights as recognized in the *United Nations Declaration on the Rights of Indigenous Peoples* and Canada's Constitution (Clogg, 2017).

Indigenous Peoples demonstrate resilience and strive for wellness. This is rooted in a holistic conception of well-being involving a healthy balance of physical, emotional, mental and spiritual wellness (NCCAH, 2013). Public policy should recognize the cultures and knowledges of Indigenous Peoples, including their inherent right to be self-determining as a means through which to attain health equity (Richmond & Cook, 2016).

Conclusions

Legally sanctioned discrimination has undermined Indigenous Peoples self-determination. Racism within government policies and health care service delivery also continues to impact their well-being (Loppie et al., 2014). Effective healing programs and addressing ongoing inequities are critical, as many

Indigenous people have been impacted by jurisdictional power, privilege and colonization. Effective interventions capable of addressing these challenges include early public education, cultural competence training and additional Indigenous health care service providers (Richmond & Cook, 2016). Improved coordination and equitable funding are critical to approaches focused on improving the wellness of Indigenous people (Lavoie et al., 2011).

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Chapter 8: Data, demographics and the diversity of Indigenous communities

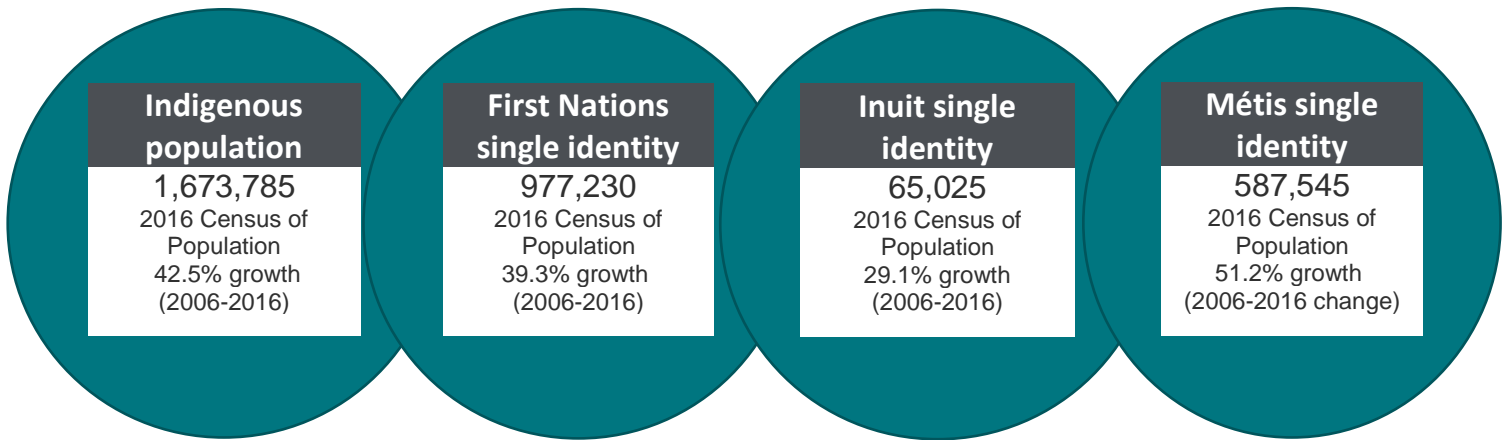
Case study

(Truth and Reconciliation Commission Calls to Action in Health, 2015)

- “We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child issues, chronic diseases, illness and injury incidence and the availability of appropriate health services.”

Population growth

According to the 2016 Census of Population, there were 1,673,785 Indigenous Peoples in what is now referred to as Canada. This accounts for 4.9 per cent of the total population. Although an increase from 3.8 per cent in 2006 and 2.8 per cent in 1996, this is likely an underestimate as some individuals may not self-identify as Indigenous. According to population projections, the Indigenous population is likely to exceed 2.5 million persons over the next 20 years (Statistics Canada, 2017).



