Summer 2017

The Assembly of First Nations

HEALTH & WELLNESS BULLETIN

ASSEMBLY of FIRST NATIONS • ASSEMBLÉE des PREMIÈRES NATIONS

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Need help? Reach out!

The First Nations and Inuit Hope for Wellness Help Line is operational and ready to take calls. The Help Line is toll-fee and will be available 24/7. The Help Line is to provide immediate culturally competent telephone-based crisis intervention counselling to First Nations and Inuit young people and adults experiencing distress. Service is available in English and French and callers may also ask about the availability of service in Cree, Ojibway and Inuktituk: **1-855-242-3310.**

The National Indian Residential School Crisis Line provides support for former Residential School students. IRS RHSP program is mandated to exist until the end of the Independent Assessment Process as part of the Indian Residential Schools Settlement Agreement. You can access emotional and crisis referral services by calling 24-Hour National Crisis Line: **1-866-925-4419**

National Inquiry into Missing and Murdered Indigenous Women and Girls. The Government of Canada has set up a national, toll-free crisis call line to provide support for anyone that is triggered and needs help or support during the Inquiry. This line is available free of charge, 24 hours a day, 7 days a week: **1-844-413-6649**

This **Health and Wellness Bulletin** (Summer 2017) is published to raise awareness of health related issues affecting First Nations communities. We hope that this Bulletin will be a resource for individuals and organizations primarily working in health policy, but may also be useful to First Nations communities and health directors more broadly. The AFN would like to thank all those who contributed to the Bulletin.

A Brief Introduction to Mental Wellness Teams

Mental Wellness Teams (MWTs) are a community-based, multi-disciplinary approach to providing mental health and addictions services to a catchment area[1] of First Nations and Inuit communities. Teams were first developed in 2007 with goals and priorities established by the Mental Wellness Advisory Committee (MWAC). Teams are now recognized as an example of the First Nations Mental Wellness Continuum Framework (FNMWCF) in action and align with principles such as improving access, linking with existing services, bringing together community, cultural and clinical approaches to care and services, providing culturally competent care, being responsive to communities, and building capacity, tailored to specific community and regional contexts.

There are currently 11 MWT across the country providing a range of services to approximately 84 communities. Prime Minister Justin Trudeau recently announced $69M over three years that will see the number of MWT increase from 11 to 43, with new teams focusing on remote and isolated communities. This new funding will also support a number of Mental Health Crisis Intervention Teams, invest in training for front-line workers and work with partners to provide access to a culturally safe 24-hour crisis line.

MWTs blend and enhance traditional, cultural, and mainstream approaches, while also having flexible delivery systems that are able to adapt to community needs. The goal of MWTs is to support access to specialized services and improve collaboration among clinical and community experts in order to increase and improve culturally safe mental health and addictions services. MWTs are designed to complement and support efforts that currently exist in First Nations and Inuit communities, while ensuring teams provide a spectrum of services from prevention to post-treatment that include, but are not limited to: direct clinical services, trauma informed care, land based healing and treatment, early intervention and screening, aftercare, and care coordination with provincial and territorial services.

MWTs are intended to be designed, defined, and driven by the catchment of communities that they serve. Most importantly, Mental Wellness Teams are intended to support an enhanced continuum of care by building partnerships across federal, provincial and territorial jurisdictions. Participation and commitment of provincial agencies and authorities as well as other federal services is important to build effective linkages and to enhance collaboration and support an integrated approach to service delivery.

MWTs often take a community development approach, prioritizing existing infrastructure. Assessing the needs of specific communities while acknowledging their strengths helps to reorient services in a meaningful and proactive way. MWTs work with current service deliverers and stakeholders to ensure partners are involved and their concerns addressed. Updates are actively disseminated to community members to welcome feedback and proactively encourage the use of new and improved services.

Outcomes of Current Mental Wellness Teams (as per the recent MW Evaluation):

- Increased cultural understanding of community partners and external service providers
- Increased access to culturally safe services
- Improved individual mental wellness through direct support
- Improved community mental wellness infrastructure including policies and procedures
- Capacity building in community to enhance infrastructure and skills training
- Support and assistance to all community members, including at-risk youth, homeless community members, and Resident School survivors.

