

First Peoples, Second Class Treatment

The role of racism in the health and well-being of Indigenous peoples in Canada



Executive Summary

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A Note on Terminology

In this paper we use the word “Indigenous” as an inclusive and international term to describe individuals and collectives who consider themselves as being related to and/or having historical continuity with “First Peoples,” whose civilizations in what is now known as Canada, the United States, the Americas, the Pacific Islands, New Zealand, Australia, Asia, and Africa predate those of subsequent invading or colonizing populations. We note that globally, no universal definition of Indigenous peoples has been accepted (Bartlett, Madriaga-Vignudo, O’Neil, & Kuhnlein, 2007) and chose this term over the constitutionally defined Canadian term “Aboriginal” partly because it is commonly understood that in using the term “Indigenous,” individuals and communities will be supported in self-defining what it means to them. Exceptions to our use of the term Indigenous have been made of necessity when we are citing specific statistics that used other terms for data collection. For example, Statistics Canada uses the term Aboriginal in its data collections, drawing on the 1982 Constitution Act definition, which includes “Indian, Inuit, and Metis” (Government of Canada, Constitution Act, 1982, section 35 (2)). We further note that there is an incredibly rich diversity of Indigenous peoples in what is now known as Canada (i.e. Pre-European contact the linguistic diversity of the Americas was ten-fold that of Eurasia) (Nettle, 1999). Out of respect for this diversity we have attempted to ensure that it is represented at least partially in the text and that specific Indigenous groups are correctly referenced in examples and citations. For more information about the terms used to describe Indigenous peoples see Textbox A in the discussion paper.

Key Messages

- Racism and colonization are intertwined (Reading, 2013) and together deeply impact the health of Indigenous peoples in Canada. Both in Canada and internationally, colonization has been recognized as having a fundamental impact on the health of Indigenous peoples (Cunningham, 2009; Mowbray, 2007).
- At the individual, family and community level, Indigenous peoples have been managing racism and its impacts on health and well-being for hundreds of years, demonstrating resilience in the face of violence, cultural genocide, legislated segregation, appropriation of lands and social and economic oppression.
- The stories of Indigenous health in Canada told in the mainstream society are generally not authored by Indigenous peoples themselves, and are often characterized by racist stereotypes and images (Browne, 2003, 2005; Clark, 2007; Gilchrist, 2010; Neegan, 2005; Watters, 2007). This paper offers an Indigenous perspective on the experiences and impacts of racism on Indigenous health and well-being.
- Information about Indigenous health cannot be understood outside of the context of colonial policies and practices both past and present. This includes:
 - The Indian Act (1876) and related policies and processes, which served to: 1) dispossess Indigenous peoples of land and disrupt traditional economies thereby cutting off sources of food and manufacturing food dependence on colonial authorities (e.g. restricting hunting and gathering practices by restricting mobility) (Smylie, 2009); 2) give colonial authorities the power to determine who could be an “Indian”; 3) impede the transmission of identity and traditional knowledge (Bourassa & Peach, 2009; Lawrence, 2004; Smylie, 2009); and 4) undermine the roles and responsibilities of women in previously matriarchal and/or matrilineal societies (Blair, 2005; Stevenson, 2011; Furi & Wherrett, 2003).
 - The forced relocation of Inuit peoples and the imposition of permanent settlements, compounded for some communities by the mass slaughter of sled dogs (Brennan, 2012; Smylie, 2009).
 - The residential school system, which subjected generations of children to sexual, emotional, physical, mental, spiritual and cultural abuse.
 - Historical and current child welfare processes, which have and continue to separate substantial numbers of children from their families and communities.
- The process of colonization has resulted in ongoing and entrenched racism against Indigenous peoples. Racist ideologies continue to significantly affect the health and well-being of Indigenous peoples, cutting across the social determinants of health, impacting access to education, housing, food security and employment, and permeating societal systems and institutions including the health care, child welfare and criminal justice systems.
- In the case of health care, barriers to access for Indigenous peoples include:
 - Racism within the health care system. Research shows that racism against Indigenous peoples in the health care system is so pervasive that people strategize around anticipated racism before visiting the emergency department or, in some cases, avoid care altogether (Kurtz et al., 2008; Tang & Browne, 2008; Browne et al., 2011).
 - The Non-Insured Health Benefits (NIHB) Program – which provides medical goods and services for status First Nations and Inuit people. The NIHB excludes Métis and non-status First Nations

