First Nations Health Authority
Health through wellness

Testimony to the National Inquiry on the Missing and Murdered Indigenous Women and Girls

December 2018

Contents

Executive Summary

In 2017, First Nations Health Authority (FNHA) received standing for Part II Hearings at the National Inquiry into Missing and Murdered Indigenous Women and Girls on the issues of the Impact of Colonization, Health and Health Services, and Death Investigation Processes.

The Commissioners invited FNHA staff to participate in the Part II hearings on Health Services, to speak about our experiences with transformation of First Nations health services and governance in BC, however due to scheduling conflicts, FNHA could not attend. In lieu, FNHA indicated we would provide written testimony that would include a broad overview of BC First Nations health governance, our work in the space of First Nations health and wellness, and the journey of FNHA in supporting the health and well-being of First Nations Women and Girls in BC.

This testimony highlights the First Nations health governance journey that led to transfer of responsibility for First Nations health services from Health Canada to FNHA. Key data trends are identified, and observations on each of the three Inquiry-level issues are provided as they relate to the challenges and opportunities FNHA and our partners face in improving the health and wellness system in BC for First Nations people and communities. Our work to respond to key health and wellness barriers for First Nations women and girls is highlighted. Recommendations speaking to specific topics are woven throughout the testimony (See Appendix A for a compiled list).

A note on our use on use of the terms 'Indigenous' and 'First Nations': our mandate serves First Nations people and communities, so we speak specifically to this population and our work serving it throughout, however, there are times when the context is wider than our work, where sources are quoted, or the testimony is taking into consideration something specific to the National Inquiry's mandate, so the term 'Indigenous' is used to speak in those instances. We recognize that we are one voice among many in addressing Indigenous health and well-being: our efforts to improve the health and wellness system for First Nations in BC helps drive our health and wellness partners to ensure that services and programs are culturally safe for the Métis and Inuit people in BC, and that the work of Métis and Inuit organizations with health and wellness partners in BC and nationally similarly benefits First Nations people in BC.

Introduction

1. In 2017, the First Nations Health Authority (FNHA) received standing for Part II Hearings at the National Inquiry into Missing and Murdered Indigenous Women and Girls. This standing privileges FNHA to provide written testimony to the Commissioners.

2. The testimony will introduce FNHA as a pillar in British Columbia's (BC) First Nations health governance structure, along with the First Nations Health Directors Association (FNHDA) and the First Nations Health Council (FNHC)[1], and introduce the Commissioners to the work done in BC to transform health governance for First Nations.

3. The testimony will reflect the particular interest FNHA has on three issues under Inquiry: (1) the Impact of Colonization, (2) Health and Health Services, and (3) Death Investigation Processes. It will discuss the health, safety and violence prevention work of FNHA before offering recommendations for consideration by the Commissioners in developing their final report and recommendations to the federal and provincial/territorial governments.

4. FNHA's testimony will focus on the issues of Health Services, Death Investigation Processes, and the Impact of Colonization from the perspective of service delivery and operations. In addressing these topics, this testimony will be guided by many of the same areas of focus the Commission is seeking to understand in its Paths of Inquiry:

A. Discussion of how Institutional policies, programs and practices contributed to ongoing violence and vulnerabilities experienced by First Nations women and girls.
B. Discussion of how the laws and policies, and discriminatory, racist and dehumanizing attitudes and practices of the colonial system have disrupted roles, responsibilities and relationships for First Nations women, reinforced unequal gender and power relations between First Nations women, men, and settler colonial society.
C. Discussion of the BC First Nations Health Governance structure as an effective approach for reducing harm and preventing violence, and promoting healing, cultural reclamation, revitalization and resurgence.
D. Outline of FNHA's partnerships, initiatives, programs and services which aim to reduce the vulnerability of First Nations Women and Girls to disappearance and violent death.

[1] FNHC also has standing at the National Inquiry and is providing written testimony. Though some FNHA and FNHC testimony may overlap, the goal is to provide complementary views of the journey toward a shared vision.

E. Discussion of the changing relationship between First Nations in BC and the BC Coroners Service.

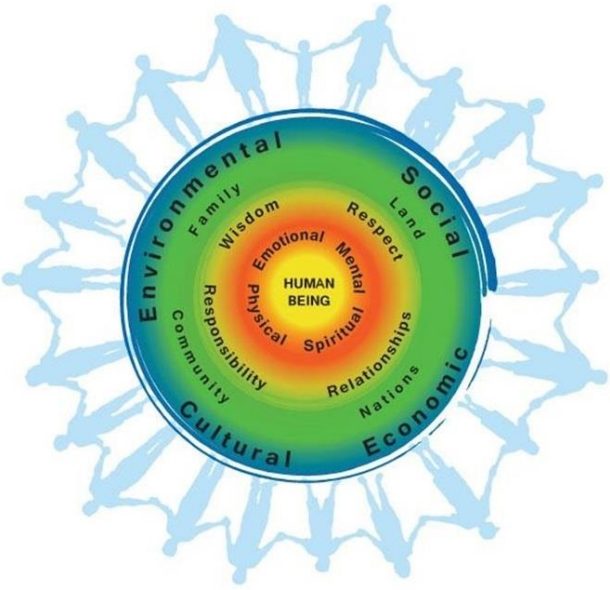
F. Discussion of how First Nations laws guide the work of FNHA, and contribute to reconciliation between First Nations and non-Indigenous people.

G. Outline of best practices for decolonizing processes that confront truth, repair trust and create empathy which are being adopted in BC.

H. Discussion of how Western-based evaluation models are problematic when viewed through a decolonizing, culturally-specific gendered and rights-based approach.

First Nations Health and Wellness in BC[2]

5. The First Nations Perspective on Health and Wellness[3] visually depicts a shared philosophy of wellness common to BC First Nations. This holistic perspective recognizes the interdependence of physical, emotional, mental and spiritual dimensions of well-being. Good health and wellness starts with every human being, and that this wellness is impacted and shaped by a range of internal and external factors. These factors extend outwards from the person, including core values, one's family, community, and relationship to land and Nation, and including broader social, economic, cultural and environmental determinants of health and wellness.



6. Through community and health systems founded in this Perspective, BC First Nations have a rich history of wellness that extends back in time for many thousands of years. First Nations practiced a mix of hunting, fishing and gathering foods and enjoyed good health and wellness due to a lifestyle that was active, based on healthy traditional diets and enriched by ceremonial, spiritual,

[2] Information and citations from '#itstartswithme: FNHA's Policy Statement on Cultural Safety and Humility' at http://www.fnha.ca/Documents/FNHA-Policy-Statement-Cultural-Safety-and-Humility.pdf

[3] A more complete explanation of this perspective is available at http://www.fnha.ca/wellness/wellness-and-the-first-nations-health-authority/first-nations-perspective-on-wellness

emotional and healing practices. However, the arrival of Europeans marked a change of course in the First Nations wellness journey.

7. First Nations health and wellness was disrupted through a process of colonialism, including aggressive tactics and policy initiatives such as the Indian Residential School System, the Indian Act, and Indian Hospitals. These institutions were part of an oppressive colonial agenda designed to eliminate First Nations jurisdiction and control and resulted in the significant degradation of First Nations health and wellness, practices, beliefs, and values, creating a legacy of trauma and health and social inequities. First Nations self-determination was undermined, and decisions about health and wellness were made for us, not with us. A Western European perspective of health became the dominant lens on which our current health care system is based.

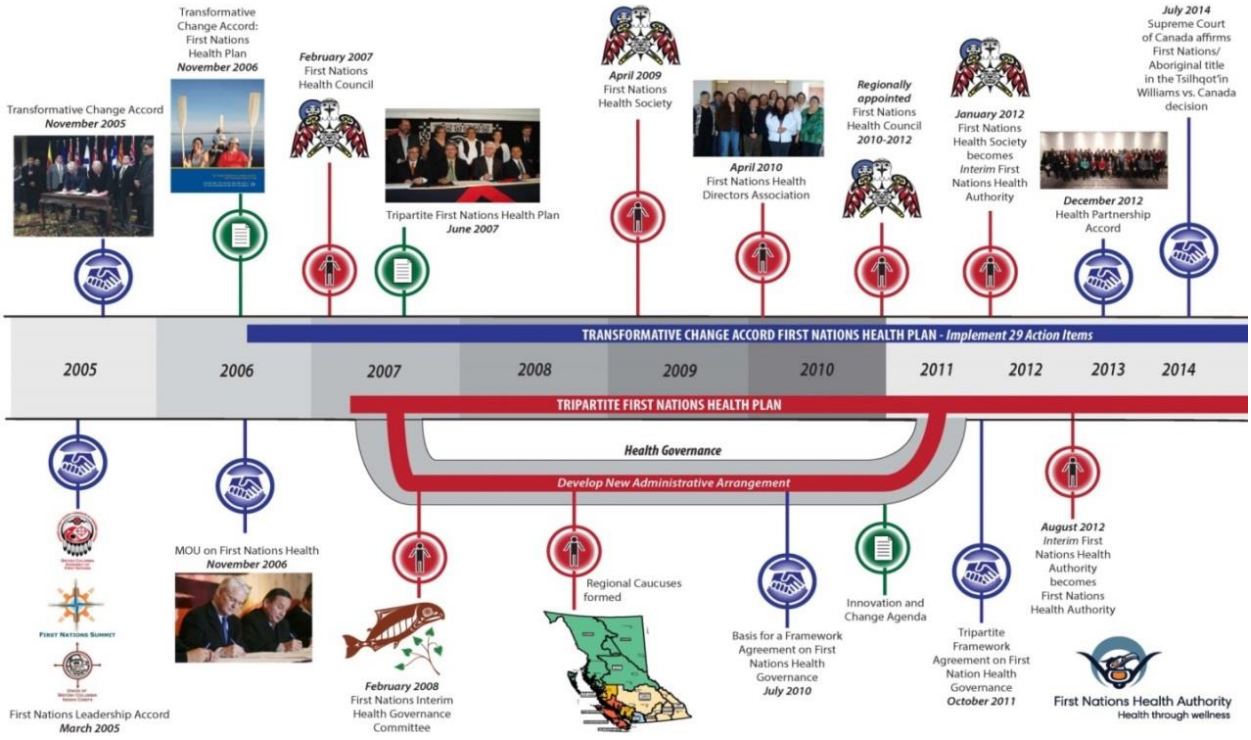
8. First Nations continue to be impacted by colonialism, manifesting as bias, racism and cultural unsafety at interpersonal and systemic levels and across multiple sectors, including health care. Systemic racism, also known as structural or institutional racism, is embedded in societal systems, structures and institutions in the form of "requirements, conditions, practices, policies or processes that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups". As a result of colonialism, many First Nations experience post-traumatic stress disorders, are challenged with substance use, suicide, loss of self-esteem and cultural identity. First Nations people, affected by intergenerational trauma and post-traumatic stress, experience racism and cultural unsafety within the health system that drives them further from health care in a reinforcing pattern resulting in poorer health and wellness outcomes for First Nations peoples.

