Social and Cultural Domains of Care with Indigenous Patients

ACH SPRING RETREAT

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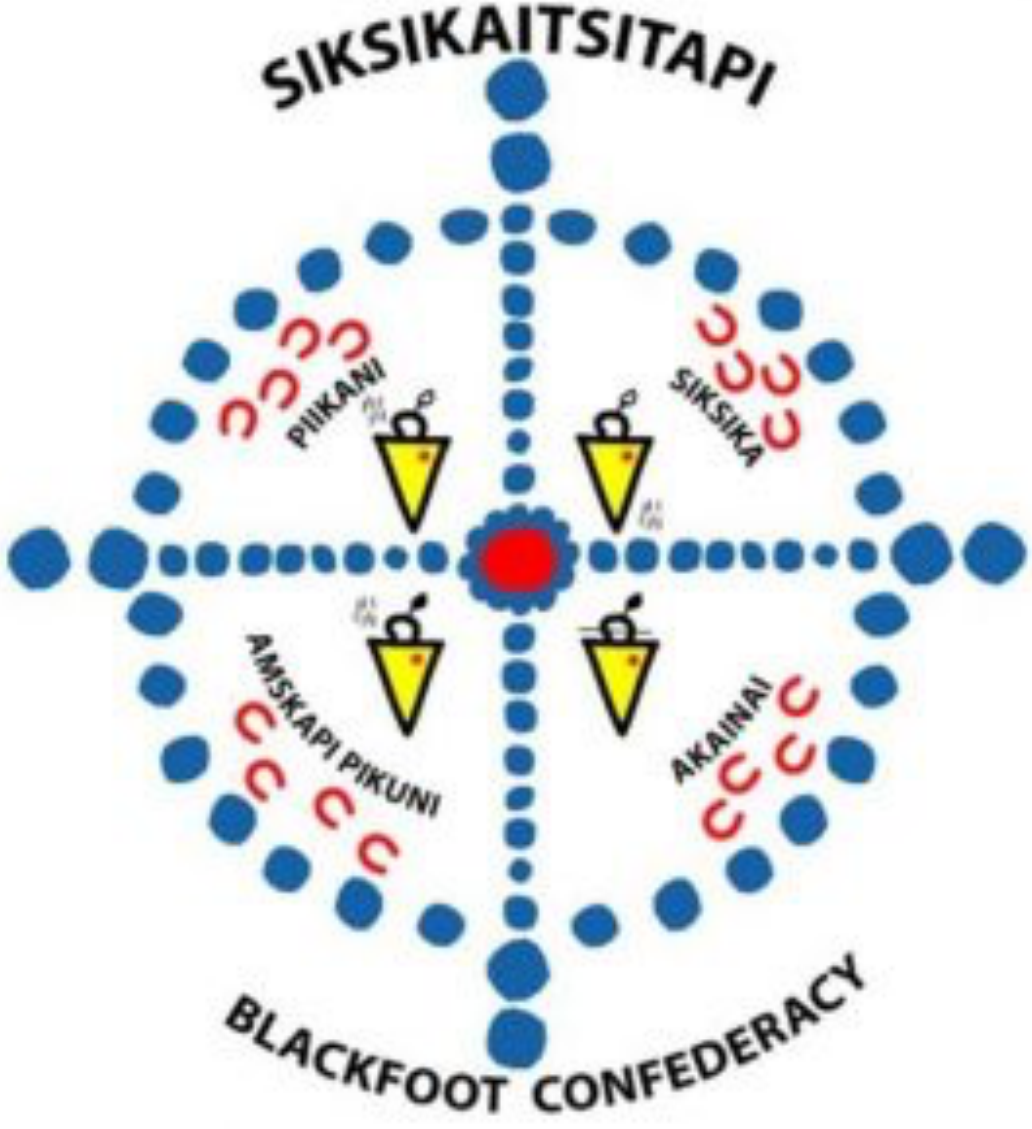
Cumming School of Medicine

Intentions

1. Understand key social and cultural factors that contribute to health outcomes of Indigenous patients
2. Begin to identify management strategies (that engage with social and cultural domains) for comprehensive care with Indigenous patients
3. Define approach to therapeutic relationship building that incorporates culturally attuned approaches and addresses discord arising from inequity


SIKSIKAITSITAPI
PIIKANI
SIKSIKA
AMSKAPI PIKUNI
AKAINAI
BLACKFOOT CONFEDERACY


Nitsitapii
Territory

"Brings Down The Sun" - Ceremonialist and Medicine Man of the North Peigan (courtesy Provincial Archive of Manitoba, E. Morris Collection, 1907)

Mrs. Laura Buffalo, 18 Sept., 1976
Courtesy of Richard J. Neatby





SKI AREA
BOUNDARY


RE WARDEN

Canadian Adult Obesity Clinical Practice GUIDELINES

obesity canada | obésité canada

L'ASSOCIATION CANADIENNE des MÉDECINS et CHIRURGIENS BARIATRIQUE
The CANADIAN ASSOCIATION of BARIATRIC PHYSICIANS and SURGEONS

Obesity Management and Indigenous Peoples

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Update History

- Validate the patient's experiences of stress and systemic disadvantage influencing poor health and obesity, exploring elements of their environment where reduced stress could shift behaviours (Level 4, Grade D, Consensus).
- Advocate for access to obesity management resources within publicly funded healthcare systems, recognizing that resources beyond may be unaffordable and unattainable for many (Level 4, Grade D, Consensus).
- Address resistance, seeming apathy and paralysis in patients and providers (Level 4, Grade D (Consensus).
- Self-reflect on anti-Indigenous sentiment common within healthcare systems, exploring patient motivations and mental health (e.g., trauma, grief) as alternative understandings of causes and solutions to their health problems. Explore one's own potential for bias influenced by systemic racism (Level 4, Grade D, Consensus).
- Expect patient mistrust in health systems; reposition yourself as a helper to the patient instead of as an expert, which may stir resistance and be a barrier to their wellness(Level 4, Grade D, Consensus).

“I don’t even know who to go to on my reserve to learn more about traditional foods, how to access them. It’s a huge barrier, I have no knowledge of where to start. It’s definitely something I’ve wanted to look into...We can go get our own meat and pick berries and everything, and I don’t know where to start, who to talk to.”

(Female, Blackfoot, age 27)

"Inequity is the presence of systematic and potentially remediable differences among population groups defined socially, economically, or geographically"

Starfield International Journal for Equity in Health 2011, 10:15
http://www.equityhealthj.com/content/10/1/15

Structural Competency

”[T]he trained ability to discern how a host of **issues defined clinically as symptoms, attitudes, or diseases** (e.g., depression, hypertension, obesity, smoking, medication “non-compliance,” trauma, psychosis) **also represent the downstream implications of a number of upstream decisions** about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health.”

1. **Recognize structures** that shape clinical interactions
2. **Rearticulate “cultural”** presentations in structural terms
3. **Develop an extra-clinical** language of structure
4. Observe and **imagine structural intervention**
5. **Develop structural humility**

Metzl JM, Hansen H. Soc Sci Med. 2014;103:126–133.

"I'm not rich. I'm just surviving. We eat what we can afford."