(Bent, Havelock & Haworth-Brockman, 2007; Bourassa & Peach, 2009; Ghosh & Spitzer, 2014; Haworth-Brockman, Bent & Havelock, 2009; Wilson et al., 2013). It also presents barriers to those who are eligible by requiring on-reserve residency for some services, continually curtailing approved medications and treatments, and limiting access due to onerous approval processes changing (Haworth-Brockman et al., 2009; Mother of Red Nations, 2006). Moreover, the delivery of NIHB poses challenges to equitable access to health services in comparison to non-Indigenous people, particularly in northern and remote communities.

- Promising and emerging responses include:
 - Indigenous directed health and health related services.
 - Efforts to increase the number of Indigenous health care providers.
 - The employment of specialized roles such as Indigenous patient navigators to serve as a bridge between Indigenous patients and the health care system.
 - Cultural safety training. While cultural sensitivity and cultural competence focus on learning about the culture of the service user, cultural safety pays explicit attention to power relations between service user and service provider.
 - Trauma-informed care, which takes up the impacts of historic, collective and intergenerational trauma and is reflected both through encounters with individual providers and the approach of organizations.
 - Interventions addressing implicit bias. Research from the United States (US) demonstrates that unconscious, pro-white bias on the part of health care providers results in health inequities for racialized patients (Blair et al., 2013; Green et al., 2007), and that effective interventions can be designed to begin to erode this bias.

- Critical next steps include:
 - Reframe the conversation around race and health in Canada by acknowledging the foundational and ongoing realities of racism and colonialism (Lawrence and Dua, 2005), which are obscured by the official framing of the Canadian nation as a harmonious multicultural mosaic.
 - Generate meaningful data in order to understand and address the role of racism in the health disparities experienced by Indigenous peoples in Canada (Paradies et al., 2008).
 - Develop or adapt effective interventions to address attitudinal, interpersonal and systemic racism towards Indigenous peoples.
 - Pursue bold and brave evaluations of existing anti-racism strategies and interventions.

Executive Summary

First Peoples, Second Class Treatment explores the role of racism in the health and well-being of Indigenous peoples in Canada. We begin with an overview of the historical and contemporary contexts of racism, and the ways in which racism is fundamentally responsible for the alarming disparities in health between Indigenous and non-Indigenous peoples. We examine Indigenous responses to racism including individual, family and community level strategies and resiliencies; health service-level responses (including Indigenous and non-Indigenous led services); efforts directed at the training of health professionals; and provincial, territorial and national-level policies and recommendations.

The Importance Of Looking At Racism And Indigenous Health

Indigenous peoples' experiences are too often omitted in discussions of racism and anti-racism (Lawrence & Dua, 2005). The reasons for these omissions typically include a rationale that argues for recognition of the unique histories, policies and contemporary circumstances shaping the lives of Indigenous peoples (Nestel, 2012; Levy et al., 2013). While this recognition is important, these omissions may contribute to a continual "writing out" or "writing over" of Indigenous experiences of racism, marginalization and violence, along with the strategies used to address and resist these same realities.

Reading This Paper: The Importance Of Context

Stories about Indigenous health in Canada are frequently presented without the context needed to make sense of the information provided. For example, epidemiological data is often gathered, analyzed and shared without the inclusion of adequate context related to the historical and present-day impacts of colonial policies on the social determinants of health for Indigenous peoples. In addition, this data can be shared in the absence of the voices and perspectives of Indigenous people themselves (Smylie, 2014). At the same time, it cannot be assumed that Canadian readers will automatically fill in this context — in large part, school systems, mainstream media and government-mediated communications do not expose Canadians to a range of Indigenous voices or to comprehensive, accurate information about the effects of colonization or about Indigenous peoples, cultures, histories or present day realities.