9. Despite continuing to be impacted by colonialism and oppression, First Nations have demonstrated remarkable resilience. The past several decades have signified a multitude of efforts by First Nations in BC to make decisions for ourselves and to reclaim our wellness through unity and by developing strategic partnerships to increase First Nations involvement in decision-making. Working together in partnership amongst federal and provincial governments and BC First Nations, the tripartite partners reached a series of political, legal and operational agreements outlining commitments to improve First Nations health, including enhancing First Nations self-determination and health governance, and improving the quality of policies, programs and services accessed by First Nations people in BC. A key shared strategy to address the ongoing legacy of colonialism, improve current realities, and realize the vision of "Healthy, Self-Determining and Vibrant BC First

Nations children, families and communities" is a commitment to hardwire cultural safety and humility in the health system.

BC First Nations Health Governance Structure[4]

10. Since 2005, BC First Nations and federal and provincial governments have been on a shared journey of health transformation founded on the recognition of First Nations self-determination and the right to participate in decision-making. This journey has been marked by a series of political, legal and operational agreements outlining tripartite commitments to improve First Nations health: the *Transformative Change Accord* (2005); the *Transformative Change Accord: First Nations Health Plan* (2006); the *First Nations Health Plan Memorandum of Understanding* (2006); the *Tripartite First Nations Health Plan* (2007); the *Basis for a Framework Agreement on First Nation Health Governance* (2010); and, the *British Columbia Tripartite Framework Agreement on First Nation Health Governance* (2011).



11. These agreements include commitments to examine policies that are not conducive to First Nations wellness, blend the "best of both worlds" through embedding the First Nations Perspective on Health and Wellness into the health care system, and to improve access to and quality of health

[4] FNHA Governance and Accountability: http://www.fnha.ca/about/governance-and-accountability

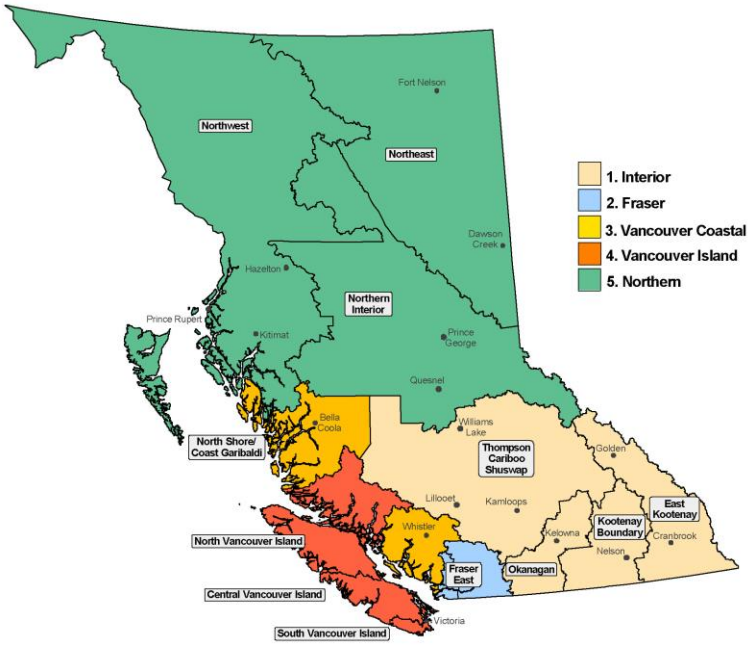
services. These agreements envision an integrated health system, and the elimination of jurisdictional barriers and parallel health systems for First Nations.

12. BC First Nations designed their own First Nations health governance structure to represent their interests in this new tripartite health partnership.[5] The First Nations health governance structure is composed of four entities:

A. The First Nations Health Authority is responsible for planning, management, service delivery and funding of health programs previously provided by Health Canada's First Nations Inuit Health Branch (FNIHB) Pacific Region. FNHA's work does not replace the role or services of the Ministry of Health and Regional Health Authorities; our role is to collaborate, coordinate, and integrate our respective health programs and services to achieve better health outcomes for First Nations in BC.
B. The First Nations Health Council provides political leadership and oversight, advocates for First Nations health and wellness priorities, and builds partnerships to make progress on the social determinants of health.
C. The First Nations Health Directors Association is composed of Health Directors and managers working in First Nations communities. It supports professional development for Health Directors and managers and acts as a technical advisory body to the FNHC and FNHA on research, policy, program planning and design.
D. The Tripartite Committee on First Nations Health (TCFNH) is the forum for coordinating and aligning programming and planning efforts between FNHA, BC Regional and Provincial Health Authorities, BC Ministry of Health, Indigenous Services Canada, and the BC Provincial Health Officer.

[5] First Nations Health Governance Structure in British Columbia at http://www.fnha.ca/Documents/First-Nations-Health-Governance-Structure-in-British-Columbia.pdf

13. These four components are informed by engagement and relationships developed across communities within five regions within the province: Fraser Salish, Interior, Northern, Vancouver Coastal and Vancouver Island.[6]



[6] FNHA Regions http://www.fnha.ca/about/regions

14. Each of these regions adopts a Regional Health & Wellness Plan that articulates the collective health and wellness priorities of communities, and establishes a Regional Partnership Accord with the respective Regional Health Authority to support collaboration, shared planning, and issue resolution as related to health services accessed by First Nations.

15. All of this work done by FNHA, FNHC and FNHDA is driven by the following key elements:

A. Seven Directives, which describe the fundamental standards and instructions for the new health governance relationship provided by BC First Nations leadership[7]:
   i. Directive #1: Community-Driven, Nation-Based
   ii. Directive #2: Increase First Nations Decision-Making and Control
   iii. Directive #3: Improve Services
   iv. Directive #4: Foster Meaningful Collaboration and Partnership
   v. Directive #5: Develop Human and Economic Capacity
   vi. Directive #6: Be Without Prejudice to First Nations Interests
   vii. Directive #7: Function at a High Operational Standard.
B. Shared Values[8] of Respect, Culture, Discipline, Excellence, Relationships, and Fairness, which recognize our origins being in the communities and connect our work to their values.
C. Reciprocal Accountability[9], which understands that traditional First Nations social systems were founded on the idea that each member of the community is accountable for the impact of their decisions and actions, and for their contributions to the community's wellness as a whole. In assuming collective responsibility for the health system, BC First Nations share responsibility and accountability with their partners to achieve common goals through BC's unique First Nations health governance structure.
D. Leave No One Behind[10] which emphasizes fairness, equity and caring across all BC First Nations communities, families, and communities, including women and girls.

[7] Directives http://www.fnha.ca/about/fnha-overview/directives
[8] Vision, Mission and Values http://www.fnha.ca/about/fnha-overview/vision-mission-and-values
[9] Consensus Paper: BC First Nations Perspectives on a New Health Governance Arrangement, pg 27 http://www.fnha.ca/Documents/FNHC_Consensus_Paper.pdf
[10] http://www.fnha.ca/about/news-and-events/news/leave-no-one-behind-end-violence-against-indigenous-women-and-girls

16. The elements are implicitly derived from traditional First Nations laws in BC, which guide their members in ways of knowing and ways of doing, and they have formed the principles by which we work with partners to achieve a strong, safe health and wellness system.

FNHA and Health System Partnership

17. FNHA works with community, health service organization, and health system partners in BC to blend the "best of both worlds" to support First Nations access to culturally safe, quality care and services with the goal of improved health and wellness outcomes. FNHA holds a multi-faceted mandate including the following core functions: policy, research, data, and quality standards supporting the health of the population; direct health benefits, public health and primary health care service delivery; funding of health services delivered by health professionals and First Nations communities/health service organizations; and, ancillary health and corporate administrative functions such as information-sharing, finance, human resources, and information management and technology.

18. FNHA deploys this mandate through three Perspectives of Quality:

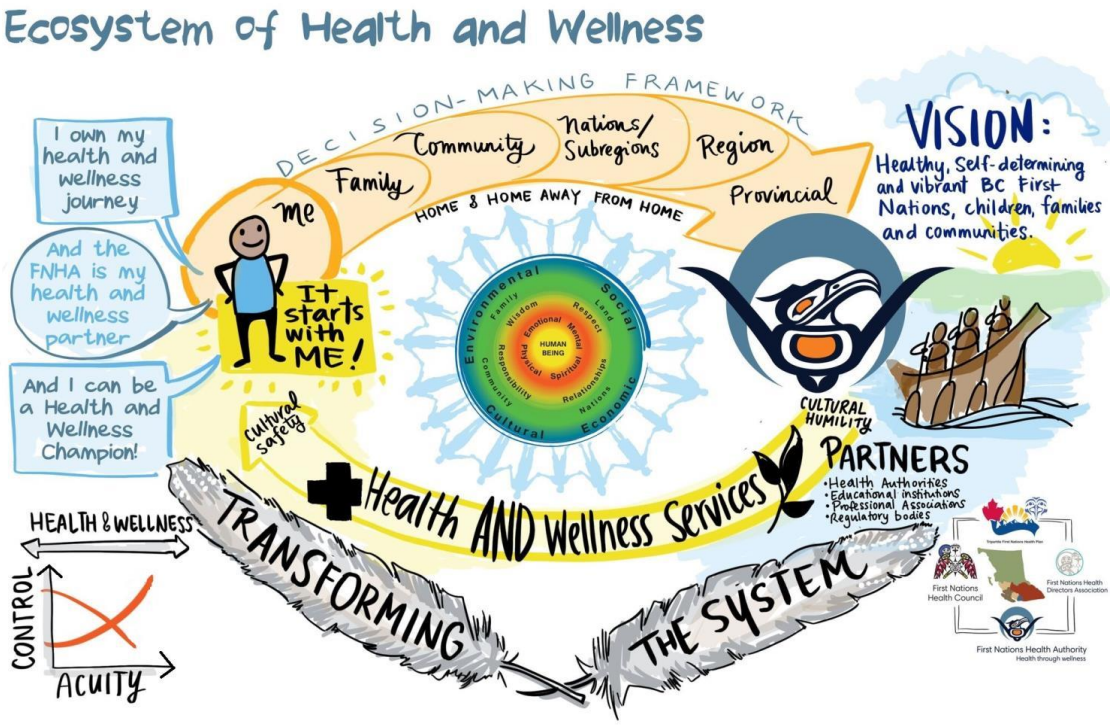
19. Under Provincial Services, FNHA operates as a catalyst and partner across the health system to address ways in which health policy, services, and research affecting BC First Nations can better reflect First Nations philosophies and paradigms, be safer and of higher quality, and focus on wellness instead of sickness/disease. FNHA's work underway to move the system in a better direction focuses on efforts to "hardwire" into the system concepts such as collaboration, reciprocal accountability, cultural safety, cultural humility, trauma informed care, and others, and seeing those efforts translate into action on quality improvement.

20. Under FNHA Services, FNHA operates as a direct deliverer of services. These primarily consist of health benefits administration and public health and nursing services assumed from the

former FNIHB-BC Region, although FNHA is increasing its direct service delivery in mental health and wellness and primary health care.

