

Skywoman, 2013. Simon Brascoup , Haudenosaunee/Anishinabeg



Health Professionals Working With First Nations, Inuit, and M tis Consensus Guideline

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Skywoman. 2013. Simon Brascoupé, Haudenosaunee/Anishinabeg

Sekon, Peace. The Skywoman was pregnant when she created the world. She lived in the spirit world above the sky dome. In the middle of her village was a tree covered in bright lights, it was a beautiful thing to behold. She wanted to learn what made it so wonderful, so she had the tree lifted out of the sacred ground to look at its roots. When she gazed at what she saw, she fell through the hole in the ground into this world. As she reached out to stop her fall she grasped strawberries in one hand and the sacred medicine tobacco in the other hand. The world back then was dark, with water and animals. As she fell into the world she brought light. The animals and birds saw her falling and decided that some birds would fly up, catch her on their backs and bring her safely onto the back of the turtle. A muskrat swam to the bottom of the water and brought up some earth in its paws so the Skywoman had something soft to stand on. The Skywoman began to walk in a counter clockwise spiral creating Mother Earth. This is the story my grandmother Sarah Patterson told me, Onen.

In this image created for the *Society of Obstetricians and Gynaecologists of Canada*, the Skywoman is falling from the Sky World at the moment of creation. In her hair are a flower and birds signifying our sacred relationship with the natural world. If you turn the image "upside down" you will see the Three Sisters; corn, beans, and squash. The corn signifies that the Skywoman is pregnant and women's ability to create life. On her dress is a branch of the Tree of Life with seven lights symbolizing human's life course; song, dance, art, gift, family, community, and spirituality. There is a Turtle with a spiral on its back to let us know that birth is still happening and that the Skywoman is still with us.

Health Professionals Working With First Nations, Inuit, and Métis Consensus Guideline

This consensus guideline has been prepared by the Aboriginal Health Initiative Committee and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

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Minwaashin Lodge

National Aboriginal Council of Midwives

National Aboriginal Health Organization

Native Women's Association of Canada

Native Youth Sexual Health Network

Pauktuutit Inuit Women of Canada

Royal College of Physicians and Surgeons of Canada

Society of Rural Physicians of Canada

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Abstract

Objective: Our aim is to provide health care professionals in Canada with the knowledge and tools to provide culturally safe care to First Nations, Inuit, and Métis women and through them, to their families, in order to improve the health of First Nations, Inuit, and Métis.

Evidence: Published literature was retrieved through searches of PubMed, CINAHL, Sociological Abstracts, and The Cochrane Library in 2011 using appropriate controlled vocabulary (e.g., cultural competency, health services, indigenous, transcultural nursing) and key words (e.g., indigenous health services, transcultural health care, cultural safety). Targeted searches on subtopics (e.g., ceremonial rites and sexual coming of age) were also performed. The PubMed search was restricted to the years 2005 and later because of the large number of records retrieved on this topic. Searches were updated on a regular basis and incorporated in the guideline to May 2012. Grey (unpublished) literature was identified through searching the websites of selected related agencies (e.g., Campbell Collaboration, Social Care Online, Institute for Healthcare Improvement).

Values: The quality of evidence in this document was rated using the criteria described in the Report of the Canadian Task force on Preventive Health Care (Table 1).

Sponsors: This consensus guideline was supported by the First Nations and Inuit Health Branch, Health Canada.

Summary Statements

- Demographically, First Nations, Inuit, and Métis people are younger and more mobile than non-Aboriginal people. This requires extra effort on the part of health care professionals to establish an environment of trust and cultural safety in their workplaces as the opportunity to provide care may be brief. (III)
- Canada ranks 6th in the world on the World Health Organization Human Development Index; however, the First Nations rank 68th. (II-3)
- There have been centuries of formal agreements between European governments and First Nations. They were initially conducted in the spirit of friendship and cooperation, but later became centred on land ownership and resource extraction. Since they have been repeatedly dishonoured, there is an environment of mistrust in First Nations towards governments, their representatives, their policies, and anyone perceived to have authority. (III)
- The Indian Act and its subsequent amendments were designed to control every aspect of a Status Indian's life and to promote assimilation. It was also a tool that the government used to access First Nations' land and resources. (III)
- The intergenerational trauma experienced by First Nation, Inuit, and Métis is the product of colonialization. Residential schools, forced relocation, involuntary sterilization, forced adoption, religious conversion, and enfranchisement are a few examples of government policy towards First Nations, Inuit, and Métis that have created intergenerational post-traumatic stress and dysfunction. However, they continue to be a resilient people. (III)
- Most Canadians are unaware that a large proportion of Canada's gross domestic product is funded by monies garnished from natural resources extracted from Aboriginal lands, while First Nations and Inuit communities rely on insufficient money transfers from the Federal government. (III)
- Multinational companies extract resources from lands that are often on or adjacent to Aboriginal communities, or lands that are under land claims negotiations. The management of lands and resources by the provinces in some regions and by the territorial and federal governments in other regions has made it difficult for First Nations, Inuit, and Métis communities to communicate with multinational corporations, especially where land claim negotiations are ongoing or non-existent. Multinational corporations do not provide revenues to these communities. Most Aboriginal communities are impoverished without adequate public health infrastructure, and without economic capital to improve their condition. (III)
- Jurisdictional issues today make it difficult to provide health care, take care of the land, and promote healthy communities. (III)
- Eating traditional country foods helps to preserve cultural identity, but increasing environmental contaminants such as lead, arsenic, mercury, and persistent organic pollutants may compromise food safety. (II-3)
- Given demographic shifts such as rapidly growing populations with large youth cohorts and the increasing urbanization of First Nations, Inuit, and Métis in Canada, it is an important reality that most clinicians will encounter First Nations, Inuit, and Métis in their practice. (II-3)
- Traditionally, men and women in First Nations, Inuit, and Métis cultures enjoyed equal and complimentary roles. Colonialization generally led to First Nations and Inuit women being objectified, disrespected, and ignored. Through specific pieces of legislation, First Nations women in particular lost their voices and powers within their communities, including their role in promoting traditional health and education. (III)
- The unemployment rate is much higher in Aboriginal communities than in those of non-Aboriginal Canadians. This is a major contributor to the gaps in socioeconomic status and access to equitable and quality health care. (II-3)
- The language of health outcome measurement often perpetuates negative stereotypes towards First Nations, Inuit, and Métis because outcomes are reported out of the context of the social, political, and economic circumstances. (III)
- Jurisdictional conflicts between federal, provincial, territorial, and band governments make it difficult to provide comprehensive public health and health services to First Nations. (III)
- The harmony of First Nations, Inuit, and Métis societies was disrupted by European colonialization at the end of the 18th century, causing widespread effects on the sexual health of First Nations, Inuit, and Métis women and men. (III)

Table 1. Key to evidence statements and grading of recommendations, using the ranking of the Canadian Task Force on Preventive Health Care

Quality of evidence assessment*	Classification of recommendations†
I: Evidence obtained from at least one properly randomized controlled trial	A. There is good evidence to recommend the clinical preventive action
II-1: Evidence from well-designed controlled trials without randomization	B. There is fair evidence to recommend the clinical preventive action
II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group	C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category	D. There is fair evidence to recommend against the clinical preventive action
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees	E. There is good evidence to recommend against the clinical preventive action
	L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

*The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

†Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.

Woolf SH, Battista RN, Angerson GM, Logan AG, Eel W. Canadian Task Force on Preventive Health Care. New grades for recommendations from the Canadian Task Force on Preventive Health Care. *CMAJ* 2003;169:207-8.

16. Research has shown that where cultural competency strategies have been implemented, health outcomes and patient satisfaction have improved. (II-3)
17. Subtle racism may occur without conscious intent, and is therefore best defined and identified by those who experience it. (III)

Recommendations

1. Health professionals should have an understanding of the terms by which First Nations, Inuit, and Métis identify themselves. (III-A)
2. Health professionals should have an understanding of the terms "cultural awareness," "cultural competence," "cultural safety," and "cultural humility." Health professionals should recognize that First Nations, Inuit, and Métis may have different perspectives about what culturally safe care is and should seek guidance on community-specific values. (III-A)
3. Health professionals should be aware of the limitations of statistics collected with respect to First Nations, Inuit, and Métis and should avoid making generalizations about mortality and morbidity risks when comparing First Nations, Inuit, and Métis with one another and with non-Aboriginal populations. (III-A)
4. Health professionals who wish to conduct research with First Nations, Inuit, and Métis must use recognized ethical frameworks that include the OCAP™ (ownership, control, access, and possession) principles, the Tri-Council Policy Statement, and community-specific guidelines. (II-2A)
5. Health professionals should recognize the intergenerational impact of residential schools as one of the root causes of health and social inequities among First Nations, Inuit, and Métis, with important implications for their experiences and practices surrounding pregnancy and parenting. (II-3A)
6. Health professionals should be aware that the discourse on health care policy and land claim negotiations often perpetuates negative stereotypes and often occurs without accurate reference to colonialization. (III-L)
7. Health professionals should be aware of ongoing debates regarding jurisdictional responsibilities that impede access to good quality, timely, and culturally safe health care for First Nations and Inuit, and of Jordan's Principle. Jordan's Principle calls on the government agency of first contact to ensure that children get necessary and timely care by paying for services immediately and seeking reimbursement from the appropriate agency later. (III-A)
8. Health professionals who provide care to First Nations and Inuit should be aware of the Non-Insured Health Benefits program, its eligibility and coverage requirements, and the exceptions and special permissions needed in some cases. Health professionals should recognize that they have a vital role in advocating for their First Nations and Inuit patients and assisting with obtaining these benefits. Health professionals should be aware that Métis do not have access to the Non-Insured Health Benefits and may face unique challenges accessing health care. (III-A)
9. All health professionals should acknowledge and respect the role that Aboriginal and Traditional midwives have in promoting the sexual and reproductive health of women and should be aware that this role is not limited to pregnancy and delivery, but often extends beyond the birth year. (II-2A)
10. Health professionals should inquire about their patients' use of Traditional medicines and practices as part of routine health practices, including prenatal care. (III-A)
11. Health professionals should be aware that each First Nations, Inuit, and Métis community has its own traditions, values, and communication practices and should engage with the community in order to become familiar with these. (III-A)
12. Health professionals should be aware of Canadian *Criminal Code* laws governing sexual activities in minors, including those under the age of 12, those between 12 and 16 years old, and those with a much older partner. (III-A)
13. Given the prevalence of sexual abuse and exploitation, health professionals must address the possibility of sexual abuse or

- exploitation once a trusting relationship has been established. All gynaecologic and obstetric examinations must be approached sensitively, allowing the patient to determine when she feels comfortable enough to proceed. (III-A)
14. Health professionals should be aware of the increased prevalence of HIV/AIDS among First Nations, Inuit, and Métis and should offer HIV counselling and screening to women who are pregnant or of child-bearing age. Culturally safe approaches to HIV and other hematogenously transferred disease counselling, testing, diagnosis, and treatment should be supported and adopted. (III-A)
 15. Health professionals should be aware of the high rates of cervical cancer and poorer outcomes once diagnosed for First Nations and Inuit patients. Health professionals should strive to limit the disparity between their Aboriginal and non-Aboriginal patients by promoting culturally safe screening options. (I-A)
 16. Health professionals must ensure that First Nations, Inuit, and Métis women have access to services for all their reproductive health needs, including terminations, without prejudice. Health professionals should strive to ensure confidentiality, particularly in small and fly-in communities. (III-A)
 17. Health professionals should recognize pregnancy as a unique opportunity to engage with and affirm the sexual and reproductive health rights, values, and beliefs of First Nations, Inuit, and Métis women. (III-L)
 18. Health care providers should ask about, respect, and advocate for institutional protocols and policies supporting the wishes of individuals and families regarding disposal or preservation of tissues involved in conception, pregnancy, miscarriages, terminations, hysterectomy, and other procedures. (III-A)
 19. Health professionals should recognize that mental illnesses such as mood disorders, anxiety, and addictions are a major public health issue for many First Nations, Inuit, and Métis. (II-3B) Use of mood-altering substances that lead to addiction is often a mechanism for coping with the pain of their intergenerational trauma. Health professionals should familiarize themselves with culturally safe harm reduction strategies that can be used to support First Nations, Inuit, and Métis women and their families struggling with substance dependence. (II-2A)
 20. Health professionals should support and promote the return of birth to rural and remote communities for women at low risk of complications. The necessary involvement of community in decision-making around the distribution and allocation of resources for maternity care should be acknowledged and facilitated. (III-A)
 21. Health professionals should be aware that there is a great lack of research, resources, and programming about mature women's health issues, including menopause, that is specific to First Nations, Inuit, and Métis. Health professionals should advocate for further research in this area. (III-A)
 22. Health professionals should seek guidance about culturally specific communication practices and should tailor communications to the specific situations and histories of their patients. (III-A)
 23. Health professionals may express to their patients that they wish to establish a respectful rapport through listening, acknowledging differences, and encouraging feedback. (III-L)
 24. First Nations, Inuit, and Métis should receive care in their own language, where possible. Health care programs and institutions providing service to significant numbers of First Nations, Inuit, and Métis should have interpreters and First Nations, Inuit, and Métis health advocates on staff. (III-A)

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Introduction

First Nations, Inuit, and Métis in Canada are diverse population groups making up nearly 4% of the nation's population. In a landmark summary published by the SOGC in 2000, in collaboration with the SOGC's Aboriginal Health Issues Committee, Dr Janet Smylie co-authored a comprehensive overview of the historical and modern challenges faced by Aboriginal peoples in their search for health, social justice, equality, education, and freedom from poverty.¹

The 2000–2001 guidelines were ground-breaking and have proved to be a valuable document for health care professionals working with Aboriginal people. Over the years there have been a number of important changes and advances regarding health care knowledge, policy, programs, and services in Canada. It is the intention of this document to provide an update on the key developments affecting First Nations, Inuit, and Métis in Canada. This document will build on the foundation of the original guideline, and expand on some key topics specific to the health and well-being of First Nations, Inuit, and Métis in Canada.

Since the first guideline was published, research on health inequities has evolved considerably. The Public Health Agency of Canada identifies 12 social determinants of health: income; social support; education and literacy; employment and working conditions; social environment; physical environment; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture.² The National Aboriginal Health Organization has likewise identified social determinants of health that are specific to Aboriginal people, highlighting the interactive nature of contextual factors, such as geography and access to basic health services.³ Awareness of the social determinants of health as a root cause of poor health outcomes among Aboriginal people has also improved. As the social and economic realities that underlie health have become better recognized, efforts to change the way health care is delivered have gained traction, notably through the development of new concepts such as “culturally safe care,” a key theme in this document. A new set of guidelines is needed in order to reflect these changes and ensure health professionals are

able to advance their knowledge and skill in the delivery of high quality, culturally safe health services for First Nations, Inuit, and Métis. The primary objective of this update is to provide a concise reference for health professionals working with First Nations, Inuit, and Métis.

In partnership with NAHO, the Aboriginal Health Initiative Committee of the SOGC convened a subcommittee of writers and special contributors to participate in this work. Within the timeline of this project, NAHO regretfully had to close its doors in the wake of the federal government's 2012 budget cuts, which had considerable effect on many Aboriginal organizations. Ever mindful of these devastating cuts, we are deeply grateful to all our partners who continued to help us complete this work.

The language used by First Nations, Inuit, and Métis to refer to themselves has changed over the years. This guideline will start with a chapter on the definitions and terms that First Nations, Inuit, and Métis use to refer to themselves, as well as an overview of the terms and concepts that form the foundation of this document. A second chapter will look at important trends in the demographics of First Nations, Inuit, and Métis and will provide some information on key characteristics of the population, including diversity, growth rate, sex and age distributions, and location. Following this, we explain the social determinants of health, how they apply to First Nations, Inuit, and Métis health experiences and outcomes, and why it is important for health professionals to have a good understanding of them. Doing so will allow readers to examine their own thoughts and perspectives on the health and life experiences of these populations. A fourth chapter will provide an overview of First Nations, Inuit, and Métis views of health, introducing health professionals to some of the core health concepts, beliefs, and practices that are valued by many First Nations, Inuit, and Métis and associated with a more holistic approach to health and well-being. Following this, a fifth chapter is dedicated to sexual and reproductive health, followed by a sixth chapter on maternal health. The seventh chapter discusses mature women's health, and its brevity reflects the lack of available information in this area. In the final chapter we discuss the concept of culturally competent care and cultural safety and how this has been shown to change outcomes for the better.

In the years since the founding of the SOGC's AHIC, countless dedicated individuals already involved in the care of First Nations, Inuit, and Métis have requested specific and practical guidance from the Committee to assist them in their provision of culturally safe and appropriate care. It is a daunting task to summarize the issues affecting First Nations, Inuit, and Métis in Canada and to provide meaningful information for health professionals working with them. We have striven to find the balance between providing detail while at the same time allowing this document to stand alone as a reference for health professionals working with Aboriginal people. In what we hope becomes a well-used portion of this guideline, we will also provide clinical tips, graphics, and case study materials with key learning points. Additionally, a companion piece will be published to accompany this document, highlighting key facts, tips, and information in the guideline in summary form for wider distribution among our partners and affiliates.

Given demographic shifts such as a rapidly growing population with a large youth component and the increasing urbanization of First Nations, Inuit, and Métis in Canada, it is an important reality that most clinicians

will encounter First Nations, Inuit, and Métis in their practice. An approach to their care based on cultural safety, respect, and awareness of their history is paramount to our commitment to ensure the right to access high-quality, timely, and culturally safe sexual and reproductive health in Canada. We hope that this update will provide a useful reference for clinicians and a guide for other stakeholders. We welcome your interest and applaud your efforts thus far in caring for First Nations, Inuit, and Métis.

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Definitions

Section 35 of the *Constitution Act* of 1982 of Canada states that the term “Aboriginal peoples of Canada” includes the Indian, Inuit, and Métis of Canada.¹ The Aboriginal people of Canada are the descendants of the original inhabitants of North America. Today, Aboriginal people prefer to refer to themselves as First Nations, Inuit, or Métis.

Where appropriate, we will use the term “Indigenous.” In recognition of the diversity of Indigenous people throughout the world, the United Nations has developed a modern understanding that includes self-identification at an individual and community level; strong links to territories and surrounding natural resources; distinct language, culture, and beliefs; and being part of a non-dominant group in society.²

The term “First Nations” came into common use in the 1970s to replace Indian. It is a collective term used to describe the original peoples of Canada, but does not include Inuit or Métis. There are 616 distinct First Nations communities in Canada.³

The Métis National Council adopted the following definition of “Métis” in 2002: “‘Métis’ refers to a person

who self-identifies as Métis, is distinct from other Aboriginal peoples, is of historic Métis Nation Ancestry, and who is accepted by the Métis Nation.”⁴ The federal government also recognizes this definition.⁴ Political representation for the Métis comes from the groups who form part of the Métis National Council, which spread from Quebec in the east into western Canada: organizations such as the Métis Nation of Ontario and the Métis Nation of British Columbia. The Métis National Council does not recognize Métis east of Quebec.