While stories about Indigenous health are frequently marked by an absence of context, they can also be characterized by the presence of racist stereotypes and inaccuracies pervasive in mainstream Canadian narratives. These include the idea that genetic predeterminations — as opposed to factors like access to the social determinants of health — are responsible for the health inequities experienced by Indigenous peoples and other racialized groups. The importance of taking care to contextualize Indigenous peoples' health cannot be overstated since, as noted by Greenwood and de Leeuw (2012), a failure to do so may result in a presumption that the extremely poor health status and socioeconomic challenges faced by many Indigenous peoples is a matter only of physiological or biomedical failure (n.p.).

As a result, this paper begins with a focus on providing some of the context necessary to understand stories about Indigenous health. While the recommendations presented in the latter half of this paper offer important next steps for policy-makers, health care and social service providers, researchers, students and communities, it is crucial that these next steps be grounded in a detailed understanding of the context of Indigenous peoples' health and well-being in Canada.

Methods: Indigenous Telling Of Indigenous Stories

This paper embodies an Indigenous approach to understanding Indigenous peoples' experiences of racism in Canada and the impact on Indigenous health and well-being. It includes narratives shared by the Well Living House Counsel of Indigenous Grandparents and employs a critical Indigenous lens to examine colonial policies and practices and the impacts on Indigenous health and well-being. This lens reflects the authors' responsibility as Indigenous scholars to locate information about the health and well-being of their families, communities and Nations within the context of their past and the vision of their future. This approach counters prevailing portrayals of Indigenous health that have pathologized Indigenous peoples as sick, disorganized and dysfunctional (O'Neil, Reading & Leader, 1998; Reading & Nowgesic, 2002).

Further, this paper is informed by a search of the indexed published literature, keeping in mind that this literature still systematically prioritizes non-Indigenous voices and perspectives (Smylie, 2014). Articles were chosen that explore attitudinal or systemic racism (including colonization and colonial policies) as it impacted the health of Indigenous individuals or populations in Canada. Sixty-four articles were identified through a literature search, and five additional articles were identified through the references of the original 64 articles (see Appendix A of *First Peoples, Second Class Treatment full report*).

Racism And Colonization

Racism and colonization are inextricably intertwined; Reading (2013) notes that the use of race as a category of identity began with European colonization of other continents. Despite the fact that race is a socially constructed category with no biological basis, it has been used for hundreds of years to argue for and promote hierarchies of supposed superiority and civility among "races" of people (Reading, 2013). Racism not only justified historic colonization but compounds its contemporary effects (Cunningham, 2009), contributing to, for example, the obstruction of Indigenous self-determination and failure to recognize treaty and land rights, the lack of access to services and resources, and the over-surveillance by criminal justice and child welfare systems. The continued marginalization and criminalization experienced by Indigenous peoples and people of colour occurs in direct relationship to the continued societal and systematic privileging of white people in Canadian society.

Impacts Of Colonization On The Social Determinations Of Health

Colonization has been recognized internationally as a key determinant of health for Indigenous peoples (Cunningham, 2009; Mowbray, 2007). In April 2007, an international delegation of Indigenous representatives met as part of ongoing consultations linked to the World Health Organization's Commission on Social Determinants of Health. The proceedings from this meeting included the statement: "Everyone agrees that there is one critical social determinant of health, the effect of colonization" (Mowbray, 2007).

In Canada, Indigenous conceptualizations of the social determinants of health have emphasized the fundamental role of colonization, racism, social exclusion and a lack of self-determination in the alarming disparities in Indigenous and non-Indigenous peoples' health. For example, Loppie Reading & Wien (2009) specifically identify the relationships between the factors listed above and determinants of health

including health care, education, housing, employment, income, food security, community infrastructure, cultural continuity and environmental stewardship.