21. Under FNHA-Funded Community Services, FNHA operates as a funder and partner of provincial programs and local health administrations and health centres. FNHA employs program managers and specialists that work with communities to improve the quality of their programs and services, their capacity to deliver these services, and broker partnerships with other parts of the health system. FNHA also produces training, tools and resources to support communities in health planning and administration.

22. Through holding this multifaceted mandate across the health ecosystem in BC, FNHA has been able to successfully leverage partnerships and implement rapid service improvements to see change not just in how care is delivered, but in its philosophical and evidentiary underpinnings. For example, some of the improvements include: a significant provincial and national movement to address systemic racism and cultural unsafety through the practice of cultural humility; significant new services available in primary health care and mental health and wellness; significantly enhanced data and evidence leading to targeted health and wellness strategies; and, a shift from sickness and deficit indicators towards health and wellness indicators and reporting.



23. The impacts of the Tripartite and the health governance transformation are already being felt, as First Nations people and communities see system improvements, which will improve both the quality of the health and wellness system and show significant potential for improving the health and wellness outcomes for First Nations Woman and Girls.

Testimony to the National Inquiry

24. FNHA's testimony will provide a snapshot of current health and wellness trends for First Nations women and girls; focus on the issues of Health Services, Death Investigation Processes, and the Impact of Colonization; and provide a summary of service delivery and operations work done by FNHA to improve outcomes for First Nations women and girls, and their communities. Based on the knowledge, learnings and experiences FNHA and its partners have gained throughout this health governance journey in BC, FNHA respectfully makes recommendations throughout the document to the Commissioners for their consideration in completing their final report to the federal and provincial/territorial governments.

Current Health and Wellness Trends

25. Through creating the BC First Nations Client File (a demographic database), the FNHA is able to undertake data linkages with other existing data to enable enhanced visibility of the health status and health system utilization of the First Nations population in BC. The story the data tells is one about lack of access to and utilization of primary care for First Nations women and girls, which drives higher use for higher acuity conditions of Emergency Departments (ED) and higher mortality for preventable conditions. This suggests that First Nations women and girls do not have access to a culturally safe health care system, and this lack of continuity of care results in greater risk of premature death, and poorer health outcomes. Matters of cultural safety and humility, ongoing legacy of colonialism, and the existence of trauma are further elaborated upon later in this submission.

Emergency Department Utilization

26. In 2014/15, 41.5% of First Nations females visited an ED at least once, a rate that was 1.9 times higher than other provincial residents (Other Residents), and also higher than the comparable First Nations male rate (36.2%) (*Appendix B: Figure 1*). First Nations girls aged 0-17 years also had a two-fold higher rate of ED use compared to Other Resident girls.

27. Among First Nations females, the most common reasons for visiting a physician in EDs were the general category of signs, symptoms and other reasons (where the exact reason for illness could not be determined within the ED, followed by physical trauma and respiratory conditions.

28. Between 2008/09 and 2014/15, the ED user rate increased significantly among First Nations females (overall, and also in the 0-17 age group), a trend which was also seen in the Other Resident female population.

Continuity of Care and Access to General Practitioners (GP)

29. BC provincial administrative data has revealed that First Nations women were less likely to visit a GP (outside of hospital) than Other Resident females in 2014/15 (80.4% vs. 81.8%). As First Nations females in BC had higher health needs (shown through chronic health conditions – see below), this GP data suggests issues with access to primary care services by First Nations.

30. The effectiveness of primary care can be enhanced by having a regular relationship with a GP. Continuity of care with a GP has been associated with avoidable hospital admissions and improvements in the experience of patients and those working in general practice.[11] Continuity of care with a single family practice was investigated in BC using GP attachment.[12] By this measure, in 2014/15, over 80% of First Nations who were 50 years of age and older had continuity of physician care. Looking at all age groups together, First Nations females were more likely to be attached to a GP compared to First Nations males (77.4% vs. 71.3%); however, here too there was a disparity with Other Resident females, with the First Nations female rate of attachment being significantly lower. By contrast, there was comparability in the GP attachment rates of both populations for girls aged 0-17 years.

31. Over the seven-year period from 2008/09 through 2014/15, attachment rates declined among First Nations females (overall, and in the 0-17 age group).

Prevalence of Chronic Disease

32. Data from the BC Chronic Condition Registries shows that the most common chronic conditions in the BC First Nations population in 2014/15 were hypertension (17.7%), asthma (17.5%),

[11] Barker, I. et al. 2017. Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data. BMJ; 56:j84

[12] GP attachment is based on the number of visits with GPs in a single practice. Individuals were considered attached to their GP if at least half of their visits within a given fiscal year were with GPs in a single practice.

osteoarthritis (13.2%), mood & anxiety disorders (11.2%), and diabetes (10.4%). In the majority of the conditions in the registry, prevalence rates were higher for First Nations females than First Nations males (except cardiovascular conditions).

33. When compared to the Other Resident population, prevalence rates were lower among females compared to Other Resident females for multiple sclerosis and Alzheimer's/dementia, however were higher in rheumatoid arthritis, dialysis, epilepsy, stroke, chronic obstructive pulmonary disease (COPD), heart failure, chronic kidney disease (CKD), asthma, cervical cancer, osteoarthritis, angina, acute myocardial infarction, diabetes, colorectal cancer, mood & anxiety disorders, osteoporosis, hypertension, and cancer 1st encounter.

34. The First Nations female population experienced increasing rates in CKD, Alzheimer's/dementia, COPD, cancer 1st encounter, asthma, breast cancer, epilepsy, diabetes, and mood & anxiety disorders.

35. Asthma and mood & anxiety disorders were chronic conditions of note among First Nations girls aged 0-17 years. In 2014/15, 15.3% of First Nations girls had asthma and 3.1% had a mood & anxiety disorder. When compared to Other Resident girls, First Nations asthma and mood & anxiety disorder prevalence rates were significantly higher.

Utilization of Mental Health and Wellness Services

36. Mental health and wellness was examined through the lens of physician services visits and hospitalizations related to mental health and substance use. In 2014/15, physician user rates for mental health services were significantly higher among First Nations females (16.4%) compared to males (9.4%) [1.7X higher], however, the reverse was seen for substance use services (First Nations males (0.7%) compared to females (0.5%) [1.4X higher]) (*Appendix B: Figure 2*).

37. With respect to both physician and hospital services, First Nations females were more likely to access services for mental health and substance use reasons than Other Resident females; these First Nations rates were stable between 2008/09 and 2014/15.

Cancer

38. First Nations women in BC are disproportionally impacted by some of the most commonly occurring cancers when compared to non-First Nations women. This is especially true for cancers where population-based screening tests exist that require patient vulnerability to undergo intimate

screening procedures in order to prevent or detect those cancers early. First Nations women have a 92 percent higher cervical cancer incidence rates compared to non-First Nations women, despite BC having a cervical cancer screening program established in the province since the early 1960's that has reduced cervical cancer incidence rates in the general population by 70 percent. To highlight this disparity further, cervical cancer is the fourth most commonly diagnosed cancer in First Nations women, whereas it's the ninth most commonly diagnosed cancer in non-First Nations women in the province. First Nations women are also significantly more likely to be diagnosed with colon cancer than non-First Nations women; again, a screen detectable cancer requiring a high degree of patient vulnerability. Finally, and most concerning, First Nations women are less likely to survive a cancer diagnoses compared to non-First Nations women in the majority of cancers reviewed, including when diagnosed with cervical or colon cancer.

FNHA Use of Data

39. FNHA uses the data intelligence available to drive health and wellness actions and results to benefit First Nations in BC, including women and girls, in a manner that upholds First Nations data governance. This includes identifying root issues such as trauma, colonialism, and racism, as well as opportunities for enhanced and equitable access to services.

40. As we grow and develop our data and intelligence capacities, there are opportunities to better understand the health and wellness environment for First Nations women and girls. An example of where this is leading to improvement is the work being done with the Provincial Health Officer to produce a comprehensive report on Aboriginal women's health and well-being in BC. The forthcoming Aboriginal Women's Health Report is intended to enhance the health and wellness of Aboriginal women and girls in BC by providing information and recommendations that support their health and wellness journeys.

Recommendation 1: Organizations working with First Nations populations increase opportunities/partnerships to support First Nations to gather data and evidence, while respecting and applying OCAP© principles, and use the results to inform service and investment planning. This data and evidence should consider as valid other ways of knowing, including performance and outcomes measurement, evaluations, research, and give space to Indigenous oral traditions and teaching.

The Impact of Colonization

41. The impact of colonization forms the foundation for the disparities described above, and the following issues to be raised in this testimony, and informs the past, present and future work for FNHA in transforming the health system in BC into a culturally safe and trauma informed health *and wellness* system. It acknowledges that the impacts of colonization, through the framework of colonialism, are still experienced and witnessed across the conditions in which people are born, grow, work, live, and age, and the wider set of forces shaping the conditions of daily life[13] known as social determinants of health.

42. As noted in the introduction, the health and wellness of First Nations individuals and communities was disrupted by the processes and institutions of colonialism, and the traditions with respect to health and healing roles and responsibilities of community members were frequently subject to targeted regulations and repression to disempower individuals and communities from maintaining health and wellness traditional activities. As a result, some practices, traditions and teachings were forced underground, surviving by transmittal from one generation to the next in secret, but many others were lost. For a more thorough discussion of the history of First Nations health and wellness in BC, both before and after contact with settlers, see **sections 2** and **3** of *Implementing the Vision: BC First Nations Health Governance – Reimagining First Nations Health in BC*[14] by the First Nations Health Council (FNHA Exhibit 1).

43. The lasting legacy of colonizing First Nations health has been negative impacts: racism in the health system becoming a determinant of health, a cycle of family and intergenerational trauma and violence, changes to the roles of women and girls in communities, and the marginalization of Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Plus (2SLGBTQ+) health and wellness.

THE ROLE OF WOMEN AND GIRLS

44. Prior to contact with European settlers, First Nations societies were steeped in a variety traditions and laws which guided the roles of men, women, two-spirit people, boys, girls, and elders for everyday and ceremonial purposes. Hanson[15] writes, "Despite the vast socio-cultural diversity amongst Canada's hundreds of First Nations, historians and experts largely agree that a balance

[13] FNHC Discussion Paper: Ten-Year Determinants of Health Strategy http://fnhc.ca/wp-content/uploads/FNHC-Discussion-Paper-Ten-Year-Determinants-of-Health-Strategy.pdf
[14] FNHC (2011) http://www.fnha.ca/Documents/FNHC_Health_Governance_Book.pdf
[15] Erin Hanson, "Marginalization of Aboriginal women: A Brief History of the Marginalization of Aboriginal Women in Canada" at: https://indigenousfoundations.arts.ubc.ca/marginalization_of_aboriginal_women/

between women and men's roles typically existed in pre-contact Aboriginal societies, where women and men had different, but complementary roles. Many First Nations were matrilineal, meaning that descent – wealth, power, and inheritance — were passed down through the mother."

