NATIONAL COLLOQUIUM ON RACISM, CULTURAL SAFETY AND ABORIGINAL PEOPLES' HEALTH

Report

The colloquium was presented by the Aboriginal Health Research Networks Secretariat (AHRNetS), and hosted by the Anisnabe Kekendazone Network Environment for Aboriginal Health Research (NEAHR) - CIETcanada.

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SECRETARIAT

Anisnabe Kekendazone
Network Environment for Aboriginal Health Research

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With special acknowledgement to the colloquium presenters and participants who shared their knowledge and expertise, and without whom this would not be possible.

Colloquium presenters: Melissa Blind, Carrie Bourassa, Simon Brascoupé, Heather Castleden, Jeffrey Denis, Malcolm King, Tracey Prentice, Charlotte Reading, Beverley Shea, Georges Sioui, Evelyn Voyageur, Cora Weber-Pillwax and Fred Wien.

The Aboriginal Health Research Networks Secretariat (AHRNetS) is the coordinating body for the nine NEAHR centres, which are funded by CIHR-IAPH. These centres lead and support a regional and national advanced research agenda in the area of Aboriginal health. The NEAHR centres promote and support innovative research and capacity-building for the improvement of the health of Aboriginal peoples in Canada.

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EXECUTIVE SUMMARY

In February 2012, with funding from the Canadian Institutes of Health Research, the Aboriginal Health Research Networks Secretariat (AHRNetS) and the Anisnabe Kekendazone Network Environment for Aboriginal Health Research (NEAHR) hosted a *National Colloquium on Racism, Cultural Safety and Aboriginal Peoples' Health* at the University of Ottawa. The colloquium focused on the effects of racism on Aboriginal peoples' health, and cultural safety as a response to systemic racism. Together 44 researchers, policy makers, and students from various academic institutions, government agencies and Aboriginal organizations shared experiences, knowledge, and ideas about the adverse health effects of systemic racism and future directions to address racism through research, policy and practice.

Dr. Georges Sioui's welcoming address carried a meaningful message about the importance of 'working together as family' to drive change and achieve common goals to counter systemic racism. This message was revisited and reiterated throughout the day by the colloquium presenters and participants. Presentations and panel discussions by researchers and representatives from Aboriginal health organizations, described the landscape of current anti-racism and cultural safety research, programs and initiatives. Building on the panel presentations, participants collaborated in breakout discussions to develop priority areas and innovative ideas for addressing systemic racism experienced by Aboriginal peoples in Canada. Common themes emerging from the colloquium seen as key to guide future action included:

> If you don't put it to work with other people, with your colleagues, your sisters, your brothers, you won't get anywhere. So that's the essential that I would like to leave with you today…feel in your hearts and act out in your lives, to work as family. To see each other as family. To have love for each other.
>
> *~Dr. Georges Sioui*

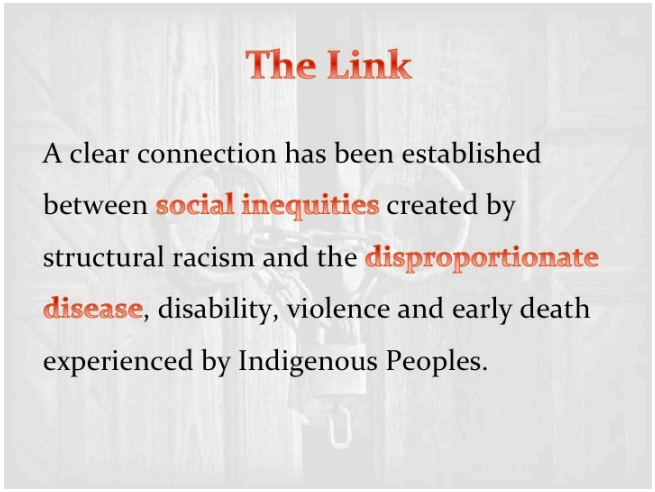
- Education and training in schools and among professionals about the history of Aboriginal peoples, cultural safety, and the realities of racism.
- Increased evaluation of current anti-racism and cultural safety initiatives, policies and programs.
- Accountability among professionals and within institutions to ensure culturally safe spaces and practices with and for Aboriginal peoples.
- Future priorities related to anti-racism and cultural safety in research, policy and practice.

BACKGROUND

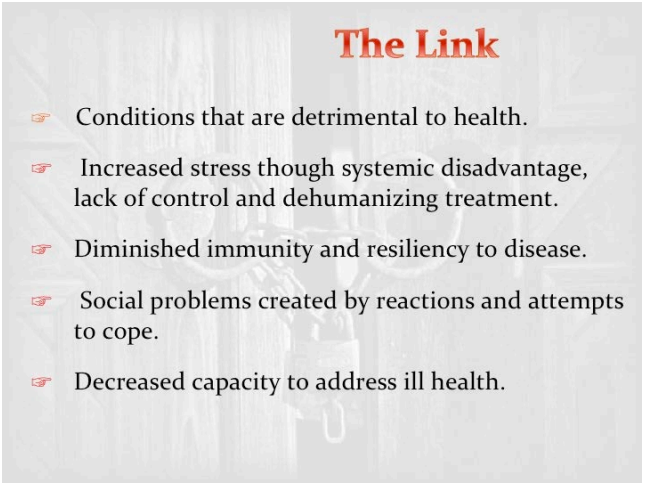
RACISM AS A SOCIAL DETERMINANT OF HEALTH

Researchers and health policy makers are increasingly acknowledging the critical influence of social determinants on the health of individuals, communities and populations (National Collaborating Centre for Aboriginal Health, 2009). While some determinants are widely recognized, others such as race, culture, and Aboriginal status, have received less mainstream attention despite being acknowledged by Health Canada and the Public Health Agency of Canada.