- *Gilbert was diagnosed with diabetes in his late 40's.*
- *He has had difficulties managing his diabetes.*
- *Poverty has been a significant factor and struggles to meet his basic needs.*
- *With his limited resources, he has supported his immediate and extended family.*

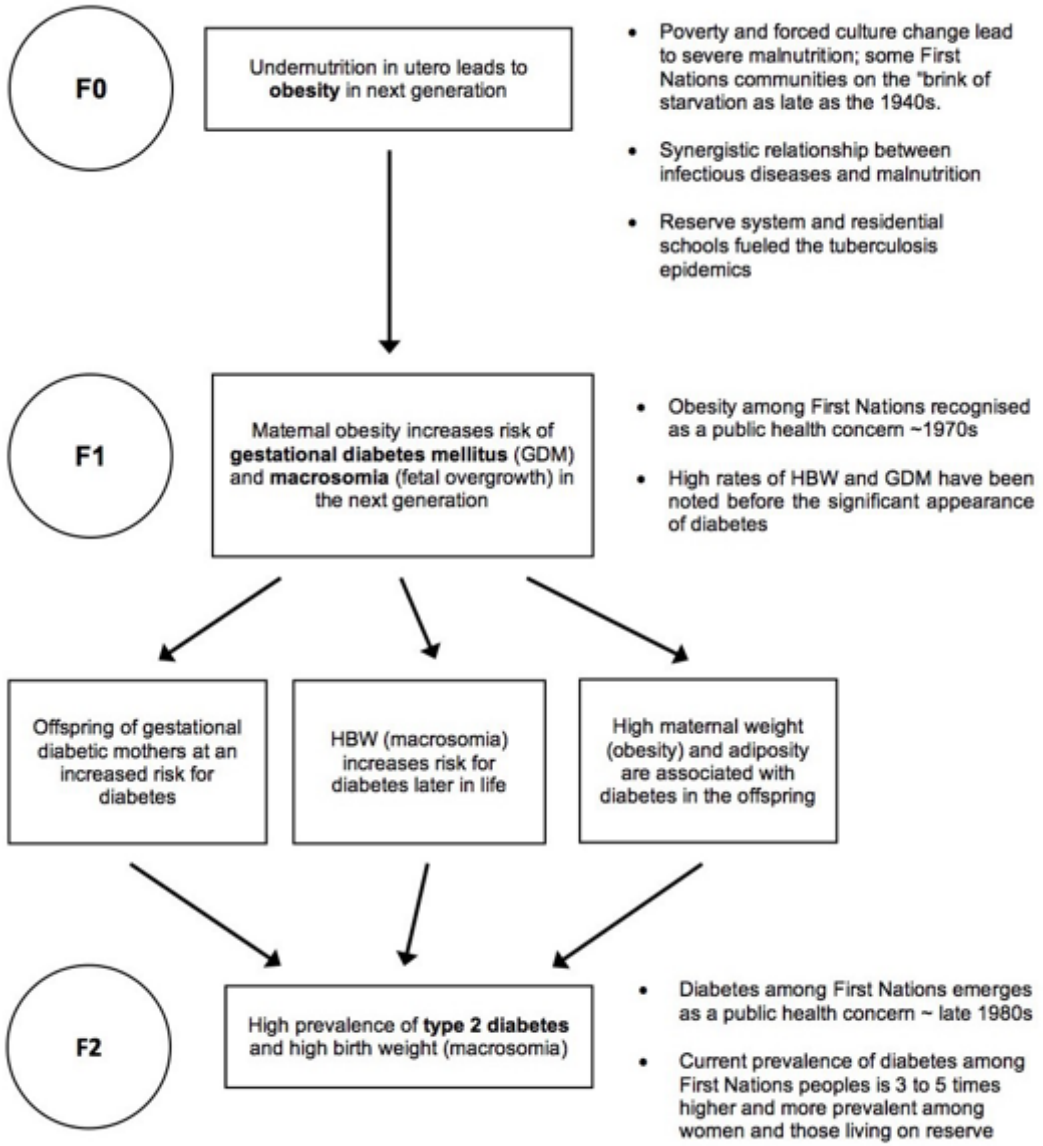
HUMANITIES | MEDICINE AND SOCIETY

"Hunger was never absent": How residential school diets shaped current patterns of diabetes among Indigenous peoples in Canada

Cite as: *CMAJ* 2017 August 14;189:E1043-5. doi: 10.1503/cmaj.170448

Mealtime at Gordon's School in January 1954, from the Grace Reed Fonds.

Ian Mosby and Tracey Galloway, CMAJ 2017



Developmental origins of diabetes among First Nations in Canada. Epidemiological and anthropometric measures appear to emerge in relative chronological order consistent with intergenerational transmission of fetal programming.

Dawson, L. (2018). Histories, Bodies, Stories, Hungers: The Colonial Origins of Diabetes as a Health Disparity among Indigenous Peoples in Canada.

*"**Household Food Insecurity** is described as uncertain, insufficient, or inadequate food access, availability, and utilization due to limited financial resources, and the compromised eating patterns and food consumption that may result"*

*(*Bush M, General RD. Canadian Community Health Survey, Cycle 2.2, Nutrition (2004): Income-Related Household Food Security in Canada. 2007.*)*

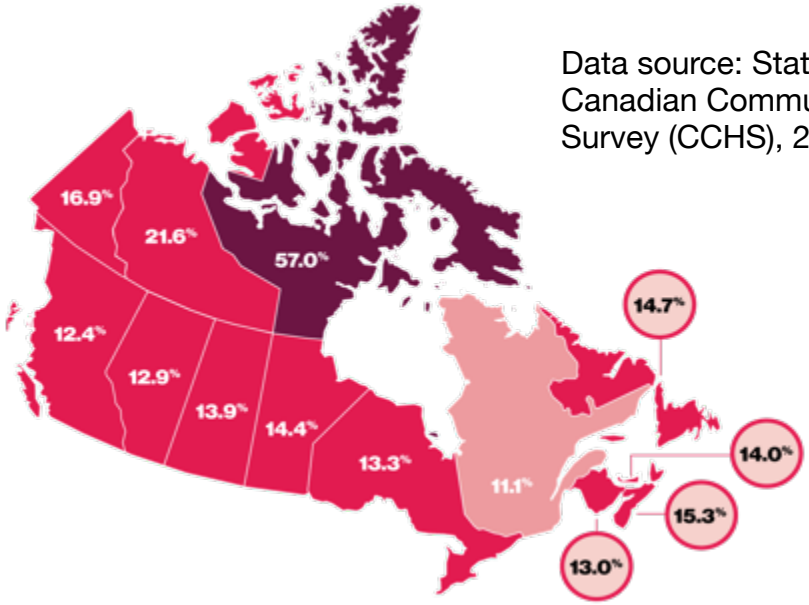
According to the 2017-18 Canadian Community Health Survey, **12.7 %** of Canadians were food insecure (4.4 million Canadians).

Tarasuk V, Mitchell A. (2020) Household food insecurity in Canada, 2017-18. Toronto: Research to identify policy options to reduce food insecurity (PROOF).

What is the prevalence of Household Food Insecurity for Indigenous people?

A. 9.8%
B. 12.7%
C. 15.5%
D. 21.7%
E. 28.2%

Household Food Insecurity by Province and Territory



Data source: Statistics Canada, Canadian Community Health Survey (CCHS), 2017-18.

Tarasuk V, Mitchell A. (2020) Household food insecurity in Canada, 2017-18. Toronto: Research to identify policy options to reduce food insecurity (PROOF).

The association between food insecurity and incident type 2 diabetes in Canada: A population-based cohort study Tait, C. A., L'Abbé, M. R., Smith, P. M., & Rosella, L. C. (2018).

Limited budgets for those in food insecure households result in purchasing cheaper, high calorie foods, which can contribute to weight gain and an increased risk of many chronic diseases including type 2 diabetes. [Vozoris NT, Tarasuk VS. Household food insufficiency is associated with poorer health. The Journal of nutrition. 2003; 133(1):120–6. and Chen J, Che J. Food insecurity in Canadian households [1998/99 data]. Health Reports. 2001; 12(4):11.]