The Indian Act

The institutionalization of colonial policies impacting the social determinants of health is illustrated by the Indian Act of 1876 which provided the federal government of Canada with the right to determine who can and cannot be an “Indian.” In addition to entrenching government control of Indigenous identity, the Indian Act enabled the movement of First Nations peoples from their homelands onto “reserve lands” which were also controlled by the federal government on behalf of those they identified to be “Indian” (Smylie, 2009). The reserve system invested tremendous power into the hands of Indian agents who could govern the movement of Indians on and off reserve through a pass system (Coates, 2008). Removal to reserve lands had a devastating impact on Indigenous ways of knowing and being in relation to land, including the restriction of traditional hunting and gathering practices which were replaced by a constructed reliance on government rations of European foods. The Indian Act also included stipulations that barred legal representation, gathering to discuss Indigenous affairs, the use of mechanized farm equipment, the slaughter of livestock on-reserve for sustenance, and the sale of agricultural goods off-reserve (Coates, 2008; Harry, 2009). In addition, the Indian Act undermined the roles and responsibilities of women in previously matriarchal and/or matrilineal societies, preventing women’s involvement in governance and rooting “Indian” identity in male lineage (Blair, 2005; Stevenson, 2011).

Colonial policies and the Métis

The Métis peoples originated in the 17th century with the intermarriage of the early waves of European (mainly French and Scottish) men and First Nations women in the western provinces (Smylie, 2009). In the following two centuries the Métis nation birthed a distinct language (Michif) and culture, and occupied a key economic role in the fur trade (Smylie, 2009). The lasting effects of land dispossession, exclusion, racism and race-based persecution are reflected in the gross disparities in health status and social determinants of health that the Métis peoples suffer alongside First Nations and Inuit peoples. At the same time, the use of state-imposed definitions of Indigenous identity, particularly via the Indian Act, means that Métis peoples and non-Status First Nations people are excluded from many Aboriginal-specific health entitlements and services, including the Non-Insured Health Benefits (NIHB) program, further exacerbating health disparities (Bent, Havelock & Haworth-Brockman, 2007; Bourassa & Peach, 2009; Ghosh & Spitzer, 2014; Haworth-Brockman, Bent & Havelock, 2009; Wilson et al., 2013).

Colonial policy and its impact on Inuit health and well-being

Inuit peoples traditionally resided in the territories above the treeline on the lands presently known as Canada, and compose part of the broader circumpolar Inuit population with traditional lands spanning Alaska, Greenland and Russia (Smylie, 2009; Smylie, 2001). Canada now recognizes four Inuit regions settled through extensive land claims, including Inuvialuit, Nunavut, Nunatsiavut and Nunavik (Inuit Tapiriit Kanatami, n.d.). The history of federal interference in Inuit life includes forced relocation to

remote permanent villages (Smylie, 2009), as well as the mass slaughter of Inuit sled dogs,¹ both of which significantly impacted the previously nomadic ways of life. The rupture of traditional Inuit life, including hunting and gathering practices and social and family structures, through the introduction of European and Christian norms and values, residential schools and forced economic dependency on the federal government has had a lasting impact on the health and well-being of Inuit peoples who experience some of the most extreme health disparities in Canada (Moller, 2005; Smylie, 2009).

Residential schools, the Sixties Scoop and contemporary child welfare

Indigenous children were historically removed from the care of their families and communities to residential schools, a system of institutionalized education and care that lasted well over 100 years. The residential school system was intended to “kill the Indian in the child” and many, including former Prime Minister of Canada Paul Martin, have since recognized the implementation of the schools as an act of cultural genocide (Miller, 1996; Neu, 2000) which has had rippling multigenerational effects on survivors, their children, grandchildren and great-grandchildren. The sexual, emotional, physical, mental, spiritual and cultural abuse experienced by generations of Indigenous children who survived residential schools has resulted in deeply painful impacts on the physical, emotional, spiritual, and mental health of survivors, their families and communities. This does not acknowledge the effects of the tremendous loss experienced by those families and communities whose children never returned, whose precious lives did not survive the horrors of these schools.