Although these determinants draw attention to important health inequities facing particular racialized groups in Canada, race, culture and Aboriginal status must be contextualized to accurately capture what is behind differences in health outcomes. Simply naming race, culture, and Aboriginal status as social determinants of health without considering the history of colonization and oppression, risks pathologizing Aboriginal peoples and ignoring the realities of systemic racism. For example, researchers have identified a number of negative health outcomes at the population level among racialized groups due to stress associated with racial discrimination (Wortley, 2003). In the case of Aboriginal peoples in Canada, complicated constructs such as race and culture must be examined within the historical and political contexts that influence access to opportunities for individual and community health (National Collaborating Centre for Aboriginal Health, 2009). The legacy of colonialism has inequitably distributed resources and power in a way that systemically disadvantages Aboriginal peoples in Canada (Brown & Fiske, 2001).



(Reading, 2012)



(Reading, 2012)

In 2007, the World Health Organization's commission on the Social Determinants of Health explicitly identified racism as a structural determinant of health (Public Health Agency of Canada, 2009). Racism is typically understood at the individual level, meaning interpersonal discriminatory encounters (Public Health Agency of Canada, 2009). Experiences of interpersonal racism can have detrimental health

effects. For example, according to First Nations Regional Longitudinal Health 2002/03, of the 40% of First Nations people who reported experiencing racism in the last 12 months, more than half (27%) reported these encounters had some or a strong effect on their self-esteem. Yet, other forms of racism such as institutional and structural must be distinguished when examining the relationship between racism and health. Structural or institutional racism refers to policies, laws, practices or procedures that create or maintain avoidable inequalities based on race, culture or ethnicity (Public Health Agency of Canada, 2009).

Structural racism and discrimination against Aboriginal peoples has created pervasive health and social inequities that have lasting, intergenerational effects. Examples of systemically racist policies and practices that continue to have detrimental effects on Aboriginal peoples include the Indian Act, the residential school system, and the disproportionate number of Aboriginal children in the child welfare system (Reading, C., 2012; King, M., 2012). Research links these social inequities created by historical and neo-colonialism to the disproportionate rates of disease, disability, violence and premature death experienced by Aboriginal peoples in Canada (Brascoupé & Watters, 2009). Although there is tremendous diversity between and within Aboriginal groups in Canada, the effects of colonialism, racism and social exclusion represent common experiences, which interact and influence all other determinants of health (National Collaborating Centre for Aboriginal Health, 2009).

CULTURAL SAFETY

Cultural safety has emerged as a research concept and a practical tool for addressing health disparities stemming from structural, institutional, and interpersonal racism. Culturally unsafe practices are defined as "any actions that diminish, demean, or disempower the cultural identity or well-being of an individual" (Cooney, 1994). The concept of cultural safety was developed by nurses working with Maori people in New Zealand to expand on the notion cultural competency in health care settings (Popps & Ramsden, 1996). The concept of cultural competence refers to increased cultural knowledge and understanding demonstrated by health care practitioners. Cultural safety moves beyond knowledge and understanding to address the power dynamics between Indigenous health service users and primarily non-Indigenous health care providers (Brascoupé & Watters, 2009), which are rooted in broader power structures and historical forces influencing the health of Aboriginal peoples (Browne & Fiske, 2001). Cultural safety shifts the power relationship in health care settings, as Aboriginal patients define what qualifies as culturally safe care according to their cultural norms and individual experiences (Brascoupé & Watters, 2009).

The colloquium explored the integration of cultural safety in research, policy, practice, and education initiatives to address the adverse effects of racism on Aboriginal peoples in Canada. Given the lack of statistical data regarding the impact of cultural safety initiatives, the presentations and discussions generated insights to advance the concept and promote its uptake in research and policy development.

> *"For us it was the participants who got to decide what was safe and what was unsafe. So at the beginning of each process they got to set their own rules."* ~Tracey Prentice

PRESENTERS AND ATTENDEES

Paul Bélanger - CIHR-Institute of Aboriginal Peoples' Health
Maria Benkhalti Jandu - University of Ottawa
Melissa Blind - Native Women's Association of Canada
Carrie Bourassa - Indigenous Peoples' Health Research Centre NEAHR
Simon Brascoupé - National Aboriginal Health Organization
Heather Castleden - Atlantic Aboriginal Health Research Program NEAHR
Sheila Cote-Meek - Laurentian University
Ashley Cunningham - Anisnabe Kekendazone NEAHR
Ali Darnay - AHRNetS
Jacques Dalton - CIHR-Institute of Aboriginal Peoples' Health
Jeffrey Denis - McMaster University
Jo-Ann Episkenew - Indigenous Peoples' Health Research Centre NEAHR
Abigail Forson - CIHR-Institute of Gender and Health
Chris Furgal - Nasivvik Centre for Inuit Health and Changing Environments NEAHR
Kristen Jacklin – Indigenous Health Research Development Program NEAHR
Alexandra King - University of Alberta
Malcolm King - CIHR-Institute of Aboriginal Peoples' Health
Laurence Kirmayer - Network for Aboriginal Mental Health Research NEAHR
Paul Lasko - CIHR-Institute of Genetics
Elisa Levi - First Nations Statistical Institute
Debbie Martin - Atlantic Aboriginal Health Research Program NEAHR
Namaste Marsden - AHRNetS
Renee Masching - Canadian Aboriginal AIDS Network
Taima Moeke-Pickering - Laurentian University
Christine Morgan - Aboriginal Affairs and Northern Development Canada
Cassandra Opikokew - Indigenous Peoples' Health Research Centre NEAHR

Doris Peltier - Canadian Aboriginal AIDS Network
Ashlee Pigford - Native Women's Association of Canada
Tracey Prentice - University of Ottawa
Kevin Qamania-Mason - Anisnabe Kekendazone NEAHR
Charlotte Reading - AHRNetS
Nicole Robinson - National Aboriginal Health Organization
Beverley Shea - Anisnabe Kekendazone NEAHR
Georges Sioui - Huron Elder, Anisnabe Kekendazone, University of Ottawa
Leona Star – Manitoba First Nations Centre for Aboriginal Health Research NEAHR
Phyllis Steeves - Alberta NEAHR Network
Jacqueline Tetroe - CIHR-Knowledge Translation Branch
Sari Tudiver - University of Ottawa
Sharon Thira - Kloshe Tillicum NEAHR
Eduardo Vides - Métis National Council
Evelyn Voyageur - Aboriginal Nurses Association of Canada
Wayne Warry - Indigenous Health Research Development Program NEAHR
Cora Weber-Pillwax - Alberta NEAHR Network
Fred Wien - Atlantic Aboriginal Health Research Program NEAHR