In other areas of the country, e.g., the Maritimes and Newfoundland and Labrador, people with mixed heritage (European and First Nations or Inuit) identify themselves as Métis and have unique language and traditions. Politically and culturally they are very different. They are aware of this and adopted the Métis name largely in order to make legal claims in the judicial system because the federal government only recognizes Métis originating from the Historic Métis Homeland.

Inuit (singular Inuk) are the peoples who pre-contact lived in the Arctic and sub-Arctic, in parts of what are now Canada, Alaska, Russia, and Greenland. Inuit are sometimes referred to by different terms outside Canada, such as Inupiat, Yupiks, and Eskimos. The Aleuts of Alaska are related to Inuit. Today, Inuit continue to live in the Arctic and sub-Arctic regions, as well as in urban areas across Canada. Although still used in the United States, the term “Eskimo” is considered pejorative by many Inuit in Canada and Greenland.

In this guideline, we use the terms First Nations, Inuit, and Métis wherever possible. Where reference is made to Aboriginal peoples, this is due to a lack of differentiation between First Nations, Inuit, and Métis in the original research we cite.

The *Constitution Act* of 1867 referred directly only to “Indians.” While the origin of the term “Indian” is still a topic for debate, the word can be offensive to many First Nations. According to federal government legislation, “Status Indians” are those who are registered under the federal *Indian Act*. First Nations who are not registered

Abbreviations

AHF	Aboriginal Healing Foundation
AHHR	Aboriginal Human Health Resources
CAITE	Canadian AIDS Information Treatment Exchange
GDP	gross domestic product
HAART	Highly Active Antiretroviral Therapy
ITC	Inuit Tapirisat of Canada
ITK	Inuit Tapiriit Kanatami
LGBT	lesbian, gay, bisexual, transgendered
NAHO	National Aboriginal Health Organization
NIHB	Non-Insured Health Benefits
NWAC	Native Women's Association of Canada
OCAP™	First Nations principles of Ownership, Control, Access, Possession
PCOS	polycystic ovary syndrome
STBBI	sexually transmitted and blood-borne infections

are referred to as “non-Status Indians.” “Treaty Indians” are those who can trace their ancestry to Indians who signed treaties with the British or Canadian governments. The First Nations band councils maintain a list of their members who are entitled to treaty arrangements.

The federal government’s widest service responsibilities are to registered First Nations (Status Indians) and include the provision of health care. Inuit also receive a number of services, but not as many as provided registered First Nations living on reserves. For example, only registered First Nations and recognized Inuit are eligible for benefits under the Non-Insured Health Benefits Program, which provides coverage for certain medically necessary goods and services.⁵

Colonialization can be defined as a process that includes geographical incursion, sociocultural dislocation, the establishment of external political control and economic dispossession, the provision of low-level social services and, finally, the creation of ideological formulations around race and skin colour, which position the colonizers at a higher evolutionary level than the colonized.⁶

“Cultural competence” and “cultural safety” are discussed and defined in the chapter entitled “Changing Outcomes through Culturally Competent Care.” These terms can be considered part of a continuum from cultural awareness to cultural competence to cultural safety. The continuum represents a learning process on the part of health care providers as they examine their own behaviour for biases and seek to understand the cultures of First Nations, Inuit, and Métis.

In Canada, cultural competence requires an understanding of the cultural, historical, and political issues that impact and continue to affect the health of First Nations, Inuit, and Métis. Cultural safety moves beyond cultural sensitivity to an analysis of power imbalances, institutional discrimination, colonialization, and colonial relationships, and awareness of one’s own culture as they apply to health care.⁷ Ultimately, it is only the patient who can decide if their care was safe.

The First Nations Principles of OCAP™ (ownership, control, access, and possession) is a new way for First Nations’ research data to be collected, stored, distributed, and accessed in that First Nations own, protect, and control the data collection processes in their communities and how the information is used.⁸ OCAP™ is a registered trademark of The First Nations Information Governance Centre, and is used with The FNIGC’s permission in this guideline.

Over the last decade, there has been dissatisfaction with the term “patient,” most often expressed in literature looking at the psychosocial aspects of care. It has been suggested that the term implies being in an inferior position. Many health professionals are also uncomfortable with the term “client,” as it implies a business arrangement. For the purpose of this guideline, a consensus was reached to use the terms “health professional” and “patient” to describe the different roles and not to convey a power differential. Given that there is a power imbalance, however, the onus is on health professionals to approach each interaction with respect and humility. In this guide, health professionals include obstetricians, gynaecologists, family doctors, nurses, midwives, health researchers, and other allied health professionals.

Recommendations

1. Health professionals should have an understanding of the terms by which First Nations, Inuit, and Métis identify themselves. (III-A)
2. Health professionals should have an understanding of the terms “cultural awareness,” “cultural competence,” “cultural safety,” and “cultural humility.” Health professionals should recognize that First Nations, Inuit, and Métis may have different perspectives about what culturally safe care is and should seek guidance on community-specific values. (III-A)

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Demographics

Studying the demographics of First Nations, Inuit, and Métis populations is a difficult task. While we rely on data from Statistics Canada in this document, we are cognizant of their shortcomings. Data acknowledging the differing geographies and cultures of Aboriginal people must continue to be collected and differentiated, particularly as pan-Aboriginal statistics do not reveal the differing needs of First Nations, Inuit, and Métis in Canada.

The two major sources of demographic information for First Nations, Inuit, and Métis in Canada are the Canadian Census and the Indian Register. The census has asked respondents to declare their ethnic origin since 1891. Until 1986, however, respondents could not indicate more than one ethnic origin. When the census changed to allow multi-ethnic responses, many more individuals identified themselves as having Aboriginal ancestry. Aboriginal ancestry was defined as having at least one Aboriginal ancestor more distant than a grandparent, but this did not seem truly to capture the degree to which an individual might identify with First Nations, Inuit, or Métis culture. Therefore, in 1996, the census asked whether individuals considered themselves First Nations, Inuit, or Métis. The census does not count individuals not resident in Canada at the time of enumeration, those in institutions (incarcerated or hospitalized), or those who are homeless.

The British colonial, and then the Canadian, government kept records of individual Indians and bands beginning in the 1850s to determine who was eligible for services. In 1951, this became a formalized registry administered by the Department of Aboriginal Affairs and Northern Development Canada. The Indian Register records First Nations individuals who are registered according to the *Indian Act* and includes those living outside Canada as well as those in institutions.

These two sources demonstrate the difficulty in providing true population numbers. In 2006 the census recorded 564 870 individuals who responded that they were Registered Indians. The Indian Registry, however, for the same year recorded 763 555 persons as Registered. The Canadian Census may have the most comprehensive statistics for First Nations, Inuit, and Métis populations, however, and we use their data for demographics.¹

In 2006, the total population of Canada was 31 241 030, of whom 1 172 785 identified as Aboriginal. Although the first results from the 2011 Canadian Census were released in February of 2012, the statistical breakdown by ethnic origin is not yet available, so we use data from the 2006 census. Figure 2.1 shows population numbers for Canadians identifying as North American Indian, Métis, and Inuit in 2006.

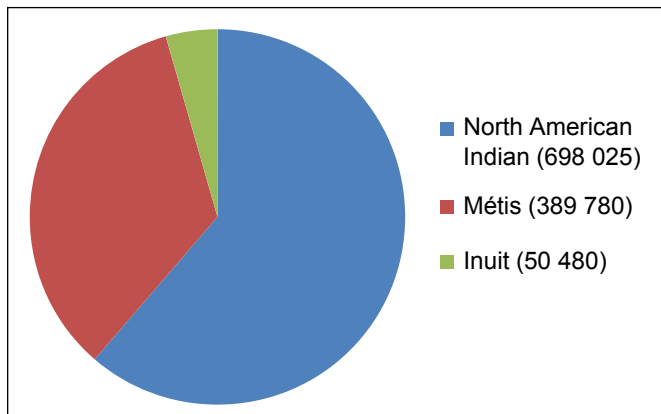
The social demographics of First Nations, Inuit, and Métis differ in several ways from that of the general Canadian population. As can be seen in Figure 2.2, the mean age of First Nations, Inuit, and Métis is significantly lower than that of the non-Aboriginal population; in fact 35% of the Inuit population is under the age of 15 compared with 18% of the total Canadian population.²

First Nations, Inuit, and Métis together make up one of the fastest growing segments of the Canadian population. It has been stated that the First Nations and Métis populations have undergone an especially rapid increase in the last decade as can be seen in Figure 2.3.

While discrepancies between published sources often point to “methodological and data quality problems,”³ the actual growth of the Aboriginal population in Canada is attributable, in part, to the increasing self-identification of First Nations, Inuit, and Métis as well as to population growth.³ Information from 2008 from Statistics Canada showed that the mean birth rate for Aboriginal women was 2.6 compared with 1.5 for the Canadian population as a whole. The proportion of the population under 5 years of age was twice that of the general population (9.29% vs. 5.26%). In addition, a significant proportion of the overall increase in Aboriginal population can be attributed to an 85% increase in the number of individuals self-identifying as Métis. In spite of the rapid population growth, the allocation of resources by the federal government has been capped and is therefore unable to adequately respond to the resource needs of this population.

It is important to emphasize that First Nations, Inuit, and Métis are not a single population entity. There are 616 identified First Nations as well as diverse Inuit and Métis

Figure 2.1. 2006 population data for North American Indians, Inuit, and Métis¹



communities. Some First Nations live on reserves while some Métis live on settlements as well as in rural, urban, and northern areas across Canada. In the 2006 census, 40% of individuals who identified themselves as North American Indians (First Nations) lived on reserves. This varied by province and territory, with higher proportions living on reserves in Manitoba and Saskatchewan.

Data from Statistics Canada also show that the population is more mobile than the general Canadian population, with an estimated 19% of Aboriginal people having moved in the last year versus 14% of non-Aboriginal people. The mobility data indicated that Aboriginal women are more likely to move than Aboriginal men, and off-reserve First Nations are much more likely to move than on-reserve First Nations. Figure 2.4 shows the percentages of people aged 5 years and over who moved within the last 5 years.

Within the last 50 years, Canada has witnessed unprecedented growth in the urban First Nations, Inuit and Métis population. In the early 1950s, less than 7% of the Aboriginal people lived in urban areas, and by the early 1960s this figure rose to 13%.^{4,5} In 1951 6.7% of the Aboriginal population lived in cities.⁴ Today almost 50% of First Nations, almost 70% of Métis, and almost 22% of Inuit live in urban areas, while only 40% of First Nations reside on reserves.¹

All of these demographic changes have implications for how health providers interact with First Nations, Inuit, and Métis. Access to high quality, timely, culturally safe services is a key challenge for a young and migratory population. Patients may find it difficult to build a sense of trust in health care professionals, and health professionals may find it difficult to ensure continuity of care, with a considerable effect on overall health outcomes.

As mentioned, studying the demographics of First Nations, Inuit, and Métis in Canada is difficult because of the several data collection issues. Data on First Nations are incomplete because some reserves decline to be included in the census and some are difficult to access because of their remoteness. First Nations living in the Yukon are often not accurately reflected in statistics, because there are no reserves there. Aboriginal Affairs and Northern Development Canada recognizes 616 Nations. At least 22 reserves, many with large populations, were not included in the 2006 census data. For example, the Iroquoian communities of Kahnawake, Akwesasne, Tyendinaga, and Six Nations are ranked in the top 20 bands by population, but did not take part in the census. However, in 2006, Statistics Canada improved the accuracy of the census data by performing an extrapolation to account for the missing data from the non-participating reserves.

A lack of accurate, accessible data regarding the health and well-being of Métis in Canada continues to be a problem. Existing information comes from academic research, national, provincial, and regional surveys, and administrative databases. Between 1980 and 2009 only approximately 80 peer-reviewed articles related to Métis health were published. Of these, only half have results stratified to isolate Métis, and 12% are Métis-specific. The lack of published Métis health articles is hypothesized to be due in part to insufficient funding, to the lack of Métis-specific research ethics guidelines, and to the lack of defined Métis communities. Some data are collected via surveys such as the Aboriginal Peoples Survey and regional surveys conducted by Métis organizations; however, these data are of limited scope and generalizability, often have inadequate sample sizes, and lack disaggregated data. Federal and provincial administrative databases collect statistics on births and deaths, hospital data, and infectious disease surveillance. However, these data are also limited with respect to Métis (and First Nations and Inuit) since most administrative databases do not have ethnic identifiers.⁶ Data-linking with provincial Métis-organization citizenship registries can be used to generate Métis-specific information from administrative databases, and several regional Métis organizations are currently undertaking such projects. In addition, unlike First Nations and Inuit, Métis do not have access to federally funded health services and benefits. As a result, data collected through these programs exclude Métis information.⁷

The existing body of research also fails to adequately reflect the urban-based population. Fifty percent of First Nations people, 70% of Métis, and 40% of Inuit live in urban areas. Increasingly urbanized populations, most Aboriginal

Figure 2.2. 2006 median age data for North American Indians, Inuit, and Métis⁸

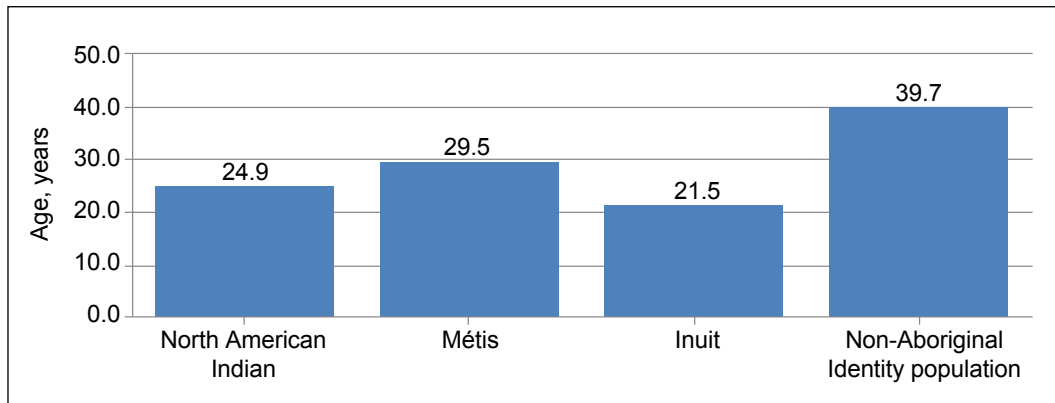


Figure 2.3. Population growth 1996–2006¹

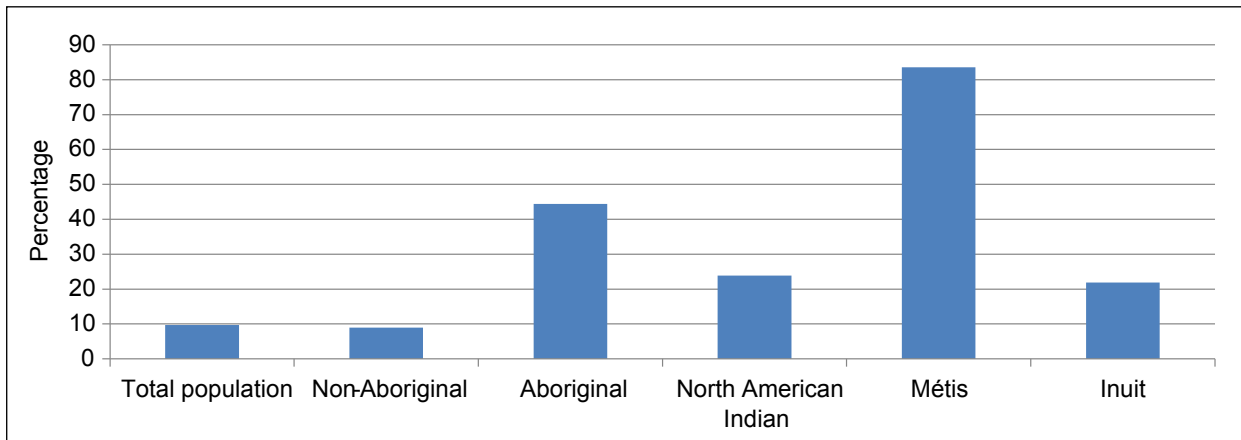
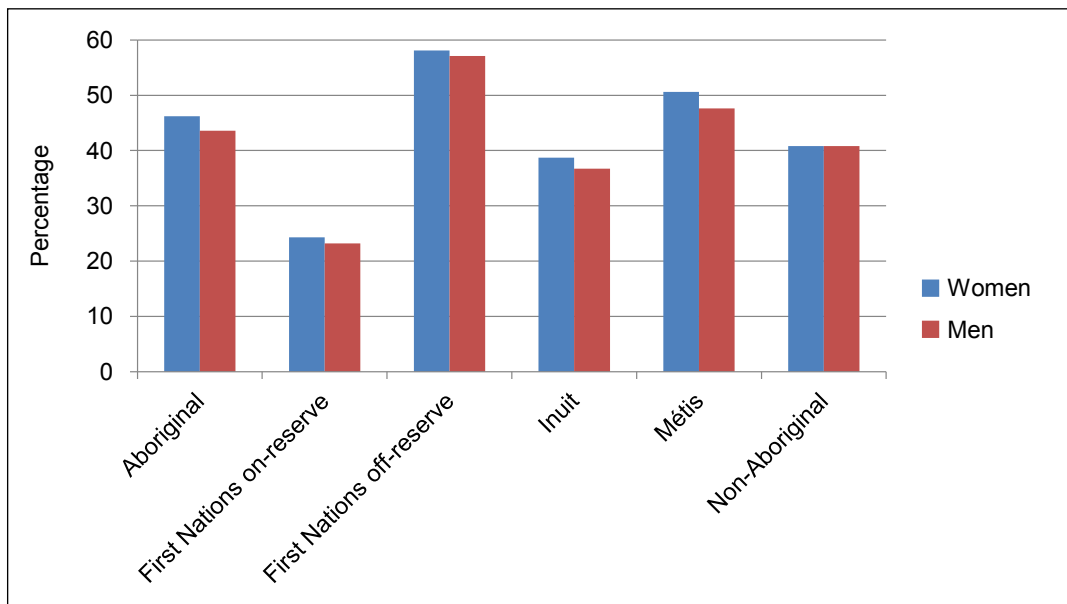


Figure 2.4. Percentages of people aged 5 and over who moved within the last 5 years¹



people live mainly in cities. Health professionals should recognize that proximity to cities, clinics, hospitals, and health professionals does not necessarily improve access to services or to culturally safe services. Fifty-seven percent of First Nations children in urban areas live in low-income families.