As concerns about poor conditions and widespread abuses surfaced, support for residential schools began to wane in the late 1940s and into the 1950s. This gave way to a new wave of assimilationist practices — beginning in the 1950s and peaking in the 1960s, there was an enormous influx of Indigenous children taken into the care of child welfare agencies which is now known as the Sixties Scoop (Sinclair, 2004). This era of mass apprehension meant that in the matter of a decade approximately one in three Indigenous children was apprehended from the care of their families and communities (Fournier & Crey, 1997; Sinclair 2007).

Overrepresentation of Indigenous children in child welfare remains an urgent and ongoing challenge facing Indigenous communities across Canada. While the most recent estimates suggest that Aboriginal peoples account for slightly more than 4 percent of the general Canadian population, Aboriginal children represent 48 percent of children in care (Statistics Canada, 2013a). A recent population based study in Hamilton, Ontario, found that 40 percent of self-identified First Nations adults had experienced involvement of a child protection agency in their own personal care as a child and 34.5 percent had experienced involvement of a child protection agency in the care of their own children. Of those adults reporting child protection agency involvement, 49 percent felt that it had a negative effect on their overall health and well-being (Smylie et al., 2011).

The rupture of identity, family and community perpetrated through the practices identified above has had lasting and intergenerational impacts, substantially interfering with or completely impeding the transmission of values, beliefs and practices, including parenting practices. The ways in which the resulting

1 While the slaughter of Inuit sled dogs has long been denied by the federal government and the RCMP, the province of Quebec acknowledged and offered compensation of \$3 million for the slaughter of sled dogs to the people of Nunavik in 2011 (Brennan, 2012; “Premier Charest’s apology for dog killings”, 2011-2012).

intergenerational trauma and damage to Indigenous identity have impacted the health and well-being of Indigenous peoples has been extensively documented (Allan, 2013; Brave Heart, 1998; Desmarais, 2013; Menzies, 2008; Smith, Varcoe & Edwards, 2005; Wesley-Esquimaux & Smolewski, 2004). For example, the abovementioned study of self-identified First Nations adults in Hamilton, Ontario found a population prevalence of post-traumatic stress disorder of 34 percent using the primary care PTSD screen (Smylie et al., 2011).

Gendered impact of colonial racism

Addressing the alarming health disparities and barriers to health care experienced by Indigenous women requires a foundational understanding of the historical and contemporary racist policies and practices that have shaped their lives, health and well-being and access to health care. For example, it is critical to examine links between contemporary rates of infant mortality, maternal morbidity and mortality, and overall poorer health in the context of the history of forced sterilization of Indigenous women (Grekul, Krahn & Odynak, 2004), the undermining of traditional midwifery, mandatory medical evacuation for pregnant Indigenous women in remote communities, and the historic and ongoing racism evident in the disproportionate rates of child welfare intervention experienced by Indigenous women and their families.

Ongoing racism is also evident in the epidemic of violence against Aboriginal women, and the failure of the Canadian state to adequately investigate and address this violence. Aboriginal women in Canada experience higher rates than non-Aboriginal women of both spousal and non-spousal violence, and report more severe forms of violence (Mathyssen, 2011; Statistics Canada, 2013b). Indigenous women in Canada are more likely to be victims of homicide and, unlike their non-Indigenous counterparts (Statistics Canada, 2013b), are as likely to be murdered by a stranger or acquaintance as they are by an intimate partner (NWAC, 2010). Violence against Indigenous women is most painfully reflected in the mass numbers of missing and murdered Indigenous girls and women in Canada, an issue which has garnered failed calls for a national inquiry by international bodies.