PLENARY PANEL PRESENTATIONS

CORA WEBER-PILLWAX - ALBERTA NEAHR

Key themes: Indigenous knowledge, early education about Aboriginal history, tensions around theorizing experiences of racism

Dr. Cora Weber-Pillwax discussed Indigenous knowledge of racism from her experience as an Aboriginal woman and an educator. She focused on the tensions arising from theorizing Indigenous Knowledge around racism and culture, particularly from a Western paradigm.

"It's easy to live in Indigenous knowledge, and how we live, as we call it. But to step back and try to theorize about it, is a whole other level of challenge."

Such challenges include decontextualizing experiences of racism from the social contexts in which they occur, and the lack of Western language that articulates the Indigenous understanding of 'being'. Dr. Weber-Pillwax described the physical, mental and emotional health effects associated with racism as something known to Aboriginal peoples through lived experience.

"Indigenous knowledge doesn't exist without Indigenous being…Any Aboriginal person can tell you, directly. We can feel our own physical, mental and emotional health responding to [racism]."

Dr. Weber-Pillwax highlighted the need to acknowledge Indigenous knowledge arising from embodied experience with racism to inform anti-racism and cultural safety initiatives. Further tensions arise when policy makers, health professionals, and educators rely on theorizing experiences of racism from a Western research paradigm to develop the evidence base from which to take action.

> *"We need people to understand, there is a place where only Aboriginal people know their experiences with racism. If you wait as a policy maker, which we all are, we wait until we understand [then] there will never be a change. We don't have to understand and know everything. There are no lies here. The facts are in front of you."*

Further, Dr. Weber-Pillwax calls for recognition of Indigenous knowledge in anti-racism work to move forward from theory to action.

"We say advocacy, but somewhere the theory has to move toward action and how we walk and so forth. It will only happen when every single person has located personally their own point of reference for their being, as well as their knowledge."

The second theme Dr. Weber-Pillwax stressed was the need for accurate education about Aboriginal peoples' history to combat racism and foster better understanding of the inequities facing Aboriginal

peoples. She drew attention to the stigmatization of Aboriginal students stemming from the missing discourses around inequities and racism in the education system. Including Aboriginal history in curriculum is not only important for educating non-Aboriginal students, but provides Aboriginal students with the language to articulate Indigenous knowledge, specifically the connection between knowing and being.

"One thing I find myself going back to many times in working with students is words. Do you have the language? Do you have the vocabulary to talk about what you have to talk about, to study what you have to study? Do you have the words? And our education system of which I have been a part of all my life at all levels, we do not teach children vocabulary to help them understand that every individual who is a human being has to link knowledge and being."

MALCOLM KING - CIHR-INSTITUTE OF ABORIGINAL PEOPLES' HEALTH

Key themes: Aboriginal health research, Knowledge Translation, social determinants of Aboriginal peoples' health

Dr. Malcolm King, Scientific Director of the Institute of Aboriginal Peoples' Health - Canadian Institute of Health Research, presented an overview of CIHR's activities related to Aboriginal health research.

"All of CIHR activity has relevance to Aboriginal health and I am happy that CIHR as a whole has dedicated as one of its major priorities-Aboriginal health. We are trying to work together."

As Aboriginal health is a CIHR research priority, Dr. King emphasized the need to consider the social determinants of health that extend beyond the Ottawa Charter to address the inequities facing Aboriginal peoples in Canada. Such determinants include the intergenerational effects of colonization, residential schools, and the overrepresentation of Aboriginal children in provincial care.

Dr. King described the main phases of health research as the development of basic knowledge about health and health systems and the translation of research findings. He emphasized the need for greater knowledge translation of interventions and community-based research projects in Aboriginal communities.

"…Where you take that already transformed knowledge and applying it to individuals and to systems, and to move it further into implementation and scale up to broad practice and policy."

> *"We need to take the knowledge from these successful interventions and transform it into knowledge that would make a difference on a National scale for the health of our people."*

Dr. King discussed Tuberculosis (TB) among Aboriginal peoples in Canada to exemplify the need for increased knowledge translation to inform policy and practice for addressing health inequities. There is a continued threat of TB among Aboriginal peoples in Canada, despite the large body of knowledge informing efforts that have nearly eradicated TB in mainstream Canada.

"There is a really good body of knowledge, so why haven't we eliminated TB among Aboriginal [people in] Canada? It's a failure to take that knowledge, to translate it, implement it, and to scale it up."

Dr. King urged researchers attending the colloquium to determine which phase of research was most needed to address racism and promote cultural safety for Aboriginal peoples in Canada. Acknowledging that more knowledge acquisition is likely needed about racism as a determinant of Aboriginal peoples' health, Dr. King stated "it's not enough".

"Ultimately we need to take that knowledge and translate it into different contexts, implement and scale up. We want to change policy and practice in this country and no longer have the ill-effects associated with racism."