Food insecurity is often cyclically manifested at the household level, due the nature of monthly pay checks, social assistance, and periodic unforeseen competing financial needs [Montonen J, Knekt P, Ha¨rka¨nen T, Ja¨rvinen R, Helio¨vaara M, Aromaa A, et al. Dietary patterns and the incidence of type 2 diabetes. Am J Epidemiol. 2005; 161(3):219–27. https://doi.org/10.1093/aje/kwi039 PMID: 15671254.].

This cycle of financial instability often contributes to episodic under-consumption, followed by occurrences of overconsumption during times of adequacy, resulting in binge-fast cycles that are associated with insulin resistance and progression to type 2 diabetes [Lee JS, Frongillo EA. Nutritional and health consequences are associated with food insecurity among US elderly persons. The Journal of nutrition. 2001; 131(5):1503–9. https://doi.org/10.1093/jn/131.5. 1503 PMID: 11340107

After being diagnosed, Gilbert continued heavy drinking and cigarette smoking (up to 3 packs per day) and often avoided taking his diabetes medications when drinking. Ten years after being diagnosed with DM, Gilbert suffered a heart attack.

Gilbert started drinking at 10 years of age because he was trying to forget about his experiences of mistreatment and sexual abuse while within the residential school system.

He drank alcohol daily and occasionally consumed wood alcohol, rubbing alcohol and melted vinyl.

His peers (who had similar life experiences) encouraged Gilbert to drink throughout his life.

The Scream
Kent Monkman

Adverse Childhood Experiences Study

Relationship of childhood abuse and household dysfunction

- Recurrent physical abuse
- Recurrent emotional abuse
- Contact sexual abuse
- An alcohol and/or drug abuser in the household
- An incarcerated household member
- Someone who is chronically depressed, mentally ill, institutionalized, or suicidal
- Mother is treated violently
- One or no parents
- Emotional or physical neglect

Felitti, et al. Am J Prev Med 1998

Trauma and Violence Informed Care (TVIC)

TVIC involves providing care that is respectful and affirming, and requires all staff within any given organization to

(a) recognize the intersecting health effects of structural and individual violence, and other forms of inequity;

(b) understand people's health and social issues in context; and

(c) work to reduce re-traumatization. Importantly, TVIC is not about eliciting trauma histories; rather, the goal is to create a safe environment **for all** based on an understanding of the traumatic effects of historical and ongoing violence and discrimination.

Browne, A. J., Varcoe, C., Lavoie, J., Smye, V., Wong, S. T., Krause, M., . . . Fridkin, A. (2016). Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. *BMC Health Services Research, 16*, 544-544. doi:10.1186/s12913-016-1707-9

Attachment

Attachment theory is a novel way to understand a person's perceptions of and ability to collaborate in relationships, including health care relationships. John Bowlby, who coined attachment theory, proposed that all people psychologically incorporate past experiences with caregivers, forming enduring cognitive models or maps of caregiving that persist throughout adulthood.

Ciechanowski, Katon, Russo, and Walker 2001

Disrupted Attachments: A Social Context Complex Trauma Framework and the Lives of Aboriginal Peoples in Canada

Lori Haskell and Melanie Randall, 2009

One of the most significant and profound harms associated with abuse, neglect and deprivation is the absence of the opportunity to develop secure attachment.

Difficulties with attachment reverberate throughout a traumatized person's entire life, and through her or his relationships with self and with others.

People with close relationships live longer lives. Safety in relationships is one of the biggest resilience factors against mental health problems and is one of the most important factors in general health and well-being

Toxic Stress

Strong, frequent, or prolonged exposure to adverse events

Brief increases in heart rate, mild elevation stress hormones

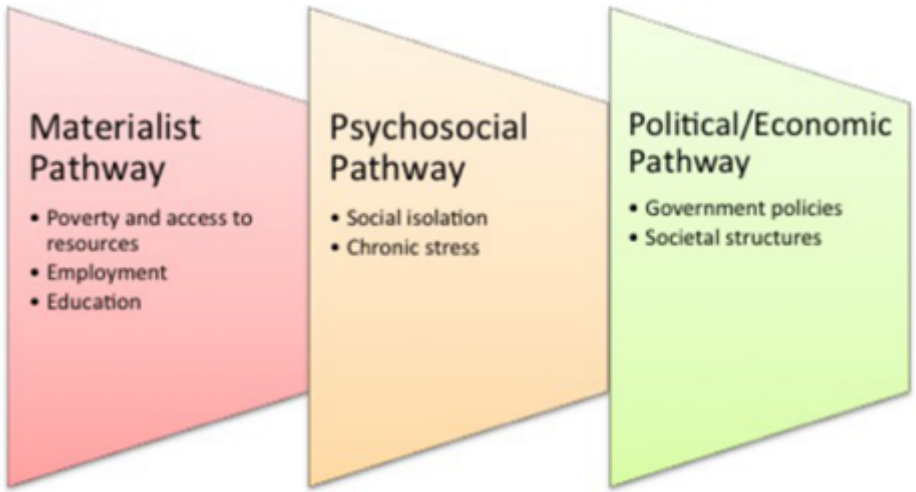
Serious, but temporary responses to stress, buffered by supports

Prolonged activation of stress response, absence of protective relationships

Especially in early life, when stress is experienced chronically, uncontrollably, or without access to support, it may provoke responses that adversely impact brain architecture

Pathways Linking Chronic Disease and Inequity

Pathways that lead from inequity to chronic disease are multiple and interdependent.