What We Know About The Magnitude Of Racism Experienced By Indigenous Peoples In Canada And Its Impact On Health, Well-Being And Access To Health Services

What we know: experiences of racism and impacts on health

In Canada, there is a range of survey data documenting the experiences of racial discrimination of Indigenous people (e.g. Regional Health Survey, Aboriginal Peoples Survey, Urban Aboriginal Peoples Study, Toronto Aboriginal Research Project, and the Our Health Counts study) and a small but growing body of research focused on documenting and delineating the relationship between racism and Indigenous health and health care access. These studies have found that many if not most Indigenous people in Canada experience racism on a recurring basis. It should also be noted that research from both Canada and the US indicates that experiences of racism are commonly underreported; such that presently available data can be best understood as an underestimate of the true prevalence of racism in Canada (Smylie, 2009; Wilson et al., 2013).

Current research also indicates that racism has direct impacts on health. A 2012 study by Currie et al.

examining experiences of racism among Aboriginal university students in Edmonton, Alberta found that student reactions to racism were indicative of racial battle fatigue (Smith, Allen & Danley, 2007), described as the depletion of mental and physical resources due to the constant engagement of stress response systems to cope with ongoing discrimination (Currie et al., 2012b; Smith et al., 2007). A study using data from the 2003 Canadian Community Health Survey (CCHS) demonstrates that there are health disparities experienced by racialized groups in Canada that cannot be explained by socioeconomic status, suggesting that these disparities are evidence of the, “wear and tear of experiences of racism and discrimination in regular encounters with societal institutions and in everyday life” (Veenstra, 2009). These studies are supported by a growing body of research in the US and Australia identifying racism as a chronic stressor implicated in the health of African Americans and Indigenous Australians.

Racism and the health care system

In the context of contemporary Indigenous health, Canada’s race-based legislation has normalized the uneven distribution of health funding, resources and services according to state-constructed Indigenous identities such that only those classified by the Canadian government as status First Nations and Inuit peoples are entitled to the Non-Insured Health Benefits (NIHB) program and to the Indigenous health services and support provided through the federal government via the First Nations and Inuit Health Branch. Métis and non-status First Nations lack access to these services and resources while facing the same determinants of health that have created egregious disparities in health in comparison to non-Indigenous people (Greenwood & de Leeuw, 2012; Loppie Reading & Wien, 2009; Smylie, 2009; Smylie & Adomako, 2009; Statistics Canada, 2008). At the same time, simply being eligible for NIHB does not necessarily ensure access since some services require on-reserve residency in order to receive funding for or access to a service or program, and the roster of approved services and medications is constantly changing (Haworth-Brockman et al., 2009; Mother of Red Nations, 2006). Moreover, the delivery of NIHB poses challenges to equitable access to health services in comparison to non-Indigenous people, particularly in northern and remote communities.

In addition to the uneven access to health services and resources created through the NIHB and other race-based policies, experiences and anticipation of racist treatment by health care providers also act as barriers to accessing needed health services for Indigenous peoples (Kurtz et al., 2008; Tang & Browne, 2008; Browne et al, 2011). For example, in examining the experiences of Indigenous and non-Indigenous persons accessing an inner-city emergency department, Browne et al. (2011) found that Indigenous participants described anticipating that being identified as Aboriginal and poor might result in a lack of credibility and/or negatively influence their chances of receiving help. This was such a common experience that participants actively strategized around how to manage negative responses from health care providers in advance of accessing care. In some cases, these experiences keep people from accessing health care at all.

Racism in the Canadian health care system can be fatal; a fact devastatingly illustrated by the death of Brian Sinclair, a 45 year old Indigenous man who visited the emergency room of the Winnipeg Health Sciences Centre in 2008. Mr. Sinclair was referred to the ER by a community physician for a bladder infection. While he waited, Mr. Sinclair vomited on himself several times, and other ER visitors pled with nurses and security guards to attend to him (Puxley, 2013a, 2013b). Following a 34-hour wait, Mr. Sinclair died of the bladder infection in the waiting room without ever receiving treatment. The Sinclair

family, their legal counsel and local Indigenous leaders asked a provincial inquest into the matter to strongly consider the ways in which Mr. Sinclair's race, disability (Mr. Sinclair was a double amputee and had suffered some cognitive impairment), and class resulted in his lack of treatment and subsequent death (Puxley, 2014a). In February 2014, the Sinclair family withdrew from the provincial inquest due to frustration with its failure to examine and address the role of systemic racism in his death, and in the treatment of Indigenous peoples in health care settings more broadly (Sinclair, 2014).

