HSN/HSNRI Strategic Plan-Speakers Series: Dr. Carrie Bourassa

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Acknowledgements

I humbly acknowledge the Robinson-Huron Treaty territory and the land on which we gather is the traditional territory of the Atikameksheng Anishnaabeg

Dr. Carrie Bourassa
Ts'iotaat Kutx Ayanaha s'eek
(Morning Star Bear)

- Member of Regina Riel Metis Council #34, Anishinaabe, Treaty #4 territory, Tlinglit

- Grandfather raised me; teen parents; grounded in ceremony

Chair, Indigenous & Northern Health, HSNRI

State of Indigenous Health

- **Aboriginal population in Canada is 4.9%**

Total Population – 1,673,785
Metis – 587,545
First Nations – 977,230
Inuit – 65,025
Since 2006, the Indigenous population has grown 42.5%.
Two main factors have contributed to the growing Aboriginal population: the first is natural growth, which includes increased life expectancy and relatively high fertility rates; the second factor relates to changes in self-reported identification. Put simply, more people are newly identifying as Aboriginal on the census—a continuation of a trend over time. (Statistics Canada, 2017)

State of Indigenous Health

In 2006, 4.8% of the Aboriginal population was 65 years of age and older; by 2016, this proportion had risen to 7.3%.

According to population projections, the proportion of the First Nations, Métis and Inuit populations 65 years of age and older could more than *double* by 2036.

http://www.statcan.gc.ca/pub/89-656-x/89-656-x2015001-eng.htm#a9)

State of Indigenous Health

44.2% of First Nations people lived on reserve in 2016, while the rest of the population lived off reserve. (Statistics Canada, 2017)

In 2011 Six in ten off-reserve First Nations people (61%) and Métis (60%) and 42% of Inuit aged 12 and older reported that they had been diagnosed **with at least one** chronic condition. The corresponding percentage for the non-Aboriginal population was 53%. http://www.statcan.gc.ca/pub/89-656-x/89-656-x2015001-eng.htm#a9)

State of Indigenous Health

- The **life expectancy of First Nations** peoples was estimated at 68.9 years for males and 76.6 years for females, reflecting differences of 7.4 and 5.2, respectively, from the Canadian population's life expectancies.

- *Preventable deaths* due to **circulatory diseases (23% of all deaths) and injury** (22% of all deaths) account for a near staggering **50% of all deaths**.

- (Health Canada, 2008)

State of Indigenous Health

- For First Nations ages 1 to 44, the most common cause of death was **injury and poisoning. The primary cause of death** for children less than 10 years was classified as unintentional (accidents).

-Suicide rates for Aboriginal youth range from 5-7 times higher than the national average.

- The potential **years of life lost from injury alone was more than all other** causes of death and was almost 3.5 times that of the general Canadian population.

(Health Canada, 2008)

State of Indigenous Health

- Indigenous populations have lower life expectancy at birth than non-Indigenous populations and is especially true for Inuit populations

-Life expectancy in 2011: First Nations M: 73 F: 78 Métis M: 74 F: 80 Inuit M: 64 F:73 Canada (total) M: 79 F: 83

-First Nations people continue to suffer from high rates of chronic and infectious disease and higher mortality and infant mortality rates compared to the general Canadian population

Health Status of Canadians 2016: A Report of the Chief Public Health Officer

http://healthycanadians.gc.ca/publications/department-ministere/state-public-health-status-2016-etat-sante-publique-statut/alt/pdf-eng.pdf

State of Indigenous Health

-In 2014, Indigenous populations made up 4% of the total Canadian population, but accounted for 21% of reported cases of TB. This resulted in a rate of 20 new or re-treatment cases per 100,000 of the Indigenous population.

- Rates vary across Indigenous populations. The rate of **TB among Inuit is almost 50 times higher** than the overall Canadian rate

Health Status of Canadians 2016: A Report of the Chief Public Health Officer

http://healthycanadians.gc.ca/publications/department-ministere/state-public-health-status-2016-etat-sante-publique-statut/alt/pdf-eng.pdf

State of Indigenous Health

- Indigenous women are greatly over-represented in HIV/AIDS statistics, yet there is a startling lack of **gender-specific, Indigenous-specific**, HIV/AIDS resources, programs and services to support them.

- The rate of new HIV infections among Indigenous women in Canada has been steadily increasing over the past two decades.

- **75%** of the new HIV infections in 2009 are associated with IDU and Indigenous women under the age of 30 are disproportionately represented in all new HIV cases in Saskatchewan (Saskatchewan Health, 2010).

The Elephant in the Room

- Disparities in health exist on the basis of race in Canada (Lasser et al, 2006). ***Racism, oppression, historical legacies and government polices*** continue to perpetuate the ongoing state of Indigenous Peoples' health inequities in many Indigenous communities (Virginia Department of Health, 2013).