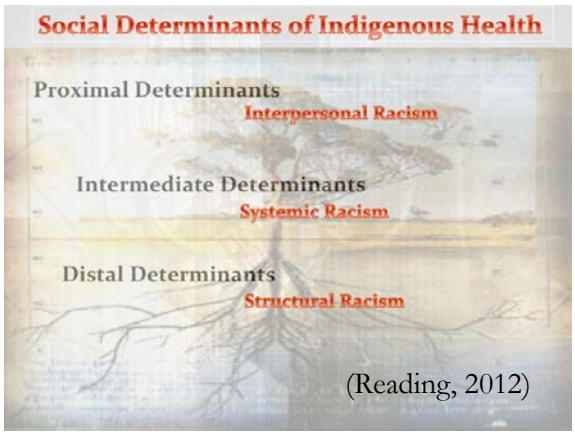
CHARLOTTE READING - ABORIGINAL HEALTH RESEARCH NETWORKS SECRETARIAT

Key themes: Systemic and structural racism, racism as a determinant of health, intergenerational trauma, Aboriginal health research, anti-racism policy solutions

Dr. Charlotte Reading provided working definitions of racism as a determinant of health for Aboriginal peoples. Defining racism as *"an ideology that assumes inherent differences between human beings that are based on biology or genetics"*, Dr. Reading differentiated between *interpersonal racism* and *systemic racism. Interpersonal racism* includes interactions between people that occur in everyday life, such as experiences of discrimination, name-calling, stigma and stereotyping. *Systemic racism*, or social exclusion, refers to the policies, practices, and institutions that disadvantage Aboriginal peoples, creating avoidable inequalities. The social determinants of health are about power and control over, and access to resources. Initiatives to address the social determinants of health aim to prevent or rectify avoidable inequalities and thus are rooted in issues of equity and fairness.

"The Indian Act is a really good example of…a legal document that is racist in its nature because it identifies Aboriginal people as a group, and then there are policies and practices that come out of that."

To illustrate racism as a social determinant of health, Dr. Reading drew upon statistics from the Regional Health Survey of First Nations funded by Health Canada, which found that of the 14,000 on-reserve First Nations people surveyed, about a third had experienced racism in the last month. Of those who had experienced racism, over half reported it had negatively affected their self-esteem.



(Reading, 2012)

Drawing on her framework of proximal, intermediate and distal social determinants of health, Dr. Reading described how systemic racism experienced by Aboriginal peoples in Canada operates as a distal determinant, creating the foundation for all other determinants of health.

"The reason that those root determinants have such a profound influence on our health is because they create the context for all other determinants."

Health inequities experienced by Aboriginal peoples in Canada stem from systemic racism brought about by colonization, residential schools, social exclusion, cultural genocide and a lack of action by those in power to address disparities.

Dr. Reading stressed that these factors have produced profound health inequities among Aboriginal peoples with lasting intergenerational effects.

"When we're in pain, we pass it to the people we love. We don't have a choice. And so that pain gets passed on from generation to generation and it grows. And so people are in pain. Why are people in pain? We can go back to the original colonization, discrimination and historic trauma."

> *"And so, the damage is not acute, the damage is chronic. And it is cumulative. And so it's not just the damage done to one person's life, to one generation, it's the damage that accumulates across generations and it actually rolls like a snowball. It gets bigger if it's not addressed."*

To respond to intergenerational trauma and health inequities, Dr. Reading emphasized the importance of continued research about the health effects of racism for Aboriginal peoples in order to secure funding for interventions, dispel misconceptions about colonialism as a historic event, and ultimately incite positive improvement for the health and wellbeing of Aboriginal peoples.

"In terms of hard research - there is not as much as we need. And we all know that we can make those connections by drawing conclusions deductively by what we see in communities, society and in the health profiles of Aboriginal people, but we have to make the links in order for those people who have the resources to address those issues - to take us seriously."

At the local, regional and national levels, Dr. Reading discussed the development of an Indigenous lens, similar to the gender lens that has been applied within government and health research, to promote dialogue around the effects of policies and practice on Indigenous peoples' health in Canada. Dr. Reading further suggested the need for a specific campaign countering racism and stigma toward Aboriginal peoples in Canada.

JEFFREY DENIS - MCMASTER UNIVERSITY

Key themes: Structural and Laissez-faire racism, racism as a determinant of health, cultural safety, transformative experiences, anti-racism, policy solutions

Dr. Jeffrey Denis presented his doctoral research about relations between white and Aboriginal people in North Western Ontario Treaty 3 territory. He revisited the definitions of interpersonal and structural racism and introduced the concept of *'laissez-faire' racism* as a determinant of Aboriginal peoples' health. *'Laissez-faire' racism* is the tendency to blame Aboriginal peoples for social inequities and poor living conditions, and a resistance to policies that address these issues.

"These laissez-faire [racist] attitudes are widespread among Canadians and they are also apparent in the Government's recent response to the crisis in Attawapiskat, where the immediate reaction was to do what? Blame the Chief and Council for financial mismanagement and refuse to build new housing until they were shamed into action."

Dr. Denis' doctoral research surveyed and interviewed 160 (82 Aboriginal) Fort Frances residents about their experiences with racism in various settings as well as their self-reported health. The figures on Aboriginal peoples' experiences with racism were much higher than nationally reported statistics.

"Over 90% of First Nations people reported at least one personal experience of discrimination compared to 40% of non-Aboriginal people. Median number of reported cases was 12 among Aboriginals, and for whites it was 0. Now these figures might seem high and they are higher than the RHS [Regional Health Survey] figures that Charlotte [Reading] gave earlier, but they are consistent with other surveys in that region."

Health issues such as higher rates of depression, suicidal thoughts, smoking, substance abuse and having multiple adverse health conditions also were reported among Aboriginal participants. These health disparities were associated with experiences of racial discrimination. Participants reporting experiences of racism and discrimination had poorer overall self-rated health.

Dr. Denis took an action focus to his work and discussed two approaches for addressing racism directed at Aboriginal peoples.

"My research aims to identify the barriers to overcoming it and the processes that enable many Canadians to maintain racist views, even in an era when racism is no longer politically correct."

Dr. Denis' work challenges the 'contact hypothesis' used in psychology that theorizes that increased contact, exposure, and familiarity between groups will resolve racial discrimination. In Fort Frances, racist attitudes persist despite a long history of contact and interaction between Aboriginal and non-Aboriginal residents.