[1] An area of people that are drawn to a specific community for its services.

Current MWT 's	Model or Service Orientation
Maliseet Mental Wellness Team, New Brunswick	Delivery of clinical services alongside community based teams; community capacity development in a culturally integrative approach
Raising the Spirit Mental Wellness Team, Ontario	Family-based and culturally safe services and capacity development to address needs associated with addictions, mental health and concurrent disorders that reflect the culture of participating First Nation communities.
Mental Wellness Team Lac-Simon/ Kitcisakik, Quebec	Clinical coaching, support and development of local capacity; networking and liaison; cultural and community services
Mental Wellness Team, Nunatsiavut	Specialized services and capacity building through a balance of western and traditional approaches
Anishinabe Mekina Mino-Ayawin—Road to Good Health, Manitoba	Coordinated access to a continuum of community based, core wellness services including traditional, cultural and mainstream approaches
White Raven Healing Lodge, Saskatchewan	Team based approach to the delivery of culturally safe therapeutic methods in both western and traditional approaches
Quu-asa Mental Wellness Team, Vancouver Island, British Columbia	Multi-disciplinary, culturally based holistic healing approach encompassing counselling, community capacity building and development
Yellowhead Tribal Council	The Program offers cultural and clinical expertise and assists in a community-based development approach to providing mental health and addictions services within each community.
Cree Nation of Chisasibi	The MWT will primarily focuses on community-based mental health and addiction services using traditional and cultural teachings that ensure holistic health and healing. A unique land-based healing program is offered that promotes personal, family and community wellness from a perspective rooted in the Cree way of life.
Kwanlin Dunn First Nation	The team provides culturally-based mental wellness services and related prevention support to Yukon First Nations. Key program components include: pre-treatment and assessment, healing on the land (land-based treatment), an intensive aftercare program and on-going support for individuals as they move forward in the healing process.
Athabasca Health Authority (AHA)/ Onion Lake Cree Nation/ Prince Albert Grand Council (PAGC)	Service delivery is primarily focused on client-centred service models and strength-based tools for capacity building and community development. Cultural programs, counselling and addiction services are offered.

Next steps in implementing MWTs and equipping First Nations communities with mental wellness tools:

- Work is underway through First Nations and Inuit Health Branch (FNIHB) regional offices, in partnership with First Nation and Inuit partners, to determine locations of new MWTs in 2016/17. While Year One will target regions with a high percentage of remote and isolated communities (MB, ON, NR), in recognition of needs across the country, all regions will receive funding in Year One to support planning and future implementation. This work involves individual community preparations and the reallocation of resources to make mental wellness funding available.
- Health Canada is launching a national, toll-free, 24/7 Crisis Line for First Nations and Inuit similar to the way the Indian Residential Schools and Missing and Murdered Indigenous Women and Girls crisis lines are offered. Health Canada will be working with partners to develop a longer-term strategy for Indigenous crisis line services. The Assembly of First Nations (AFN) is currently advocating that Indigenous crisis line services be transferred to one or more Indigenous health organizations as soon as possible.

Building an Urban Indigenous Health Centre in Canada: A How-to Guide

Authors: Jacinda Weiss and Cheryl Currie (Faculty of Health Sciences, University of Lethbridge)

Background & Project Purpose

A growing number of Indigenous-led health centres are being organized around the country to ensure urban Indigenous populations are being served in culturally competent, holistic, and self-determined ways. The purpose of this study was to understand key steps needed to successfully develop and maintain urban Indigenous-led health centres in Canada. We sought to understand the various ways in which urban communities mobilized for this purpose, describe promising practices in management and program delivery, and highlight recommendations established centres had for communities beginning this work.

Methods

This qualitative study involved in-depth interviews with 22 individuals who initiated, organized and/or currently led 11 full-service Indigenous health centres in Canadian cities, including Indigenous physicians, nurses, healers, Elders, and health care managers. We also conducted document and website reviews for supplementary information.