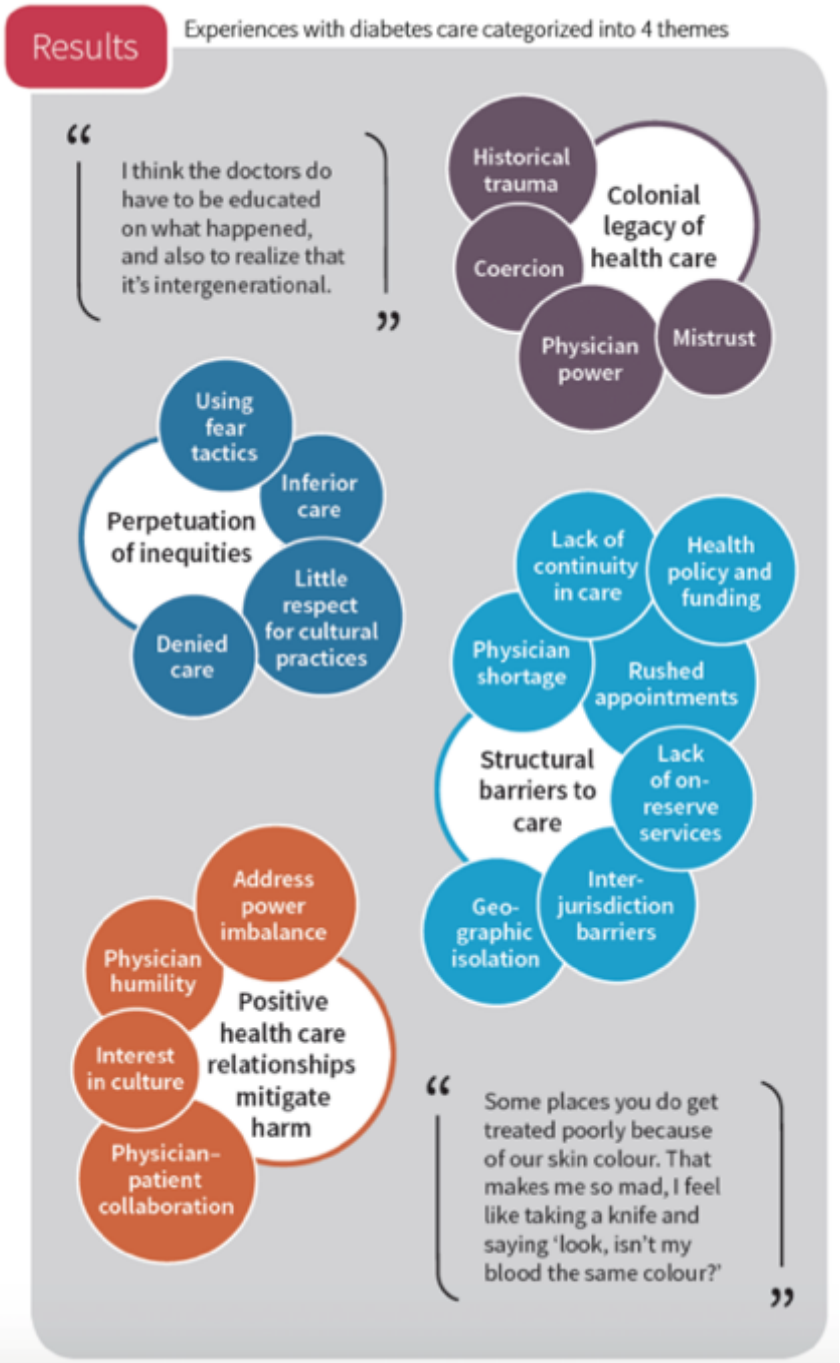


Source: Public Health Agency of Canada (2010). The Tides of Change: Addressing Inequity and Chronic Disease in Atlantic Canada: A Discussion Paper.

Health care experiences of Indigenous people living with type 2 diabetes in Canada

Question

How are social determinants of health embodied and enacted during clinical encounters of Indigenous people living with type 2 diabetes in Canada?

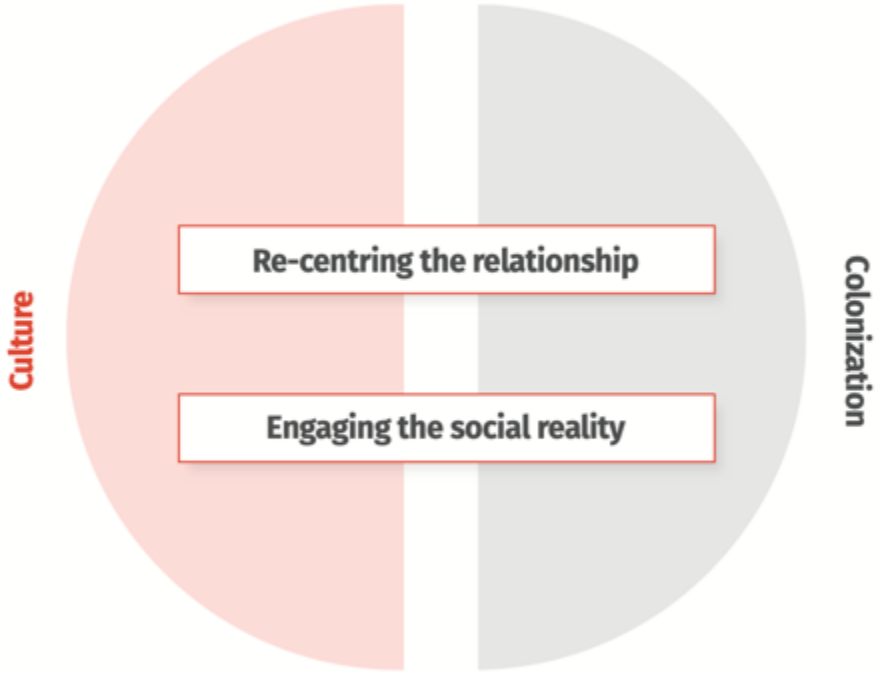


- Sequential focus groups and interviews were conducted in 5 Indigenous communities
- A phenomenological thematic analysis used to categorize diabetes experiences.
- 4 themes:
  - the colonial legacy of health care;
  - the perpetuation of inequalities;
  - structural barriers to care;
  - the role of the health care relationship in mitigating harm.

Jacklin, K. M., Henderson, R. I., Green, M. E., Walker, L. M., Calam, B., & Crowshoe, L. J. (2017). Health care experiences of Indigenous people living with type 2 diabetes in Canada. *Canadian Medical Association Journal*, *189*(3), E106-E112.

Education for Equity Care Framework

Culture and Diabetes: A key facilitator for approaching diabetes management. Cultural beliefs, values, and practices might play a role for patients in acquiring health knowledge and resilience. Culture was viewed as a protective factor and a facilitator for improving health and managing diabetes. Resilience through reaffirming cultural identity and continuity is nurtured by accessing cultural knowledge and cultural supports.



Colonization and diabetes.
Colonization is the predominant determinant of health for Indigenous people. Colonization is a distal determinant that undermines individual resilience and leads to negative health outcomes through pervasive poverty, adverse life experiences, and ongoing racism. These unfavourable conditions underlie and exacerbate Indigenous people's experiences of diabetes, as the structural barriers and psychosocial effects of poverty have consequences for health.

From: Crowshoe, L., Henderson, R., Jacklin, K., Calam, B., Walker, L., and Green, M. (2019). Education for Equity Care Framework: Addressing social barriers of Indigenous patients with type 2 diabetes. *Canadian Family Physician,* 65(1), 25-33.

Dorothy (Part 1)

Dorothy is a 55-year-old female who lives and works in a local First Nations community.

She is booked to see you today regarding concerns of diabetes.

Past medical history includes hypertension, occasional migraine headaches, cholecystectomy and a right tibia fracture repair.

Here is the link to view the video:
http://youtu.be/DIixF_aGB74

Regarding social issues and cultural context:

WHAT do you see?
SO WHAT why important?
NOW WHAT do you do about it?

Societal Health Determinants

- Social Cohesion
- Inequality
- Relative Poverty

Unhealthy Societies: The Afflictions of Inequality (1997)
Wilkinson

“there are health-enhancing and health-damaging properties of the health–social support relationship, and that the negative dimensions significantly outweigh the positive ones, particularly when they operate in response to poor material conditions.”

Richmond, C. A., & Ross, N. A. (2008). Social support, material circumstance and health behaviour: Influences on health in First Nation and Inuit communities of Canada. Social Science & Medicine, 67(9), 1423-1433.

Effort-reward Imbalance

A theoretical model to identify a stressful psychosocial work environment and to explain its adverse effects on stress-related health risks.

Failed reciprocity between high efforts spent at work and low rewards received in turn elicits strong negative emotions and stress reactions with adverse long-term effects on health.

Siegrist, J. (2017). The Effort–Reward Imbalance Model. In *The Handbook of Stress and Health: A Guide to Research and Practice, First Edition* (pp. 24-35). Hoboken, NJ: Wiley Blackwell.

Lateral Violence

"Lateral violence describes a range of damaging behaviours expressed by those of a minority oppressed group towards others of that group rather than towards the system of oppression. Although the behaviours result from experience of oppression, they are expressed sideways (laterally) towards peers."

Gorringe, Ross & Fforde, 2011, p.8.