45. For example, McAdams[16], Wright[17], Lux[18], et.al., have documented the roles women and girls had as the keepers of their Nation's laws, ceremonies, and traditions, noting in several societies that women controlled the ownership of tipis and lodges, and were responsible for the birth process as midwives. Those who held the roles of midwife were "empirically trained", with children being birthed "through the care and experience of the midwife and her helpers" (Lux, 91-92). Midwives held important knowledge about the protocols and medicines to provide a safer experience for mothers and infants, and observed traditions such as remaining in the home of the mother to do her work while she healed. Women were also the "first teacher, healer, and counsellor"[19] (Snyder, 102) in the lives of children born into their Nation.

46. This reality clashed with the patriarchal notions and beliefs of European colonizers and settlers about the role and identity of women. These newcomers came from societies where women were generally considered weak, delicate, or frail, were defined as property with few or no rights, and were confined to the role of mothers in the private spheres of the home. The meeting of two disparate ways of life and the implementation of Settler governance would have terrible impacts on the lives and roles of First Nations women and girls and their communities in several key ways:

A. As Snyder (35) notes, the introduction of "colonial policy and violence via the Indian Act, residential schools, and the general imposition of Victorian gender norms affected and altered Indigenous gender relations in Canada." The Indian Act, over the course of its long history, was amended several times to restrict the recognition of thousands of women and their children as members of a First Nation through disastrous disenfranchisement policies, thus separating them from their traditions, cultures and roles. The imposition of patriarchy and patrilineal norms on First Nations cultures further served to diminish the power women had in their societies.

[16] Sylvia McAdams (Saysewahum). (2015). Nationhood Interrupted: Revitalizing nêhiyaw Legal Systems. Saskatoon: Purich Publishing Limited.
[17] Mary C. Wright. (2006). "*The Women's Lodge: Constructing Gender on the Nineteenth-Century Pacific Northwest Plateau*." in Mary-Ellen Kelm and Lorna Townsend, eds, "In the Days of Our Grandmothers: A Reader in Aboriginal Women's History in Canada." (Toronto: University of Toronto Press).
[18] Maureen Lux. (2007). Medicine That Walks: Disease, Medicine, and Canadian Plains Native People, 1880-1940. Toronto: University of Toronto Press.
[19] Emily Snyder. (2018). Gender, Power and Representations of Cree Law. Vancouver: UBC Press.

B. As Lux (96) notes, with the establishment of settler male-operated hospitals and medical missionaries, "Native midwives were seen at unwelcome competition." Pressure was brought on First Nations people to start having births in hospital settings, or overseen by settler male doctors, and the policies of these settings were disruptive to the First Nations traditions involved with the birthing process—mothers were separated from their infants, ceremonies were discouraged, and the roles of Indigenous midwives were usurped to the point of valuable knowledge and skills disappearing and being lost.

C. As Carter[20] (147) notes, "The Canadian state adopted increasingly segregationist policies toward the Aboriginal people of the West, and central to these policies were images of Aboriginal woman as dissolute, dangerous, and sinister." In order to establish power over First Nations by diminishing the roles of women and girls, various characterizations became popularized, including First Nations women as 'Indian Princesses', or squalid and immoral 'Squaws', serving to de-humanize them in their homes, communities, and wider Canadian society.

47. As these impacts were perpetuated through formal and informal social and institutional structures, it set a permissive tone for the poor systemic treatment of Indigenous women and girls, with detrimental impacts on their health and well-being.

Recommendation 2: Governments and organizations adopt a gender-based lens in their work and approach.

Recommendation 3: More investment in specific programming for Indigenous women, not only for health care, but focused also on resiliency and restoring the role of Indigenous women.

RACISM

48. The presence of racism in the health system is a major contributor to health inequities faced by First Nations peoples, including those described earlier, and frequently acts as a deterrent to seeking care, which exacerbates the health issues for which they need attention.

49. Racism categories that First Nations peoples experience includes internalized (acceptance of racist beliefs into one's worldview), interpersonal (person-to-person) and systemic (societal and institutional). Systemic racism is a recognized barrier to accessing appropriate care that

[20] Sarah Carter. (2006). "*Categories and Terrains of Exclusion: Constructing the 'Indian woman' in the Early Settlement Era in Western Canada*." in Mary-Ellen Kelm and Lorna Townsend, eds, "In the Days of Our Grandmothers: A Reader in Aboriginal Women's History in Canada." (Toronto: University of Toronto Press).

disproportionately affects First Nations. Both interpersonal and internalized racism result from systemic racism and directly harm the health of individuals through psychological, social, behavioural and physical processes, such as the mental and physical effects of stress, and negative coping mechanisms (e.g., self harm, unhealthy diet, substance use).[21] Interpersonal and internalized racism can put a First Nations individual's health and wellness at risk when it stops them from seeking help or being fully open and honest with their care provider about the way they feel or the symptoms they experience.

50. Colonialism created the space which allowed racism to become embedded into the health system. It serves as a foundation for the racist and stereotypical beliefs and perspectives of many health care providers, which inform their interactions with Indigenous people in their care. Its structures and institutions are designed in ways that permit these beliefs and perspectives to go unexamined by those who hold them and those holding care providers accountable. Colonialism is perpetuated further in the education system, meaning those studying to be care providers can continue their studies without questioning or disrupting their biases about or against Indigenous people.

51. For further insight, see *FNHA Cultural Safety and Humility Action Serious 10* (FNHA Exhibit 2); *"They treated me like crap and I know it was because I was Native": The healthcare experiences of Aboriginal peoples living in Vancouver's inner city* by Goodman et. al. (FNHA Exhibit 3); and *'Stereotypes are reality': addressing stereotyping in Canadian Aboriginal medical education* by Ly & Crowshoe (FNHA Exhibit 4).

Recommendation 4: Mandatory embedding of Cultural Safety, Cultural Humility, and Trauma Informed Practice into the work, programming, care and services touching Indigenous women.

Recommendation 5: Governments and institutions work to "hardwire" Cultural Safety, Cultural Humility, and Trauma Informed Practice into the larger health and wellness system.

Recommendation 6: Post-secondary and professional education institutions embed Cultural Safety, Cultural Humility, and Trauma Informed Practice into their curriculum for practitioners and allied health professions.

[21] FNHA and BC Cancer (2017): Cancer and First Nations Peoples in BC: A Community Resource http://www.fnha.ca/wellnessContent/Wellness/Cancer-and-First-Nations-Peoples-in-BC.PDF

FAMILY AND INTERGENERATIONAL TRAUMA AND VIOLENCE

52. Through the testimony at the Royal Commission of Aboriginal Peoples, which was tabled in the final report released in 1996[22], it became clear that colonizing and assimilationist policies such as displacement/forced relocation, Indian Hospitals and Indian Residential Schools deeply impacted Indigenous families:

A. At the community level, generations-long connections to traditional territories, sustenance practices, food sovereignty, and knowledge of local medicines and healing practices were severed by relocation programs and the creation of the reserve system (including subsequent policies of land-base reduction).
B. At the level of the individual, generations of children were removed from their homes and communities, severing their connections to a loving family environment, and displacing them from their languages and cultures, in many cases, permanently.

53. These and other policies in effect amount to cultural genocide, and under the framework of colonialism, have led to "limited economic development opportunities, greater dependency on the government for financial help, cultural loss and an undermining of the social and cultural fabric that is central to [Indigenous] identity, decreased self-reliance and a sense of powerlessness."[23] These factors contribute to lower self-esteem and poor mechanisms for coping individuals, and combined with the abuses many experienced in residential schools and Indian hospitals, form the basis for family violence as a learned behaviour which has been perpetuated through generations.

54. The impacts of family and intergenerational violence contribute to a host of crises which impact First Nations families and communities, and are contributing factors to the deaths and disappearances of many First Nations women and girls, as well as men and boys, and non-binary individuals. For specific evidence on the impacts, see *Family Violence as a Social Determinant of First Nations, Inuit and Métis Health* by the National Collaborating Centre for Aboriginal Health (FNHA Exhibit 5).

[22] Report of the Royal Commission on Aboriginal Peoples (1996) https://www.bac-lac.gc.ca/eng/discover/aboriginal-heritage/royal-commission-aboriginal-peoples/Pages/final-report.aspx
[23] National Collaborating Centre for Aboriginal Health https://www.bac-lac.gc.ca/eng/discover/aboriginal-heritage/royal-commission-aboriginal-peoples/Pages/final-report.aspx

Recommendation 7: Identify resources for Nation-led practices to promote healing for Indigenous men and boys, and to support communities in lifting up all of their members, and to break cycles of violence and trauma.

IMPACTS ON 2SLGBTQ+

55. Another impact of colonialism has been the marginalization of non-traditional gender and sexual identities in Indigenous communities. In oral traditions, ethnographic accounts, and Indigenous languages across the continent, there is strong evidence to support diversity in sexuality and gender identities and roles in First Nations communities and societies (Hunt)[24]. Post-contact, Hunt (105) notes that "[c]olonial laws and ideologies have entailed the imposition of gendered and racialized categories" through tools such as the Indian Act (which confirmed patrilineality and disenfranchisement) and Indian Residential Schools, which imposed rigidly defined gender and sexuality norms on Indigenous societies. For a more detailed understanding of the history of European perspectives on First Nations Sexuality and Gender identities, see *The Regulation of First Nations Sexuality* by Martin Cannon (FNHA Exhibit 6).

56. Unfortunately, as Hunt (110) and Ristock, Zoccole et. al.[25] (5) note, there is limited research available regarding the health and wellbeing of Two-Spirit and Trans people, and what research findings do exist are from the United States. From that research, the conclusions indicate that "[h]istorical trauma, health care system inequities, hate-motivated violence, and childhood physical and sexual abuse are some of the determinants that can be linked to negative health outcomes for Two-Spirit people. In considering health concerns, we also know that both Indigenous and LGBTTQ individuals move as a result of marginalization and/or to seek health care (in addition to other reasons)." (Ristock, Zoccole, et. al., 5) As Wechsler[26] reports, the stigma "has material consequences in health. Both Indigenous and queer youth are disproportionately represented in local and national populations experiencing homelessness, at risk to attempt suicide or to experience violence."

[24] Sarah Hunt. (2015). "*Embodying Self-Determination: Beyond the Gender Binary*." in Margo Greenwood, Sarah de Leeuw, Nicole Marie Lindsay and Charlotte Reading, eds, "Determinants of Indigenous Peoples' Health in Canada: Beyond the Social." (Toronto: Canadian Scholars' Press).

[25] Janice Ristock, Art Zoccole et. al. (2011). "Aboriginal Two-Spirit and LGBTQ Migration, Mobility, and Health." at: http://www.2spirits.com/PDFolder/2011%20Vancouver%20full%20report%20final.pdf

[26] Steph Wechsler. (2016). "Why LGBTQ indigenous communities struggle with healthcare for the homeless" at: https://tvo.org/article/current-affairs/why-lgbtq-indigenous-communities-struggle-with-healthcare-for-the-homeless

57. With such gaps in knowledge, it is challenging for health and wellness organizations to identify strategies and best practices to meet the needs of the 2SLGBTQ+ population in a way which promotes their safety and wellbeing.