Racism, Health And Health Care: Responses And Interventions

Individual, family, and community strategies and resiliencies

At the individual, family and community level, Indigenous people have been managing racism and its effects on their health for hundreds of years, demonstrating resilience and resourcefulness in the face of exclusion and marginalization. Traditional Indigenous community-based systems of reciprocal economic and social support such as community food sharing and intergenerational and extended family child-rearing roles have been and continue to be important mitigating factors (Food Secure Canada, n.d.; Castellano, 2002). Community and scholarly knowledge have also documented the powerful role of identity and culture in the health and well-being of Indigenous peoples (Gone, 2013). Indigenous communities come together in creative ways to bridge gaps in federal and provincial/territorial financial and policy support to improve health care access. For instance, community-based fundraisers held in some rural Métis communities helped to collectively provide the critical resources needed for the travel costs of community members to access needed specialist health services that are only available outside of their communities.

Health care and service delivery responses

Within Canada, there have been various attempts to increase access to health care and to mitigate the impact of racism on Indigenous peoples at the health care service and delivery level. It is important to note that evaluations of the interventions listed below, in particular education and training programs, seem to be the exception rather than the norm. Further assessment, in particular in Indigenous contexts, is urgently required. Some current strategies and interventions include:

- **Health services, programs and systems directed by Indigenous peoples.** These include:
 - First Nations (on reserve) communities administering and managing their own health services (Lavoie, Forget & O`Neal, 2007);
 - The First Nations Health Authority in British Columbia, governed through an agreement between BC First Nations and the federal and provincial governments;
 - The maternity program at the Inuulitsivik Health Centre in Puvirnituk, Quebec which dramatically reduced the percentage of women required to leave the community to give birth (Epoo & Van Wagner, 2005); and
 - Urban Indigenous health centres, the majority of which are run by Indigenous Boards of Directors and offer both traditional healing and medical services (Anishnawbe Health Toronto, 2011).
- **Community-directed Indigenous services related to health** (e.g. housing, education, employment, language and culture), resulting from decades of advocacy, organizing, implementation and expansion work by Indigenous leaders from across Canada, representing diverse Indigenous groups.

- **Community-based and health-impacting services and programs.** There are many important non-Indigenous specific community level health and health-impacting services that are making important inroads with respect to Indigenous access to health care. For example, some mainstream community health centres, such as the Queen West Community Health Centre in Toronto, offer Indigenous-specific programming.
- **Interventions at the level of mainstream health institutions.** These include:
 - Indigenous-specific programs or services (e.g. Aboriginal Services of the Centre for Addiction and Mental Health (CAMH); First Nations Health Programs at the Whitehorse Hospital).
 - The development of specialized roles such as Aboriginal Patient Navigators (APNs) to serve as a bridge between Indigenous patients and the health care system. The positive impact of these specialized roles on health care outcomes and improved access to care is highlighted in emerging program evaluations of Canadian APN programs (Dicker, 2012; Foreman & Steward, 2011).
- **Promising interventions and training responses.** Since 2000, there has been a steady emergence of policy statements and guidelines for medical professional and medical training organizations in Canada intended to identify and develop the competencies needed by health professionals in order to optimize the care they provide to Indigenous individuals and communities. US-based research largely focused on African American and Latino populations has also pointed to potentially promising interventions (Chin, Walters, Cook & Huang, 2007). Core concepts, frameworks and initiatives that have emerged include:
 - Cultural safety training. While cultural sensitivity and cultural competence focus on learning about the culture of the service user – and can therefore serve to pave over power differences – cultural safety pays explicit attention to power relations between service user and service provider, charging the service provider with the responsibility to consider and address the role of their socially-constructed power in contributing to culturally safe or unsafe care (DeSouza, 2008).
 - Trauma-informed care, which takes up the impacts of historic, collective and intergenerational trauma and is reflected both through encounters with individual providers and the approach of organizations themselves (i.e. welcoming spaces, intake processes, etc.).
 - Initiatives to increase the number of Indigenous health professionals in Canada (Health Canada, 2012b).
 - Ensuring organizational capacity and readiness to address racial and ethnic disparities in health care (Chin et al., 2012).
 - Training aimed at addressing implicit, pro-white bias in health care which has been linked to differential treatment in health care service provision; in the US context, pro-white bias has been linked to disparities in the distribution of pain medications with Black and Latino patients less likely to receive pain treatment than white patients (Todd, Samaroo & Hoffman, 1993; Todd, Deaton, D'Admo & Goe, 2000).