Summary Statement

1. Demographically, First Nations, Inuit, and Métis peoples are younger and more mobile than non-Aboriginal people. This requires extra effort on the part of health care professionals to establish an environment of trust and cultural safety in their workplaces as the opportunity to provide care may be brief. (III)

Recommendations

3. Health professionals should be aware of the limitations of statistics collected with respect to First Nations, Inuit, and Métis and should avoid making generalizations about mortality and morbidity risks when comparing First Nations, Inuit, and Métis with one another and with non-Aboriginal populations. (III-A)
4. Health professionals who wish to conduct research with First Nations, Inuit, and Métis must use recognized ethical frameworks that include the OCAP (ownership, control, access, and possession) principles, the Tri-Council Policy Statement, and community-specific guidelines. (II-2A)

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Social Determinants of Health Among First Nations, Inuit, and Métis

The World Health Organization's Human Development Index is a quality of life calculation that measures life expectancy, education, standard of living, and gross domestic product collected at a national level. According to the index, Canada ranks 6th out of 187 countries, pointing to a quality of life that is celebrated and cherished by many Canadians. Yet, when these measures are calculated using statistics from First Nations communities in Canada, we see gross disparity, as First Nations rank 68th on the Index.¹ In many cases, Inuit- and Métis-specific statistics indicate similarly disturbing inequities. For example, life expectancy tables from Statistics Canada for the years 1991 to 2006 show that, on average, life expectancy for First Nations is 5 years less than for non-Aboriginal people. Those with Métis identity live an average of 1 year longer than First Nations. Inuit showed a 12- to 15-year lower life expectancy than Canadians as a whole during the period 1998 to 2003. And the situation is worsening.²

A holistic view of health recognizes that health is a state of complete physical, mental, and social well-being, and that "health inequities arise from the societal conditions in which people are born, grow, live, work and age."³ The social conditions in which many Aboriginal people live have a significant influence on their disproportionate rates of illness and disease, and are referred to as the social determinants of health.

Summary Statement

2. Canada ranks 6th in the world on the World Health Organization Human Development Index; however, the First Nations rank 68th. (II-3)

The WHO's Commission on the Social Determinants of Health has focused on 9 broad areas felt to contain the key determinants of health: early childhood development, employment conditions, globalization, social exclusion, health systems, priority public health conditions, measurement and evidence, gender equity, and urbanization.³ Determinants of health can be conceptualized as either distal (historical) or proximal (contemporary). To understand the interconnectedness of these determinants and their

combined influence on the general health of First Nations, Inuit, and Métis, one must look into the past, to the distal determinants of health (Figure 3.1).⁴

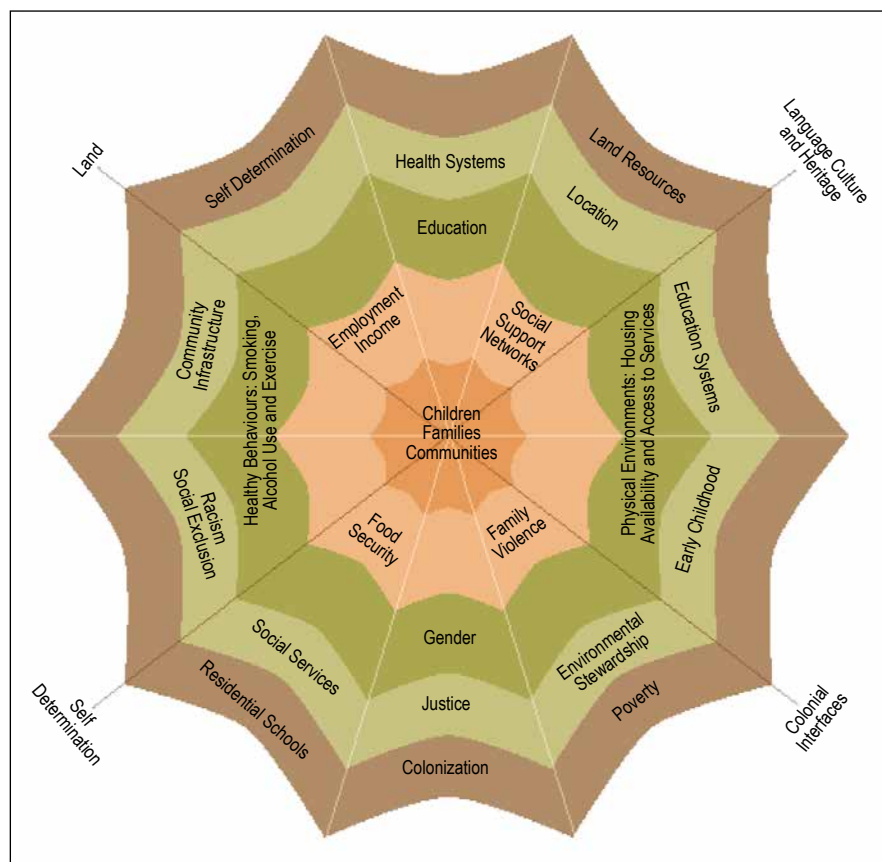
This chapter is not a comprehensive analysis of the histories of First Nations, Inuit, and Métis in Canada. Four main themes are threaded through history and impact the health of First Nations, Inuit, and Métis today. First, First Nations, Inuit, and Métis were active, not passive, participants in history. Agreements were made that reflect the world views of the parties involved, and some were so important their influence has threaded through time and underlies many of the political and legal arguments today. Second, land title was and continues to be a forceful undercurrent in their political situation and health status today.⁵ Jurisdictional conflicts represent huge barriers for implementing strategies and services aimed at improving First Nations and Inuit access to care and health outcomes. Third, intergenerational trauma, the grief that results following centuries of suffering due to colonialization, underlies many of the unhealthy behaviours that perpetuate poor health. Fourth, these historical and contemporary forces disproportionately affect women. Overall, there appears to be little understanding or acknowledgement, including among health professionals, that First Nations, Inuit, and Métis came into this poor situation by means of exceptional, consistent, and systemic forces.

HISTORICAL CONTEXT: FIRST NATIONS

North America has vast lands and natural resources. The early colonial record saw trading and alliances formed between the various Native nations with the English, French, and Dutch, the encroachment and formation of their colonies, and conflict. The earliest known treaty made in North America was the *Two Row Wampum Treaty* of 1613, made between the Iroquois and the Dutch.

There is a bead of white wampum, which symbolizes the purity of the agreement. There are two rows of purple, and those two rows have the spirit of your ancestors and mine. There are

Figure 3.1. Web of Being: Determinants and Indigenous People's Health



Prepared by: Dr. Margo Greenwood, NCCA, 2009

three beads of wampum separating the two rows and they symbolize peace, friendship and respect. These two rows will symbolize two paths or two vessels, traveling down the same river together. One, a birch bark canoe, will be for the Indian people, their laws, their customs and their ways. The other, a ship, will be for the white people and their laws, their customs, and their ways. We shall each travel the river together, side by side, but in our own boat. Neither of us will try to steer the other's vessel.⁶

The *Two Row Wampum's* assertion that no Nation would give up their sovereignty is one that was reaffirmed in subsequent treaties and allegiances. This series of agreements became known as the Covenant Chain of Friendship, effective for "as long as the sun shines upon the earth, as long as the waters flow, and as long as the grass grows green, peace will last."⁶

The next 150 years saw conflict between England and France for control of trade through North America, which many nations call Turtle Island. Small colonies of settlers emerged throughout the frontier. War, infectious diseases, hunger, and internal strife saw the decimation

of First Nations peoples; however, they continued to play an active role by making allegiances in the conflict between England and France. After the British acquisition of French territory in North America, King George III issued the Royal Proclamation of 1763 which outlined the constitutional framework for negotiating treaties of land with First Nations peoples. The following year, a large number of First Nations gathered for the *Treaty of Niagara* negotiations where the Covenant Chain of Friendship—and Native sovereignty—was reaffirmed.

The Royal Proclamation and the *Treaty of Niagara* continue to have legal relevance in Canada. The *British North America Act* of 1867, signed during Canada's Confederation listed the Royal Proclamation and the *Treaty of Niagara* as active treaties. The *Constitution Act* of 1982 reaffirms all treaties made before and after Confederation.

After Confederation, a number of agreements, collectively termed the Numbered Treaties were signed between 1871 and 1921. These treaties were made between the Crown and Native communities in Ontario and the western territories and provinces. In exchange for land, Canada promised education, cash, tools, and farming supplies,

among other items. In *Treaty Number 6*, a medicine chest was also promised. Recognition of the treaties is fraught with challenges, in part because they were not made between Nations, but between colonially established Bands or communities, and the Crown, and also because of their basic assumptions and what they did and did not promise.

Summary Statement

3. There have been centuries of formal agreements between European governments and First Nations. They were initially conducted in the spirit of friendship and cooperation, but later became centred on land ownership and resource extraction. Since they have been repeatedly dishonoured, there is an environment of mistrust in First Nations towards governments, their representatives, their policies, and anyone perceived to have authority. (III)

In 1876, Parliament passed the *Indian Act*, narrowing the concepts set forth under the Royal Proclamation and allocating a small land base—a reserve—for the exclusive use of those defined as Indians. An Indian was defined as any male person of Indian blood reputed to belong to a particular band; any child of such a person; and any woman lawfully married to such a person. Indian women who married non-Indian men lost their Status.

Status Indians were allocated reserve lands where no meaningful development could occur. The *Act* was essentially a tool that provided the federal government exclusive authority to legislate in relation to Indians and lands reserved for the Indians. For instance, Status Indians needed to have a pass to enter and leave reserves, they were not considered persons, were not allowed to vote, not allowed to express their cultures through dance and ceremonies, and were prevented from exercising hereditary forms of government. The *Act* allowed for municipalities and companies to expropriate parts of reserves for roads, railways, and other public works. If First Nations individuals wished to own property or pursue a higher education, they were “enfranchised,” losing their Indian Status and their right to live on reserve or to receive any of the few treaty-allocated benefits. It is important to note that the *Indian Act* also legislated that First Nations women who married non-First Nations men were also enfranchised, resulting in their loss of Indian Status for themselves and their children.

Summary Statement

4. The *Indian Act* and its subsequent amendments were designed to control every aspect of a Status Indian’s life and to promote assimilation. It was also a tool that the government used to access First Nations’ land and resources. (III)

“Our objective is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic, and there is no Indian question, and no Indian department.”⁷ (A famous statement made in 1920 by Duncan Campbell Scott, poet, essayist, and Deputy Superintendent General of Indian Affairs for 19 years.)

In the *Act*, the definition of Indians excluded the two other main groups of Aboriginal peoples, Inuit and Métis. Neither Inuit nor Métis had any recognized title. It was not until the *Constitution Act* of 1982 that Inuit and Métis peoples were recognized as distinctive groups of Aboriginal peoples in Canada (Section 35).⁸

HISTORICAL CONTEXT: INUIT

Inuit have occupied the Arctic land and waters for more than 4000 years. A migratory, land-based way of life was practiced for thousands of years until the arrival of Europeans, beginning with whalers in the 16th century. By the 1700s, Inuit lifestyle had begun to change in response to the continued presence of European whalers. Whalers traded trinkets, tools, and some food supplies with Inuit in exchange for assistance finding the best whaling locations and learning the best butchering practices. Intensive whaling quickly depleted the whale populations, and the Europeans lost interest in Arctic whaling. As a result, Inuit were left without access to the European supplies on which they had become dependent, and with limited access to the whales which had formed an essential part of their livelihood for centuries.

By the beginning of the 20th century, the main source of commerce between Inuit and Europeans had moved from whaling to fur trading, with Inuit trading furs for guns, ammunition, tobacco, tea, sugar, cloth, metal tools, and other items. Trapping continues to be an important part of Inuit livelihood, and fur is still used to make clothing, although the economic benefit has been seriously undermined in light of southern-based animal rights groups. The arrival of Europeans in the Arctic exposed Inuit to new diseases such as measles and tuberculosis. Because their immune systems were not adapted to these diseases, many Inuit died.

By the 1940s the Arctic was deeply altered due to a strong government presence, even more heavily established during WWII and the Cold War. In addition, due to efforts to demonstrate sovereignty and to more easily govern the North, the Canadian government implemented initiatives to move Inuit from their traditional migratory camps to larger permanent settlements. This was a dramatic change for Inuit families and communities. “Modern” homes

were provided for Inuit in these settlements, in addition to health, education, and social services. Within 3 decades Inuit became almost entirely dependent on government assistance. Within a few generations Inuit went from being completely self-reliant, living entirely off the land, to having cell phones and surfing the Internet.

Forced relocation was extremely damaging to many Inuit families and communities. Their way of life was drastically changed, there were few economic opportunities, and many were moved to areas of the high Arctic where the basics of sustaining life were extremely difficult to obtain. On August 18, 2010, Indian and Northern Affairs Minister John Duncan issued an apology for the forced relocation of families from Inukjuak and Pond Inlet to the high Arctic areas of Grise Fiord and Resolute Bay (see Appendix 1).

Politics and Self-government: Inuit

In 1971 Inuit Tapirisat of Canada was created to lobby and negotiate changes in government policies, and to put control back into the hands of Inuit. ITC supported land claims negotiations with the federal and provincial governments in the 4 Inuit regions of Nunavik, Inuvialuit, Nunavut, and Labrador. Unlike many First Nations, Inuit never signed any treaties.

Each of the 4 regions has a different self-government structure. For example, Nunavik, the northern area of Quebec, has a unique political history emerging from its involvement with the James Bay Project. This has resulted in the first modern comprehensive land claims agreement in Canada, namely, the *James Bay and Northern Quebec Agreement*. Nunavut, on the other hand is the most well-known Inuit region and in 1999 Nunavut became Canada's newest territory. Inuit traditions, values, and beliefs form an important part of the way in which the Nunavut government operates, with Inuktitut as one of its official languages. In 2001, the ITC changed its name to Inuit Tapiriit Kanatami, "Inuit are United in Canada," to reflect their success in land claims settlements in all 4 regions.

HISTORICAL CONTEXT: MÉTIS

Although the Métis were recognized by the *Constitution Act* of 1982, Métis rights in relation to lands, waters, and wildlife have often been disregarded. Métis are descendants of European fur traders (largely French, Scottish, or English) and First Nations women. During the 18th and 19th centuries, European fur traders travelled far across Canada, sometimes becoming involved with First Nations women for political or strategic reasons (e.g., marrying a chief's daughter), other times becoming involved with First Nations women simply for their companionship. Their

First Nations wives were also extremely valuable resources, possessing in-depth knowledge of the land and the ability to communicate with other First Nations people.

Women began to have children who were half European and half First Nations. Children with French fathers became known as Métis, and those with English or Scottish fathers were known as "countryborn." These children were often referred to with more offensive terms such as "bois-brûlés," "mixed-blood," or "half-breed."

Over time communities of Métis began to emerge. Métis married and had children with other Métis, and a unique culture, based on a mix of European and First Nations traditions and practices, developed. Their knowledge of both European and First Nations language and culture allowed them to bridge cultural gaps and thus improve trading relationships. During the 19th century, Métis communities continued to grow, with many settling in the Red River area of what is now Manitoba. This area, referred to as Rupertsland, was originally considered by the Imperial authorities to be the property of the Hudson's Bay Company, but it was sold to the newly formed Dominion of Canada in 1869. The Métis were not consulted about this transfer or the impact it would have on their land and livelihood.

These concerns were exacerbated when an English speaking outsider, William MacDougall, was appointed to oversee the transfer. In 1870, under the leadership of Louis Riel, the residents of Red River formed a Provisional Government to resist the takeover of their land. After several months of tension, three Red River representatives, including Louis Riel, went to Ottawa to negotiate with the Canadian Government. These negotiations resulted in the *Manitoba Act* which stated that the Red River settlement would enter Confederation as the Province of Manitoba.

The *Manitoba Act* of 1870 also laid the foundations for establishing who was eligible to own land.⁹ The result was the issuance of scrip to distribute land. Métis were issued a certificate which was redeemable for land or money. There were many barriers to the scrip process for Métis individuals and families, including administrative and literacy barriers, fraud, and long delays in decision-making. These administrative and bureaucratic barriers proved insurmountable to many Métis, resulting in their lack of participation in the scrip process.

Riel was ultimately put on trial and hanged for his leadership of the resistance. Many other Métis were killed or persecuted, and many of the rest went underground, resulting in significant migration westward. To protect themselves and their families, many people stopped

identifying as Métis. The Métis became known as the “Road Allowance People,” living on the edges of towns, with extremely limited economic opportunities, and no access to education or social services.

RESIDENTIAL SCHOOLS

After Confederation, the education of Aboriginal children became a federal responsibility and was subcontracted to Christian churches. The Canadian residential schools were the “ultimate tool of assimilation”¹⁰ and aimed at “killing the Indian in the child.”¹¹ From the mid-1800s until as late as 1996 an estimated 100 000 Aboriginal children aged 4 to 18 were removed from their families and placed in residential schools.^{12,13} First Nations, Inuit, and Métis children alike were sent to residential schools, although their experiences varied. For example, while some Inuit began to be sent to residential schools in the 1860s, it was only after the government implemented forced settlement policies that almost all Inuit children were required to attend these schools (also called federal hostels), with the first government-regulated school opening in Chesterfield Inlet in 1951.

Most children attending residential school were kept at school the whole year. In some cases, to be closer to their children, parents would leave their homes to move to camps surrounding the schools. At these church-run schools, children had their hair cut short, were forbidden to speak their language, were forced to convert to the religious denomination of the school, were subjected to corporal punishment, and were often sexually abused. The rates of infectious diseases due to the unsanitary conditions resulted in high mortality rates. In 1907, Dr Peter Bryce, an official of the Ontario Health Department, toured the residential schools of western Canada and reported children being deliberately infected with diseases like tuberculosis, with an average death rate of 40%. Dr Bryce’s report only became public in 1922 after he left public office and published the book *The Story of a National Crime: Being a Record of the Health Conditions of the Indians of Canada from 1904 to 1921*.¹⁴ The children rarely had opportunities to see and experience normal family life. Over time, the effects of continually being told and shown how they, their parents, and their ancestors were unworthy resulted in lifelong self-depreciation and dysfunction.

Aboriginal children learned to despise the traditions and accomplishments of their people, to reject the values and spirituality that had always given meaning to their lives, to distrust the knowledge and life ways of their families and kin. By the time they were free to return to their villages, many had learned to despise themselves.¹³

Although First Nations, Inuit, and Métis no longer attend residential schools, the legacy of these schools continues to significantly impact their lives today. For example, according to the Aboriginal Peoples Survey,¹⁵ 3000 Inuit who attended residential school are still alive today and close to half (44%) of all Inuit between 44 and 54 have a close family member who attended residential school.

The residential school experience deeply impacted the transfer of traditional knowledge about childbirth and raising a family. Many residential school survivors grew up never having known affection from their parents, and often they only recalled cruelty and abuse at the hands of people in positions of power at various residential schools. As residential school survivors grew up to have families of their own, they did so without having learned parenting skills from their own parents. Often the fathers were either unable or unwilling to participate in the family life, and the mother raised the family.

On a population level, the effects of this aggressive social experiment were catastrophic. In 2008 Prime Minister Stephen Harper of Canada made a formal apology for the federal government’s wrongdoing in the implementation of the residential school program (see Appendix 2).

Recommendation

5. Health professionals should recognize the intergenerational impact of residential schools as one of the root causes of the health and social inequities among First Nations, Inuit, and Métis, with important implications for their experiences and practices surrounding pregnancy and parenting. (II-3A)

CLINICAL TIP

Intergenerational survivors of residential schools may struggle with poorer self-esteem. A low sense of self-worth may make a patient feel unworthy of the attention of her health professional.

The residential school system was the prime institutional agent aimed at assimilating First Nations, Inuit, and Métis. However, in the 1950s, as fewer children were being sent to residential schools, the child welfare system gradually became the institutional means of assimilation and colonialization. At this time, as a result of an amendment to the *Indian Act*, the provinces were guaranteed federal funding for each Aboriginal child apprehended by child protection agencies. Child welfare agents, often from white middle-class backgrounds, would evaluate the families and homes of Aboriginal children according to their own standards and values.