Recommendation 8: Encourage governments, not-for-profit organizations, health researchers, and academic institutions to engage in more study on the health and wellness status and needs of 2SLGBTQ+ people.

Recommendation 9: Governments and organizations adopt an intersectionality lens in their work and approach.

Observations about Health Services

ACCESS AND SAFETY, INCLUDING CULTURAL SAFETY & HUMILITY

58. In BC, the majority of First Nations communities are smaller (less than 500 inhabitants), and most First Nations people therefore access health services out of their communities. These individuals often encounter practical issues related to poor coordination for getting to and from appointments and services, unfamiliarity with the town/city or the language, unfamiliarity with the workings of the health care system, lack of supports, lack of coordination between care providers, and no discharge planning that includes the nurse in their community. This lack of a coordinated system can pose risk for clients, particularly women and girls. It can also discourage people from seeking further care for an ongoing or future health issues.

59. As discussed, First Nations people may also encounter racism and stereotyping, which is discouraging or exacerbates an already complex journey. Without practitioners who practice cultural safety and cultural humility, and who are trained in trauma informed practice, First Nations people could be further deterred from seeking care or engaging in prevention activities. For instance and as evidenced in the earlier data, if the journey of a First Nations person included sexual violence or trauma, it could deter them from taking part in preventative screening for certain illnesses such as breast, cervical or colon cancer, because those procedures may create situations of re-traumatization. A practitioner not practicing cultural safety and humility, or not engaging in trauma-informed practice may fail to recognize the possible or potential negative impacts of screening procedures, and fail to adequately prepare their patients.

60. It is encouraging to see a growing commitment to Cultural Safety and Cultural Humility in the health and wellness sector in BC and across the country, but those are two steps on a longer journey

to ensuring that health and wellness care and practice are safe for First Nations people. To explain, it is important to understand the definitions of Cultural Safety and Cultural Humility that FNHA is working with, as well as general definitions of Trauma Informed related concepts which may guide the Commission in considering their value for recommendations:

A. Cultural Safety: Cultural safety includes and goes beyond cultural awareness, which refers to awareness of differences between cultures. It also goes beyond cultural sensitivity, which is about realizing the legitimacy of difference and the power of one's own life experience can have on others. *Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.*
B. Cultural Humility: Cultural humility is a process of self-reflection to understand personal and systemic conditioned biases, and to develop and maintain respectful processes and relationships based on mutual trust. *Cultural humility involves humbly acknowledging oneself as a life-long learner when it comes to understanding another's experience.*

61. FNHA has initiated a province-wide movement towards Cultural Safety and Humility in health services in BC. This includes the signing of a Declaration of Commitment to Cultural Safety and Humility by all key players in the health system in BC, including the BC Ministry of Health and Ministry of Mental Health & Addictions, all Health Authorities, and the 23 regulatory bodies that govern health care professions in BC (these organizations regulate and oversee the practice of 110,000 health professionals across the province, including nurses, doctors, dentists, pharmacists and many others)[27]. These Declarations have led to action planning, strategy, and learning about systemic bias and racism and to make the health system more welcoming for all Indigenous peoples.

62. Trauma is understood as past and/or current experiences which overwhelm the ability to cope physically, emotionally, mentally and spiritually. It is experienced uniquely, and it is important to respect that it is a person's subjective experience that determines whether an event is traumatic, and that every individual, family, community and/or Nation may respond differently (i.e., there is no "right way" to respond to trauma). Indigenous people in Canada have experienced trauma over

[27] "All regulated health professions commit to a safer health system for First Nations and Aboriginal People" http://www.fnha.ca/about/news-and-events/news/health-regulators-commit-to-cultural-safety

multiple generations, leaving long-lasting visible and invisible scars. It is vital that health and wellness practitioners, providers and allied health workers, as well as the health and wellness system overall, are aware of this reality, are trained to address it with their clients and patients, and respond to it as professionals.

A. Trauma-informed and responsive: An approach to care that considers the need for services to respond to an individual's experiences of trauma as an underlying cause of mental health and substance use concerns. The principles of trauma-informed care include:
    i. Trauma awareness among service providers and acknowledgement of how trauma has impacted the wellness of the person receiving care.
    ii. Emphasis on safety and trustworthiness: physical, mental, emotional, spiritual, and cultural safety
    iii. Emphasis on choice, collaboration and relational connection
    iv. Emphasis on a strengths-based approach to care.
B. At an organizational level, becoming a trauma-informed organization can look like the development of trauma informed organizational policies which recognize the potential that trauma has occurred and strives to mitigate re-traumatization.
C. Trauma informed principles[28]: include avoiding re-traumatization; empowering the individual; working collaboratively with flexibility; understanding cycles of trauma and intergenerational trauma; and recognizing trauma symptoms as adaptations.
D. Trauma-specific services: Beyond the need for all care that support First Nations to be trauma-informed, it is critical there also be investment in trauma-specific services, which are services provided by highly trained and culturally safe professionals who are able to help people move through and heal from their trauma.

MENTAL HEALTH AND WELLNESS, SUBSTANCE USE AND ADDICTIONS

63. In 2005, the Assembly of First Nations (AFN) rolled out a Health Blueprint process across the country whereby regions would develop their own regional health blueprints describing regional health priorities that would be rolled into a national blueprint document on Aboriginal health. At that time, BC leaders identified, among other key issues, that there was a serious gap in services in

[28] BC Coroner Service. November 2016. "BC Coroners Service Death Review Panel: A Review of Intimate Partner Violence Deaths, 2010-2015." at: https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/death-review-panel/intimate-partner-violence2010-2015.pdf

the mental health and addictions field including insufficient detoxification beds.[29] In 2018, BC First Nations continue to identify mental wellness and substance use concerns as a key priority.

64. The challenges and gaps experienced by First Nations in accessing mental health and wellness care come with additional considerations related to the context of First Nations health and wellness and the historical and ongoing impacts of colonialism. Racism, intergenerational trauma and continued systemic barriers have many implications for mental health and wellness. The FNHA recognizes that mental health and substance use disorders amongst First Nations is primarily symptomatic of an underlying issue of pain, trauma, and loss.

65. A key example is the current Opioid Crisis.[30] There has been an emergency of unintentional overdose deaths in Canada, which has been influenced by the tainting of substances with powerful synthetic opioids (fentanyl or fentanyl analogues) as well as concurrent substance use. In 2016, the opioid emergency was declared a public health emergency by the BC Provincial Health Officer under the *Public Health Act* due to the unprecedented increase in overdoses and deaths in the province. Preliminary data from January to April 2017 shows that fentanyl was detected in 72% of overdose deaths in BC. Often people who use substances are not aware that fentanyl is present in the drug.

66. First Nations people are not the only group affected by the crisis, but data shows that it has disproportionately affected First Nations people and communities: Although First Nations in BC comprise 3.4% of the population, 14% of all overdose events in BC were experienced by this population, and First Nations people are five times more likely than non-First Nations people to experience an event. Furthermore, 10% of all overdose deaths in BC were First Nations people, and they were three times more likely to die due to an overdose than non-First Nations people.

67. More pertinent to the National Inquiry, analysis also showed that in BC, First Nations women were experiencing eight times more overdose events and five times more deaths from overdose than non-First Nations women. This is in stark contrast to the patterns in the mainstream population; amongst First Nations, men and women are equally affected by the overdose crisis (52% men, 48% women), whereas in the mainstream population the crisis is mainly affecting men (71%

[29] FNHC *Our Story: The Made-in-BC Tripartite Health Transformation Journey* http://www.fnha.ca/Documents/FNHA_Our_Story.pdf

[30] Following information from FNHA "Overdose Data and First Nations in BC: Preliminary Findings" at: http://www.fnha.ca/newsContent/Documents/FNHA_OverdoseDataAndFirstNationsInBC_PreliminaryFindings_FinalWeb_July2017.pdf

men, 20% women). This clearly demonstrates the much higher degree of risk that First Nations women are facing for overdose events and deaths, and the need for to address root causes and healthy responses.

68. First Nations peoples, including women, with substance use disorders are often in contact with justice and correctional systems. First Nations women are overrepresented in correctional facilities, and often are admitted to these facilities with extremely acute health needs. This is a key opportunity to provide high quality health and wellness care for women and girls, including for substance use disorders, and provide for better continuity of care upon their release.

Recommendation 10: Encourage governments to ensure that people coming out of the Corrections system who are accessing opioid agonist therapy are connected to a prescriber close to home as well as connecting with formal and informal/natural supports to continue the therapy.

69. There are many issues contributing to the increased risk for First Nations people: racism and intergenerational trauma as a barrier to health care, the higher risks of substance use among those impacted by intergenerational trauma, reduced access to mental health treatment, reduced access to addiction treatment, such as methadone maintenance therapy and suboxone, and medical dismissal or refusal of pain-relieving substances in health settings leading to increased patient reliance on other substances for pain management. This last point—the dismissal or refusal of pain-relieving substances—is driving many people to find other substances, exposing them to higher risk of an overdose event and possible death.

70. Ensuring supportive contexts for First Nations individuals, families and communities to be mentally healthy and well require whole-of-government and whole-of-society approaches that ensure all First Nations people have access to a culturally-safe, comprehensive, and coordinated continuum of mental health and wellness approaches. As demonstrated by the opioid overdose crisis and the disproportionate impact experienced by First Nations, health and wellness system partners cannot afford to be siloed; a system that is populated by stakeholders who are unaware of the efforts of others is one where gaps allow the mental health and well-being of First Nations women and girls to go unaddressed, putting them at further risk. A systems-wide paradigm shift in approaches to mental health and wellness is required for significant progress to be made towards a vision where all First Nations experience support for positive mental health and wellness where they

live their lives, while accessing a full continuum of holistic and culturally safe programs and services when needed.

Observations about Death Investigation Processes

71. The death investigation process is a traumatic experience for family members left behind when a First Nations person is murdered or goes missing. Throughout the Inquiry's Part I Truth Gathering Process, the Commissioners heard the truths of surviving family members who had poor experiences with authorities throughout a death investigation process, which has prolonged the pain and grief of losing their loved one.

72. The interest FNHA has in the issue of death investigation processes relates to cultural safety and humility, the role the office of the Coroner or Medical Examiner (depending on the appropriate provincial or territorial legislation) and the interactions between these services and families of missing or murdered First Nations people.

73. In BC, that office is the BC Coroners Service (BCCS), which has worked since 2012 to improve its processes by taking a more culturally safe approach to working with First Nations families and communities. Though the BCCS journey initially was driven by an unrelated issue, FNHA and FNHC became involved in advocating for needed changes in Coroner practices and processes. Through dialogue which was difficult at times, BCCS came to understand that families' and communities' spiritual and emotional needs need to be elevated for consideration and First Nations families and communities need to have a significant role in the decisions being made. This dialogue made it clear that there were mutual areas of interest for BCCS and FNHA, culminating in a formal partnership through a Memorandum of Understanding in May 2014.