E4E Canada
Addressing Social Drivers of Type 2 Diabetes with Indigenous Patients

Culture Informs Relationships

Reciprocity

Process and pace

Connectedness

Culture Frames Knowledge

Contextualization and exchange

Culture as Therapeutic

Culture is protective

Traditional Medicine and Ceremony

Social and Economic Resource Disparities

Socioeconomic disadvantage

Family and limited resources

Knowledge barriers

Accumulation of Adverse Life Experiences

Adversity and support

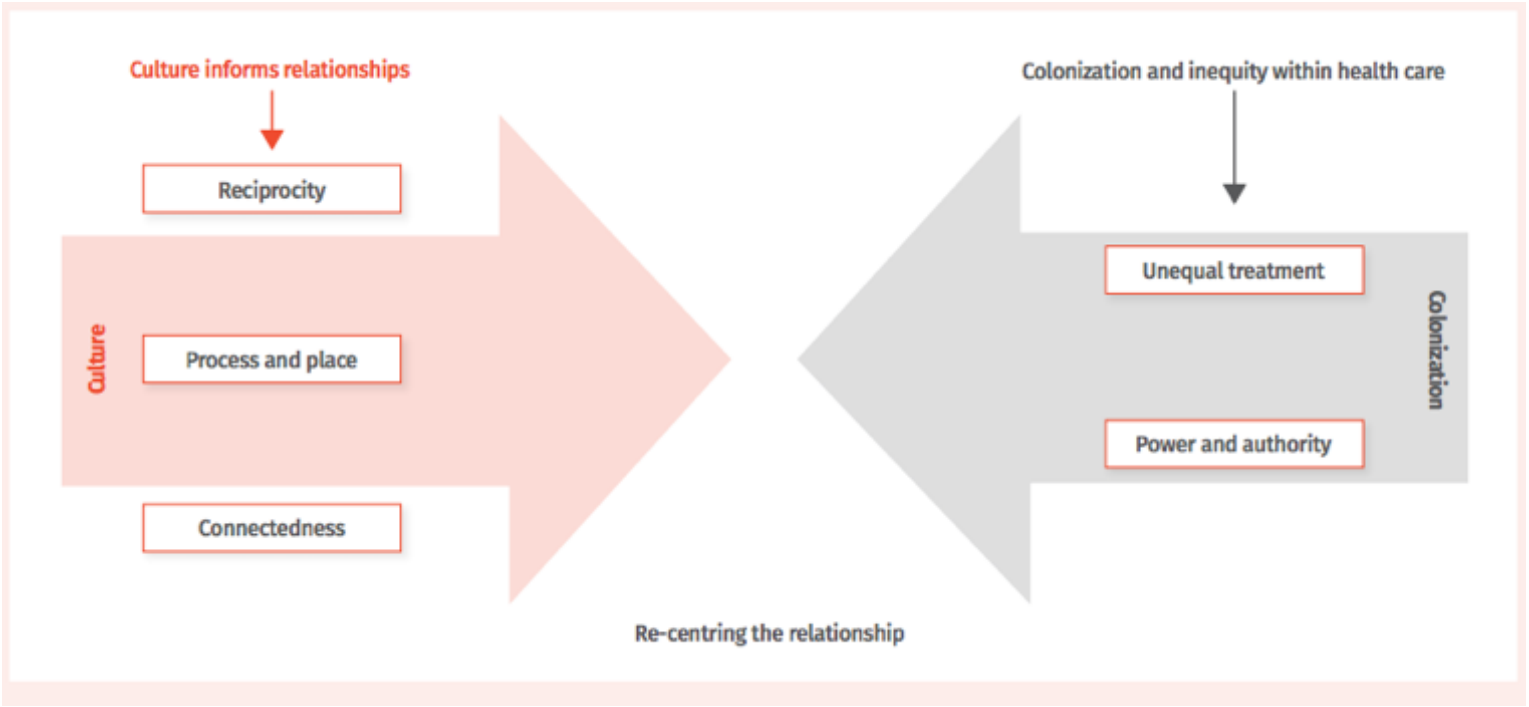
Personal and collective loss

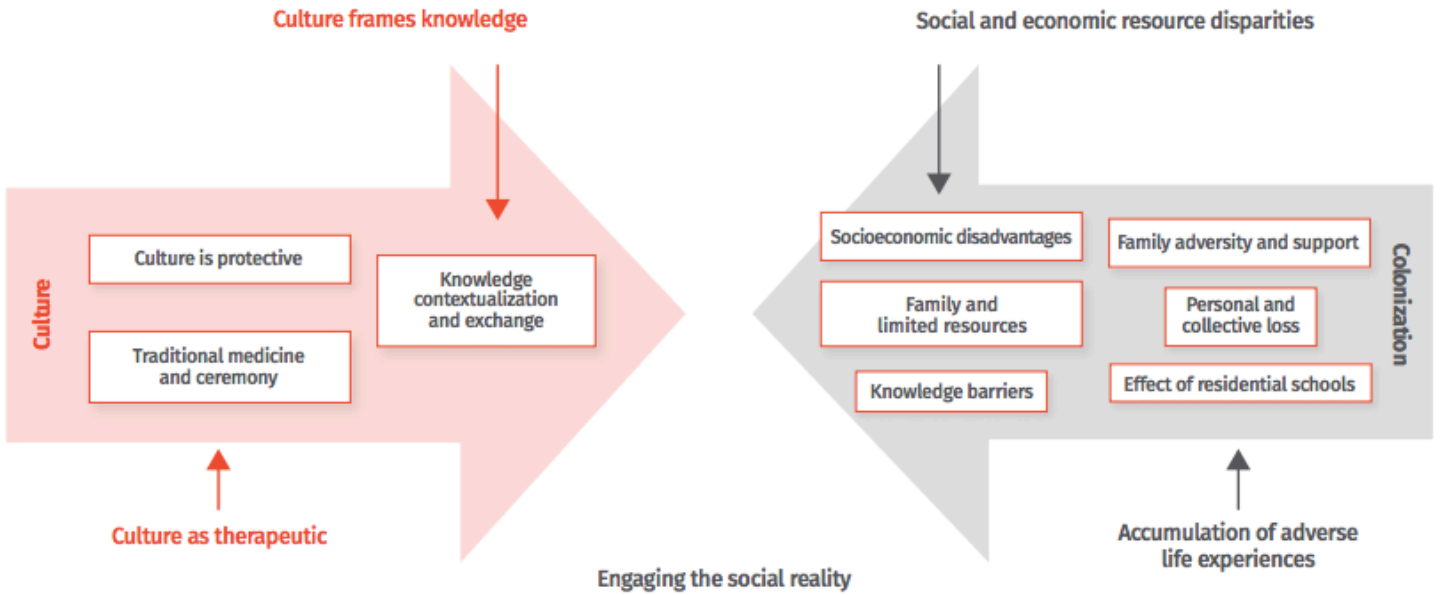
Impact of residential school

Colonization, Inequality and Health Care

Unequal Treatment

Power and Authority





From: Crowshoe, L., Henderson, R., Jacklin, K., Calam, B., Walker, L., and Green, M. (2019). Education for Equity Care Framework: Addressing social barriers of Indigenous patients with type 2 diabetes. *Canadian Family Physician,* 65(1), 25-33.

Social and Economic Resource Disparities: Resource limitations within the social environment impacts diabetes through material deprivation acting on the individual, family and community. Resource limitations also influence diabetes through psychosocial pathways involving stress, depression, anxiety and loss of control.