These homes were often perceived to be overcrowded and unkempt. Government policies and systemic racism had created intergenerational poverty for many First Nations, Inuit, and Métis families. In addition, parents were often the product of the residential schools, many continuing to suffer the long-term impacts of abuse and neglect and of having grown up without access to their parents and thus to parenting skills. Rather than addressing the underlying socioeconomic issues, child welfare agents began removing Aboriginal children from their parents. Acting “in the best interest of the child,” this accelerated removal of Aboriginal children from their homes over several decades came to be known as the Sixties Scoop.

In 1955, there were 3,433 children in the care of B.C.’s child welfare branch. Of that number it was estimated that 29 children, or less than 1 percent of the total, were of Indian ancestry. By 1964, however, 1,446 children in care in B.C. were of Indian extraction. That number represented 34.2 percent of all children in care. Within ten years, in other words, the representation of Native children in B.C.’s child welfare system had jumped from almost nil to a third. It was a pattern being repeated in other parts of Canada as well.¹⁶

CLINICAL TIP

Recognize that many First Nations, Inuit, and Métis women, families, and communities have had significantly negative experiences with child protection and social services personnel, and that it can have a profound effect on their interaction with the health care system.

In addition, between 1937 and 1972, thousands of forced sterilizations occurred among Aboriginal women in Alberta and British Columbia. As a result there is a notable wariness on the part of Aboriginal women when it comes to any discussion about contraception. Fear that there is a relation between routine Pap smear testing and sterilization makes some women wary of having this testing done during the well-woman visit. Health professionals should be aware of this historical context when discussing contraception and Pap testing with First Nations, Inuit, and Métis women.

For an Aboriginal person who was born at the turn of the last century, it is not unreasonable to imagine a series of life experiences and the overwhelming confusion, isolation, and sadness that would accompany them. In their lifetime, they saw the last days of living the traditional ways. They experienced the impositions of the *Indian Act* in their families and communities. Entire Inuit communities were displaced. First Nations, Inuit, and Métis children were taken from their families and forced to attend schools far

away. Their ties to the land, ice, and water were continually questioned and dishonoured. Resources were extracted without permission or surrender. They continued to live in poverty while the rest of Canada developed. Their grandchildren were removed by social services. Intergenerational or historical grief has been described as entering into this world as a Native with the burden of centuries of suffering behind you. This grief is even more pronounced in the collectivist or egalitarian orientation of the Indigenous world view.¹⁷

Despite overwhelming odds Aboriginal peoples demand fair and equitable treatment. The resilience of First Nations, Inuit, and Métis women in this struggle is profound.

Summary Statement

5. The intergenerational trauma experienced by First Nations, Inuit, and Métis is the product of colonialization. Residential schools, forced relocation, involuntary sterilization, forced adoption, religious conversion, and enfranchisement are a few examples of government policy towards First Nations, Inuit, and Métis that have created intergenerational posttraumatic stress and dysfunction. However, they continue to be a resilient people. (III)

As mentioned, the World Health Organization Commission on the Social Determinants of Health focused on 9 broad areas containing key determinants of health: globalization, public health conditions, health systems, urbanization, gender and gender inequity, social exclusion, early childhood development and education, employment conditions, and measurement or evidence. In this next section, we will review each of these 9 areas with First Nations-, Inuit-, and Métis-specific examples and perspectives.

GLOBALIZATION

To a large extent, globalization is fuelled by the disbursement of the earth’s resources and the associated economics. A question of money, power, and resources, the processes and outcomes of globalization have vast implications on population and community health, as well as on the health of the land, waters, air, and ice.

Canada is considered an international economic leader. Our main source of GDP continues to be the exportation of natural resources, most importantly minerals, oil, and eventually water.¹⁸ However, these natural resources are extracted from lands, ice, and water that for the most part are embroiled in continued negotiations with First Nations and Inuit. This results in First Nations and Inuit

communities relying on insufficient money transfers from the federal government and the social welfare system while a large proportion of Canada's GDP is funded by monies garnished from Aboriginal lands.

The Métis—who do not receive federal transfers—have negotiated settlements at the regional level, including co-management agreements regarding natural resources under Settlement lands. The *Metis Settlements Accord* is a package of legislation and financial agreements between the Métis Settlements and the province of Alberta. This includes a *Co-Management Agreement* between the Métis Settlements and the province of Alberta regarding the long-term management of natural resources under Settlement lands.¹⁹

Summary Statements

6. Most Canadians are unaware that a large proportion of Canada's gross domestic product is funded by monies garnished from natural resources extracted from Aboriginal lands, while First Nations and Inuit communities rely on insufficient money transfers from the Federal government. (III)
7. Multinational companies extract resources from lands that are often on or adjacent to Aboriginal communities, or lands that are under land claims negotiations. The management of lands and resources by the provinces in some regions and by the territorial and federal governments in other regions has made it difficult for First Nations Inuit and Métis communities to communicate with multinational corporations, especially where land claim negotiations are ongoing or non-existent. Multinational corporations do not provide revenues to these communities. Most Aboriginal communities are impoverished without adequate public health infrastructure, and without economic capital to improve their condition. (III)

Recommendation

6. Health professionals should be aware that the discourse on health care policy and land claim negotiations often perpetuates negative stereotypes and often occurs without accurate reference to colonialization. (III-L)

PUBLIC HEALTH CONDITIONS AND HEALTH SYSTEMS

Many diseases have been contained or almost eradicated in Canada with the advent of better living conditions, availability of antibiotics, immunizations, new technology, and the universality of health care.²⁰ However, inadequate,

insufficient, and unsafe housing, lack of basic sanitary infrastructure, and food inaccessibility are commonplace in most First Nations, Inuit, and Métis communities.²¹ Jurisdictional conflicts between the federal, provincial, territorial, and Aboriginal governance systems (Bands for First Nations and Municipal Representatives for Inuit) make it difficult to provide comprehensive public health and health services. The federal government has the mandate for the management of funds, including the provision of public health infrastructure, on reserves. Off reserve, in accordance with the *Land Transfer Act*, provincial governments are responsible for health, social services, roads, and infrastructure.

As of November 2011, 131 First Nations communities were under a boil-water advisory. Access to clean drinking water and nutritious food is of particular concern for pregnant and lactating women and their children. The quality and variety of healthy food choices is limited in Aboriginal communities, and a food security study conducted in Nunavut found that “half of those surveyed reported there was not enough to eat in the house in the previous month.”²² Up to 70% of Inuit preschoolers in Nunavut live in food-insecure homes.²² It is also not uncommon to find a house with at least 20 people living within it, with only one toilet. Overcrowded housing is a particular public health concern in Inuit communities, with significant implications for communicable diseases such as tuberculosis.²³ (Tuberculosis rates in Inuit communities have doubled since 2006 and are currently 185 times higher than the rates for non-Aboriginal Canadians.²³) Garbage collection is variable. The regulation of disposal of hazardous waste, garbage landfills, incinerators, and pollution from industry in and adjacent to First Nations reserves is generally absent. The implications for the general health of those who live, eat the meats and fish, drink the water, and procure traditional herbal medicines from the areas near these sites are easily understood.

Katsi Cook, Mohawk midwife, argues that this attack upon nature is yet another attack on Native women's bodies because the effects of toxic and radiation poisoning are most apparent in their effect on women's reproductive systems. In the areas where there is uranium mining, such as in Four Corners and the Black Hills (United States), Indian people face skyrocketing rates of cancer, miscarriages, and birth defects. Children growing up in Four Corners are developing ovarian and testicular cancers at fifteen times the national average (Taliman 1992). Meanwhile, Indian women on Pine Ridge experience a miscarriage rate six times higher than the national average (Harden 1980, 15). And on the Akwesasne

Mohawk reserve, one of the most polluted areas in the country, the PCBs, DDT, Mirex, and HCBs that are dumped into their waters eventually become stored in women's breast milk (Contaminated 1994, 11). Through the rape of earth, Native women's bodies are raped once again.²⁴

Summary Statement

8. Jurisdictional issues today make it difficult to provide health care, take care of the land, and promote healthy communities. (III)

Recent knowledge of the effects of environmental contaminants on the health of susceptible First Nations, Inuit, and Métis populations suggest that there are contaminants in country foods. Further research on this is needed, however, and it is argued that "the benefits of eating country foods still outweigh the risks, particularly when the cultural, economic, and nutritional value of traditional foods is factored in." As access to traditional foods is increasingly affected by climate change, the protein and nutrient intakes of already food-insecure households are projected to decline significantly.²⁵⁻²⁷

CLINICAL TIP

Arctic char and caribou carry low levels of contaminants, and pregnant and lactating women are actively encouraged to consume these foods.²²

Summary Statement

9. Eating traditional country foods helps to preserve cultural identity, but increasing environmental contaminants such as lead, arsenic, mercury, and persistent organic pollutants may compromise food safety. (II-3)

URBANIZATION

While urbanization offers benefits such as increased economic opportunity, access to health services and education, and professional development opportunities, migration from the reserves to the cities, and mobility within cities, often occurs in the absence of viable alternatives. Poverty, poor employment opportunities, low education, violence, and single parenthood are among key factors spurring the increasing mobility. While the process of moving to an urban centre does not necessarily lead to negative health outcomes, acculturation and rapidly changing lifestyles have been shown to result in a greater incidence of chronic disease.⁵ Racism and social exclusion also carry unique and gender-specific health implications. For example, it is well known that women who are isolated and living in poverty are in a vulnerable position, forced to take up work under exploitative terms and conditions. However, it is important to note that the outcomes of

urbanization of First Nations, Inuit, and Métis are variable across individuals, families, and communities. Although First Nations, Inuit, and Métis do have a greater chance of living in poor neighbourhoods, they can increasingly be found living all across different urban Canadian centres, and many are working to build communities and cultural continuity in cities.²⁸

Summary Statement

10. Given demographic shifts such as rapidly growing populations with large youth cohorts and the increasing urbanization of First Nations, Inuit, and Métis in Canada, it is an important reality that most clinicians will encounter First Nations, Inuit, and Métis in their practice. (II-3)

GENDER AND GENDER INEQUITY

Indigenous societies were often matriarchal or egalitarian, and gender roles within many First Nations, Inuit, and Métis communities are often described as complementary, with defined social, political, and spiritual roles. For example, women often held the knowledge of medicines, including those used to terminate pregnancy, induce labour, ease the pain of labour, and enhance breast milk. During colonization, this was overturned.^{29,30}

The historical record both ignored female strengths and redefined their position.

The male missionaries, the male Indian Agents, the male traders, and the male clergy often found themselves bargaining with Aboriginal women at contact, and each refused to accept the emancipated position of the Aboriginal woman.³¹

The complementary positions of First Nations, Inuit, and Métis women and men were further eroded by different pieces of legislation. For example, the *Indian Act*, which defined a woman's Status in relation to her father and husband, and forbade traditional hereditary transfer of lands to a woman, thus removing the female as the protector and title-holder of the land. Later, in 1986, the Supreme Court of Canada ruled that provincial and territorial laws pertaining to matrimonial real property do not apply on Indian reserves. Therefore, when a marriage or relationship ends, if the parties do not agree, the law does not protect a woman who has left a relationship from losing her home.³¹ The residential schools and the Sixties Scoop removed First Nations, Inuit, and Métis women from their role as mothers, preventing them from passing on medical information, oral history, ceremonies, and values.

The control over women's reproductive abilities and destruction of women and children are essential in destroying a people. If the women of a nation are not disproportionately killed, then that nation's population will not be severely affected. Native women and children were targeted for wholesale killing in order to destroy the Indian nations (1992, 121). This is why colonizers such as Andrew Jackson recommended that troops systematically kill Indian women and children after massacres in order to complete extermination.³²

Summary Statement

11. Traditionally, men and women in First Nations, Inuit, and Métis cultures enjoyed equal and complimentary roles. Colonialization generally led to First Nations and Inuit women being objectified, disrespected, and ignored. Through specific pieces of legislation, First Nations women in particular lost their voices and powers within their communities, including their role in promoting traditional health and education. (III)

SOCIAL EXCLUSION

Much of the Canadian health care system and health research fails to appreciate the dimension of social exclusion on women's health outcomes. First Nations, Inuit, and Métis, racialized group members, and recent immigrants have been identified as the most marginalized groups in Canadian society. Social exclusion refers to the structures and "processes in which individuals and entire communities of people are systematically blocked from rights, opportunities, and resources that are normally available to members of society and which are key to social integration."³²

EARLY CHILDHOOD DEVELOPMENT AND EDUCATION

Early childhood development refers to the growth that takes place from pre-conception until the age of 6, when neuronal plasticity is at its peak. A meta-analysis of 38 studies examining neonatal outcomes among Aboriginal women revealed increased rates of low birth weight, preterm birth, stillbirth, and neonatal mortality when compared to non-Aboriginal women.²⁰ There are a number of programs in place that aim to offset the complex negative factors within the social and cultural environment of children to improve their readiness and success for primary school. The Aboriginal Head Start program is one successful example. Further efforts are needed to ensure these programs are accessible to all communities

EMPLOYMENT CONDITIONS

Unequal and insecure employment opportunities and income disparity negatively affect health, resulting in economic strain and associated social and economic stresses.³³ Approximately 14.8% of Aboriginal people in Canada are unemployed, compared with the national average of 6.3%.³⁴ Although unemployment rates for Aboriginal people in Canada are improving, Figure 3.2 indicates that unemployment rates for Aboriginal people continue to be significantly higher than in the general Canadian population.³⁵

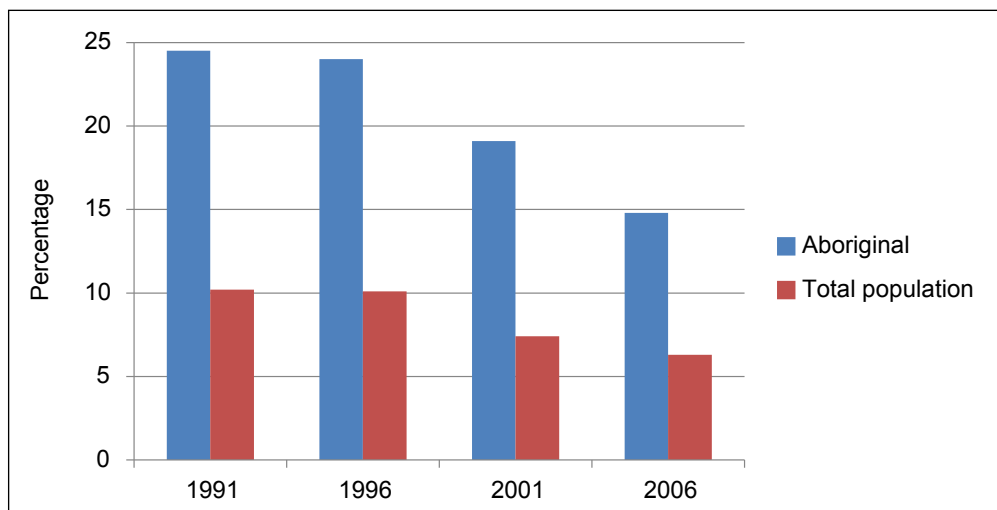
An estimated 35% of Aboriginal women live in poverty. As a result of chronic unemployment and underemployment, Aboriginal women are more likely to live in substandard and overcrowded housing, to cope with food insecurity, and to have poor nutrition. Aboriginal women are also less likely than non-Aboriginal women to finish high school or graduate from college. According to one study, 39% of Aboriginal single mothers earn less than \$12 000 a year. This has important implications for their housing and food security, their care for their children, and their opportunities to engage in higher education.³⁶ The lack of employment among First Nations, Inuit, and Métis is also viewed as a significant social problem by the communities themselves, as seen in the Aboriginal People's Survey, in which 67.1% of residents indicated that unemployment was their most important social issue.³⁷

Summary Statement

12. The unemployment rate is much higher in Aboriginal communities than in those of non-Aboriginal Canadians. This is a major contributor to the gaps in socioeconomic status and access to equitable and quality health care. (II-3)

MEASUREMENT AND EVIDENCE

Epidemiology is the study of the distribution and determinants of disease frequency in human populations. Certain sentinel outcomes have been identified and are measured over time to help evaluate the effectiveness of health prevention strategies. Unfortunately, many of these health prevention strategies have focused on risk reduction, and are often linked to lifestyle behaviours. When risk factors are removed from their historical, social, and economic contexts, there is the potential to encourage or reinforce the development of negative stereotypes. For example, it is well known that smoking, age at first sexual contact, multiparity, and history of sexually transmitted diseases are all risk factors for cervical cancer. It is also increasingly recognized that Aboriginal women have a

Figure 3.2. Unemployment rates according to 1991, 1996, 2001, and 2006 Canadian Census

higher incidence of cervical cancer and related mortality. In isolation, such epidemiological data readily lend to stereotypes characterizing Aboriginal women as lascivious or lacking in will power, judgement, or moral fortitude, while social, geographic, and financial barriers to screening and follow-up are easily overlooked. Furthermore, the language of “supporting” First Nations, Inuit, and Métis to take greater responsibility implies that First Nations, Inuit, and Métis do not already struggle to protect and promote their own health and well-being.

Summary Statement

13. The language of health outcome measurement often perpetuates negative stereotypes towards First Nations, Inuit, and Métis because outcomes are reported out of the context of the social, political, and economic circumstances. (III)

As illustrated in this chapter, there is a growing body of knowledge clearly indicating the impact of social determinants on First Nations, Inuit, and Métis women’s health. It is imperative for health professionals to realize that First Nations, Inuit, and Métis survive despite incredible structural forces aimed at assimilation, and yet in practice resulting in systematic marginalization and exclusion with unacceptable sexual and reproductive health consequences. In spite of this, their resiliency, collectivity, and holistic view of health remain strong, representing an essential aspect of communities, individuals, and leaders striving to advance the health and status of Aboriginal people in Canada. Self-determination has become well-regarded as a key enabling component in advancing health outcomes in First Nations, Inuit, and Métis communities.

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Health Systems, Policies, and Services for First Nations, Inuit, and Métis

After Confederation in 1867, the federal government was deemed to be responsible for First Nations and their reserves. In 1871, Indian Agents were appointed to administer First Nation affairs and to implement the conditions of the Numbered Treaties, including medical care.

Although there has been considerable controversy regarding the extent of governmental health care obligations towards First Nations and Inuit, provision of health care services for First Nations communities was part of at least some treaty negotiations.

“The ‘medicine chest clause’ of Treaty No. 6 has been interpreted by many as evidence that the provision of health care services by the federal government is a negotiated treaty right.”¹ This forms the basis of delivery of health care by the Canadian government. It should be noted that the federal government still provides funds per capita that are significantly less than the amount the provincial governments provide for the general population.