The growth in the Indigenous population reported by the census is mainly due to natural growth but also from changes in self-reported identification. Since the census allowed respondents to report multiple ethnic origins, there has been a trend of increasing numbers of people identifying themselves as Indigenous (Statistics Canada, 2017).

Age

Indigenous Peoples are young in comparison to the overall population (Figures 1, 2 and 3). In 2016, the average non-Indigenous individual was 41 years, while the average age of First Nations individuals living on-reserve and in Northern communities was 30.8 years; over half were under the age of 30 (First Nations Information Governance Centre [FNIGC], 2018). The Inuit population is also young. In 2011, the overall median age was 23 years-old with a median age of 23 years in Inuit Nunagat and 26 years among those living elsewhere (Wallace, 2015).

The Indigenous population is also aging, with the proportion of Indigenous Peoples over 65 years rising from 4.8 per cent in 2006 to 7.3 per cent in 2016. According to population projections, the proportion of Indigenous Peoples aged 65 years and older could more than double by 2036 (Statistics Canada, 2017).

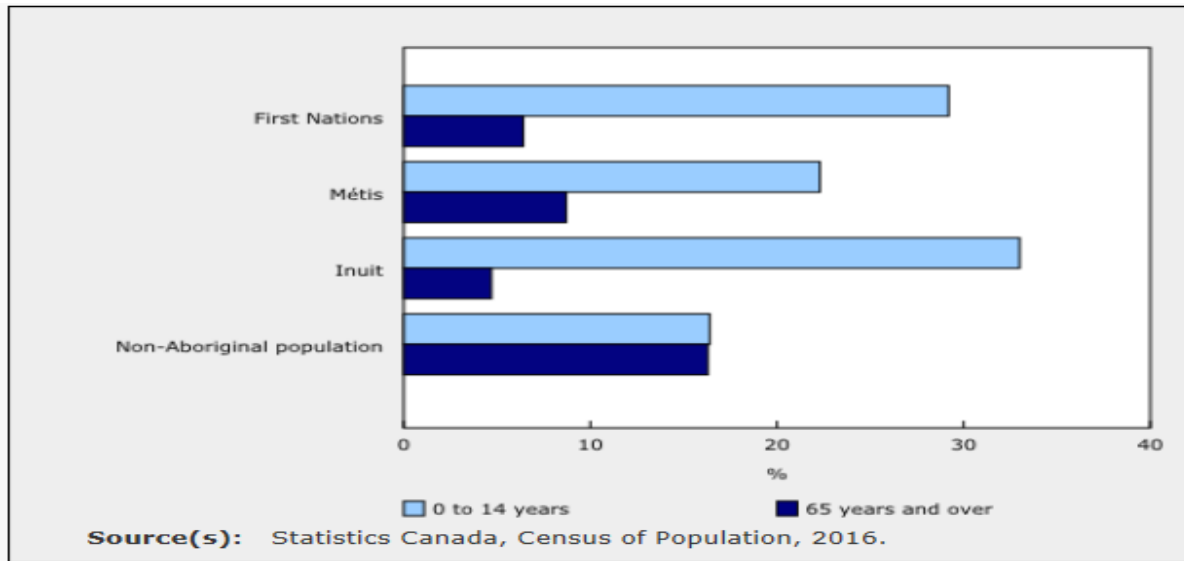


Figure 1: Share (in percentage) of the population aged 0 to 14 years and 65 years and over by Aboriginal identity, Canada, 2016