The Elephant in the Room

-Indigenous Peoples carry an inordinate burden of health issues and suffer the worst health of any group in Canada. Beyond that, Indigenous people experience the poorest living conditions, inequitable access to education, food, employment and healthcare/health services in a country that reliably ranks in the top ten on the United Nations human development index (Diffey and Lavallee, 2016; Allan & Smylie, 2015; Reading & Wien, 2009)

The Elephant in the Room

Inequitable access leads to the worst health outcomes (Aboriginal Health Advisory Committee, 2012; Reading & Wien, 2009), but most importantly ***racism*** has been identified as the major factor in creating and reinforcing these disparities (Diffey and Lavallee, 2016; Allan & Smylie, 2015; Hart & Lavallee, 2015; Loppie, Reading, & de Leeuw, 2014).

The Elephant in the Room

-This racism is rooted in our *colonial history* and the processes that have – and continue to – *disconnect Indigenous communities from their lands, languages, and cultures* (Diffey and Lavallee, 2016; King, Smith, & Gracey, 2009; Commission on Social Determinants of Health, 2007).

-However, Indigenous people are **resilient**, we do have greater capacity to undertake research and we have far more community engagement and direction than ever before.

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The Elephant in the Room

Immediate priorities of HSN/HSNRI and Institute of Indigenous Peoples' Health – CIHR is to engage Indigenous grassroots communities (Indigenous health research priorities)

Ensure Indigenous health research **priorities identified truly reflect community priorities**.

Ensure research initiatives are **strengths and asset based** (rather than deficit based)

Access to culturally safe care (not only physical access)

Create a safe workplace for all including Indigenous staff

Cultural Safety

Cultural safety takes us beyond cultural awareness and the acknowledgement of difference (Yeung, 2016)

It surpasses cultural sensitivity, which recognizes the importance of respecting difference.

Cultural safety helps us to understand the limitations of cultural competence, which focuses on the skills, knowledge, and attitudes of practitioners.

Cultural safety is predicted on understanding power differentials inherent in health service delivery and redressing these inequities through educational processes (Aboriginal Nurses Association of Canada, 2009)

Cultural Safety

It is a patient-centered and family-centred approach and encourages self-reflection among health care practitioners which is seen as an essential skill fundamental to the relationship between patient (and family) and physician (Indigenous Physician's Association of Canada, 2009).

Cultural safety focuses on systemic issues, including colonial-based racism, as noted by Diffey and Lavallee (2014)

A central tenet of cultural safety is that it is the patient who defines what "safe service" means to them. (IPAC, 2009)

Cultural Safety

- This opens up opportunities to learn about the unique histories, current challenges and successes of Indigenous communities in achieving an equitable level of health and wellness as enjoyed by many non-Indigenous citizens.

- Health care providers are encouraged to ask patients (family members and communities as appropriate) what matters most to them in their experience of illness and its treatment.

- When health care providers engage with patients in this way, it can present opportunities to become more Indigenous patient-centred.

Cultural Safety

Diffey and Lavallee (2014) point out that, despite the name "cultural safety," it is not *culture,* but rather *power* inequities that are being considered.

Furthermore, the decision about whether a clinical encounter between a patient and clinician is *safe* lies with the Indigenous patient. They argue that issues of race and social difference should be explicitly identified as originating in colonial power struggles, and not as matters of *culture* or *ethnicity*. Thus, by addressing colonial-based racism at these more structural levels, safety in clinical encounters is ensured.

Cultural Safety

The [health] care of an Indigenous person reflects the dimensions of quality for patient-centred care that resonate with his/her culture in all stages of that person's life. The physician demonstrates empathy, open-mindedness, consensus and understanding of the issues facing Indigenous people and the social determinants of health that contribute to their health status. The decision-making process 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 2013, 3)

Social Accountability

WHO defines it as :

“the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve. Priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public” (Boelen & Heck, 1995, 2000)

Social Accountability

Elements of SA:

- requires the engagement of all stakeholders – engaged citizens/communities, all levels of governments and public providers (ie. health providers)

- a rights based approach to social accountability is essential (Indigenous rights, for example – **UNDRIP – United Nations Declaration on the Rights of Indigenous Peoples)**

- acknowledge and access socially constructed knowledge from the worldviews of our people, our populations, our community and our region

Social Accountability: UNDRIP

What is UNDRIP?

- adopted by the General Assembly in September 2007 CAN, AUS, NZ, AUS (CAN dropped their objection in May 2016).

- Declaration confirms the right of Indigenous peoples to self-determination and recognizes subsistence rights and rights to lands, territories and resources

- The Declaration outlaws discrimination against indigenous peoples, promotes their full and effective participation in all matters that concern them, as well as their right to remain distinct and to pursue their own visions of economic and social development.