Medical services and benefits are provided to First Nations and Inuit through a complex process and providers are then reimbursed by the federal government for services provided to Status Indians and enrolled Inuit. This is guided by the *Canada Health Act*.² Health care services include insured hospital care and primary health care, such as services by physicians and other health professionals. What is not covered by provincial and territorial health insurance may be covered by the First Nations and Inuit Health Branch, Health Canada, through the NIHB program. This national program provides coverage for benefit claims for a specified, medically necessary range of drugs, dental care, vision care, medical supplies and equipment, short-term crisis-intervention mental health counselling, and medical transportation to eligible First Nations and Inuit who are not covered under other insurance.³

Aboriginal Affairs and Northern Development Canada also has a role in improving the health and well-being of Aboriginal and northern individuals, families, and

communities. This heterogeneous structure has led to a fairly complicated service delivery system with jurisdictional gaps and overlaps. First Nations and Inuit communities living in remote, fly-in communities face additional challenges accessing health services. Inuit, particularly those living in the North, have distinct needs which are difficult to meet with standard models of health care delivery. The rural and remote location of many Inuit communities creates barriers in access to appropriate, coordinated, culturally safe care. Most communities are largely serviced by a nursing station staffed with a nurse or community health representative with physicians and other specialists periodically flying in. Inuit who require access to advanced care must be transferred to southern Canadian cities.⁴ This includes almost all pregnant Inuit women, who are flown to southern cities several weeks before giving birth.⁵

There is a unique situation in the Yukon, in which First Nations can be “beneficiaries” of their First Nation whether or not they have Status under the *Indian Act*. In this case, First Nations have the right to take over (or “take down”) the responsibility for providing programs and services to their citizens. A community that has taken down has acted on that right and has taken over the responsibilities of the federal and/or territorial governments. First Nations that have taken down program areas are therefore responsible for delivering them, and receive a lump-sum transfer payment to do so. NIHB still provides funding to Yukon First Nations on the basis of the number of registered Status Indians they have as members and many Yukon First Nations will pool the resources of the health transfer payments and the per person benefits provided through NIHB, and redistribute them to beneficiaries, both Status and non-Status. While this improves health outcomes for non-Status health beneficiaries, it simultaneously decreases resources available for Status beneficiaries, which are already limited through NIHB.

The complexities and challenges of the design, delivery, and implementation of health services and policies for

First Nations and Inuit have clear implications on access to quality, timely, and culturally safe care. An example of the complexities and challenges is the case of Jordan River Anderson of Norway House Cree Nation.

Jordan's Principle

Jordan was a child with severe medical needs who was ready to go home from hospital when he was 2 years old; however, he went on to spend over two more years in hospital unnecessarily because the Province of Manitoba and the Government of Canada could not agree on who should pay for his at-home care. Jordan died at the age of 5 having never spent a day in a family home while the governments continued to argue. "Jordan's Principle" is a child-first principle that calls upon the government agency of first contact to pay for services for a child and to seek reimbursement later, if appropriate, so the child does not become tragically entangled in government red tape. Jordan's Principle applies to all government services and must be adopted and fully implemented by the Government of Canada and all provinces and territories.⁶

BC Tripartite Framework Agreement

Transferring control of health care into First Nations hands may yield better success. Such a transfer occurred in British Columbia with the signing of the BC Tripartite Framework Agreement on October 13th, 2011. This agreement between the Government of Canada, the BC First Nations Health Council, and the Government of BC allowed for the creation of the BC First Nations Health Authority, which administers federal health services to First Nations in BC.⁷

Although Métis are one of the founding peoples of Canada, and continue as a group to experience significant health disparities, they are considered by the federal and provincial governments to be part of the non-Aboriginal population. This means that Métis do not have access to the additional health services delivered to First Nations and Inuit by the federal government.⁸ Métis groups have argued for many years that as one of the founding peoples of Canada they should receive the same additional considerations which First Nations and Inuit receive from the federal government.⁹

There are useful resources to help health professionals learn more about the health care systems and specific policies relevant to their First Nations, Inuit, and Métis patients, including the Assembly of First Nations' benefits guide to the NIHB Program¹⁰ and the SOGC's Aboriginal Health Initiative's reference sheet on NIHB, which is available through the SOGC website.¹¹

CLINICAL TIPS

Go to the website for Non-Insured Health Benefits¹² and familiarize yourself with the program.

Familiarize yourself with the logistics of specialist care in your region or centre, including the surrounding Aboriginal communities serviced by your centre and what particular services are provided in each centre.

Summary Statement

14. Jurisdictional conflicts between federal, provincial, territorial, and band governments make it difficult to provide comprehensive public health and health services to First Nations. (III)

Recommendations

7. Health professionals should be aware of ongoing debates regarding jurisdictional responsibilities that impede access to good quality, timely, and culturally safe health care for First Nations and Inuit, and of Jordan's Principle. Jordan's Principle calls on the government agency of first contact to ensure that children get necessary and timely care by paying for services immediately and seeking reimbursement from the appropriate agency later. (III-A)
8. Health professionals who provide care to First Nations and Inuit should be aware of the Non-Insured Health Benefits program, its eligibility and coverage requirements, and the exceptions and special permissions needed in some cases. Health professionals should recognize that they have a vital role in advocating for their First Nations and Inuit patients and assisting with obtaining these benefits. Health professionals should be aware that Métis do not have access to Non-Insured Health Benefits and may face unique challenges accessing health care. (III-A)

While First Nations, Inuit, and Métis make up approximately 4% of the Canadian population, Aboriginal health professionals are very under-represented. In 1996, the *Report of the Royal Commission on Aboriginal Peoples* identified Aboriginal human health resources as a key element in the potential success of new approaches to health and healing and recommended that "governments and educational institutions undertake to train 10 000 Aboriginal people in health including professional and managerial roles, over the next decade."¹³ Quota systems have been developed in a number of Canada's post-secondary institutions for training health professionals with an emphasis on increasing the number of Aboriginal health professionals. In addition, IITK recently published the *2011–2021 Inuit Health Human Resources Framework and Action Plan* whose goal is to advance Inuit health

by creating an Inuit workforce that will deliver a full spectrum of health and wellness services within Inuit communities, primarily in the Inuit language.¹⁴

Traditional healing and Traditional midwifery also present important AHHR issues. Midwives are women with specialized knowledge in prenatal care, birthing assistance, and aftercare. The midwife may use massage, diets, medicines, ritual, prayers, and/or counselling. Midwifery practice was discredited and discouraged through colonialization; however, Aboriginal midwifery is currently regaining an important and respected role in many Aboriginal communities. Legislative variability, access, recruitment and education, and peer support are midwifery AHHR issues that need to be further examined and addressed.¹³

Recommendation

9. All health professionals should acknowledge and respect the role that Aboriginal and Traditional midwives have in promoting the sexual and reproductive health of women and should be aware that this role is not limited to pregnancy and delivery, but often extends beyond the birth year. (II-2A)

FIRST NATIONS, INUIT, AND MÉTIS VIEWS OF HEALTH

There are important distinctions between and among First Nations, Inuit, and Métis views of health and wellness. There are, however, a number of values that appear to be universal within an Aboriginal view of health. These include respect, humility, holism, and balance. For example, Eurocentric views of health and health care tend to function hierarchically, with a focus on patient compliance. Health professionals are seen as superior, and the expectation is for their patients to respect and comply with their advice. Respect is a significant concept in many First Nations, Inuit, and Métis communities. However, the focus is on mutual respect rather than on deference. It means understanding and acknowledgement without judgement of another person's behaviour, believing that that individual will do what is best for her situation with the skill set that she has. Respect is the key to providing culturally safe care to First Nations, Inuit, and Métis individuals, but it is the area where European medicine is most likely to cause offence due to its directive model. Among many Indigenous peoples, when two members of a relationship treat each other as equals, they are practicing humility. First Nations, Inuit, and Métis in Canada perceive health as holistic, encompassing a balance between physical, emotional, mental, and spiritual elements. The importance

of balance also extends beyond the individual to include the family, the community, and the environment. Close linkages and balanced relationships with land, water, and ice, and with their communities and their societies govern their sense of well-being.

First Nations, Inuit, and Métis have strong, unique traditions of health and healing. These include the use of traditional plant- and animal-based medicines, teachings, and ceremonies, all of which help to maintain or restore the balance and health of individuals, families, and communities. Examples include the medicine wheel teachings, the medicinal use of Labrador tea, the sweat lodge ceremonies, smudging, and the offering of tobacco.

COLONIALIZATION OF FIRST NATIONS, INUIT, AND MÉTIS HEALTH BELIEFS, VALUES, AND TRADITIONAL PRACTICES

Before contact with European settlers, First Nations and Inuit healers bore the responsibility of health for their people and relied upon a rich body of knowledge of traditional medicines and sociocultural practices. Milestones in individuals' lives were marked with birth celebrations, naming ceremonies, puberty ceremonies, coming of age ceremonies, and death ceremonies. Given that the Métis did not exist pre-contact, traditional healing practices must be viewed through a control test which identifies those practices which existed prior to the establishment of European controls over health in a given area.¹⁵

After years of imposed governance structures, relocations, displacements, and the residential school system, First Nations, Inuit, and Métis have witnessed the outlawing, discrediting, and loss of their traditional healers, beliefs, values, and traditions. Practised traditions were lost in time, and the effect on societal structure was an overturning of generations of knowledge, which was the cause of many social ills, as people lost sight of their roles and values within their families and communities.

It is important to note that many First Nations, Inuit, and Métis families converted to Christianity, and this continues to be a central influence on contemporary values and beliefs.

In spite of widespread criticism and skepticism, not to mention explicit efforts to discredit traditional healers and their knowledge in some academic circles, traditional medicine is increasingly acknowledged as a coherent set of "... beliefs and practices which are well integrated within Aboriginal societies and which served important social and religious as well as medical functions".¹⁶ Even so, many

health professionals have been much more accepting of naturopathic and other traditional and natural forms of medicine and healing than of First Nations, Inuit, or Métis approaches. Herbal remedies are part of cultural healing and health. Through the work of traditional healers and ethnobotanists to quantify the benefits of traditional medicine, “more than 170 drugs which have been or still are listed in the *Pharmacopoeia of the United States of America* owe their origin to Aboriginal usage”.¹⁷

Recommendations

10. Health professionals should inquire about their patients’ use of traditional medicines and practices as part of routine health practices, including prenatal care. (III-A)
11. Health professionals should be aware that each First Nations, Inuit, and Métis community has its own traditions, values, and communication practices and should engage with the community in order to become familiar with these. (III-A)

CLINICAL TIPS

Recognize that women have the right to make informed decisions in all aspects of their sexual and reproductive health care, including the right to use traditional knowledge exclusively or in combination with Western medicine.

In your clinic communicate warmth, understanding, and culturally safe public health information that is relevant to First Nations, Inuit, and Métis.

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First Nations, Inuit, and Métis Women's Sexual and Reproductive Health

First Nations, Inuit, and Métis women experience a disproportionately high rate of adverse health outcomes, including sexually transmitted infections, complications in pregnancy and delivery, and sexual violence. Efforts to improve sexual and reproductive health must aim to reduce inequities in the availability and accessibility of sexual and reproductive services for First Nations, Inuit, and Métis women.

HEALTHY SEXUAL RELATIONSHIPS AND THE LEGACY OF COLONIZATION

Like most women, First Nations, Inuit, and Métis women strive for healthy sexual relationships. Sexuality and healthy sexual relationships in First Nations, Inuit, and Métis communities are celebrated, and the roles and responsibilities that each partner assumes in the relationship include an attitude toward equality, generosity, tenderness, trust, and patience. Although a number of social determinants of health affect First Nations, Inuit, and Métis women's abilities to achieve these goals, it is important for health professionals to recognize efforts towards approaching sexual and reproductive wellness from the strength-based perspective of healthy relationships.

Many patriarchal societies ascribe to a hetero-normative ideal. In contrast, many Indigenous cultures traditionally had more complex non-binary concepts of gender and sexuality and have long recognized the existence of a third and even a fourth gender, which cannot be defined as solely male or female. At the first Aboriginal lesbian, gay, bisexual, transgender conference held in Winnipeg in the early 1990s, the English term "two-spirit" was coined. The Northeast Two-Spirit Society defines two-spirit as a modern universal phrase that can be applied to Native Americans who are LGBT. Use of the term carries with it the general inference of respect to the traditional role that a LGBT individual would have played among their people(s) prior to colonization.¹ As a result of ongoing colonialization, gender non-conformity in children and adults is now a source of psychological stress, and self-identification of two-spirit, lesbian, gay, bisexual, transsexual, transgender, intersex,

queer, questioning, two-spirited, and allied people in First Nations, Inuit, and Métis cultures is now often fraught with heterocentrism, homophobia, and transphobia.

It is increasingly well-established that the destruction of traditional culture has put women and children at increased risk of sexual violence.² Rape and incest were portrayed by ancient societies, so these did not occur de novo with colonialization. However, First Nations, Inuit, and Métis governance structures had mechanisms to ensure punishment for sexual offenders. Traditional approaches to healing a community after incidents of sexual abuse involved healing both the victim and the abuser.^{3,4} Sexual abuse increased as women's social position was devalued during colonialization and as cycles of abuse were created through the residential school system.

Rates of child sexual abuse vary between studies and communities; however, in compiling data from 20 studies, Collin-Vezina et al. determined that up to 50% of Aboriginal adults were sexually abused before the age of 18.³ It is important to note that this estimate excludes studies of very high-risk populations such as sex workers. In addition, very few of the studies distinguished between First Nations, Inuit, and Métis, instead referring to Aboriginal or Native. There are currently limited data on rates of sexual abuse among Métis, however more and more Métis victims are coming forward to report sexual abuse, suggesting that rates are likely to be close to those experienced by First Nations. Sexual offences against children have an incidence of 11.4 per 100 000 in Canada, and that rate increases to 14 per 100 000 for the First Nations population.² This number is likely an underestimate, given that disclosure rates are as low as 3% to 5%. Sadly, victims often go unrecognized and their abusers go undetected.³ The legacy of sexual abuse is intergenerational, and victims and abusers struggle with being the victim and the abuser, with being related, or with being close to each other in a community.

Health care providers should also be aware of the provincial and federal laws that govern their area with regard to sexual activities involving persons under the age of 18.

There are specific laws regarding sexual activity in children under age 12 and between 12 and 16, and regarding the age difference between partners. Children under the age of 12 do not have the legal capacity to consent to any form of sexual activity, and sexual activity with a child under 12 is a reportable crime. If sexual activity in a child under the age of 12 is suspected, health professionals should approach the issue with sensitivity in conjunction with social services.

Recommendation

12. Health professionals should be aware of *Canadian Criminal Code* laws governing sexual activities in minors, including those under age 12, those between 12 and 16 years old, and those with a much older partner. (III-A)

Aboriginal women are the most at-risk group in Canada for violence: 10% of Canadian women who are murdered are Aboriginal, even though Aboriginal women make up only 3% of the population. There are also inequities in the justice system with regard to violence against women, especially for those women involved in sex trade work. First Nations, Inuit, and Métis women often face significant barriers to reporting physical and sexual violence to authorities, and fewer of their reports result in convictions; 50% of murders of Aboriginal women are still unsolved.⁵

Summary Statement

15. The harmony of First Nations, Inuit, and Métis societies was disrupted by European colonialization at the end of the 18th century, causing widespread effects on the sexual health of First Nations, Inuit, and Métis women and men. (III)

Recommendation

13. Given the prevalence of sexual abuse and exploitation, health professionals must address the possibility of sexual abuse or exploitation once a trusting relationship has been established. All gynaecologic and obstetric examinations must be approached sensitively, allowing the patient to determine when she feels comfortable enough to proceed. (III-A)

SEXUALLY TRANSMITTED AND BLOOD-BORNE INFECTIONS

The incidence of STBIs among First Nations, Inuit, and Métis is higher than in the general population. Marginalization, low socioeconomic status, and high rates of sexual abuse can give rise to women with lower self-worth, who may not use barrier contraception as often with new partners, and who may be vulnerable to exploitation and violence.

HIV/AIDS

First Nations, Inuit, and Métis are disproportionately affected by HIV/AIDS. The prevalence of HIV/AIDS in First Nations, Inuit, and Métis is increasing, and the fastest growing subset of new HIV cases is intravenous drug users.^{6,7} HIV affects Aboriginal women at higher rates than non-Aboriginal women, with close to half of positive Aboriginal HIV test reports between 1998 and 2008 representing women. Aboriginal youth are also more affected, with 19% of reported AIDS cases among Aboriginal people between 1979 and 2008 in youth between 15 and 29.^{7,8}

According to Larkin, HIV/AIDS research has overemphasized the increased incidence and prevalence of HIV/AIDS while the social determinants of health are too often overlooked.⁹ Examining social determinants of health such as employment, education, housing, social exclusion, etc. shifts the focus of HIV prevention activities from individual behaviours, potentially stigmatizing and discriminating against individuals, to structural, systemic factors which constrain the individual's behaviour.

There is a significant body of research which has examined the most effective prevention approaches for First Nations, Inuit, and Métis women. Recent research has suggested the effectiveness of a strength-based approach to HIV prevention. This approach involves emphasizing the power and strength that women possess and re-affirming their value as members of their families and communities. For example, Kecia Larkin, an Aboriginal AIDS activist, coined the acronym PAW for Positive Aboriginal Women. Other research also indicates that prevention efforts are more effective when begun early in a woman's life. By working to improve the safety and well-being of a woman early on in her life, it is possible to reduce the chance of her engaging in risk-taking behaviours later on in her life. Research also indicates that prevention efforts are more effective if they focus on harm-reduction, for example by encouraging women to engage in safe sex rather than no sex. The Canadian AIDS Treatment Information Exchange has produced a document that outlines the key success factors for Aboriginal HIV prevention initiatives.¹⁰ Pauktuutit Inuit Women of Canada also has a fact sheet available.¹¹

Research has identified certain barriers and facilitators to HIV testing for Aboriginal people in Canada. Individuals are more likely to obtain an HIV test if they are two-spirited, have had prior testing for STIs, currently use cocaine, or have self-described poor use of drug paraphernalia. First Nations on reserve and those over 40 are less likely to have HIV testing.¹² Analysis of content of Aboriginal newspapers and literature has shown there is an erroneous

assumption that the individuals at greatest risk are men who have sex with men, and risk via heterosexual and vertical transmission is often overlooked completely.¹³

PREGNANCY WITH HIV/AIDS AND PERINATAL TRANSMISSION

Fetal transmission of HIV (vertical transmission) can occur when the mother is infected. Prenatal treatment with antiretroviral therapy continues to be the best prevention to protect the fetus from infection. HIV infection among pregnant women in Canada is estimated to be only between 0.2% and 0.9%; however Aboriginal infants are more likely than non-Aboriginal infants to acquire HIV perinatally.⁸ Rates of transmission are 5% with a Caesarean delivery, or as high as 20% with a vaginal delivery. Post-delivery, it is recommended that the mother avoid breastfeeding, as HIV can also be transmitted through breast milk to the newborn/infant. The provision of care by a multidisciplinary team is also important for ongoing follow-up and support for those who have substance dependence and other complex social issues.

There is currently very little information regarding strategies for preventing perinatal transmission of HIV for First Nations, Inuit, or Métis women. Given that Aboriginal infants are overrepresented among infants who acquire HIV perinatally, and the increasingly young age of HIV exposure for Aboriginal women, innovative strategies are needed to decrease the rate of HIV infection among First Nations, Inuit, and Métis with child-bearing potential.