74. The Memorandum committed both parties to "mutually and collaboratively supporting each other in positive and constructive manner to improve First Nations public safety and the prevention of First Nation's deaths. It also outlines the goals of working towards cultural competency and culturally safe services, and strengthening relationships between coroners and First Nations communities, families, and individuals in a way that respects Community-Driven and Nation-Based decision-making. Commitments also included quarterly meetings on annual workplans, and annual

meetings between senior executives of both organizations."[31] The partnership was further recognized when on May 17, 2017, BCCS and FNHA signed a joint *Declaration of Commitment to Cultural Safety and Humility* (Appendix C).

75. A key outcome of the relationship is the move by BCCS toward adopting culturally safe investigative practices which take into account the importance of First Nations beliefs and spiritual and cultural practices or protocols around death, and openness to the practice in some First Nations to identify a spokesperson to advocate for the family and take care of matters during their time of grief. Where before, BCCS expected to work with the legal next of kin, they are now open to working with those the family designates during a difficult emotional journey through the loss of a loved one.

76. Another key outcome of the relationship has been the completion the first-of-its-kind Joint Death Review Panel in BC. The BCCS-FNHA joint death review report, which reviewed the circumstances of injury-related deaths of 95 First Nations youth and young adults aged 15 to 24, shows us that the mortality rate for First Nations youth and young adults is almost twice that of their non-First Nations peers. The report concludes with specific recommendations for ourselves and partners within four areas:

A. Promote Connectedness to Peers, Family, Community and Culture;
B. Reduce Barriers and Increase Access to Services;
C. Promote Cultural Safety and Humility and Trauma-Informed Care; and
D. Elicit Feedback through Community Engagement.

77. In response to these recommendations, FNHA developed an action plan to outline key activities to address injuries or untimely deaths of First Nations youth and young adults.[32] For further details about the findings and recommendations, see *A Review of First Nation Youth and Young Adult Injury Deaths: 2010-2015* (FNHA Exhibit 7).

[31] First Nations Health Authority and BC Coroners Service Partnership, http://www.fnha.ca/about/news-and-events/news/first-nations-health-authority-and-bc-coroners-service-partnership
[32] FNHA, July 5, 2018, "The FNHA's Response to the BC Coroners Service (BCCS) & FNHA Injury Death Review Panel Recommendations" at: http://www.fnha.ca/about/news-and-events/news/the-fnhas-response-to-the-bc-coroners-service-bccs-fnha-injury-death-review-panel-recommendations

78. Though there is still much work ahead for BCCS, FNHA, key partners, communities and families, it is hopeful that the steps taken together may lead to better interactions between families and Coroners or Medical Examiners services.

Recommendation 11: In addition to addressing gaps and issues in the health system, organizations serving Indigenous peoples must promote healing and protective factors, such as:

- wellness promotion and prevention,
- improved outcomes for social determinants of health,
- mitigation of the impact of colonialism, racism, marginalization and intergenerational trauma, and
- providing a meaningful role for family and community, cultural traditions and healing/spiritual practices.

FNHA Work on Health, Safety and Violence Prevention for Women and Girls[33]

79. FNHA is a relatively young organization, focused on working with partners across the health and wellness system in BC to support First Nations access to culturally safe, quality care and services. Where FNHA can have the best impact in working to improve health and safety for and prevent violence against Indigenous women and girls is in improving access to culturally safe, supportive health and wellness care and services in First Nations communities and across BC. The work underway in BC to improve the health and wellness system is supported at FNHA with a Quality Agenda that organizes our work through the previously discussed lens of three Perspectives of Quality. For the purposes of this submission, the description of our work is divided into those services which are more directly serving the health, safety and violence prevention for women and girls, and those which indirectly serve women and girls through overall system improvement.

80. Under **Provincial Services**, FNHA works with key partners to address ways in which their work can support higher utilization of health and wellness services and improve health and wellness outcomes. Examples of this work include:

[33] Unless otherwise indicated, information for this section from either the 2018/2019 FNHA SUMMARY SERVICE PLAN: An Operational Plan for the Fiscal Year 2018/2019 at: http://www.fnha.ca/Documents/FNHA-Summary-Service-Plan-2018-2019.pdf **or** FNHA 2017-2018 Annual Report, at http://www.fnha.ca/Documents/FNHA-Annual-Report-2017-2018.pdf

A. FNHA support in 2015 for First Nations communities to attend the Highway 16 Transportation Symposium[34], which focused on transportation solutions for increasing safety for First Nations and Aboriginal girls and women and creating efficiencies for medical transportation programs.

B. FNHA representation on the BC Government's Advisory Group on the Highway 16 Transportation Action Plan[35], including input to GIS mapping exercises to better find solutions that integrate the needs of those traveling from First Nations communities for medical purposes.

C. In October 2017, the BC Provincial Health Services Authority (PHSA) took over the delivery of health services in provincial correctional facilities. FNHA provided input into PHSA's Clinical Services Plan to improve the cultural safety of health care service delivery, and to increase the number of cultural services and programs (e.g., access to Elders and traditional healers) in BC's provincially run correctional facilities. FNHA work over the year also included:

    i. Presenting and providing materials on cultural safety and humility to all BC Corrections health staff.

    ii. Co-hosting a one-day dialogue session with First Nations leaders working in corrections.

    iii. Providing renewed funding for "Unlocking the Gates," a peer health mentoring program, to expand mentoring services for men and women upon release from select provincial correctional facilities.

D. FNHA has also be invited to participate in informing and shaping some of BC Women's Hospital & Health Centre projects and services, such as:

    i. The Gender-Based Violence Prevention and Response Online Curriculum for health care providers, led by the BC Women's Population Health Promotion team.

    ii. The Safe Methods at the Right Time program, which aims to offer free contraceptive supplies to women accessing abortion clinics across BC.

[34] FNHA, November 24, 2015, First Nations Health Authority Statement on Highway 16 Transportation Symposium, at: http://www.fnha.ca/about/news-and-events/news/fnha-statement-on-highway-16-transportation-symposium

[35] BC Government, Highway 16 Transportation Action Plan, at: https://www2.gov.bc.ca/gov/content/transportation/transportation-reports-and-reference/reports-studies/planning-strategic-economic/highway16-action-plan

iii. The Indigenous Care Coordination team for women and children with complex health care needs in its early development and roll out.

iv. Information sharing strategy development to promote cord blood banking for Indigenous women patients access care.

E. FNHA and Office of the Provincial Health Officer are partnering on a number of important initiatives related to data, which include ongoing work on development of a report for the seven core wellness indicators and development of a women's health report expected to be released in 2018/2019.

F. FNHA is working with the BC Ministry of Health as it revises its Provincial Women's Health Strategy to ensure that Indigenous priorities are incorporated throughout.

G. BC Cancer and FNHA partnered to conduct first-of-its-kind research which found that the most commonly diagnosed cancers in First Nations women in BC are breast, colon, lung and cervical, and that First Nations women are significantly more likely to be diagnosed with colon and cervical cancers compared to non-First Nations women. First Nations women are also less likely to survive a cancer diagnosis compared to non-First Nations women in the majority of cancers reviewed. In response, and in the context of reconciliation, a provincial Indigenous Cancer Strategy was developed using a gender-based approach that posits that these cancer outcome disparities are at least partially attributable to processes of colonialism, intergenerational trauma and a lack of cultural safety in the healthcare system. Acting as a guide for health system partners, the strategy is being implemented by amplifying individual and collective First Nations women, girls and community voices and stories to guide quality improvement and cultural safety efforts in health services. For further insights, see *Cancer in First Nations people living in British Columbia, Canada: an analysis of incidence and survival from 1993 to 2010* (FNHA exhibit 8) and *Improving Indigenous Cancer Journeys: A Road Map* (FNHA Exhibit 9).

i. FNHA has worked to showcase the voices and stories of First Nations women in this work, including: Marion Erickson from the Nak'azdli Whut'en First Nation and her video story about intergenerational trauma and getting screened for cervical cancer; Sandra Teegee from Takla Lake First Nation and her podcast story about quitting commercial

tobacco; and Johnna Sparrow from Musqueam Nation and her video story about getting screened for breast cancer and detecting it early.

81. Under **FNHA Services**, we strive to improve quality through the establishment and tracking of service standards for programs and services we provide directly to individuals and communities. Examples include:

A. FNHA continues to support nurses with training and hosted its annual Nursing Education Forum. The forum brings together nurses working in First Nations communities across the province to share and learn from one another on many areas, including those related to care for Women and Girls. In addition, the FNHA Nursing Services team has introduced nurse practitioner and midwifery models of care; supported community nurses with training; established an inter-professional medication quality and safety committee in January 2018; and developed practice competencies for all areas of specialty practice.

B. FNHA has been partnering with multiple organizations in this area over the years to work towards service and health outcome improvements across prenatal, labour and delivery and postpartum care. Bringing birth "closer to home and into the hands of women" is a goal that FNHA has dedicated a significant amount of its efforts towards, given that it was an original Transformative Change Accord health action and given the cultural and spiritual significance for families and communities when birth can occur on traditional territory.

    i. Much of FNHA's work to date in relation to improving maternity services has focused on both midwifery and doula care. This has largely been because both professions tend to approach maternity care in a holistic and wellness oriented way, which aligns the perspectives and priorities that FNHA has heard from First Nations in BC. FNHA has worked to create alternate rural midwifery payment and care models as well as develop the Doulas for Aboriginal Families Grant Program and community-based doula training.

    ii. FNHA also has an interest to support physicians, nurse practitioners, and nurses as well, to make sure that the whole inter-disciplinary care team for maternity care can best serve women at such an important time.

iii. In 2013/2014, FNHA developed parenting resources for First Nations, and in 2014/2015, it developed a Pregnancy Passport resource for First Nations and Aboriginal women with PHSA.

C. FNHA administers the BC portion of the Government of Canada's Missing and Murdered Indigenous Women and Girls Counselling Program. FNHA is providing cultural and traditional supports primarily through existing Indian Residential School Resolution Health Support Program partners, as well as mental health counselling services. FNHA's MMIWG counselling services are delivered through FNHA's Health Benefit team by FNHA's existing mental health provider network. All of these mental health providers have the experience and cultural safety training needed to support First Nations and Aboriginal people in BC.

D. Women Deliver Conference: FNHA is co-hosting a one day learning event in affiliation with the Women Deliver Conference scheduled in Vancouver in June, 2019. It is FNHA's vision that participants of this day will be inspired, informed and equipped to further advocate for and advance the rights and wellness of Indigenous girls and women locally, nationally and internationally. Through a culturally grounded day of experiential learning, relationship building and sharing of knowledge, participants will have more information, confidence and connections to advance priorities for action in Indigenous girls and women's wellness.

i. As a leading global advocate for the health, rights and wellbeing of girls and women, Women Deliver aims to catalyze action by bringing together diverse voices and interests to drive progress for gender equality, with a particular focus on maternal, sexual, and reproductive health and rights.