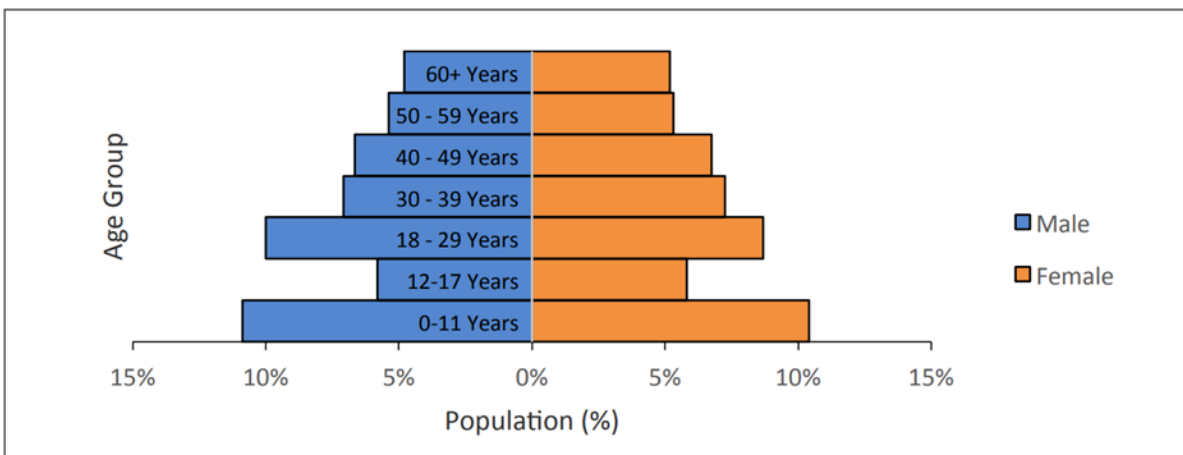


Figure 2: Population pyramid for First Nations children, youth and adults living in First Nations communities (FNIGC, 2018:19)

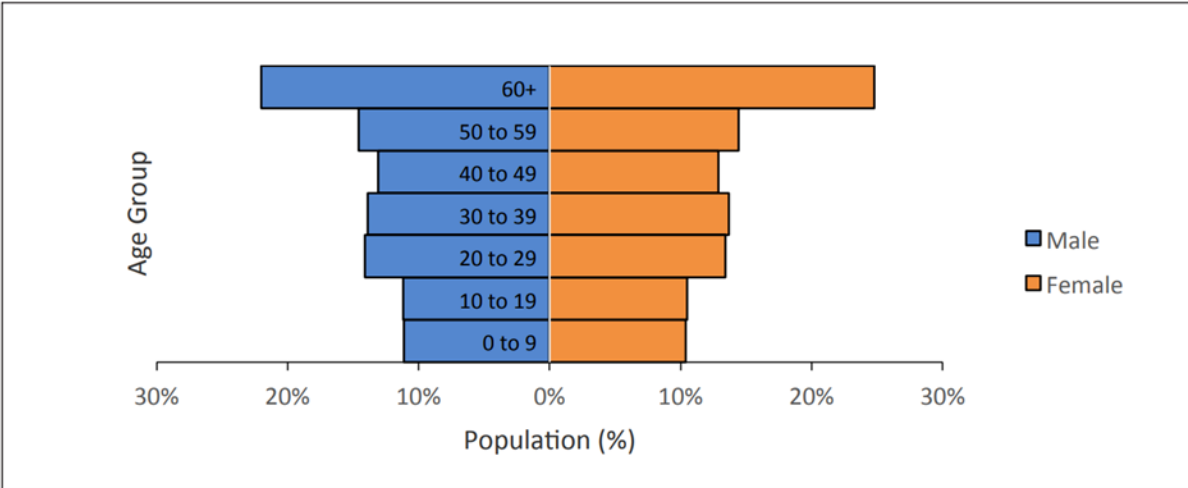


Figure 3: Population pyramid for the general population in Canada, 2017 (FNIGC, 2018:19)

Indigenous languages

Over 70 Indigenous languages were reported in 2016. More than 15 per cent of Indigenous people (15.6) reported the ability to conduct a conversation in an Indigenous language, compared with 21.4 per cent in 2006. Of these individuals, 64 per cent were Inuit and 21.3 per cent were First Nations. The languages most often reported were Cree languages (96,575), Ojibway (28,130) and Oji Cree (15,585) (Statistics Canada, 2017; 2018).