Although evidence indicates no significant difference in response to HAART between Aboriginal patients and non-Aboriginal patients, Aboriginal patients have a mortality rate approximately 3 times that of non-Aboriginal patients after initiating HAART. This may be due in part to a higher incidence of co-infection with hepatitis C virus; however, some studies also suggest that Aboriginal people may have variable access to HAART. NIHB coverage applies only to people registered under the *Indian Act* of Canada, meaning that some Aboriginal patients, Métis in particular, may have trouble obtaining needed care and treatment. There is a process for appeal if an Aboriginal person is denied coverage for HIV medication.¹⁴

CHLAMYDIA AND GONORRHOEA

Chlamydia and gonorrhoea have a high prevalence among First Nations and Inuit.¹⁵ Tests for chlamydia and gonorrhoea should be undertaken at least yearly in younger women who are sexually active whether or not they have a steady partner, as this will not always confer protection to them. Research has demonstrated support for universal screening

in communities with STI prevalence rates of more than 10%.¹⁵ It is critical to ensure confidentiality of testing, which can be especially challenging in small communities.

Recommendation

14. Health professionals should be aware of the increased prevalence of HIV/AIDS among First Nations, Inuit, and Métis and should offer HIV counselling and screening to women who are pregnant or of child-bearing age. Culturally safe approaches to HIV and other hematogenously transferred disease counselling, testing, diagnosis, and treatment should be supported and adopted. (III-A)

HPV, PAP SMEARS, AND CERVICAL CANCER

HPV is the most common sexually transmitted infection. High-risk, oncogenic strains of HPV cause vulvar, anal, and oral cancers. Low-risk HPV types cause genital warts, recurrent respiratory papillomatosis, and oral or conjunctival papillomas. Vaccination programs across the country may provide the best primary prevention method, as condoms have only been shown to help prevent HPV transmission if they are used consistently. Unfortunately, regional policies on vaccination vary, and this may affect how easily the vaccination is accessed. NIHB unfortunately does not cover the cost of the vaccination for patients, who have to rely on the publicly funded programs to obtain the vaccination. For now, certain ages of girls in schools have been selected for vaccination.

The incidence of cervical cancer for Aboriginal women is up to 3 times that of the non-Aboriginal population in Canada. Cervical cancer mortality is also significantly higher for Aboriginal women. Cervical cancer rates in Inuit women are higher than the national average due to the high prevalence (26%) of oncogenic HPV. These disparities are thought to be a result of barriers to accessing appropriate preventive care, such as geographic and cultural barriers to accessing services, distrust of health professionals and vaccinations, and issues with culturally insensitive communication.¹⁶ First Nations, Inuit, and Métis populations in Canada are young, and by age 16, 60% of Aboriginal women will be sexually active. HPV and cervical cancer prevention efforts are critical, and the HPV vaccine is the widely accepted prevention method.

As earlier discussed, because of the history of forced sterilization and high rates of sexual violence, First Nations, Inuit, and Métis women may be particularly unreceptive to cervical cancer screening and HPV vaccination. The key to successful prevention strategies with First Nations, Inuit,

and Métis women is to understand the specific context of your patient, and overcome the associated barriers by building trusting and safe relationships with your patients.¹⁷

CLINICAL TIP

Truly understanding the personal context of your First Nations, Inuit, or Métis patients, and acquiring their trust takes time; however, it will allow you to provide them with optimal HPV and cervical cancer preventive care that is responsive to their specific needs.

Recommendation

15. Health professionals should be aware of the high rates of cervical cancer and poorer outcomes once diagnosed for First Nations and Inuit patients. Health professionals should strive to limit the disparity between their Aboriginal and non-Aboriginal patients by promoting culturally safe screening options. (I-A)

PLANNING THE FAMILY: CONTRACEPTION, UNINTENDED PREGNANCIES, AND ACCESS TO CULTURALLY SAFE SERVICES

Traditionally Aboriginal women were prepared for childrearing and womanhood by societal cues and teachings they obtained from their extended families during everyday community living, but also through rites of passage, e.g. coming of age ceremonies. The concept of “planning the family” was a key consideration for women, with a focus on their emotional, physical, and spiritual preparedness for parenting rather than only their age.

Contraceptive methods currently covered by NIHB include most oral contraceptive pills, the transdermal patch, the vaginal ring, depot medroxyprogesterone acetate, the copper IUD, and the levonorgestrel intrauterine system. The rate of condom usage among First Nations adults on reserves is 44%.³ The cultural violence imposed on women through forced sterilization has created in some a mistrust of contraceptive methods.

While most women in Canada have access to safe and legal terminations, in some remote areas this service is not as easily accessible. Confidentiality can be difficult to achieve and the stigma of medical travel is enough for some to avoid requesting the service. It is important to note that Aboriginal women have been exercising their right to choose to be pregnant for generations, using traditional medicines to avoid pregnancy and occasionally end unwanted pregnancy.¹⁸ There are 24-hour toll-free telephone services available for women wishing to discuss pregnancy options, as well as pre- and post-termination care. For example, Canadians for Choice hosts a First Nations, Inuit, and Métis Committee to support the

delivery of culturally safe services,¹⁹ as do volunteers from the Native Youth Sexual Health Network.²⁰

In some Aboriginal communities, a teen pregnancy may be a planned, desired pregnancy, and a dense network of extended family may be positioned to help her raise the child. Health professionals should recognize that there is a distinct difference between a pregnant teenager with no social support and a pregnant teenager with the support of a loving partner and parents. Her support network may be well developed no matter how remote her community; conversely, she may be isolated from her support network in a large urban setting where there are few people she knows.

Although there is very little research conducted in this area, health issues more common among Aboriginal women can affect fertility. For example, Aboriginal women tend to experience higher rates of chlamydia which can result in tubal factor infertility. Higher rates of obesity—a result of the transition to a more sedentary lifestyle, along with the heightened food insecurity and limited access to recreational facilities experienced by many Aboriginal women—may result in more women suffering from PCOS/metabolic syndrome, and this may negatively impact their ability to get pregnant. Oral hypoglycemic agents aimed at treating a woman's type 2 diabetes mellitus may in fact help her resume menses and fertility.

CLINICAL TIPS

If a woman is using metformin to regulate her blood sugars, make sure she is aware that ovulation may occur and she could become pregnant. A method of birth control suitable for the individual, taking into consideration her health issues, would need to be selected.

Recognize that some women choose a termination largely out of fear that if carried to term, her child will be taken into care. With the intention of supporting a culturally safe experience that respects a woman's self-determination, health professionals should be careful to inquire about the context surrounding the choice to terminate, as well as the desire to observe a specific ceremony or protocol upon termination. For women who would choose to terminate out of fear that their child would be taken away, health professionals should work with social services and advocate for access to resources that support the woman's choice.

Recommendations

16. Health professionals must ensure that First Nations, Inuit, and Métis women have access to services for all their reproductive health needs, including terminations, without prejudice. Health professionals should strive to ensure confidentiality, particularly in small and fly-in communities. (III-A)
17. Health professionals should recognize pregnancy as a unique opportunity to engage with and affirm the sexual and reproductive health rights, values, and beliefs of First Nations, Inuit, and Métis women. (III-L)

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First Nations, Inuit, and Métis Maternal Health

Many First Nations, Inuit, and Métis experience poor access to quality and culturally safe maternal health care, and are at an increased risk of poor maternal health outcomes, including higher rates of low and high birth weight babies, preterm birth, gestational diabetes, Caesarean sections, and poor access to specialist care due to geographic location, among other outcomes.¹

Maternal health outcomes are a result of genetic and environmental factors. Genetic factors, conventionally seen as non-modifiable, are increasingly evaluated using epigenetics, which will be discussed later. Environmental factors are conventionally seen as modifiable factors, such as behaviours that can impact on obesity and weight gain; diet and exercise, substance abuse, stress and depression, social support, and violence. Each of these environmental factors can be assessed during the prenatal encounter.

THE COLONIALIZATION OF BIRTH

Historically, women were often considered the centre of the Nation or the backbone of the community. They gave birth, raised the children, provided teachings to their younger relatives about the mothering process, understood the medicines that would help them have a less painful birth, stop postpartum bleeding, and promote breast milk, and were involved in women's societies that saw children through the stages of their childhood.

In the 20th century, the birthing process was colonized, and women were no longer the prime caregivers during the birthing process. Presently, in rural and remote communities, pregnant women are transferred midway through their third trimester to distant medical centres to give birth. There, for several weeks, they are often alone, without the help of their families. The birth is not a community event, as traditionally intended.

The absence of birth in a community disrupts the transference of experiential, traditional knowledge. Traditionally, young girls would be present for the labour and the delivery, and learn about the process. They would learn that they were part of a community responsible for the upbringing of this new being. Most importantly, they would see their family

and other women as active participants throughout this intense experience. It easily follows that this experience would impact their future pre-conceptual and perinatal expectations, behaviours, and overall health, including the cultural knowledge and values surrounding birth. Bringing birth back into the hands of the community would have profound, unmeasured implications for both mothers and the women around them. Currently there are efforts to bring back birth to remote and rural communities for women who have low-risk pregnancies. The ultimate goal is to provide the best pre-conceptual and perinatal care possible to ensure that the most pregnancies possible are rendered low risk and the expectant mothers can therefore deliver at home in their communities.

CLINICAL TIP

It is important to many First Nations, Inuit, and Métis women to have family members present when seeing a health professional. The presence of family members at a birth is an important way many First Nations, Inuit, and Métis communities are "reclaiming birth" for their healing. Ensure that there is adequate space and chairs so that everyone can be seated at the same level, including the health professional.

Some traditional practices for birth are still in use today, such as the First Nations and Métis practice of burying the placenta in the lands the child lives on, to ground the child and offer it a sense of belonging and connectedness for the rest of its life. Others believe that the placenta provides nutrients for the mother and may process it for consumption after the birth. Tissue obtained from miscarriages or surgical removal via dilatation and curettage for a missed, incomplete, or therapeutic abortion should be handled in a culturally safe manner. Burial of fetal and/or placental tissue after a miscarriage may be a symbolic event offering much solace to the mother and family.

Certain postmortem evaluations of bodies or organs may be culturally inappropriate. For some peoples, in order for someone to remain spiritually whole, the physical body must be buried with all organs and tissues intact. These beliefs have clinical implications for autopsy in the cases of a stillborn, maternal death, or postoperative death, as well as for cord blood banking and bone marrow donation. It is important to ask your patient about her beliefs and values.

Recommendation

18. Health care providers should ask about, respect, and advocate for institutional protocols and policies supporting the wishes of individuals and families regarding disposal or preservation of tissues involved in conception, pregnancy, miscarriages, terminations, hysterectomy, and other procedures. (III-A)

PRENATAL CARE

The first prenatal visit is the most important clinical encounter, because if done well, it identifies the modifiable risk factors that can be focused on to provide the most effective care, result in a low-risk third trimester pregnancy, and achieve a better health outcome. In the first prenatal visit with a First Nations, Inuit, or Métis patient, using the intake sheet as a template, health professionals should be particularly sensitive to issues such as geographic location, personal history of sexually transmitted disease, mental health, home environment, social support network, trauma/abuse, recent viral exposure, the use of alcohol, drugs, and cigarettes, and access to quality foods.

Adequate prenatal care has been defined as consisting of at least 6 visits with a health care practitioner, and a Manitoba study found that Aboriginal women were 5 times more likely than non-Aboriginal women not to have accessed adequate prenatal care.² Risk factors for inadequate prenatal care include low family income, higher unemployment, low education, single-parent families, immigrant status, smoking during pregnancy, and Aboriginal status.³ Therefore, consideration should be given to whether the barriers to adequate prenatal care for a given individual are financial, cultural, social, attitudinal, geographical, or related to accessibility of services. Another important consideration is to evaluate what Aboriginal women expect from their prenatal care provider. Prenatal vitamins and other medications needed during the prenatal course are covered by NIHB for Status First Nations and Inuit.

Geographic location can be a significant barrier to a woman getting to her prenatal, blood work, ultrasound, or specialist appointments on time. Transportation barriers include lacking such things as a car or driver, a babysitter to take care of older children, and the money to pay for gas and parking. Non-Insured Health Benefits have not kept up with the cost of living and do not provide adequate funding to travel to a larger centre for appointments.

CLINICAL TIPS

Instruct staff to inquire about best appointment times rather than assigning them. Be aware of a patient's travel context in terms of

distance, financial constraints, child care challenges, etc. If you are receiving patients from the North, be aware of flight schedules and travel time and schedule your appointments accordingly.

Use your prenatal sheet: the checklist on your prenatal sheet can help you identify barriers and challenges to a healthy pregnancy and inquire about the patient's socioeconomic situation in a sensitive manner. Go through the sheet one question at a time, ask follow-up questions sensitively, and allow time for your patient to respond.

The standard of care is a timely gynaecological examination early in the prenatal period. If there is a history of sexual abuse, however, a timely gynaecological examination may be very difficult for a patient to accept, and may also be a reason for her presenting to the clinic for prenatal care later on in her pregnancy. It may be culturally safer to offer a gynaecological examination after the establishment of a safe physician–patient relationship if the pregnant woman is a low risk for gynaecological infection.

Depression is more common among Aboriginal women, and women with depression use more tobacco, alcohol, and drugs than those without depression. Women who quit smoking and drinking in pregnancy may need to be monitored more closely for depression than those who stop before becoming pregnant. The high prevalence of smoking during pregnancy, particularly among Aboriginal women, necessitates coordinated efforts aimed at smoking prevention and cessation. Self-advocating during pregnancy for a healthier environment is difficult if women do not own the home they reside in.

CLINICAL TIP

Ask your patient about her support networks and if there are other agencies involved in her care, such as mental health or social services.

Weight gain and obesity during pregnancy are common physical health issues for Aboriginal women. As discussed in the Social Determinants of Health chapter, food insecurity is a significant issue for many First Nations, Inuit, and Métis women. Transitions away from a traditional diet and lack of access to healthy foods may contribute to weight gain and obesity. The Canadian Nutrition Guide does not consider the cultural and nutritional value of country foods, but there are more culturally relevant resources such as Pauktuutit's prenatal guide, "Born on the Land with Helping Hands."⁴

A recent paradigm shift in the field of developmental biology, termed epigenetics, suggests that environmental factors such as nutrition, environmental compounds, and stress during the prenatal period are associated with early alterations in the normal development of cells and tissues. There is particular interest in the relation between the

prenatal environment of the fetus and the development of adiposity and insulin resistance later in life.⁵ Evidence has been found showing Aboriginal people as part of a biological food chain consuming deleterious amounts of harmful organic compounds that affect their personal health, but also the health of future generations via fetal absorption, breast milk contamination, consumption by newborns, and other exposures that cause disease.⁶

CLINICAL TIP

For many First Nations communities, tobacco has a sacred role in healing and ceremonies. Being culturally safe includes respecting this sacred role and clearly distinguishing between smoking and ceremonial tobacco use.

Recommendation

19. Health professionals should recognize that mental illnesses such as mood disorders, anxiety, and addictions are a major public health issue for many First Nations, Inuit, and Métis. (II-3B)
Use of mood-altering substances that lead to addiction is often a mechanism for coping with the pain of their intergenerational trauma. Health professionals should familiarize themselves with culturally safe harm reduction strategies that can be used to support First Nations, Inuit, and Métis women and their families struggling with substance dependence. (II-2A)

THE POSTNATAL PERIOD

The postnatal period includes the influences of breastfeeding and nutrition, healthy environments, and early childhood education. Breastfeeding among Aboriginal women in Saskatchewan was found to be related to the sociocultural and environmental context, and to attitudes, knowledge, beliefs, information, previous infant feeding experiences, and psychological factors.⁷ Women who experience food insecurity and are more socioeconomically disadvantaged are less likely to breastfeed.⁸ Estimates of the prevalence of breastfeeding in First Nations, Inuit, and Métis women are variable, but parallel to the general Canadian population, there is a trend towards increased breastfeeding.⁸ Among Inuit breastfeeding rates are notably high, and ongoing promotion is a key priority of Inuit women's organizations such as Pauktuutit Inuit Women of Canada.

MISCARRIAGE

Spontaneous abortion or miscarriage likely occurs as frequently in Aboriginal populations as in others. However, because of the widespread understanding of

Mother Nature and her often indiscriminate decisions, the event may be felt to be part of the cycle of life. There is very little reference to this stressful life event among First Nations, Inuit, and Métis women.

SEXUAL ABUSE AND BIRTH: RE-TRAUMATIZATION

It is crucial for health care providers to be aware of the high rates of sexual abuse among First Nations, Inuit, and Métis women, and to shape their care in a way that will not re-traumatize a victim of sexual abuse or assault. There are a number of challenges that a sexual abuse/assault survivor may face during the birthing process.⁹ In 2004, Simkin and Klaus published the document, *When Survivors Give Birth: Understanding and Healing the Effects of Early Sexual Abuse on Childbearing Women*,¹⁰ which includes important recommendations excerpted in Appendix 3.

TURNING IT AROUND

Though most of the childbearing women today did not attend the residential schools, they have heard of and indirectly experienced the trauma inflicted on their families. This is termed intergenerational trauma. Furthermore, many current Aboriginal childbearing women are also products of the Sixties Scoop, and were raised by non-Aboriginal families. In each case, there is a feeling of immeasurable cultural loss, and for many people, a desire to consciously reverse the effects of this troubled past. Many women see pregnancy and child rearing as an opportunity to turn their lifestyles and behaviours around for the well-being of their children. They are turning towards their families, communities, and other support systems to relearn some of the cultural values and teachings and they are making changes in their lives. In a study on the intergenerational impacts of residential schools, participants described their efforts to develop the knowledge, skills, confidence, and networks of support required to work towards their vision for a strong and healthy family and community.

CLINICAL TIPS

Communication and collaboration is important. Engage with others in your community of practice to ensure continuity of culturally safe care, including within intervention chains, should they be needed.

Know your local social service resources, personnel, and their contact information, and establish a collaborative rapport with them. Encourage your local social services to connect with you on an ongoing basis so that you can strengthen efforts made to achieve positive outcomes.

Be aware of and educate staff about patterns of automatic referral and understand that flags are flexible. When appropriate, work collaboratively with medical and social services to implement preventative care and support your patient and her family in improving outcomes.

CHALLENGES AND SOLUTIONS: MATERNITY CARE IN CANADA

As Canada enters an era that is facing an extreme shortage of maternity care providers, and as the global economic recession increasingly affects existing resources and funding, it is necessary to re-examine current practice and find a balance that will blend sustainability, safety, and cultural sensitivity in future interventions that aim to reduce maternal mortality and morbidity. Canada has already taken steps towards achieving this goal. For example, there are a growing number of Aboriginal midwives. Some of the barriers to the growth and establishment of Aboriginal midwifery include misunderstanding of the scope and role of midwives; pay structures; lack of culturally appropriate education programs and community based education opportunities; and lack of understanding of midwives by other health professionals. Inter-professional collaboration between obstetricians, physicians, and midwives is not only key to bringing birth closer to home in rural and remote areas, but also to the ability to address the overarching shortage of maternity care providers experienced across the country.