Dr. Denis suggested two approaches for addressing racism: confronting racism head on with the intention of eliminating it, or intervening to break the link between racism and health and alleviate some of the negative health consequences of racism. Under the first approach, Dr. Denis highlighted the need for structural and institutional change.

"Structural change such as fixing funding inequities and supporting Indigenous self-determination. We also need an ongoing dialogue about what it means to have a treaty relationship in the 21st century. What do we want our relationship to look like?"

In terms of the second approach, Dr. Denis suggested increased resources for culturally appropriate service development to mitigate the negative health effects associated with experiences of racism. In discussion of how he incorporated the second approach into his research agenda, Dr. Denis emphasized the need for Aboriginal peoples to define culturally safe care.

"One way to [break the link between racism and negative health outcomes] is to ensure access to culturally appropriate health care services, mental health crisis counseling etc. to help Aboriginal peoples deal with the interpersonal and systemic racism that they face, as well as the intergenerational trauma from historical racism. This is one place where I think the term cultural safety is relevant but what cultural safety means in the context of health care is not for me to define as a non-Indigenous person."

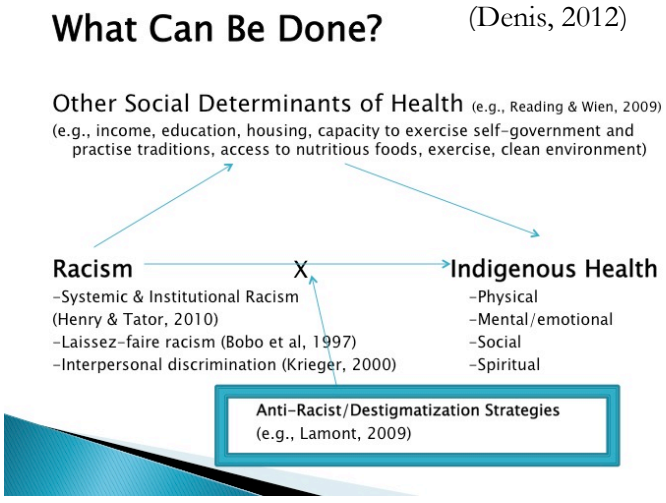
In addition to culturally safe health care services, Dr. Denis emphasized the importance of building on the strategies Indigenous peoples already use to deal with racism. His research documented the "destigmatization strategies" used by First Nations peoples and analyzed their relevance to health.

> *"But a second way to alleviate health impacts of racism, which I want to emphasize, is to better understand and promote strategies that Indigenous peoples themselves already use to deal with racism and stigmatization in their daily lives... In short, their ways of responding to racism that seeks to transform meanings and relationships."*

"…rather than internalizing a belief in their inferiority that others project on them, Indigenous peoples who reframe their experiences, find strength in spiritual traditions and ceremonies, and strategically confront racism when there is a realistic chance to make a difference, may be more likely to have more positive health outcomes."

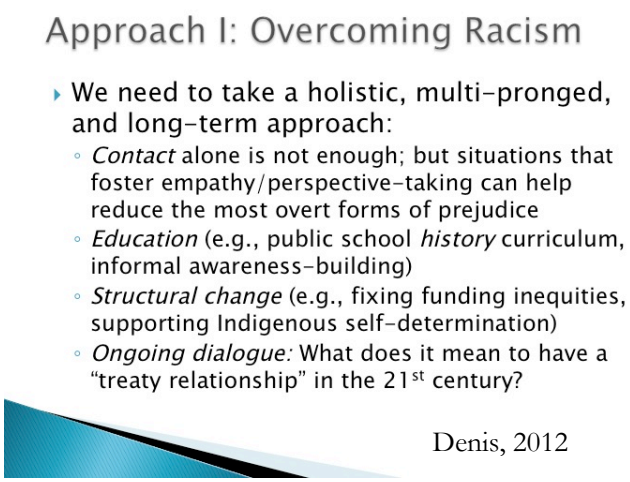
An example of such a strategy in Fort Frances was a community event and healing circle with Aboriginal people and non-Aboriginal peoples held in response to a racist video created by non-Aboriginal high school students in the community.

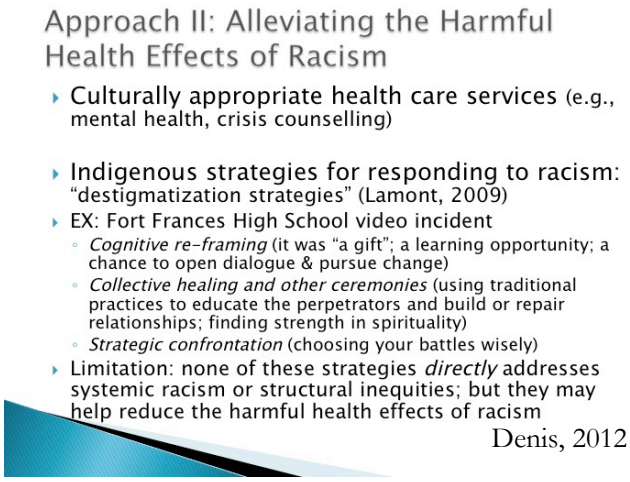
"I strongly suspect that there are ways of responding to racism that partially mediate the association with health and there are other ways of responding that might exacerbate the negative health effects of racism and if we can figure out which strategies work and find ways to support them and promote them then that might be one practical policy solution."



Dr. Denis suggested the utility of understanding and promoting destigmatization strategies that could reduce the negative health impacts associated with racism at the individual level, until improvements are made at the broader, structural level. He acknowledged the limitations of this approach, as it does not *"directly address the*

underlying structural inequities. Various forms of systemic racism can remain in place. Nevertheless, until that broader structural or systemic change happens, these sorts of incidents need to be addressed on a case by case basis and on an individual level these anti-racist strategies might serve as useful coping mechanisms that help reduce the negative health effects of racism."