82. Under **FNHA-Funded Community Services**, we support communities and regions to bring planning and capacity development closer to home in order to improve utilization and outcomes. Examples include:

A. FNHA support for and promotion of grassroots and community driven awareness campaigns such as the Moose Hide Campaign, which is "a grassroots movement of Indigenous and non-Indigenous men and boys who are standing up against violence towards women and children"[36],

[36] Moose Hide Campaign, at https://www.moosehidecampaign.ca/

and the Esk'etemc Commitment Sticks[37] campaign, which symbolize a personal commitment to live violence free and a commitment to actively stop violence against Indigenous women and girls.

B. The Kwakwaka'wakw Primary Maternal, Child & Family Health Collaborative Team provides high quality, culturally safe, accessible care that is close to home for women and families in the Kwakwaka'wakw territory of North Vancouver Island. Since the launch of the service in October 2017, there have been 45 referrals. The team is currently working with 26 families. To date, feedback has been very positive regarding families' and care providers' experiences with the program, Island Health, Campbell River Hospital and the Campbell River Maternity Clinic.

C. FNHA partnered with the BC Association of Aboriginal Friendship Centres to offer the Doulas for Aboriginal Families Grant Program. The program provides up to $1,000 for each pregnancy in a family for prenatal, birthing and postpartum doula services for expectant Aboriginal mothers and families living in BC, both on- and off-reserve. In 2017/2018, FNHA also published the second edition of the educational toolkit, "Honouring our Babies: Safe Sleep discussion Cards & Guide."

Recommendation 12: Federal supports created during the National Inquiry continue to be funded to support families and survivors in the post-report period.

Recommendation 13: Federal and provincial supports continue and expand for indigenous-led initiatives such as those outlined in this submission.

83. This submission has intended to demonstrate outstanding gaps in understanding and serving First Nations women and girls and other issues relevant to the National Inquiry. With humility, the FNHA acknowledges that there are areas where, as an organization, can continue to improve our partnerships and services to serve as a better partner to Indigenous women and girls. While we have come far as an organization in the health governance space in BC, we are still on a journey of growth and development, and we can still find new strengths and challenges to take on. We encourage our partners in health and wellness to similarly acknowledge where they can strive to be better for the health and well-being of Indigenous women and girls.

[37] FNHA, Commitment Stick Initiative, at: http://www.fnha.ca/wellness/commitment-stick

Conclusion

84. Over the course of the Inquiry's Truth Gathering Process, two more First Nations women went missing and were found dead here in BC. Brittany Martel of Hay River, Northwest Territories, and Jessica Patrick from Lake Babine Nation serve to remind us all that, even as the National Inquiry continues to ask and answer hard questions about a system that has let down so many Indigenous people and families, our collective efforts have to continue to challenge every entity in that system to do better.

85. FNHA, FNHC and FNHDA serve more than 200 communities and collaborate with dozens of partners across the health and wellness system, not just to improve care and access across the health continuum, but to ensure that First Nations people and their concerns are heard, understood, and acted on in a good way. A health and wellness system that strives to be culturally safe and trauma informed can create more opportunities for Indigenous people to find the care and support they need to go beyond surviving, and thrive.

List of FNHA Exhibits

Details	Link
1. Implementing the Vision: BC First Nations Health Governance – Reimagining First Nations Health in BC. (2011). First Nations Health Council.	http://www.fnha.ca/Documents/FNHC_Health_Governance_Book.pdf
2. FNHA Cultural Safety and Humility Action Serious 10: Responding to Anti-Indigenous Racism in the Health Care System with Yvette Ringham Cowan and Laurie Harding. (2017).	http://www.fnha.ca/wellness/cultural-humility/webinars
3. "They treated me like crap and I know it was because I was Native": The healthcare experiences of Aboriginal peoples living in Vancouver's inner city. A. Goodman, K. Fleming, N. Markwick, T. Morrison, L. Lagimodiere, T. Kerr, Western Aboriginal Harm Reduction Society. Social Science & Medicine 178 (2017) 87-94.	Goodman et. al. 2017.pdf
4. 'Stereotypes are reality': addressing stereotyping in Canadian Aboriginal medical education. A. Ly & L. Crowshoe. Medical Education 49 (2015) 612–622.	Ly & Crowshoe 2015.pdf
5. *"Family Violence as a Social Determinant of First Nations, Inuit and Métis Health".* National Collaborating Centre for Aboriginal Health. (2009-2010).	https://www.ccnsa-nccah.ca/docs/determinants/FS-FamilyViolenceSDOH-EN.pdf
6. The Regulation of First Nations Sexuality. M. Cannon. Canadian Journal of Native Studies XVIII, 1 (1998): 1-18.	Cannon 1998.pdf
7. A Review of First Nation Youth and Young Adult Injury Deaths: 2010-2015. (2017). BC Coroner Service and First Nations Health Authority Death Review Panel.	http://www.fnha.ca/Documents/FNHA-BCCS-A-Review-of-First-Nations-Youth-and-Young-Adults-Injury-Deaths-2010-2015.pdf
8. Cancer in First Nations people living in British Columbia, Canada: an analysis of incidence and survival from 1993 to 2010. C.E. McGahan, K. Linn, P. Guno, H. Johnson, A.J. Coldman, J.J. Spinelli, N.R. Caron. Cancer Causes Control 2017 Oct;28(10):1105-1116.	McGahan et al. BC First Nations Cancer J
9. Improving Indigenous Cancer Journeys: A Road Map. (2017). First Nations Health Authority; Métis Nation of British Columbia; BC Association of Aboriginal Friendship Centres; and BC Cancer.	http://www.fnha.ca/wellnessContent/Wellness/improving-indigenous-cancer-journeys-in-bc.pdf

Appendix A: FNHA Recommendations

Based on the knowledge, learnings and experiences FNHA and its partners have gained throughout this health governance journey in BC, FNHA respectfully makes the following recommendations to the Commissioners for their consideration in completing their final report to the federal and provincial/territorial governments:

Recommendation 1: Organizations working with First Nations populations increase opportunities/partnerships to support First Nations to gather data and evidence, while respecting and applying OCAP© principles, and use the results to inform service and investment planning. This data and evidence should consider as valid other ways of knowing, including performance and outcomes measurement, evaluations, research, and give space to Indigenous oral traditions and teaching.

Recommendation 2: Governments and organizations adopt a gender-based lens in their work and approach.

Recommendation 3: More investment in specific programming for Indigenous women, not only for health care, but focused also on resiliency and restoring the role of Indigenous women.

Recommendation 4: Mandatory embedding of Cultural Safety, Cultural Humility, and Trauma Informed Practice into the work, programming, care and services touching Indigenous women.

Recommendation 5: Governments and institutions work to "hardwire" Cultural Safety, Cultural Humility, and Trauma Informed Practice into the larger health and wellness system.

Recommendation 6: Post-secondary and professional education institutions embed Cultural Safety, Cultural Humility, and Trauma Informed Practice into their curriculum for practitioners and allied health professions.

Recommendation 7: Identify resources for Nation-led practices to promote healing for Indigenous men and boys, and to support communities in lifting up all of their members, and to break cycles of violence and trauma.

Recommendation 8: Encourage governments, not-for-profit organizations, health researchers, and academic institutions to engage in more study on the health and wellness status and needs of 2SLGBTQ+ people.

Recommendation 9: Governments and organizations adopt an intersectionality lens in their work and approach.

Recommendation 10: Encourage governments to ensure that people coming out of the Corrections system who are accessing opioid agonist therapy are connected to a prescriber close to home as well as connecting with formal and informal/natural supports to continue the therapy.

Recommendation 11: In addition to addressing gaps and issues in the health system, organizations serving Indigenous peoples must promote healing and protective factors, such as:

- wellness promotion and prevention,
- improved outcomes for social determinants of health,
- mitigation of the impact of colonialism, racism, marginalization and intergenerational trauma, and
- providing a meaningful role for family and community, cultural traditions and healing/spiritual practices.

Recommendation 12: Federal supports created during the National Inquiry continue to be funded to support families and survivors in the post-report period.

Recommendation 13: Federal and provincial supports continue and expand for indigenous-led initiatives such as those outlined in this submission.

Appendix B: Data Figures

Figure 1: A/S emergency department user rates by sex, First Nations and Other Residents, 2008/09 – 2014/15