Training both Traditional and direct-entry midwives is a strategic approach to improving maternal health, which integrates community involvement and cultural sensitivity. It is also key to providing services in rural and remote areas that lack proper health facilities. The return of midwifery care to Aboriginal communities could reduce the number of obstacles inhibiting the success of maternal health care delivery while allowing for a more holistic and patient-centred approach to providing health services in general. Successful examples include the Hudson Bay communities' midwife-led maternity care program and the Midwifery Program in Fort Smith.

Recommendation

20. Health professionals should support and promote the return of birth to rural and remote communities for women at low risk of complications. The necessary involvement of community in decision-making around the distribution and allocation of resources for maternity care should be acknowledged and facilitated. (III-A)

Providing timely, accessible, and flexible prenatal care, with knowledge of the social determinants of health and the cultural values of the population that is being served, would be an initial step towards providing culturally and socially competent care. Many young pregnant women are maximizing their new role as mothers to make changes in their lives and follow a healthier path. The barriers towards following this healthier path are innumerable and unpredictable. By recognizing these barriers health care practitioners can support these women to meet the challenges and provide a healthier future for themselves, their children, families, and communities. After all, being in control of one's future is one of the strongest correlates of health.

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Mature Women's Health

There is very little research available on menopause and First Nations, Inuit, and Métis women, and from the research that has been performed, it is difficult to make any generalizations. There are limited resources available on this topic, such as Pauktuutit's guide for mature Inuit women called *As Time Goes On*, which offers some suggestions on the importance of diet and nutrition for mature women's health. The guide advises women about the importance of calcium and reviews calcium-rich foods in Inuit communities, such as fish heads, fish skin, eggs, bone marrow, and bannock.¹

In 2002 the Aboriginal Nurses Association of Canada produced *Finding Our Way: Sexual and Reproductive Health Sourcebook for Aboriginal Communities*. In it, menopause is described as

... the time when our moon cycles end; we no longer menstruate or have our period. . . . In contrast, native culture as seen from the traditional teachings, views aging and menopause as a time of renewal and wisdom, sharing through the grace of grandparenting . . . not just your own kin, but the youth of the nation. For women, it was seen as a state when our duties of birthing and mothering could be exchanged for a clearer focus on our own gifts including more intense spiritual work however this was done.²

Research conducted in the area of Aboriginal women and menopause includes a literature review conducted by Webster in 2002.³ This review indicated that menopause may have a positive effect on the lives of Aboriginal women with respect to increasing their freedom within the community. In addition, Aboriginal women appear to experience fewer vasomotor symptoms than other North American women. Webster concluded that more research needed to be done to determine the effect menopause has on Aboriginal women in Canada and their coexisting diseases such as cardiovascular disease, hypertension, and diabetes mellitus.

Madden et al. reviewed the literature and found little more to add, however they also conducted interviews of 18 First Nations women from the Sioux Lookout area and found that menopause was generally not discussed, particularly with health care providers.⁴ They also noted that a variety of experiences and symptoms typical of menopause from a medical perspective might not be conceptually linked to menopause by First Nations women. The authors suggest referring to menopause as “the time when periods stop” in order to discuss these experiences with First Nations women. The study highlighted the importance of understanding the different influences on a woman's menopause experience and cautioned against attaching preconceived ideas to the meaning and importance of the menopause experience.

Recommendation

21. Health professionals should be aware that there is a great lack of research, resources, and programming about mature women's health issues, including menopause, that is specific to First Nations, Inuit, and Métis. Health professionals should advocate for further research in this area. (III-A)

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Changing Outcomes Through Culturally Competent Care

CULTURAL AWARENESS, CULTURAL COMPETENCY, AND CULTURAL SAFETY: THE CONTINUUM

“I Know You Smudge” Versus “You Can Smudge”

Health professionals working with Indigenous populations around the world have begun to incorporate culturally safe care into their practices, supporting the delivery of meaningful, respectful, and effective care. Similarly, curricula on culturally safe care are being incorporated directly into undergraduate and graduate health professional programs, including those in obstetrics and gynaecology (Figure 8.1).^{1,2}

Cultural awareness can be defined as the realization that other individuals have different languages, behaviours, and traditions from oneself. A willingness to learn, understand, and accept that other cultures have different world views and different approaches to their health and wellness is key to the development of cultural competence. In Canada, cultural competence requires an understanding of the cultural, historical, and political issues that have and continue to impact First Nations, Inuit, and Métis health.³

Cultural safety has been defined as the effective care of a person or family from another culture by a health practitioner who has undertaken a process of reflection on their own cultural identity and who recognizes the impact of their culture on their own clinical practice. With time, it is hoped that trust can be established. Unsafe practice is any action or omission that endangers the well-being of, demeans the personhood of, or disempowers the cultural identity of the patient.⁴ The development of cultural safety was steered by the late Maori nurse, Irihapeti Ramsden,⁵ who believed the work of cultural safety was “to challenge [health care providers] to identify that there are other ways in which people experience life and view the world.”⁶ Cultural safety challenges the power imbalances inherent in the relationship between health care provider and health care recipient.⁶ Cultural safety implies that health care practitioners have knowledge of the cultural practices

of their patients, have made sure that both the physical space and their own personal behaviours are welcoming, and treats the patient as an equal in the health partnership. Ultimately, it is the patient who decides whether or not the care was safe.^{2,5,6}

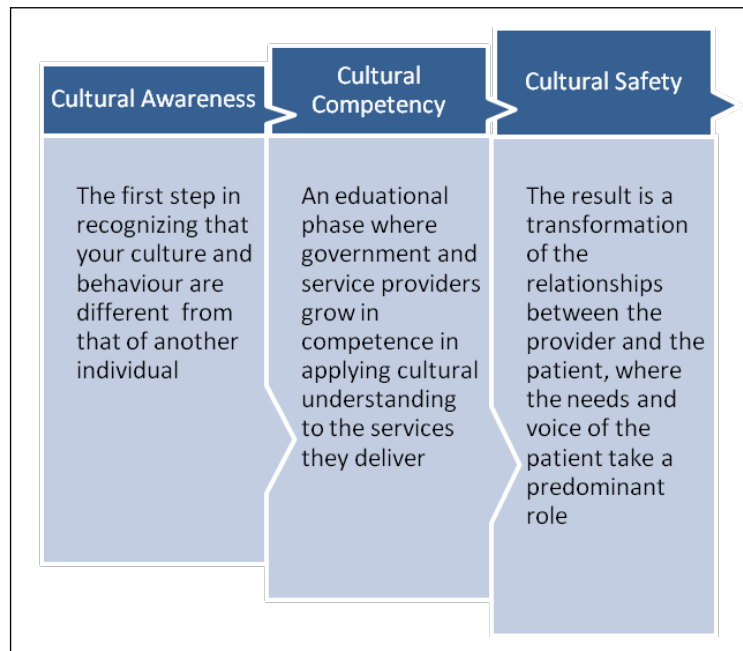
More recent literature suggests that the term “cultural humility” may be more appropriate than cultural competence as people can never be truly competent in a culture other than their own. Cultural humility requires both lifelong learning about how their culture influences patients’ perceptions of health and a willingness to apologize for cultural missteps.⁷

There is emerging evidence supporting improved health outcomes with the practice of culturally competent care. Preliminary findings indicate that health outcomes and patient satisfaction are improved with delivery of culturally competent care. The review also found strong preliminary evidence for reduced litigation rates following the implementation of cultural competency training.⁸ Another review of literature from 1980 to 2003 found excellent evidence supporting cultural competence training as a strategy for improving the knowledge, attitudes, and skills of health professionals, and for improving patient satisfaction.⁹

Summary Statement

16. Research has shown that where cultural competency strategies have been implemented, health outcomes and patient satisfaction have improved. (II-3)

There is also emerging evidence for cultural safety. From a traditional knowledge perspective, the evidence base for cultural safety is ancient and embedded in traditional teachings of such sacred values as humility and respect.¹⁰ In 2003, the Aboriginal Healing Foundation—an Aboriginal-operated, non-profit organization created in 1998 to offer resources to support Aboriginal communities healing from the destructive legacy of residential schools and the resultant intergenerational traumas of physical, sexual, mental, cultural, and spiritual abuses—conducted a detailed

Figure 8.1. Cultural awareness, competency, and safety

Adapted with permission of Simon Brascoupé/National Aboriginal Health Organization

evaluation of their program.¹¹ The evaluation identified cultural safety as critical to the healing process. The AHF advocates that relationships based on acceptance, trust, and safety are the first step in the healing process.^{10,11}

There is also community-based evidence on the value of culturally safe approaches to communities in crisis. Initiatives in Alkali Lake in British Columbia, Hollow Water in Manitoba, and Clyde River in Nunavut clearly demonstrate the success of healing strategies that are centred on cultural safety.

Hollow Water: The culturally safe healing of a community in crisis

Hollow Water is a First Nations community north-east of Winnipeg, Manitoba, in close proximity to the Métis settlements of Manigotogan, Aghaming, and Seymourville.³ Unfortunately all 4 communities had been affected by addiction, suicide, violence, and high incidences of sexual abuse. In 1984, partly inspired by the grassroots, community-driven changes at Alkali Lake, the community mobilized to address these devastating issues by embarking on a healing journey grounded in traditional knowledge. They established a group called Community Holistic Circle Healing composed of community political leaders, service providers, and health and service agencies. This team gave the community a mechanism to start dealing with the historical, intergenerational trauma and destructive legacy of residential school. In

1988 community members created a new program called Self-Awareness For Everyone which was modelled on a similar training program offered by Alkali Lake. SAFE enabled many community members to begin their healing journey. Healing was conceptualized and grounded in the medicine wheel, whose 4 sections represented a 4-step process meant to result in restitution and reconciliation between the abusers and the victims, the victims' families, and the community as a whole.

Many health professionals are working hard to challenge the stereotypical images of First Nations and Inuit which unfortunately still appear in all aspects of society, including the media and our school curricula, while in many cases Métis-specific images are altogether absent. In addition to challenging attitudinal and structural racism, however, it is important to recognize that although respect is a universal concept, some of the behaviours which generate or manifest respect are culturally specific.

Characteristics of respectful encounters include treating people as inherently worthy and equal: knowledge should be used as a springboard for curiosity. When a relationship is being established, First Nations, Inuit, and Métis patients may appreciate being asked about their home communities and personal histories. Being understood as an individual helps to build the trust necessary for meaningful therapeutic relationships.

Recommendation

22. Health professionals should seek guidance about culturally specific communication practices and should tailor communications to the specific situations and histories of their patients. (IIIA)

CLINICAL TIP

Understand that there can be large cultural variations between patients. Get to know your First Nations, Inuit, and Métis patients individually and do not make assumptions.

Recommendation

23. Health professionals may express to their patients that they wish to establish a respectful rapport through listening, acknowledging differences, and encouraging feedback. (III-L)

CLINICAL TIP

Schedule longer appointment times. Investing more time from the beginning helps establish a more effective and respectful rapport. Health professionals should be aware that the health narrative begins with the context and ends with the individual. This is rooted in language as well as in the value of humility, and it requires professionals to be skilled in active listening. Health professionals should appreciate that adapting their practices will actually save time in the long run and that giving the patient more time is an investment in the care. Recognize that when patients are not listened to, it is a continuation of the oppression.

Summary Statement

17. Subtle racism may occur without conscious intent, and is therefore best defined and identified by those who experience it. (III)

The current western medical approach remains founded on the “expert” health care provider who makes the major decisions regarding the need for diagnostic tests, prescriptions, and other medical resources and then “advises” the patient. This approach fails to situate health behaviours within the social determinants of health, and with respect to the impacts of colonialization it may impair clinical judgement and limit treatment options.¹²

Researchers in the area of cultural safety assert that to improve care for First Nations, Inuit, and Métis we must recognize the effects of colonialization on health, sexuality, reproduction and birth, access to care, health care policies, and the ability of health professionals to deliver culturally safe care. Care accessed by those who are very vulnerable, exploited, and/or marginalized may be an indicator of the safety and responsiveness of the organization and providers.¹³

Language is an integral part of any culture and its identity. Many Indigenous languages have been lost

since first contact with Europeans. As of 1996, only 3 of more than 50 Aboriginal languages in Canada—Cree, Ojibway, and Inuktitut—have enough speakers to be considered safe from extinction. In the 2006 Census, only 18% of those claiming Aboriginal identity stated that a First Nations, Inuit, or Métis language was their mother tongue (defined as the language first spoken at home), and even fewer regularly spoke their language at home.¹⁴ Information regarding the many First Nations, Inuit, and Métis languages spoken across Canada can be found in the 2006 Canadian Census and the 2000 SOGC Guidelines for Professionals Working with Aboriginal Peoples.^{15,16}

Communication is important to culturally safe practice. Besides differences in language and dialect, there may be differences in understandings of slang, street talk, or professional jargon. According to Little Bear,¹⁷ whereas Aboriginal languages tend to be noun-oriented and structured on relationships, most health professionals speak from a verb-based language structured on actions; rather than talking *with*, health professionals talk *at*. Yet, listening is one of the most vital components of improving awareness and, ultimately, safety. Eye contact is another important form of communication and is often culturally specific. For example, an Inuk may not look the health practitioner in the eye when discussing something they might find embarrassing, such as a positive HIV diagnosis. This is likely to be a cultural reaction to discussion about a serious topic, rather than an indication of disinterest or inattention.

The patient–provider relationship is at the heart of effective health care; central to this is the need for a consistent provider, with acceptable time dedicated to the visit. In order to optimize communication with First Nations, Inuit, and Métis patients, providers should be familiar with the taboo topics, cultural sensitivities, culturally appropriate wording, social norms, and socially acceptable behaviours of their patients’ cultures.¹⁸

CLINICAL TIP

Try to familiarize yourself a bit with the culture so you can get a sense of a woman’s expectations and preferences about medical examinations and health practitioner–patient interactions.

Recommendation

24. First Nations, Inuit, and Métis should receive care in their own language, where possible. Health care programs and institutions providing service to significant numbers of First Nations, Inuit, and Métis should have interpreters and First Nations, Inuit, and Métis health advocates on staff. (III-A)

CLINICAL TIP

Verify your patient's understanding of your recommendations. Do not assume that they understand what you are asking them to do or how to do it. For example, they may not know where to go to get a blood sample taken.

Seven essential qualities of ethical approaches to communication and caregiving involving Aboriginal people¹⁹:

- Respecting the individual
- Practising conscious communication
- Using interpreters (where needed)
- Involving the (extended) family
- Recognizing alternative approaches to truth-telling
- Practising non-interference
- Respecting and honouring the Aboriginal patient's desire to involve traditional healers or practices in their care

Ultimately, cultural safety is an approach to care centred on the patient's experiences, values, and beliefs. It involves building awareness and trust; recognizing power inequities and the role of socioeconomic conditions, history, and politics; and knowing that it is the patient who determines whether care is safe. No one formula exists for achieving successful rapport.

CLINICAL TIPS

Rather than viewing the individual and the culture as barriers to the delivery of care, it is better to consider how our beliefs and values as health care providers, and the system in which we practise, has created challenges for First Nations, Inuit, and Métis health and well-being.

For many First Nations, Inuit, and Métis a positive experience from first entering the clinic or hospital is critical to feeling welcome and safe. Educate front-line staff, including front desk staff, on key principles of cultural safety. Greet all patients in a respectful, warm manner, even if they are late, and train staff to do the same: doing so will help ensure that the first interaction with a patient is a safe one. Be aware of policies or common practices that may be discriminatory, for example policies or routine practices of automatic drug screening upon presentation for labour and delivery.

Being able to provide culturally safe care involves a learning process. It takes time to build and refine effective relationships with First Nations, Inuit, and Métis. Patience, compassion, curiosity, and genuine interest are needed.

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Conclusion

The development of this guideline was undertaken with an important mandate: to provide health professionals in Canada with the knowledge and tools to provide culturally safe care to First Nations, Inuit, and Métis women, and through them, to their families. Recommendations were carefully written to encourage reflection and consideration of the important aspects of sexual and reproductive health care services provided to Aboriginal people. The Aboriginal Health Initiative Committee, along with select experts in First Nations, Inuit, and Métis health, convened to develop this updated guide. A majority of those involved in its production are themselves First Nations, Inuit, or Métis. Our hope is that we have provided some practical tools to assist health professionals to make strides in the right direction.

The goal of all health professionals is to ensure the provision of care that improves the well-being of their patients. The provision of culturally appropriate and safe health care services to First Nations, Inuit, and Métis in Canada remains a challenge. In order to provide safe and adequate care, health professionals must navigate their interactions with Aboriginal patients with skill, sensitivity, and awareness, recognizing the challenges of geography, historical trauma, cultural and linguistic differences, socioeconomic status, and an increased burden of disease.

Aboriginal health care services are delivered in an environment that at times seems to increase barriers rather than facilitate access to high quality, effective care. Confusion often exists regarding Status, jurisdiction (provincial, territorial, federal, or local), and health insurance coverage. Local service networks and referral patterns are often established through trial and error and the hard work of the health care team involved. An effort to gain some understanding of these issues, although complex, will be invaluable to any health care provider. Familiarity with programs such as the NIHB program for First Nations and Inuit will contribute to better care and access to necessary medications and devices for this vulnerable segment of the population.

The sexual and reproductive health of Aboriginal people has not been at the forefront of health care in Canada.

This sensitive topic is still difficult to address when there may already exist barriers to trust and concerns about confidentiality. Access to contraception, abortion services, and simple screening testing can be difficult or impossible for several reasons, some of which may not be recognized by non-Aboriginal health professionals.

Maternal health care services are of particular concern in Aboriginal populations. Many factors such as geography (rural or remote), urban isolation, evacuation for delivery, access to contraception, cultural shifts, loss of extended family support, and others may contribute to poorer obstetrical outcomes. Maternal health care needs to be improved through efforts at many levels, including federal policies and funding, provincial programs and funding, and local health authorities working together to improve access and quality of care.

Context is important. Although some generalizations are made in this guide, we wish to emphasize that each individual and community is unique in their needs and should be regarded this way. Likewise, while our discussion of culturally safe care focuses on overarching principles and recommendations, attempts should be made to understand links between broad social determinants and the health status and experiences of an individual and a community. This will serve to improve the cultural safety of the care provided. Every First Nations, Inuit, or Métis individual comes with a multi-layered history that affects that person's current health; national and local historical events set the stage for present realities. Intergenerational trauma and intergenerational and cultural resilience play out in the lives of real people. Socioeconomic forces, educational levels, access to food and housing, language(s) used, community leadership, employment opportunities, government policies, and current health issues all interact to create the environment in which a given First Nation, Inuit, or Métis person lives. A sensitive approach to learning more about these factors goes a long way to enable the health professional to provide adequate and culturally safe care. Asking a few questions about what an individual deems important in terms of their health is a simple but invaluable intervention. In so doing, the health

professional demonstrates an interest that goes beyond the presenting health concern, and may lay the foundation for a rapport with more trust and more therapeutic benefit.

Many gaps exist in the medical literature regarding the health of First Nations, Inuit, and particularly, Métis. Since all health professionals will likely encounter Aboriginal patients in the course of their practice, these gaps should be addressed. Indigenous-specific guidelines on culturally appropriate research methodologies are becoming increasingly well-established and encourage research that aims to improve the health and well-being of Aboriginal people, not to answer questions only out of intellectual curiosity.