Chronic health conditions

In comparison to the general population, Indigenous Peoples experience a disproportionately high burden of chronic diseases and associated risk factors (King, Smith & Gracey, 2009). In 2006, over half of Métis people over 15 years of age reported having been diagnosed with a chronic condition. The most common conditions were arthritis or rheumatism, high blood pressure and asthma — all of which occurred in Métis people at rates higher than the overall Canadian population (Statistics Canada, 2010).

According to the First Nations Information Governance Centre's (FNIGC) Regional Health Survey (RHS), in 2016, 59.8 per cent of First Nations adults reported having one or more chronic health conditions. Diabetes, arthritis, high blood pressure, allergies and chronic back pain remain the most commonly

reported conditions (FNIGC, 2018). In 2012, 43 per cent of Inuit reported at least one chronic condition. The chronic conditions most commonly reported were high blood pressure, arthritis, asthma, and mood disorders like depression or bipolar disorder (Wallace, 2015).

The prevalence of diabetes among First Nations adults living off-reserve and Métis adults is 1.9 and 1.5 times higher than the rate among non-Indigenous adults (Pan-Canadian Health Inequities Reporting Initiative, 2018). Rates of Type 2 diabetes among Indigenous children and youth have also been identified as an area of concern (Earle, 2011). The prevalence of obesity among First Nations living off-reserve and Inuit is 1.6 times that of non-Indigenous people (Pan-Canadian Health Inequities Reporting Initiative, 2018). Further, according to 2014 national estimates, Indigenous populations had HIV incidence rates 2.7 times higher than people of other ethnicities (Yang, et al., 2016).

Mental wellness

Fortunately, recent data from the RHS suggests that the majority of First Nations youth and adults are abstaining from prescription and illegal drug use. Over 75 per cent of First Nations youth (75.3) reported that they had abstained from consuming alcohol and 72.8 to 99.7 per cent reported never having used certain kinds of prescription and illegal drugs. Additionally, 42.6 per cent of First Nations adults reported that they had not consumed any alcoholic beverage in the past 12 months and the majority (69.7 to 99.7 per cent) said they did not partake in a range of prescription or illegal drugs in the previous 12 months (FNIGC, 2018). RHS data also shows that more than half of First Nations adults and youth reported having very good or excellent mental health. Stronger, culturally informed data could explain why the RHS results show high self-ratings of mental health and high abstinence from substance use in comparison to literature which identified high prevalence of substance misuse (FNIGC, 2018).

In 2012, 24 per cent of First Nations living off-reserve, 23.5 per cent of Inuit and 19.6 per cent of Métis reported having ever had suicidal thoughts (Statistics Canada, 2016). According to the Pan-Canadian Health Inequalities Reporting Initiative (2018), areas where many people identify as First Nations, Inuit and Métis have suicide rates that are 3.7, 6.5 and 2.7 times higher than in areas with a low concentration of people who identify as Indigenous. This translates respectively to 29.2, 61.0, and 18.6 more deaths by suicide per 100,000 people, than among the non-Indigenous population.

Understanding health inequities

There are “Indigenous data quality challenges including misclassification errors and non-response bias [that] systematically contribute to a significant underestimate of inequities in health determinants, health status, and health care access between Indigenous and non-Indigenous people in Canada” (Smylie & Firestone, 2015: 1). The information that is available indicates that health disparities persist for Indigenous Peoples.

Due to racist colonial policies, many Indigenous Peoples have suffered the loss of connections to their land, languages and traditional ways of life. Health disparities among the Indigenous and non-Indigenous population are rooted in colonial practices that resulted in forced relocation, the reservation system, residential schools, child apprehensions and endangered languages (National Collaborating Centre for Aboriginal Health, 2013). These profound human rights violations aimed to eliminate Indigenous languages, cultural practices, and their identities as distinct peoples. The subsequent trauma has resulted in higher rates of suicide, mental health and addictions issues, and significant health disparities (Assembly of First Nations & Health Canada, 2015).