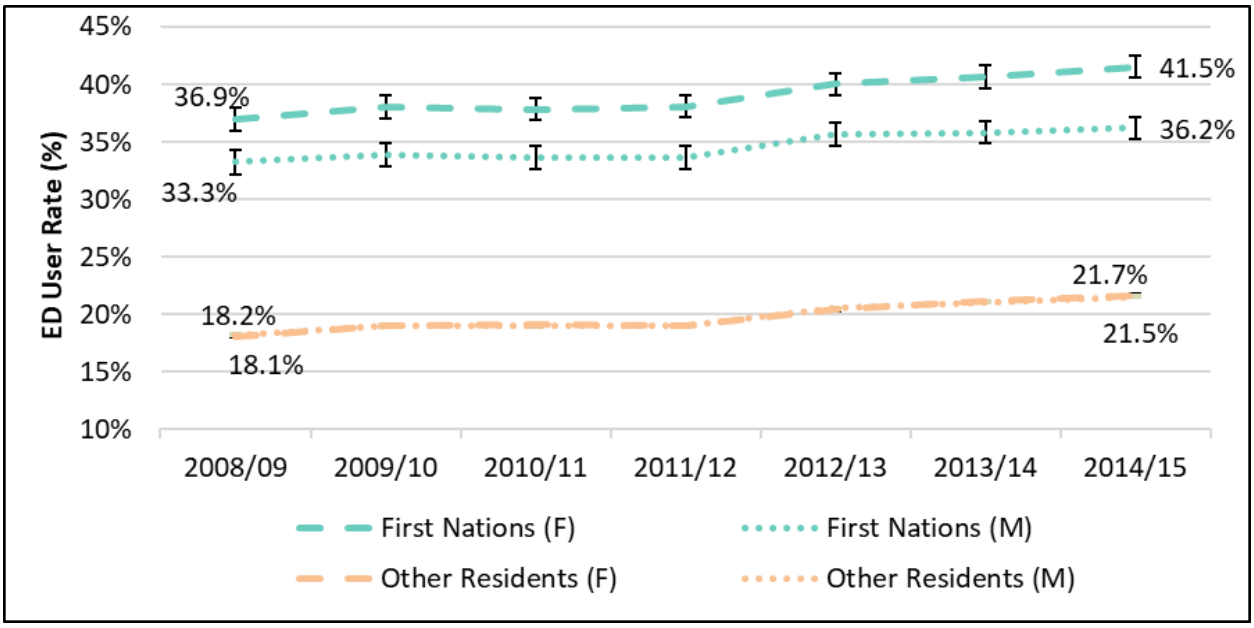
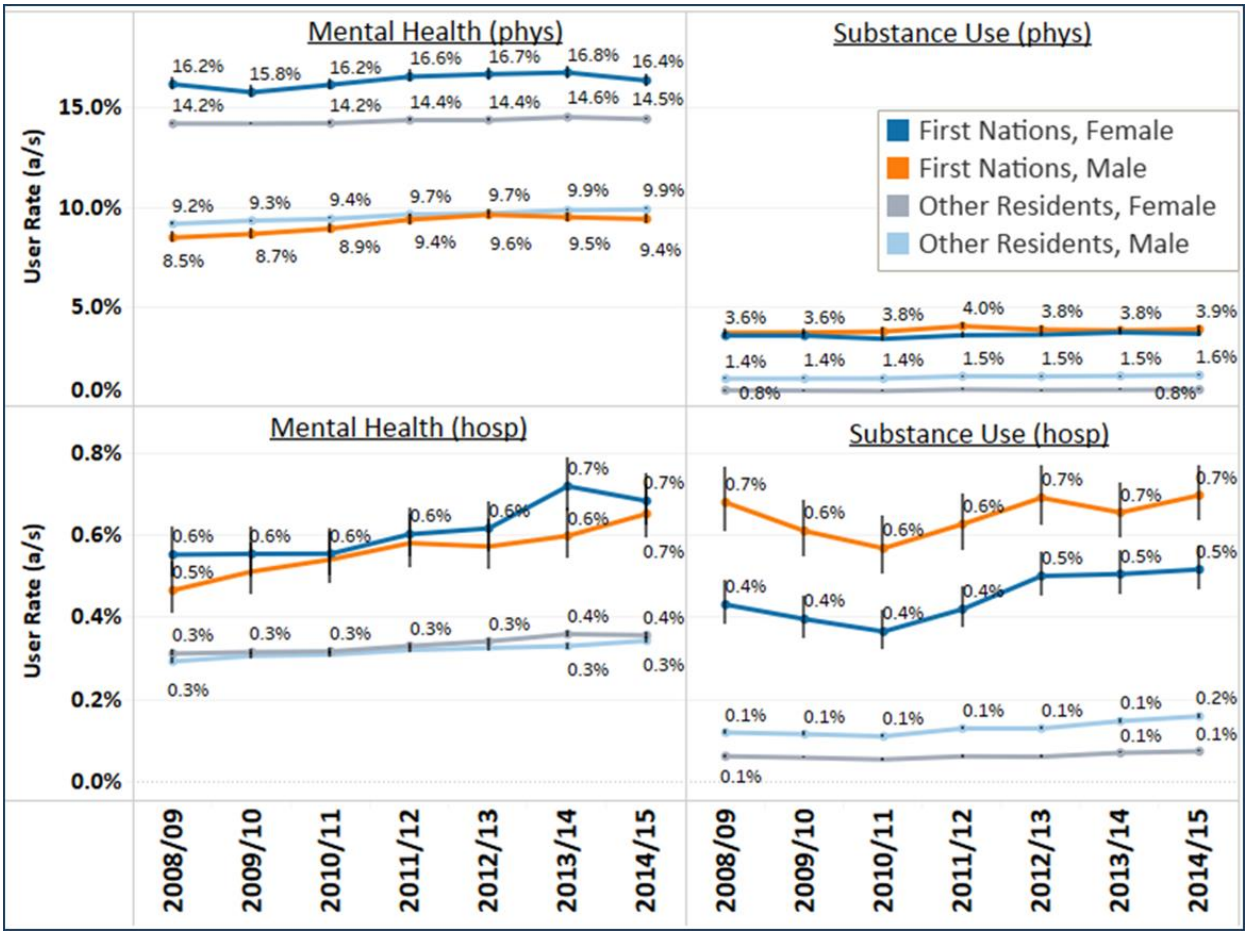


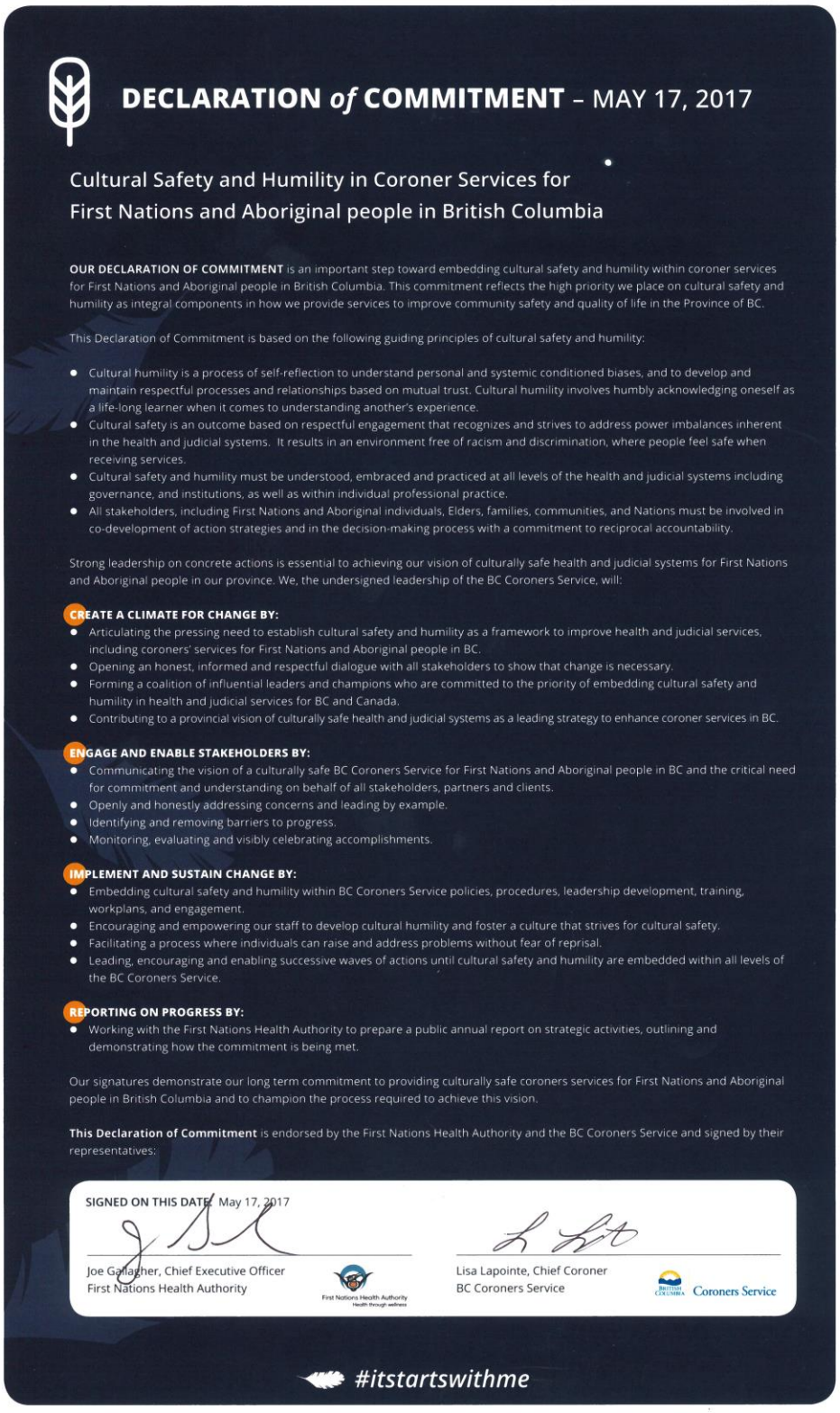
Figure 2: Trends in mental health and substance use user rates, physician and hospital, by sex, First



Nations and Other Residents, 2008/09 – 2014/15

*Note: axis scales are independent for the top and bottom figures.
Physician and hospital user rates for mental health services increased among First Nations males, rising from 8.5% to 9.4% and 0.5% to 0.7%, respectively, between 2008/09 and 2014/15.
Hospital user rates for substance use services were stable among Other Resident females, while rates increased among females. Physician and hospital user rates for mental health services increased among both Other Resident males and females.
A/S, age-standardized; hosp, hospital; phys, physician.

Appendix C: Declaration on Cultural Safety and Humility



DECLARATION *of* COMMITMENT – MAY 17, 2017

Cultural Safety and Humility in Coroner Services for First Nations and Aboriginal people in British Columbia

OUR DECLARATION OF COMMITMENT is an important step toward embedding cultural safety and humility within coroner services for First Nations and Aboriginal people in British Columbia. This commitment reflects the high priority we place on cultural safety and humility as integral components in how we provide services to improve community safety and quality of life in the Province of BC.

This Declaration of Commitment is based on the following guiding principles of cultural safety and humility:

- Cultural humility is a process of self-reflection to understand personal and systemic conditioned biases, and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a life-long learner when it comes to understanding another's experience.
- Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health and judicial systems. It results in an environment free of racism and discrimination, where people feel safe when receiving services.
- Cultural safety and humility must be understood, embraced and practiced at all levels of the health and judicial systems including governance, and institutions, as well as within individual professional practice.
- All stakeholders, including First Nations and Aboriginal individuals, Elders, families, communities, and Nations must be involved in co-development of action strategies and in the decision-making process with a commitment to reciprocal accountability.

Strong leadership on concrete actions is essential to achieving our vision of culturally safe health and judicial systems for First Nations and Aboriginal people in our province. We, the undersigned leadership of the BC Coroners Service, will:

CREATE A CLIMATE FOR CHANGE BY:

- Articulating the pressing need to establish cultural safety and humility as a framework to improve health and judicial services, including coroners' services for First Nations and Aboriginal people in BC.
- Opening an honest, informed and respectful dialogue with all stakeholders to show that change is necessary.
- Forming a coalition of influential leaders and champions who are committed to the priority of embedding cultural safety and humility in health and judicial services for BC and Canada.
- Contributing to a provincial vision of culturally safe health and judicial systems as a leading strategy to enhance coroner services in BC.

ENGAGE AND ENABLE STAKEHOLDERS BY:

- Communicating the vision of a culturally safe BC Coroners Service for First Nations and Aboriginal people in BC and the critical need for commitment and understanding on behalf of all stakeholders, partners and clients.
- Openly and honestly addressing concerns and leading by example.
- Identifying and removing barriers to progress.
- Monitoring, evaluating and visibly celebrating accomplishments.

IMPLEMENT AND SUSTAIN CHANGE BY:

- Embedding cultural safety and humility within BC Coroners Service policies, procedures, leadership development, training, workplans, and engagement.
- Encouraging and empowering our staff to develop cultural humility and foster a culture that strives for cultural safety.
- Facilitating a process where individuals can raise and address problems without fear of reprisal.
- Leading, encouraging and enabling successive waves of actions until cultural safety and humility are embedded within all levels of the BC Coroners Service.

REPORTING ON PROGRESS BY:

- Working with the First Nations Health Authority to prepare a public annual report on strategic activities, outlining and demonstrating how the commitment is being met.

Our signatures demonstrate our long term commitment to providing culturally safe coroners services for First Nations and Aboriginal people in British Columbia and to champion the process required to achieve this vision.

This Declaration of Commitment is endorsed by the First Nations Health Authority and the BC Coroners Service and signed by their representatives:

SIGNED ON THIS DATE: May 17, 2017

Joe Gallagher, Chief Executive Officer
First Nations Health Authority

First Nations Health Authority
Health through wellness

Lisa Lapointe, Chief Coroner
BC Coroners Service

Coroners Service

#itstartswithme