Social Accountability

SA aligns well with Cultural Safety:

- Encourages self-reflection (examining one's standpoint or worldview)
- Encourages social inclusion
- Promotes a focus on community-engagement inclusive of all members of the community but focusing particularly on marginalized populations
- Health priorities based on community priorities
- Expectation of clear outcomes and evaluation measures that are accountable to the community

Strategies to Address Indigenous Health Issues

- Indigenous community-based health research led by and with Indigenous communities

- Cultural Safety, Evaluation, Training and Research Lab is getting built – this will be a benefit to communities, academia, clinical researchers and the larger Northern Ontario communities

- Examine cultural safety models and training (NE – LIHN Cultural Mindfulness Training; Saskatoon FN/Metis Health Representative Workforce Cultural Competency Program)

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Strategies to Address Indigenous Health Issues

- Indigenous Health Advisory Committee Interim Terms of Reference have been drafted

Consider a social accountability framework to complement the cultural safety model

Recruitment and Retention Plan for Indigenous Health Professionals at HSN/HSNRI

Other Strategies to Consider?

The Health Council of Canada (HCC) in 2012 suggest:

Take leadership from First Nations, Inuit, and Métis people and acknowledge their expertise with respect to the identification of their individual and collective needs, capabilities, strengths, and opportunities.

Value and acknowledge the knowledge, expertise, and skills of traditional healers, counsellors, teachers, and other traditional knowledge keepers and practitioners.

Other Strategies to Consider?

Develop policies and initiatives that will support the recruitment and retention of Aboriginal employees at all levels of your organization.

Develop methodologies that can be used to assess qualitative outcomes of activities that enhance cultural competency and cultural safety.

Build capacity within communities through research that enhances accountability and understanding.

Other Strategies to Consider?

Provide patient-centred care that meets patient-identified needs.

Look for and create opportunities for partnership and collaboration that will enhance cultural safety for First Nations, Inuit, and Métis people.

Use collaboration and partnership opportunities to enhance the cultural competency of urban health systems and cultural safety for First Nations, Inuit and Métis community members using those systems.

Reconciliation

- Truth and Reconciliation Commission (TRC)
  - Health related recommendations #18-24. These speak generally about acknowledging that the current state of Indigenous health in Canada is a direct result of previous Canadian government policies, and that recognition and implementation of actions around the distinct needs of Indigenous peoples' health should take a rights-based approach according to international and constitutional laws as well as the Treaties.

Reconciliation

- #19 is a clear call for health research – it refers to establishing measurable goals, closing the gaps in health outcomes, monitoring a number of indicators, and communicating results through annual reporting .
- #23 concerns increasing the number of Indigenous health professionals who are working in the health professions, which logically includes health research and to provide cultural competency training to all health care professionals.
- #43 and 44 of the TRC are directed to all levels of government to adopt and implement the UNDRIP as a framework of reconciliation.

TRUTH in Reconciliation

- Canadian Indigenous Nurses' Association (CINA) and the Indigenous Physicians' Association of Canada recommend:

- Understanding colonization and its historical impact including the historical treatment of Indigenous peoples;
- How the contemporary lives of Indigenous peoples have been duly affected by colonialism;
- The suffering inflicted on Indigenous peoples as a consequence of Canadian laws;
- Residential schools;
- Effect of Historic Trauma Transmission on the health and well-being of Indigenous Peoples

TRUTH in Reconciliation

- Canadian Indigenous Nurses' Association (CINA) and the Indigenous Physicians' Association of Canada recommend:

- The resultant intergenerational health outcomes and determinants of health that impact Indigenous clients, families, patients, and communities.

- Articulate ways of redressing inequity of access to health care/information with Indigenous communities, clients, families

- Articulate how the emotional/physical/spiritual/mental DOH and wellbeing for Indigenous peoples impact their health

“Medicine Bundle”

- Contains sacred objects and medicines which have meaning for the owner
- Mementos of events which occurred during different times
- Objects are added along the journey

Interconnected

Summary of Recommendations

- Develop a model of patient/family centred care using: Cultural Safety/Social Accountability? HCC Recommendations (2012)? A combination of these?
- Indigenous Health Advisory Committee
- Recruitment and Retention Plan (this could be embedded within a larger model/plan
- Develop clear outcomes and evaluation measures (part of larger model?)
- Cultural safety training

Questions?

How do you think we might respond collectively to the TRC calls to action?

How do you think we at HSN/HSNRI could improve the experiences of Indigenous people including our own staff? That is, how can create a culturally safe space?

Should we develop a comprehensive plan or model with clear outcomes and evaluation measures?

Megweetch, Merci

Thank you all.

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