According to the RHS, the majority of First Nations adults who reported chronic health conditions and who also attended residential schools indicated that their overall health and well-being was negatively affected by their residential school experiences. Further, a higher proportion of First Nations adults and youth who had at least one parent attend a residential school, reported higher rates of using opioids, having seriously considered suicide at some point in their lives, binge drinking, using cannabis and using non-prescription drugs (other than cannabis), compared to those without a parent who attended a residential school (FNIGC, 2018).

Colonization impacts the health of Indigenous Peoples through a legacy of environmental dispossession, substandard living conditions and inadequate access to health services (King, Smith & Gracey, 2009; NCCAH, 2013). The major dietary and lifestyle changes experienced among Indigenous Peoples as a result of colonization have also contributed to high obesity rates and the prevalence of diabetes (Haman et al., 2010).

System and practice implications

Ongoing systemic inequities — such as disproportionate child apprehensions, issues with access to safe drinking water and food insecurity — disrupt the healing process (Tasker, 2017; FNIGC, 2018). Household mould and mildew also remain public health issues. A higher percentage of First Nations adults with chronic health conditions reported living in homes where household mould or mildew was present, compared to those with none (FNIGC, 2018). These ongoing public health issues require further research and policy to address the links between water access, housing quality and chronic health conditions.

Timely access to screening, treatment and monitoring of chronic health conditions for Indigenous Peoples is needed (FNIGC, 2018). Furthermore, sustainable funding is required for sovereign, community-based programs that promote wellness (Assembly of First Nations & Health Canada, 2015; Royal Commission on Aboriginal Peoples, 1996). Revitalizing Indigenous languages and traditions would also have a profound restorative impact on health and well-being (NCCA, 2013; Hodge, & Nandy, 2011; Oster et al., 2014). In addition, community-based participatory research that facilitates the growth of culturally appropriate health programs is needed, in light of evidence that Western interventions and programs rooted in First Nations culture can be successfully combined to improve health outcomes like those related to opioid dependence (Kanate et al., 2015).

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Chapter 9: Glossary of terms

Case study

Why does terminology matter?

(First Nation and Indigenous Studies, The University of British Columbia, 2009)

“The history of relationships between the Canadian state and Indigenous peoples is complex, and has oftentimes been paternalistic and damaging. As a result, terminology can represent something more than just a word. It can represent certain colonial histories and power dynamics. Terminology can be critical for Indigenous populations, as the term for a group may not have been selected by the population themselves but instead imposed on them by colonizers. With this in mind, one might understand how a term can be a loaded word, used as a powerful method to divide peoples, misrepresent them, and control their identity — what we can see today in Canada with ‘[status](#)’ and ‘[non-status Indians](#),’ the legally defined categories of people under the *Indian Act*.

On the other hand, terms can empower populations when the people have the power to self-identify. It is important to recognize the potential these words may hold — but it is also important and very possible to understand these terms well enough to feel confident in using them and creating dialogue. We have included several of these general terms below, although many Indigenous people may prefer to identify themselves by their specific cultural group. As you will see, the most respectful approach is often to use the most specific term for a population when possible.”

Several excellent Indigenous resources are available for reference.

Editorial principles in Indigenous writing

Elements of Indigenous Style. (Younging, 2018)

- Collaborate with Indigenous writers, editors and knowledge keepers.

- Be mindful of biased language and colonial paternalism (i.e. refer to Indigenous people as active participants with strengths rather than passive participants with diminished capacities).
- Use Indigenous “resilience” instead of Indigenous “struggle.”
- Use “assert” rather than “demand.”
- Capitalize; not doing so dehumanizes the Indigenous person as having no identity or human rights. Not capitalizing is disrespectful.

Common terms and their meanings

Anti-racism

Where racism is confronted, this attribute is an integral part of being culturally safe. This term is now expanding and is being used more accurately to reflect the purpose of being culturally safe by employing anti-racism interventions.