Considering Indigenous patients' social and economic realities:

- Screen for and explore resource limitations that influence diabetes onset and management

- Acknowledge with the patient the effect of resource limitations on diabetes onset and management

- Support access to key proximal health determinants

- Assess diabetes knowledge and health literacy

Accumulation of Adverse Life Experiences: Persistent and recurring throughout the life course of Indigenous individuals and communities, experiences of adversity accumulate and pervasively influence wellness and health by undermining health behaviours and diminishing resilience and capacity to cope with disease.

Considering patients' adverse life experiences:

- Acknowledge with the patient the connections between adverse life experiences and capacity for diabetes management

- Explore patients' perspectives on personal adverse experiences in the context of diabetes in order to address their priorities

Dorothy appears to have concerns about the care she is to receive from her doctor…

What did you see in the case?

What are your thoughts?

Colonization and Inequity within Healthcare: Colonization is a traumatic historical episode and an ongoing process resulting in uneven power relations between Indigenous people and Canadian society. It is the mechanism by which inequality shapes diabetes and healthcare outcomes for Indigenous people. Participants attributed racism and societal exclusion of Indigenous people to ongoing processes of colonization. Approaches that establish physician authority, expertise, status, and professional distance can negatively impact clinical relationships in the context of these historical relationships, social exclusion, and trauma.

Colonization and Inequity within Healthcare: Colonization is a traumatic historical episode and an ongoing process resulting in uneven power relations between Indigenous people and Canadian society. It is the mechanism by which inequality shapes diabetes and healthcare outcomes for Indigenous people. Participants attributed racism and societal exclusion of Indigenous people to ongoing processes of colonization. Approaches that establish physician authority, expertise, status, and professional distance can negatively impact clinical relationships in the context of these historical relationships, social exclusion, and trauma.

Unequal Treatment: *The health system, as a social & cultural construct of Canadian society, is perceived (and experienced) by patients as an institution that supports & facilitates ongoing colonization & control over Indigenous people through racist, oppressive, & exclusionary practices.*

Power and Authority: *Indigenous patients' heightened awareness & reaction to the power & authority mismatch within the doctor-patient relationship arises from historical injustices that undermined individual autonomy and negative experiences of authority from residential schooling.*

The Scream
Kent Monkman

“[A] modern industrial health care system can be a determinant of *ill* health, especially where it is culturally unsafe. At present, Canadian health care for Indigenous people is not culturally safe owing to the ways that health law, health policy and health practice continue to erode Indigenous cultural identities.”

R. Matthews CMAJ 2017 January 16;189:E78-9. doi: 10.1503/cmaj.160167

What are examples of worst imaginable healthcare?

https://jamboard.google.com/d/1BPPzCAtBYEQ7zcJ4DecH42rdAFLkcsjwsV44W8mD41w/edit?usp=sharing

Case Study: Lucille

- 48 yo female presented to ER 3x w/ headache
- Dx: migraine
- Rx: IM morphine

Excerpt from transcribed interview with a Métis participant in AB:

"When they'd see on my chart what my nationality was and that I was Métis, they immediately started to question me about how much I had been drinking because I was having trouble speaking and then they would send me home. Three times they just gave me a shot of morphine and sent me home."

"So then finally I suffered a major stroke, my brother and sister-in-law came in and my mother and took me to emergency at Foothills and they kept saying how much did she have to drink because I couldn't speak …"

- Eventually readmitted w/ unilateral weakness and aphasia
- Ultimate Dx: left-sided CVA

Patty is a 30 year old Indigenous woman with a history of PTSD and severe depression. She had recently escaped a 10-year abusive relationship where she experienced extreme physical and emotional abuse. She voluntarily was hospitalized for her mental health crisis.

As her mental health has stabilized, she requests discharge. She is quite focused on custody of her children as they were placed in foster care during her admission.

During her discharge planning meeting the Public Guardian laments, rolling her eyes, "*too bad that forced sterilization is not an option because of all of the lawsuits right now!*"

What do you think happened next?

True or False: Alberta legislated forced sterilization through its Sexual Sterilization Act

TRUE

The United Farm Women of Alberta, which was at the forefront of lobbying for sterilization laws, embraced “the ambitious goal of remodeling society through social improvements … The group emphasized well-raised and genetically ‘superior’ children as the hope for a future utopian society.” [Clément 2012] Alberta’s 1928 Sexual Sterilization Act created a Eugenics Board that was empowered to recommend sterilization as a condition for release from a mental health institution. The purpose was to ensure that “the danger of procreation with its attendant risk of multiplification of the evil by transmission of the disability to progeny were eliminated.” [Clément 2012] An amendment in 1937 permitted the sterilization of “mental defectives” without their consent.

https://historyofrights.ca/encyclopaedia/main-events/eugenics/

COLLAGE BY CATHRYN VIRGINIA | IMAGES FROM SHUTTERSTOCK, WIKIMEDIA COMMONS AND COURTESY OF SOURCES.

Health

Indigenous Women in Canada Are Still Being Sterilized Without Their Consent

In the 20th century, the U.S. and Canada carried out a quiet genocide against Indigenous women through coerced sterilization. In 2019, it's still happening.

By Ankita Rao

https://www.vice.com/en/article/9keaev/indigenous-women-in-canada-are-still-being-sterilized-without-their-consent

The Current with Anna Maria Tremonti

Indigenous women kept from seeing their newborn babies until agreeing to sterilization, says lawyer

Episode November 13, 2018
Forced Sterilization of Indigenous Women
https://www.cbc.ca/player/play/1369311299550

Brian Sinclair

45-year-old Indigenous man, double-amputee died in Winnipeg ER waiting room September 21, 2008 after left for 34 hours unattended with blocked catheter & treatable bladder infection.

Release Date: December 12, 2014

IN THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***THE FATALITY INQUIRIES ACT***

AND IN THE MATTER OF: **BRIAN LLOYD SINCLAIR, Deceased**

http://www.manitobacourts.mb.ca/site/assets/files/1051/brian_sinclair_inquest_-_dec_14.pdf

Brian Sinclair was never assessed by hospital staff after he arrived and while he sat at Health Sciences Centre Emergency Department

Mr. Sinclair arrives at the Health Sciences Centre at 14h53 on September 19, 2008.

September 19, 2008, 134 patients were triaged

September 20, 2008, 138 patients were triaged

Brian Sinclair was neither entered into the hospital system nor assessed medically by hospital staff during his 34 hours in the ED.

http://www.manitobacourts.mb.ca/site/assets/files/1051/brian_sinclair_inquest_-_dec_14.pdf

September 20, 2008: ” While standing by in adult emergency a lady by the name of Debbien {MacPhail-Abraham} approached writer {Gary Francis, night shift HSC Security Supervisor} at the security kiosk and whispered that she thinks the person sitting in the black wheelchair in the aisle close to the front of the waiting room was dead. Writer looked over to see Brian Sinclair sitting there with his head slumped over as if sleeping. I explained to Debbie that he is a regular patient and that is the usual position you would find him in when intoxicated. Debbie stated that she was pretty sure he was dead because the back of his neck is a pasty white color and his catheter bag is not attached to the line and it is dry.”

http://www.manitobacourts.mb.ca/site/assets/files/1051/brian_sinclair_inquest_-_dec_14.pdf

Joyce Echaquan
37-year-old Indigenous woman and mother of seven children, attended a Quebec emergency room in September 2020. Endured racist abuse and recorded it in the moments leading up to her death.

What COULD you DO to reliably recreate the worst healthcare imaginable for Indigenous Peoples?

What COULD you DO to reliably recreate the worst healthcare imaginable for Indigenous Peoples?

Is there anything in that previous list that you are CURRENTLY DOING in any way, shape, or form?

What can you stop doing that perpetuates these undesirable results?