NEAHR PANEL PRESENTATIONS

CARRIE BOURASSA - INDIGENOUS PEOPLES' HEALTH RESEARCH CENTRE

Key themes: Health and social inequities among Métis peoples, race as a determinant of health, tensions around theorizing experiences of racism, cultural safety in health care

Dr. Carrie Bourassa presented the findings of her doctoral research about the effects of race and class on the self-reported health of Métis people. The impetus for this research came from Dr. Bourassa's community who identified a need for quantitative data about the health of Métis people, given the dearth of data available for this population. Dr. Bourassa examined information from three large databases: the Aboriginal Peoples' Survey, the Canadian Census and the Canadian Community Health Survey. Her study compared socioeconomic (SES) status between Métis peoples and non-Aboriginal people in Canada and the relationship between SES and self-reported health status.

Contrary to her committee's expectations that class would act as a protective factor for Métis people, the findings identified race as a determinant of health for Métis people in her study. The study findings revealed that Métis people had lower total average incomes, wages and salary in comparison to the general Canadian

population. The percentage of Métis people who fell below the low income cut off was nearly double that of non-Aboriginal people in Canada (30.7& and 16.4% respectively) and more Métis people collected government transfer payments, child tax benefits, and employment insurance. Simultaneously, the unemployment rate of Métis people was double that of the general population while Métis peoples were over represented in the labour force. This was interpreted as greater participation of Métis people in unsecured, low wage labour, such as seasonal employment. Dr. Bourassa contextualized this finding within the history of Métis peoples' involvement in the fur trade through seasonal, temporary employment.

An important finding was that regardless of occupation or education level, Métis people experience lower incomes and poorer self-rated health status; therefore, class was not a protective factor. Further, Métis people had lower incomes than the general Canadian population in three of the five education levels: high school or less, some post-secondary education, and post-secondary education.

> *"So you know how we tell our kids, education is a great equalizer, you go out, you get your education, your university degree and…you're going to have that equity in society. That was not the case. They continued to earn less. So, class isn't protecting them. What was the difference here? This is where the study revealed that race is the difference. By virtue of being Métis, they were earning less and their self-rated health status was poor."*

Given the limitations of self-reported health status imposed on the study findings, Dr. Bourassa described the challenges and frustrations of needing to quantify experiences of racism in the data when the issue is apparent. In response to the call for more research to 'qualify' and 'quantify' racism as a determinant of Aboriginal peoples' health, Dr. Bourassa commented on the need for more research emphasis on addressing institutional and systemic disadvantage. Specifically, Dr. Bourassa referred to the need for tools clinicians can use to address issues associated with racism and cultural safety when interacting with Aboriginal patients.

"And I think that already there is obviously some work being done in this area and I also was at a meeting with the Royal College of Medicine…and there were many clinicians there who said 'you know we need some practical tools, because when I'm in the clinic and I have five minutes with people I actually need some practical tools to try to address these, I can't address all of the social determinants of health, so what can I as a clinician do within my limited time?' I thought that was a really good question and I didn't have any answers. So I think there is a lot of work we can do in that area as well."

HEATHER CASTLEDEN - ATLANTIC ABORIGINAL HEALTH RESEARCH PROGRAM

Key themes: Cultural safety, social and geographic location, creating culturally safe physical spaces, relationships, palliative care for First Nations peoples

Dr. Heather Castleden's presentation addressed cultural safety in the context of end of life care for First Nations peoples in a rural region of interior British Columbia (West Kootenay). Her approach to

systemic racism was examining how social and physical spaces can be transformed to be culturally safe for First Nations peoples in the palliative care system.

Dr. Castleden introduced the concept of 'power and place' as determinants of Aboriginal health, meaning the social location (power) one occupies within their physical location (place) can have profound effects on health and wellbeing. The West Kootenay region is described as being 'palliative care poor' (that is, limited services and available experts in the region) and having a small Aboriginal population. Thus, Dr. Castleden describes the situation for First Nations peoples in palliative care in this region in relation to "geographies of ignorance".

In terms of racism within health care settings, respondents reported a variety of experiences with First Nations clients and families. Reports ranged from overt racist encounters with doctors, to perceptions that health care providers held no prejudice toward Aboriginal people.

"So when you think back about the piece at the start around physical and social location, that doctor has an awful lot of power in the emergency room and when that doctor like [says]"you people are always doing this" and the feeling that that person would have had when they came in and probably left will be afraid to go back again. And when you think about a hospital this is a place where you are supposed to go and be cared for and not be attacked."

Dr. Castleden discussed how neglecting to consider culture in palliative care not only compromises the cultural safety of First Nations peoples, but is also inappropriate as end of life is a time when culture, religion and spirituality are particularly important.

"What's interesting in the second quote is when a hospice worker [says] "we don't have any prejudice around culture and religion" and yet that implies that they don't factor that in and yet culture, religion and spirituality are very important especially at the end of life when you're going through a very important life change."

In terms of place or geographic location, the perception in the West Kootenay region is that there are very few Aboriginal people, despite the Sinixt people's land claims in the area. The lack of recognition of Aboriginal peoples in the area may contribute to barriers to accessing services as well as varied perceptions and attitudes among hospital workers about providing culturally appropriate care.

"As I said there is collective memory in that area that there are no Aboriginal people here and some people were saying when Aboriginal people are here, when it comes to that point where it's difficult to access services they leave, they go back home, back to their reserve, back to Alberta or back to other parts of B.C. but other people were saying no I think they stay here."

The Aboriginal participants in this study commented on the importance of ensuring that the physical space for end of life care that does not resemble the institutionalized residential school experience.