The processes and experiences of colonialization and its ongoing effects on Aboriginal people cannot be underestimated. Many policies and attitudes persist that are based on colonial attitudes and subtle or overt racism. The

Canadian ratification of the United Nations *Declaration on the Rights of Indigenous Peoples* in 2011 establishes that Canada has committed to the fundamental rights of Indigenous people in Canada. As part of society, health professionals are also encouraged to participate in the respect for and improvement of the lives of Indigenous people under their care.

This guide is but a beginning. Becoming familiar with the needs and values of First Nations, Inuit, and Métis patients takes time. A willingness to learn directly from Aboriginal people about their own needs is key to ongoing success. Many health professionals are already committed to providing culturally safe care, and it is our hope that this document may help to narrow some knowledge gaps and to provide some helpful guidance in the ongoing effort to improve the health and well-being of First Nations, Inuit, and Métis women, their families, and their communities.

Case Studies

CASE STUDY 1: YOUTH AND SEXUAL HEALTH

Nita is 21 years old and lives in Toronto, where she attends university and works part-time as a waitress. Her studies keep her busy, and she is doing well. As often as possible she returns to see her family in her community north-east of Montreal. On a recent trip home, she makes an appointment to see a family doctor at the community health centre, which she prefers to the university clinic. She sees the visiting family physician, Dr Pear, at the clinic, where she presents with vaginal discharge and itching, but is otherwise healthy and physically active. She has no fever or urinary symptoms and has normal bowel movements. She lives with her boyfriend and is taking birth control pills as prescribed.

Scenario 1

Dr Pear prepares to examine her. It is a busy day in the clinic and he is running behind schedule. He asks if she is sexually active, but does not take a full history. He proceeds to examine her without much interaction and recommends doing a Pap smear. He does not realize that she has regular examinations, is in a stable relationship, and is taking good care of herself. After finishing the examination, he says that the exam is inconclusive and he is not sure what is going on. He suggests that she might have an STI, does not explain other possibilities, and says that the nurse will call her when the results are back. He arranges for the nurse to come in and talk to her about birth control.

Scenario 2

Dr Pear greets Nita and asks her a few questions about herself. She tells him how she is doing in university, that she is in a happy and stable relationship, and about her symptoms. Dr Pear explains that he is going to do an examination to see what is going on. He leaves the room so that she can undress and asks her to drape herself so that she will feel more comfortable. He returns and prepares to examine her, going slowly and gently, and explaining what he is doing as he goes along. After finishing the examination, including taking a sample and examining the slide, he tells her that it seems she has bacterial vaginosis. He explains what this is and that it can be easily treated. He gives her a prescription for antibiotics and reminds her

that if she has a Status card, she should show it to the pharmacist since her medication is covered.

Dr Pear asks Nita if she has any questions. He also asks if she has regular health checks and if she has ever had a Pap smear. Nita explains that she has regular examinations and knows the importance of staying healthy, but that she doesn't really like going to the clinic on campus. Dr Pear lets her know about Anishnawbe Health Toronto, an Aboriginal community health centre.

Learning Points

- Do not make assumptions about a young woman's sexual activity, such as that she has multiple partners or dysfunctional relationships.
- Always explain what you are doing during procedures and why.
- Ask about Status as it relates to medication coverage. Be familiar with the medications that are covered by the NIHB, or have a reference readily accessible.
- Ask open-ended questions, since these often give patients the opportunity to disclose things they are uncomfortable with.
- Ask the patient if there is anything else you should know or anything else they would like to talk about.

CASE STUDY 2: ADOLESCENCE AND PREGNANCY— MIDWIFERY CARE

Tracy is a 16-year-old woman from a semi-remote First Nation community. She is 36 weeks pregnant and attending a prenatal visit with her community midwife. This is her first pregnancy and she has attended all previous visits with her mother and/or Frank, the father of her baby. Tracy is very quiet and makes limited eye contact during these visits. Tracy's pregnancy has been fairly uneventful. Her weight gain has been 23 pounds. Laboratory values and blood pressure have been within normal limits. A 20-week ultrasound found no abnormalities of fetal anatomy. At her last visit the midwife told her they would be discussing place of birth today. Tracy's options are to deliver in one

of two tertiary care centres in a large city 9 hours away, or at a hospital in a smaller city closer to home. Tracy arrives for her visit with her mother and her midwife notices that they seem to be more serious than usual today.

Scenario 1

Her midwife Mandy quickly asks them what is wrong. When there is little response, she asks if Tracy is starting to experience some fears around labour and birth, and quickly goes on to reassure Tracy that they will discuss all the options for coping. Tracy does not make eye contact. After an uncomfortable silence Mandy begins to enquire about fetal movement, changes in vaginal discharge, whether Tracy is taking her prenatal supplement, headaches, etc. Tracy answers with yes or no.

Mandy explains Tracy's options for delivery, and asks her whether she has thought about which hospital she would prefer to give birth in. After a moment, Tracy's mother replies that she will give birth at _____ tertiary care hospital and that she will be escorting Tracy. Tracy's mother informs Mandy that Tracy is upset because she does not want to leave Frank behind when she flies into the city to give birth. Mandy asks Tracy how she feels about that and she shrugs her shoulders. Mandy proceeds to explain the next steps in setting an appointment with a referral physician and arranging transportation.

Scenario 2

Although her midwife Mandy suspects that there may be something bothering Tracy, she begins the appointment by asking about Tracy's sister and her 1-year-old son, who she helped to deliver. Mandy casually asks whether there are any plans yet for who will be able to attend Tracy's birth, knowing that the family is very close and Tracy would like more than one person to be there. There are some vague responses. When Mandy asks a question, she speaks directly to Tracy's mother until Tracy initiates eye contact.

She goes on to ask about fetal movements and jokes about how active the baby is at 1:00 a.m., saying that the baby is just like her mother. Tracy smiles a little and makes brief eye contact with Mandy, which Mandy sees as an indication that she is ready to speak about today's concerns. When she feels that Tracy has relaxed, she asks about Frank and how they are doing as a couple. Tracy answers that she is worried about having to choose between bringing her mother or Frank with her to the city to give birth.

Tracy's mother then asks when Tracy will be "sent out." Mandy reviews Tracy's options for where to give birth and asks them if they have discussed their plans and considerations. Tracy's mother replies that Tracy will

give birth at _____ tertiary hospital and that she will be escorting her. Mandy glances at Tracy to see how she reacts. She reassures them that she will request funding for Frank to be able to accompany them.

The referral appointment is booked for one week from the current visit.

The day following Tracy's scheduled appointment in the city, Tracy calls Mandy to tell her that she has noticed blood in the toilet and that she is still in the community. The midwife arranges to meet Tracy at the clinic to assess her. Frank comes with Tracy to the clinic.

Scenario 1

A medivac flight is organized to transport Tracy to the hospital to query early labour. Her mother arrives at the clinic with a suitcase and escorts Tracy. There are vague plans for Frank to travel later with Tracy's father.

Scenario 2

Mandy comments on how Frank and Tracy are treating each other well and how important this is for Tracy and the baby. A medivac flight is organized to transport Tracy to the hospital, to query early labour. Her mother arrives at the clinic with a suitcase and escorts Tracy. There are vague plans for Frank to travel later with Tracy's father. Mandy asks Tracy and her mother to keep in touch.

Learning Points

- Indirect questioning about feelings is often more effective, allowing the underlying story to emerge.
- Noticing eye contact is an important aspect of reading body language since it is an invitation to communicate. Young people may initially hesitate to make eye contact.
- When accompanied by her mother or another Elder, a young woman will often defer to her mother or Elder when questions are asked. Politely address the Elder directly in the conversation and respect and recognize her role as decision maker while carefully considering the patient's perspective.
- When a mother has to leave her community to give birth it can cause considerable stress in her intimate relationship. This stress can sometimes present as conflicted feelings about being with the partner or complying with guidelines and recommendations for leaving. This is especially difficult for young women in new relationships, and it is important to recognize that they are not deliberately being irresponsible; they are generally willing to be guided by caring adults in making significant decisions in their lives.

CASE STUDY 3: PREGNANCY AND BIRTH EVACUATION POLICIES

Marni is 31 years old and 35 weeks pregnant. She was initially seen in the emergency room of the hospital in her community and was referred to a tertiary care centre in the city after being assessed by the family doctor, who was concerned about preterm labour because of clear changes in her cervix. Marni arrives at the tertiary centre escorted by a nurse who reports that she was comfortable and had no contractions during the transfer. She reports that Marni has had no fever, urinary symptoms, nausea, or vomiting and that her bowel movements have been normal. Dr Green, the on-call obstetrician, proceeds with a medical history. Marni is a grand multipara, gravida 5, para 5, delivering at 37 to 38 weeks. She has not had any terminations, miscarriages, or stillbirths and has had 5 live births, all vaginal with short, uncomplicated labours and uneventful deliveries. She had gestational diabetes in her last 2 pregnancies and her antenatal visits for this pregnancy were unremarkable apart from the diabetes, which is being well-controlled with insulin.

Being away from home, Marni is concerned about her other children and is eager to get back home. Since her contractions have settled down, Marni asks if she can go home. She tells Dr Green that there is a family doctor who comes to her community to deliver babies. She wants to be close to home for the birth so that she can be with her family.

Scenario 1

Dr Green explains that given her history, there could be complications. She tells her it is not safe for her to give birth in her community and that she will have to be flown out for delivery. Her husband will be able to accompany her, but not her children. Dr Green sends Marni home to prepare.

Scenario 2

Dr Green is worried that given her family concerns, Marni might present very late in her labour so that it would be too late to fly her out. She tells Marni that her reasons for wanting to give birth in her community are good reasons. Dr Green takes some time to explain why she thinks it is important for Marni to deliver in a tertiary centre, explaining the risk of delivering in her community in easy-to-understand language. She also gives her some information about things the hospital can do to support her through the labour and help honour the birth of her baby even though she will be away from her family. She gives her the contact information of the liaison officer.

Learning Points

- Consider the reality of living in rural locations, and the complex and multiple considerations a woman must make in leaving her community.
- Familiarize yourself with the services available in rural areas.
- Communicate with the mother about the plans she will need to make to leave her community.
- Appreciate the cultural significance of birth to the family and community.
- Acknowledge and validate the concerns of your patient; do not dismiss concerns beyond the safety of the unborn baby.
- Be familiar with the programs and services available at the hospital to better support the inclusion of families.

CASE STUDY 4: MATURE WOMEN'S HEALTH

Jaci is a 66-year-old woman from a remote, fly-in community who presents to a nursing station reporting vaginal bleeding as spotting occurring several times per week for multiple weeks. She has no pain, no urinary symptoms, and no fever. She is voiding well and her bowel habits are normal. The nurse assesses her symptoms and medical history and then examines her. Her pelvic examination is unremarkable and her abdomen is benign, with no lumps or pain. The nurse refers Jaci to the doctor who is coming the next week.

When the doctor arrives she examines Jaci and conducts an endometrial biopsy, which returns positive for abnormal cells and Jaci is referred to a tertiary centre in the south. Because of her age and difficulty speaking English, Jaci is accompanied by her daughter. At the tertiary centre, Jaci meets Dr London, the gynaecologist.

Scenario 1

Dr London takes Jaci's history, running through a checklist of questions. Jaci's daughter feels rushed, does not understand all the questions, and has difficulty responding, in addition to needing to translate the questions for her mother. When he proceeds to examine Jaci, he does not explain what he is doing or why. Jaci feels exposed and uncomfortable. Her daughter recognizes this, but does not feel comfortable interrupting the examination to tell Dr London this. He finishes the examination, tells Jaci that he needs further imaging and says the nurse will come to make arrangements. Since neither Jaci nor her daughter pose any questions, Dr London assumes that Jaci understands and he leaves the room.

At their next visit, when Dr London has the results of the ultrasound, he explains that there is a tumour in her uterus and that she will need surgery. He asks the nurse to give Jaci her appointment dates and leaves the room to attend to his next appointment.

Scenario 2

Dr London greets Jaci and asks her where she is from, about her family, and how many children she has had. He asks if she travelled far to get to the appointment and if she understands the reason she was sent to see him. He explains that her bleeding symptoms are not normal because she has already experienced her change of life (i.e., menopause), and that the family doctor who comes to her community did a test that showed that the lining in her womb was not well. He explains that it is important to examine her uterus to understand the cause of the bleeding and that he will do this examination for her today. With Jaci's daughter's help, Dr London tries to find the word for uterus in Jaci's language, so that Jaci can better understand what is happening.

Jaci's daughter helps her mother prepare for the examination, covering her as instructed by Dr London. He proceeds with the examination and warns her that it might be uncomfortable at times. When conducting the examination, Dr London explains each part of the examination and talks and examines slowly, so that Jaci's daughter can translate what he is saying. Dr London finishes the examination and leaves the room so that Jaci can get dressed. He then returns and tells Jaci that she will need to have an ultrasound, ensuring that she and her daughter understand why and how this will be arranged.

At the appointment to discuss the ultrasound results, Dr London sits down across from Jaci and explains that the ultrasound showed some growth in the uterus. Dr London explains that the growth could be serious or not dangerous at all, but it is important to be sure, so he needs to do an operation to take out the uterus. He asks if Jaci understands what he is saying and if she has any questions. Jaci and her daughter both agree that they understand. Jaci asks when she needs to have the operation and how long will she have to stay here. Dr London carefully explains the next steps.

Learning points

- Having a uterus is an important part of most women's sense of identity, including Aboriginal women, even as grandmothers.
- Be sensitive to shyness, modesty, and high rates of sexual abuse. Being aware of the legacy of the residential school system is particularly important when working with older Aboriginal women.
- Always drape appropriately, taking a gentle approach and explaining each step of the procedure.
- Use a professional interpreter if needed and ask if the patient is comfortable with the service. If using a family member to translate, be sure to use accessible language so that they understand what you are saying.
- Check with your patient regularly to make sure that she understands what you are doing and what is happening with her. Do not assume that silence indicates agreement or understanding.

APPENDIX

APPENDIX 1. APOLOGY FOR THE FORCED RELOCATION OF INUKJUAQ AND POND INLET FAMILIES

On August 18, 2010 Indian and Northern Affairs Minister John Duncan issued the following apology for the forced relocation of families from Inukjuak and Pond Inlet to the high Arctic areas of Grise Fiord and Resolute Bay.

On behalf of the Government of Canada and all Canadians, I would like to offer a full and sincere apology to Inuit for the relocation of families from Inukjuak and Pond Inlet to Grise Fiord and Resolute Bay during the 1950s.

We would like to express our deepest sorrow for the extreme hardship and suffering caused by the relocation. The families were separated from their home communities and extended families by more than a thousand kilometers. They were not provided with adequate shelter and supplies. They were not properly informed of how far away and how different from Inukjuak their new homes would be, and they were not aware that they would be separated into two communities once they arrived in the High Arctic. Moreover, the Government failed to act on its promise to return anyone that did not wish to stay in the High Arctic to their old homes.

The Government of Canada deeply regrets the mistakes and broken promises of this dark chapter of our history and apologizes for the High Arctic relocation having taken place. I would like to pay tribute to the relocatees for their perseverance and courage. Despite the suffering and hardship, the relocatees and their descendants were successful in building vibrant communities in Grise Fiord and Resolute Bay. The Government of Canada recognizes that these communities have contributed to a strong Canadian presence in the High Arctic.

The relocation of Inuit families to the High Arctic is a tragic chapter in Canada's history that we should not forget, but that we must acknowledge, learn from and teach our children. Acknowledging our shared history allows us to move forward in partnership and in a spirit of reconciliation. The Government of Canada and Inuit have accomplished many great things together, and all Canadians have benefitted from the contributions of Inuit to our culture and history. We must continue to strengthen our connections and deepen our understanding and respect. We must jointly build a stronger, healthier and more vibrant Inuit Nunangat and, in turn, build a stronger, healthier and more vibrant Canada.

The Government of Canada hopes that this apology will help heal the wounds caused by events that began nearly 60 years ago and turn the page on this sad chapter in Canada's history. May it strengthen the foundation upon which the Government of Canada and the Inuit can build and help keep the True North Strong and Free.¹

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APPENDIX 2. APOLOGY FOR THE RESIDENTIAL SCHOOL SYSTEM

In 2008, Prime Minister Stephen Harper apologized for the residential school system, saying in part:

We now recognize that, in separating children from their families, we undermined the ability of many to adequately parent their own children and sowed the seeds for generations to follow, and we apologize for having done this.

We now recognize that, far too often, these institutions gave rise to abuse or neglect and were inadequately controlled, and we apologize for failing to protect you.

Not only did you suffer these abuses as children, but as you became parents, you were powerless to protect your own children from suffering the same experience, and for this we are sorry.

The burden of this experience has been on your shoulders for far too long.

The burden is properly ours as a government, and as a country.

There is no place in Canada for the attitudes that inspired the Indian residential schools system to ever again prevail.

You have been working on recovering from this experience for a long time and in a very real sense, we are now joining you on this journey.

The government of Canada sincerely apologizes and asks the forgiveness of the Aboriginal peoples of this country for failing them so profoundly. We are sorry.¹

REFERENCE

1. CBC News. Prime Minister Stephen Harper's statement of apology. June 11, 2008. Available at: <http://www.cbc.ca/news/canada/story/2008/06/11/pm-statement.html>. Accessed on March 15, 2013.

APPENDIX 3.
AVOIDING RE-TRAUMATIZATION OF SEXUAL ABUSE/ASSAULT VICTIMS
DURING THE BIRTHING PROCESS

1. Regardless of the history a woman has given you, treat *all women* who are birthing as if they were survivors of sexual abuse (sadly, it is more likely than not that they are survivors).
2. Be aware of your body language and position. The fact that you are in a position of authority (standing) and she is likely laying on her back in a vulnerable or exposed position can cause her to feel re-traumatized.
3. Always explain what you are doing (every single step).
4. Ask her permission to do vaginal, pelvic, or other intimate exams, and don't leave her exposed when you are finished, cover her up when you have completed the necessary exam.
5. Do not assume that a woman is comfortable telling you she has a history of sexual abuse or assault. She may not be comfortable telling you about the incident or she may not be aware that there is a possibility that the birthing experience will trigger or re-traumatize her.
6. Be very mindful of the language that you use, your tone of voice and your choice of words – often survivors have been told to “relax,” “breathe,” “be quiet,” “just let go,” “open up,” or have heard “shhhhh,” “I’ll be done in a minute,” “it’ll be over soon” while they were being abused/assaulted. This kind of language (especially coming from someone in a position of authority) can trigger a woman who is giving birth.
7. Be aware that even if you choose your language carefully and you have awareness of the potential triggers for survivors and impeccable care methods, *a woman may still experience trauma.*
8. Trauma is also likely to be triggered when the baby descends into the birth canal, as the physical sensation of birthing (including vaginal dilation, turtling, crowning), combined with the lack of control over the physical aspects of the birthing process can cause a survivor to feel as if their trauma is reoccurring at that moment.¹

REFERENCE

1. Simkin P, Klaus P. When survivors give birth: understanding and healing the effects of early sexual abuse on childbearing women. Seattle: Classic Day Publishing; 2004.

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