Dorothy appears to have concerns about the care she is to receive from her doctor…

What did you see in the case?

What are your thoughts?

What do you do?

Culture Informs Relationships: Cultural perspectives inform how patients experience diabetes and engage with health care, as well as how physicians approach care. Patient resistance might reflect incongruence and the need for physician reflection.

Reciprocity: *Creating an authentic relationship involves sharing key social contexts in order to build rapport and trust*

Process and Pace: *Providing appropriate care requires attention to issues of process and pace to allow for exploration of and reflection on the patient's experiences*

Connectedness: *Patient experience of diabetes and diabetes care is embedded in relationships, family dynamics, and community supports and structures*

Culture Informs Relationships: Cultural perspectives inform how patients experience diabetes and engage with health care, as well as how physicians approach care. Patient resistance might reflect incongruence and the need for physician reflection.

Reflecting on how culture informs relationships:

- Critically reflect on your own concepts of health and diabetes care and potential assumptions about Indigenous perspectives
- Reflect on professional distance and objectivity, and in the spirit of reciprocity, consider sharing aspects about yourself to build trust
- Adjust your pace when exploring the patient's world
- Connect and work to foster positive relationships at the individual, family, and community levels

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

CanMEDS–Family Medicine

Indigenous Health Supplement

Professional

Definition

The Professional Role calls on family physicians to incorporate cultural, social, and ethical dimensions of care with diverse Indigenous patients and populations. Defining competent medical practice with Indigenous patients frames accountabilities to patients, colleagues, the community, and the profession. They direct us to act on cultural, structural, and systemic dynamics that influence health and health care as experienced by Indigenous people.

Equity Oriented Services

Browne et al., 2016

- **Contextually Tailored Care (CTC)** expands the individually focused concept of patient-centered care to include offering services tailored to the specific health care organization, the populations served, and the local and wider social contexts.
- **Trauma and Violence Informed Care (TVIC)** draws on previous work on trauma-informed care, but is founded on the assumption that people disadvantaged by systemic inequities experience varying forms of violence that have traumatic impacts on an ongoing basis

Key Dimensions of Equity-Oriented Services

4 General Approaches:

- Partnerships with Indigenous peoples
- Action at all levels (patient-provider; organizations; systems)
- Attention to local and global histories
- Attention to unintended and potentially harmful impacts of each strategy

10 Strategies to Guide Equity-Oriented Services with Indigenous Peoples:

- Explicitly commit to fostering health equity
- Develop supportive organizational structures, policies, and processes
- Optimize use of place and space
- Re-vision the use of time
- Attend to power differentials
- Tailor care, programs and services to local Indigenous contexts
- Actively counter racism and discrimination
- Ensure meaningful engagement of patients and community leaders
- Tailor care to address inter-related forms of violence
- Tailor care to address the social determinants of health

Truth and Reconciliation Commission of Canada

- Established by Indian Residential Schools Settlement Agreement to settle class action lawsuit
- For 6 years, 3 commissioners travelled Canada listening to Indigenous people taken from their families as children and placed in residential schools
- 6,000 witnesses, most survivors of the schools
- Published 527 page report in June 2015 with 94 calls to action and 7 related to health

"Getting to the truth was hard, but getting to reconciliation will be harder… Reconciliation requires that a new vision, based on a commitment to mutual respect, be developed… Reconciliation is not an Aboriginal problem; it is a Canadian one. Virtually all aspects of Canadian society may need to be reconsidered."

(**TRC Executive Summary Report**: http://www.myrobust.com/websites/trcinstitution/File/Reports/Executive_Summary_English_Web.pdf)

18.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 Canadian 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.

19.We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes call upon the federal government to appoint, in 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.

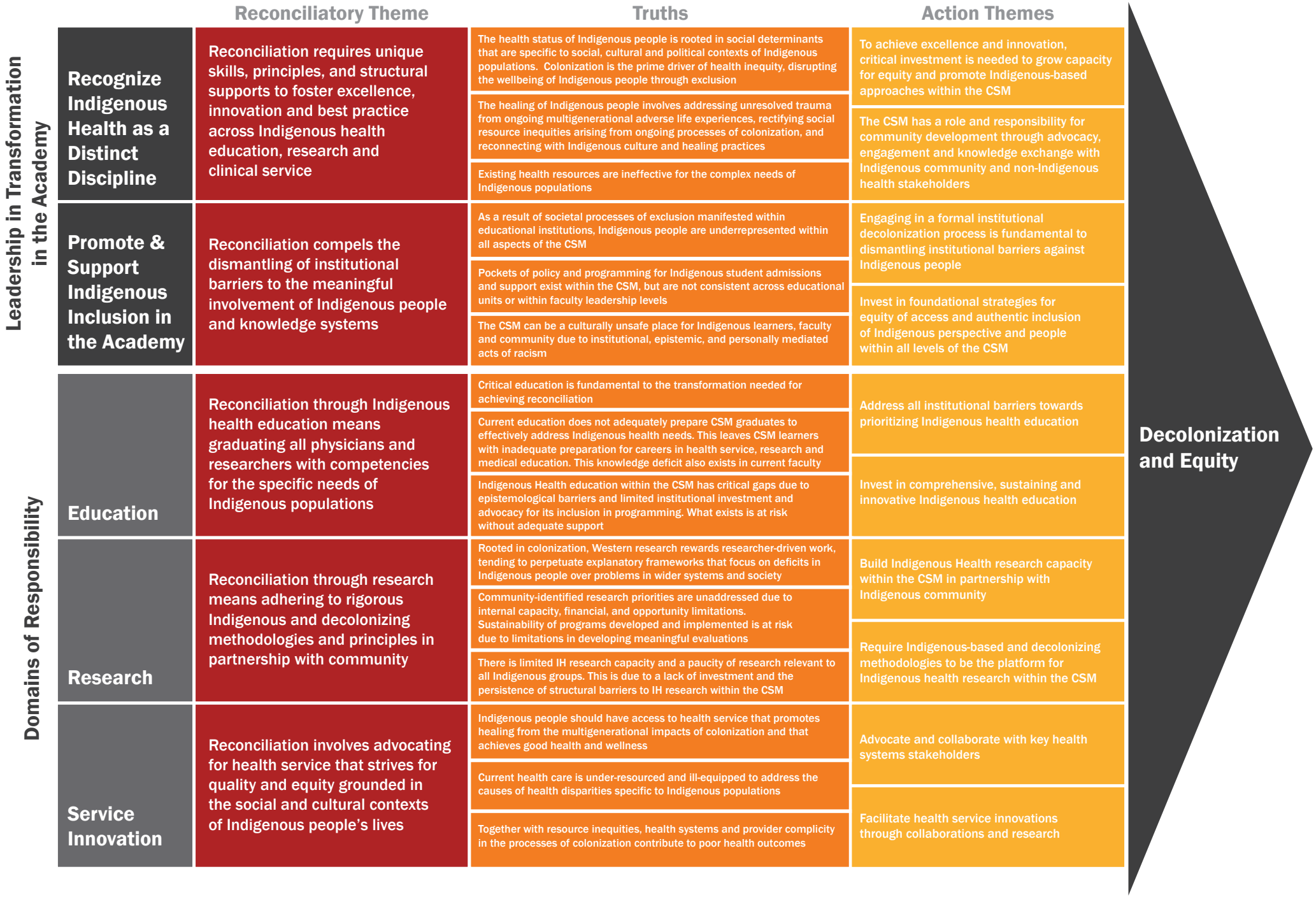
20.In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.

21.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.

22.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.

23.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 health- care professionals.