Colonization

This term refers to the exploitation, subjugation and genocide of Indigenous Peoples and their cultures using instruments of power that include political, economic and social policies to de-humanize, oppress and control.

Communities under threat

It is more appropriate to use the term “communities under threat” in place of “disadvantaged populations” when referring to Indigenous populations, as the latter positions these communities as victims rather than focusing on the upstream factors (such as racism and oppression) and other determinants of health.

Cultural competence

Although cultural competence is widely touted as a panacea, it does have its limits. Cultural competence can be seen as “a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations” (U.S. Department of Health and Human Services, 2001).” Cultural competence denotes the attainment or application of knowledge and skills, but it does not necessarily translate into desired outcomes in the patient-provider experience if a trusting relationship has not been forged.

Cultural safety

Cultural safety goes beyond cultural competence in improving Indigenous health; it analyzes power imbalances, institutional discrimination, colonization and colonial relationships as they apply to health, care and health education. Culturally safe practices require critical thinking and self-reflection about power, privilege and racism in educational and clinical settings. It is the patient and student who define whether a culturally safe space is being created in a relationship.

Cultural humility

Cultural humility is an extension of cultural safety, where honest contrition translates into actions to right wrongs and to humbly place oneself as a respectful learner of the other's way of being. It is about true respect in a relationship, built on trust and a dismantling of power imbalances.

De-colonization

This is the process of undoing the harms caused by colonization by correcting power imbalances, practising cultural safety through anti-racism interventions, and reforming systems to embrace Indigenous Peoples as equals who possess strengths, rather than seeing deficits.

Epistemology

This is the branch of philosophy concerned with the nature and origin of knowledge, including its limits and validity; in Indigenous health, it examines the roots of dominant (colonial) cultural perspectives.

Health disparities

Health disparities are those indicators that show a disproportionate burden of disease on a particular population.

Health inequities

Health inequities point to the underlying causes of health disparities.

Indigenous

For consistency of terminology — encompassing cultural diversities, reflecting historical accuracies and respecting the people this document is intended to benefit — the term “Indigenous” is used throughout in place of Aboriginal people, First Nations, Inuit and Métis. To borrow from the National Aboriginal Health

Organization's (NAHO) glossary and terms (2008), "Indigenous" means "native to the area." In this sense, according to NAHO's terminology, "Aboriginal Peoples" are indeed "Indigenous" to North America. The term Indigenous also recognizes the ownership of land by the original people, prior to colonization.

Indigenous science

This term is a morphology that values and legitimizes Indigenous wisdom at the same level as other sciences; it is a form of respect and recognition that elevates culture, history and ways beyond subjugation.

Racism

Racism includes the belief that one's own race is superior to another. It also includes discrimination based on policy, and outright hatred or intolerance. Racism is shaped by the distribution of money, power and resources that control the social determinants of health. (Reading, 2013). Racism appears in many forms, all of which are destructive and lead to negative health effects on individuals, families and communities (National Collaborating Centre for Aboriginal Health, 2013).

Reconciliation

This is the movement to redress the legacy of residential schools in Canada through Calls to Action. This process germinated from Justice Murray Sinclair's inquiry into a historical record of racism faced by Indigenous communities that resulted in 94 Calls to Action for the colonizing powers to follow to start the healing process.

Reflexivity

This term denotes a thought or belief bias, which is reflected in a person's work or behaviour.

*The term is also used by the United Nations in its working groups and in its Decade of the World's Indigenous People. It is also a term used extensively by the World Health Organization: "Indigenous populations are communities that live within, or are attached to, geographically distinct traditional habitats or ancestral territories, and who identify themselves as being part of a distinct cultural group, descended from groups present in the area before modern states were created and current borders defined. They generally maintain cultural and social identities, and social, economic, cultural and political institutions, separate from the mainstream or dominant society or culture." (World Health Organization, n.d.)

The Royal College also recognizes and respects the diversity amongst Indigenous populations in Canada.

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Indigenous Corporate Training

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