> *"It's not institutionalized, it's not the square room with the green paint and that funny smell that a hospital has, because you're trying to avoid recreating more trauma when you are entering a health care setting."*

Dr. Castleden reiterated the need for anti-racism strategies to include early education about Aboriginal history, and transform negative experiences of racism into learning opportunities and community-wide healing initiatives that involve Aboriginal and non-Aboriginal peoples spending time together. From her study findings, Dr. Castleden discussed expanding the understanding of cultural safety beyond simply training health care practitioners in a classroom to creating culturally safe physical spaces for these (non-Aboriginal) health care practitioners to learn about colonialism and racism. At the same time culturally safe physical spaces for Aboriginal peoples at end of life are urgently needed. As a practical recommendation for operationalizing cultural safety in physical spaces, Dr. Castleden suggested incorporating symbols of cultural safety into signage (similar to markers for lesbian, gay, bisexual, trans, two-spirit and queer (LGBTTQ) allies or Queer-friendly spaces), designed and structured as a way to discourage systemic racism. Another practical recommendation would be to include the display of Aboriginal art in palliative care spaces. With enough thoughtful planning and resources, Aboriginal-inspired architectural design might also be a strong signal of 'welcome' to those at end of life.

(Castleden, 2012)

(Castleden, 2012)

BEVERLEY SHEA, TRACEY PRENTICE AND DORIS PELTIER: ANISNABE KEKENDAZONE NEAHR, CANADIAN ABORIGINAL AIDS NETWORK

Key themes: Aboriginal health research, culturally safe research processes, HIV/AIDS epidemiology among Indigenous peoples, international research partnerships

Dr. Beverley Shea presented epidemiological data about HIV among Indigenous peoples from an international research project between New Zealand, Australia and Canada. The tri-partnership funding for this project was between the Canadian Institutes of Health Research and the medical research councils in Australia and New Zealand. The intention of the project was to explore the differences in HIV infection and modes of transmission among Indigenous peoples in the three countries.

The data show different trends in HIV/AIDS infection and transmission in Canada compared to the other two countries. For example in Canada, Aboriginal women are disproportionately affected by HIV/AIDS, heterosexual transmission was much higher among Indigenous than non-Indigenous peoples, and injection drug users were at higher risk due to higher rates of transmission.

Dr. Shea emphasized the importance of accurate data to develop culturally safe, appropriate, and effective HIV/AIDS interventions.

"Effective programs require good data, trusting relationships, culturally safe interventions and involvement of all levels of government."

Ms. Tracey Prentice's presentation focused on creating cultural safety within the research process, in an AK-NEAHR funded research project that explored narratives of Aboriginal women around what it means to be healthy in the context of living with HIV. For this pilot project, the researchers engaged with 13 women, in three different locations and used arts-based techniques (photography and drum making) to explore the research questions. This project was community-based, arts informed, strengths-based, and incorporated Indigenous knowledge with a woman-centered focus.

Ms. Prentice described the steps taken to foster trusting, long-term relationships with the study participants - essential to creating a culturally safe, fun, and mutually beneficial environment for the study. The researchers took a decolonizing approach, adhering to the OCAP[1] principles and building local capacity by hiring Research assistants from the community and giving back as much as possible.

"Spending the time with the participants the way we did, really did create the conditions for deeper engagement in the project, it created the conditions for deeper reflection, and broader learning"

[1] The First Nations OCAP principles of *ownership, control, access, and possession* are a framework for self-determination of First Nations peoples in the realm of research. Adhering to these principles ensures that First Nations peoples control how data is collected in their communities and how this information is accessed and used. (First Nations Centre, 2007).

Cultural safety, as defined by the study participants, was imperative to the group process and building relationships among the participants.

"For us it was the participants who got to decide what was safe and what was unsafe. So at the beginning of each process they got to set their own rules. They had a big discussion about what was going to make us feel good about coming here."

Ms. Prentice emphasized the importance of cultural safety as both a research process and outcome.

> *"So the ultimate goal here is for participants really to come to a place of cultural safety from within and once they can feel secure in themselves, in their voice, in their culture then the true healing can begin."*

NATIONAL ABORIGINAL ORGANIZATION PANEL PRESENTATIONS

SIMON BRASCOUPÉ – NATIONAL ABORIGINAL HEALTH ORGANIZATION

Key themes: Cultural safety training, creating culturally safe spaces

Mr. Simon Brascoupé discussed his article on cultural safety, co-authored by Catherine Waters, which informed workshops conducted with health service providers for Aboriginal communities as well as with organizations such as Kids Help Phone and One Match. He elaborated on the topics raised throughout the colloquium such as creating culturally safe spaces, and the need for language from which to articulate experiences of racism.

"Racism-you deal with it and then you move on from it. But not everyone is able to do that so you have to have some language and you have to be able to assess the person in a way that you're supporting their healing journey, their cultural safety in a way that's appropriate to them"

Mr. Brascoupé acknowledged Dr. Heather Castleden's work referencing the need for culturally safe spaces to reflect Aboriginal culture and ways of knowing.

"Not only internal space, but outdoor space in terms of, people feeling culturally safe so you feel comfortable in an environment that reflects who you are. That was an important idea that I think Heather's certainly exploring."

MELISSA BLIND - NATIVE WOMEN'S ASSOCIATION OF CANADA

Key themes: Culturally safe resources, working together with health organizations, neurological disorders among Aboriginal women

Ms. Melissa Blind presented an ongoing research project examining the interaction between health care practitioners and Aboriginal women with neurological disorders and their caregivers. One aspect of this project assesses participants' experiences at the community level, and another involves exploring the educational component of neurological disorders among Aboriginal women.

"Specifically in terms of how this is being understood and how are Aboriginal people living with or caring for someone living with a neurological condition - being cared for by health care providers."

In terms of cultural safety, this study surveyed neurological health charities in Canada (such as Alzheimer's and Parkinson's disease foundations) about their educational materials, and whether they provided information specific to Aboriginal peoples living with a neurological condition.

"…a lot of the different organizations came back saying "no we don't and no we don't know where to start, what to look for, what to ask". And so that's part of our project and what we're going to be doing."

Ms. Blind emphasized the importance of working in partnership with organizations and charities to provide culturally relevant materials and information to better address the needs of Aboriginal service users.