24.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.


Leadership in Transformation in the Academy
Domains of Responsibility
Reconciliatory Theme
Truths
Action Themes
Recognize Indigenous Health as a Distinct Discipline
Reconciliation requires unique skills, principles, and structural supports to foster excellence, innovation and best practice across Indigenous health education, research and clinical service
The health status of Indigenous people is rooted in social determinants that are specific to social, cultural and political contexts of Indigenous populations. Colonization is the prime driver of health inequity, disrupting the wellbeing of Indigenous people through exclusion
The healing of Indigenous people involves addressing unresolved trauma from ongoing multigenerational adverse life experiences, rectifying social resource inequities arising from ongoing processes of colonization, and reconnecting with Indigenous culture and healing practices
Existing health resources are ineffective for the complex needs of Indigenous populations
To achieve excellence and innovation, critical investment is needed to grow capacity for equity and promote Indigenous-based approaches within the CSM
The CSM has a role and responsibility for community development through advocacy, engagement and knowledge exchange with Indigenous community and non-Indigenous health stakeholders
Promote & Support Indigenous Inclusion in the Academy
Reconciliation compels the dismantling of institutional barriers to the meaningful involvement of Indigenous people and knowledge systems
As a result of societal processes of exclusion manifested within educational institutions, Indigenous people are underrepresented within all aspects of the CSM
Pockets of policy and programming for Indigenous student admissions and support exist within the CSM, but are not consistent across educational units or within faculty leadership levels
The CSM can be a culturally unsafe place for Indigenous learners, faculty and community due to institutional, epistemic, and personally mediated acts of racism
Engaging in a formal institutional decolonization process is fundamental to dismantling institutional barriers against Indigenous people
Invest in foundational strategies for equity of access and authentic inclusion of Indigenous perspective and people within all levels of the CSM
Education
Reconciliation through Indigenous health education means graduating all physicians and researchers with competencies for the specific needs of Indigenous populations
Critical education is fundamental to the transformation needed for achieving reconciliation
Current education does not adequately prepare CSM graduates to effectively address Indigenous health needs. This leaves CSM learners with inadequate preparation for careers in health service, research and medical education. This knowledge deficit also exists in current faculty
Indigenous Health education within the CSM has critical gaps due to epistemological barriers and limited institutional investment and advocacy for its inclusion in programming. What exists is at risk without adequate support
Address all institutional barriers towards prioritizing Indigenous health education
Invest in comprehensive, sustaining and innovative Indigenous health education
Research
Reconciliation through research means adhering to rigorous Indigenous and decolonizing methodologies and principles in partnership with community
Rooted in colonization, Western research rewards researcher-driven work, tending to perpetuate explanatory frameworks that focus on deficits in Indigenous people over problems in wider systems and society
Community-identified research priorities are unaddressed due to internal capacity, financial, and opportunity limitations. Sustainability of programs developed and implemented is at risk due to limitations in developing meaningful evaluations
There is limited IH research capacity and a paucity of research relevant to all Indigenous groups. This is due to a lack of investment and the persistence of structural barriers to IH research within the CSM
Build Indigenous Health research capacity within the CSM in partnership with Indigenous community
Require Indigenous-based and decolonizing methodologies to be the platform for Indigenous health research within the CSM
Service Innovation
Reconciliation involves advocating for health service that strives for quality and equity grounded in the social and cultural contexts of Indigenous people's lives
Indigenous people should have access to health service that promotes healing from the multigenerational impacts of colonization and that achieves good health and wellness
Current health care is under-resourced and ill-equipped to address the causes of health disparities specific to Indigenous populations
Together with resource inequities, health systems and provider complicity in the processes of colonization contribute to poor health outcomes
Advocate and collaborate with key health systems stakeholders
Facilitate health service innovations through collaborations and research
Decolonization and Equity

Principle TRUTHS

1. Health inequities experienced by Indigenous people are rooted in determinants specific to the social, cultural and political contexts of Indigenous populations. Colonization is the prime driver of ongoing inequity.
2. Healing involves addressing impacts from multigenerational adverse life experiences, rectifying ongoing social resource inequities and reconnecting with Indigenous culture and healing practices.
3. Complicity with ongoing colonization manifests as a health care system that is too often ***under resourced*** and ***ill equipped*** to address the health disparities specific to Indigenous populations.

Societal Health Determinants

- Social Cohesion
- Inequality
- Relative Poverty

Unhealthy Societies: The Afflictions of Inequality (1997)
Wilkinson

In 1977, the Parliament of Canada established the Canadian Human Rights Act (CHRA) :

“The existence of fundamental human rights and freedoms, including the right of every individual to participate in society without... discrimination, is a basic and underlying principle which has long been recognized by the Parliament and Government of Canada.”

What is controversial about section 67 of the CHRA?

A. It asserts free education for all Aboriginal Canadians.
B. It gives Indigenous people special privileges within the human rights process.
C. It denies Indigenous Canadians full access to the human rights complaint resolution system.
D. It outlines provisions for Indigenous Canadian land disputes.
E. It exempts Indigenous Canadians from certain federal laws.

Answer: C

- It denies Indigenous Canadians full access to the human rights complaint resolution system
- Section 67 is the only provision in Canadian human rights law that restricts access of a particular group of persons to the human rights process.
    - *"Nothing in this Act affects any provision of the Indian Act or any provision made under or pursuant to that Act."*
- This meant that they did not have full access to human rights protection and were unable to file complaints with the Canadian Human Rights Commission alleging discrimination on a prohibited ground arising from actions taken or decisions made under or pursuant to the *Indian Act*.
    - *AADNC: https://www.aadnc-aandc.gc.ca/eng/1100100032550/1100100032551*

In June 2008, section 67 of the *Act* was repealed with the passing of an amendment to the *Canadian Human Rights Act*, applying immediately to the federal government with a three year delayed application for First Nation governments. The revised legislation means that First Nations individuals who are registered Indians and members of Bands, or individuals residing or working on reserves can make complaints of discrimination to the Canadian Human Rights Commission relating to decisions or actions arising from or pursuant to the *Indian Act*.
https://www.aadnc-aandc.gc.ca/eng/1394023867658/1394024066806

In 1970, Sandra Lovelace married an American airman and moved to California. By marrying a non-native she lost her status as an "Indian". Her marriage ended a few years later, and upon returning to Tobique First Nation, she found that since she and her children were no longer recognized as having status as an "Indian", they were denied access to housing, health care, and education.

As a result, Sandra Lovelace became an international figure when she petitioned the United Nations in 1977. On December 29 of that year, she presented her case to the Human Rights Commission of the United Nations, arguing that Canada's Indian Act discriminated against Native women by depriving them of their status as "Indian" when they married a non-native person. In protest of discriminatory clauses in the Indian Act, Senator Lovelace, along with members of the Tobique First Nation, led a 132-km march of women and children from Oka (Québec) to Ottawa (Ontario) on July 17, 1979.

After eight years, the Government of Canada passed **Bill C-31**, **An Act to Amend the Indian Act**, on June 28, 1985. As a result of this amendment, many of the discriminatory provisions in the Indian Act were eliminated, and the meaning of "status" was altered, allowing for reinstatement of Aboriginal people who had been denied or lost status and/or band membership.

Source: www.gnb.ca/cnb/news/wcs/2007e0088wc.htm

If you were TEN TIMES BOLDER, what big system/structural change would you do?

https://jamboard.google.com/d/1BPPzCAtBYEQ7zcJ4DecH42rdAFLkcsjwsV44W8mD41w/edit?usp=sharing

Lisa Boivin