National, Provincial Or Territorial Level Policy Responses

In addition to federal policies regarding transferring the control of First Nations health services to First Nations communities and the First Nations Health Authority, there are several other sets of policies and policy recommendations aimed at increasing Indigenous governance and management of Indigenous health services. These efforts represent important restitutions with respect to the colonial policies that have undermined Indigenous rights to Indigenous-determined health services in Canada. At the national level, both the Royal Commission on Aboriginal Peoples (1996) and the Kelowna Accord (2005) deliberations advocated for fundamental shifts in the governance and management of Indigenous health services from

the federal government to Indigenous communities (First Ministers and National Aboriginal Leaders, 2005; RCAP, 1996). The Aboriginal Healing and Wellness Strategy (AHWS) was tabled and implemented by Aboriginal organizations and provincial ministries in Ontario in 1990, bringing Indigenous people and the provincial government together to combat poor health and family violence, an exemplar that has resulted in multiple Indigenous-led health services and programs (Anishinabek Nation, 2008). Despite these policy recommendations and agreements, multiple international obligations related to the rights of Indigenous peoples, and, constitutionally protected Aboriginal and treaty rights, jurisdictional disputes continue to present major challenges to Indigenous health assessments, health policy, and equitable access to adequate health services.

Critical Next Steps

Transforming the conversation about race and health in Canada

In order to address the health disparities experienced by Indigenous peoples and racialized groups in Canada, we must accurately apprehend and engage the realities of our shared physical and societal landscape. This requires a fundamental acknowledgement of the historical and ongoing colonization of Indigenous peoples (Lawrence and Dua, 2005). This work also demands a foundational shift in how matters of racism and racialization are taken up by Canadian social institutions beyond the health care system, including education, child protection and justice, as well as how these issues are accounted for and addressed by public policies, formal legislation and mainstream stories. It requires a departure from the cherished image of Canada as a well-meaning, international peacekeeper and the imagined harmony of the multicultural mosaic, and a long walk towards truth and reconciliation in a country that our current Prime Minister claims has “no history of colonialism.” (Henderson & Wakeham, 2009). There is also much that can be learned from our international Indigenous colleagues regarding approaches to policymaking, programming, service provision and anti-racism interventions.

Improving Indigenous health data collection in order to address racism as a driver of Indigenous health disparities

Data challenges pose a significant barrier to improving Indigenous health generally and for understanding the impact of racism specifically. The available population health data for Indigenous peoples in Canada is a patchwork, drawing largely on sources with significant limitations (Anderson et al., 2006; Smylie and Anderson, 2006). Meaningful data is critical to understanding and addressing the role of racism in the health disparities experienced by Indigenous people living in Canada. This echoes the work of scholars from Australia and New Zealand who are at the forefront of advancing knowledge addressing the impact of racism on Indigenous health (Paradies et al., 2008) and their call for research in four key areas: 1) the prevalence and experience of racism experienced by Indigenous peoples across the life course; 2) the impact of racism on Indigenous health across the life course; 3) the development of measures to assess systemic racism against Indigenous peoples; and 4) identifying best practices in addressing systemic racism against Indigenous peoples.

We especially argue for concerted effort to develop or adapt effective interventions addressing attitudinal/interpersonal and systemic racism towards Indigenous peoples, and to undertake bold and brave evaluation of existing anti-racism strategies and interventions.

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