EVELYN VOYAGEUR - ABORIGINAL NURSES ASSOCIATION OF CANADA

Key themes: Cultural safety training and nursing education, transformative experiences

Ms. Evelyn Voyageur presented her work with North Island College during the past six years around cultural safety in nursing education and building relationships when working with Aboriginal communities. She described a successful and unique program that takes nursing students and faculty to live in two remote Aboriginal communities in British Columbia for one week. The program has provided transformative experiences for both nursing students and faculty.

"These students say they're transformed when they come back. Some can change, they live with the First Nations, they do whatever the people in the village do, picking berries, fishing, whatever. They live in the homes of the people and get to know the people. Our classes are held in the community in our traditional ceremonial houses, and the community is allowed to come."

Ms. Voyageur provided information about several other cultural safety education programs in hospitals and schools throughout the island around First Nations history, which are attended by health care workers and community health workers. These workshops center on the effects of colonization to contextualize the health issues facing Aboriginal communities.

"And as an Elder in Alberta said – it didn't take us overnight to become what we are. It took a long time. But with your love and understanding we can get back to being healthy again. So I really believe that educating the other is what's going to help us."

Another exemplary cultural awareness and education initiative was the school system in the Comox Valley, where curriculum in this area now incorporates Aboriginal cultures and history. The changes were initiated by Ms. Voyageur's granddaughter who brought the lack of curriculum around First Nations history and culture to the attention of her school principal and later the school board.

"And why can't we have credit when we go sit in ceremonial houses. You give credits for those students who go on sports, go to concerts, they get credits. We don't get anything for learning about our culture in our ceremonial houses she said. Well that changed things. They started to implement culture and they hired what they called principal that oversees one area - like in Comox valley there is a principal for all the First Nations schools there."

GROUP DISCUSSIONS: REFLECTIONS AND FUTURE DIRECTIONS

Following the panel presentations, the colloquium participants divided into discussion groups facilitated by NEAHR investigators. The groups shared knowledge and discussed ideas around how to address racism and create conditions of cultural safety for Aboriginal peoples in Canada. The themes emerging from these discussions were shared among the larger group with the intention of informing future research, policy development and community efforts to address racism and cultural safety. The participants expressed interest in a second meeting to continue the work started at this colloquium. AHRNetS has initiated discussions for development of a collaborative research project that would examine racism experienced by Aboriginal peoples and its relationship to health. The following presents an overview of the topics, key points and recommendations emerging from the breakout group discussions at the colloquium.

Education and Training

The importance of increased, coordinated and regularly evaluated education and training, in various forms and venues to address racism and promote cultural safety emerged from group discussions.

Institutional Change

Education across all sectors, not only in medical education and practice, was unanimously identified as imperative to improving the health of Aboriginal peoples. The effectiveness and adequacy of sensitization training to address racism was challenged. The inclusion of education around the realities of racism in conjunction with cultural safety training was identified as crucial to generating genuine understanding about the experiences of Aboriginal peoples and communities. One group pointed to the particular importance of paying attention to the subversive re-colonization that can occur; for example through medical care utilizing Western therapies and approach, particularly in mental health.

Transformative Experiences

Two groups mentioned the importance for training and education that includes opportunities for transformative experiences through lived experience. Programs that involve cultural immersion and opportunities for non-Aboriginal people to engage with Aboriginal cultures can foster greater understanding of issues facing Aboriginal communities.

One group identified the media as an important tool for educating the general public and creating social changes in regard to racism experienced by Aboriginal peoples. Expanding educational broadcast television programming such as CBC's the 8th Fire series and APTN was discussed as a way to generate dialogue in the family setting around racism.

Evaluation

Several groups stressed the importance of increased and improved evaluation of current programs addressing cultural safety, with the intention of building on existing strengths as well as identifying the needs of institutions to implementing such programs. It is crucial that this work is not re-stigmatizing in its practice or outcome.

Early Education

A re-occurring theme from all of the breakout groups was the importance of including an accurate historical and contemporary description of the colonization and oppression of Aboriginal peoples in Canada into school curriculum from an early age. Presenting a true story of the history and current circumstances of Aboriginal peoples will benefit both Aboriginal and non-Aboriginal students as it would promote greater understanding.

Working Together and the Importance of Relationships

Discussion group participants identified relationships as significant for structural changes in government and institutional policy and practice. The notion of working together which Dr. Georges Sioui introduced in his welcoming address, was revisited and emphasized as crucial to provoking meaningful action to address racism and foster cultural safety.

Changing Power Relationships

All groups referred to the notion of redistributing power in institutions and practices that influence the health and wellbeing of Aboriginal peoples. Involving Aboriginal peoples and communities in decision making was highlighted as vital to transforming the ways in which government works and relates to Aboriginal communities. Meaningful participation of Aboriginal Elders and scholars on university boards can prompt institutional change and recognition of Indigenous knowledge. It is also necessary to engage and empower Aboriginal youth by focusing on skills development and adopting a strengths-based approach building on customs and language. At the service level, one group suggested health care providers visit Aboriginal patients in community centers as a way to change the power dynamics of the patient-health care provider relationship.

Structural and Policy Level Changes

An emerging recommendation was to implement a decolonizing framework that is active both inside Aboriginal communities tackling internalized racism, and within societal institutions. There is a need to reinforce leadership at all levels in order to build trust and ensure accountability for policy changes that need to take place.

Local Solutions

The development of local solutions was discussed as a means of transforming relationships with government to better addresses the needs of Aboriginal communities. Local or regional approaches in relation to what a reformed treaty relationship might look like emerged in discussions as an important aspect of transforming the relationship between government and First Nations communities.

Working Together

All of the breakout discussion groups emphasized the importance of working together. One group identified a need to foster greater support, interaction and celebration of success both within Aboriginal communities and for Aboriginal peoples working outside their communities. Working together was discussed not only as important to relations between Aboriginal and non-Aboriginal peoples and organizations but also within Aboriginal groups. One group discussed breaking down government structures which undermine the ability to work together, such as government administrative and finance models in which First Nations, Métis and Inuit communities must compete for resources. There is a need to adopt common principles and articulate changes required expressed in one coherent voice.

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