Results: A How-to Guide

1. **What is the first step?** Findings highlight the importance of provincial bodies engaging Indigenous urban-based community stakeholders to begin discussions in an inclusive "all voices welcome" way. These discussions were the gateway to initiating the community leadership process in many cities. Aboriginal Friendship Centres played an essential role in this work in most jurisdictions. Having some funds on the table from the province often helped jurisdictions move to the next step.
2. **Who does the work?** Those we interviewed recommended starting with Indigenous and non-Indigenous people and organizations who have the most knowledge about the clients to be served by the new Indigenous health centre. The role of community champions was highlighted across interviews.
3. **Where does the funding come from?** The initial and core funder for most urban Indigenous health centres is the provincial ministry of health. The funding is often awarded through a community response to a government call for proposals. In some cases, smaller funds were are derived from donors, the federal government, and other provincial ministries, but as one interviewee stated: "It just made sense that it would be operated by the health authority, because the long-term funding would be there, [it's better] than having to rely on grant funding and so on."
4. **Planning beyond typical health care boundaries.** Those we interviewed highlighted the importance of planning for health services that address all levels of wellness, levels that extended far beyond typical health care. Others spoke of "seeking multiple wellnesses" for the clients served. The importance of building evaluation strategies into service planning was highlighted as an essential and often overlooked step. As stated by an Indigenous physician interviewed: "A primary care model has to think beyond its boundaries into population health & recruiting a specialty base. And it needs to move, at least for Aboriginal people, into the social advocacy realm, structural issues, big picture stuff and how it interfaces with traditional cultural components. And then how to create appropriate and effective evaluation so that we know how we are doing."
5. **Culture is the centre of what we do.** Those we interviewed described cultural and traditional healing as "paramount", "primary" and "foundational." In most centres, all services were provided through the lens of Indigenous cultures

and ways of knowing. For example, once centre described honoring traditional ways of collective healing by incorporating group medical visits into the services they offered.

6. **Leveling hierarchy.** This was described as a difficult but important component of the work in many centres – removing hierarchies between staff, and between clients and staff. As stated by an interviewee: "Whether it is a doctor, whether it is a psychiatrist, whether it's a traditional healer, we respect all equally. If you can get that kind of climate & atmosphere, that acceptance, then your model begins to really have traction."
7. **Integrated health service delivery that goes beyond the walls of the centre was highlighted as a key strength of the services most centres offered**. As an interviewee described: "We have rheumatology; we have behavioural paediatricians, neurology, internal medicine, and nephrology all doing sort of community outreach - they are part of our team now. Faster referrals, more abilities to interface with family, and get more knowledge translation back and forth."
8. **Who are the Clients?** Most centres interviewed accepted Indigenous patients only. A small group of centres also accepted non-Indigenous clients who had needs that their Centre specialized in. For example, one centre offered harm reduction services to non-Indigenous clients living close to the street.
9. **Governance.** Most centres are being led by an Indigenous community-based and skills-based board. Interviewees highlighted the importance of selecting committed members who bring "huge skill sets and connections". Others noted the importance of ensuring that the individuals at the table were representing themselves, and not an organization. As one interview stated: "There are no organizations on the board. We saw that once there was an organization they would send different people, there was no continuity… and they would say 'well I can't make a decision because we gotta go back to our organization.' Well you can't function as a board like that."
10. **Where to build it?** Most interviewees argued it was important that urban Indigenous health centres were placed in the centre of the city where things are happening, where people want to go to engage other services, and where there is easy public transportation access.

Urban Indigenous Health Centres in Canada – Reconnecting to That Which We are Seeking

We would like to conclude this summary of our work with a quote from a staff member working at one of the centres we engaged:

> **"We take them to overnight retreats, sharing circles, teaching circles in all our programs. That is what our people are asking for - to be reconnected to something they are seeking - and it's safe to do that here. I think that is key, that people who walk in feel safe and welcomed into our centre, because when they go to other places they feel so judged, and unaccepted, and unwelcomed. Here, it's like coming home."**

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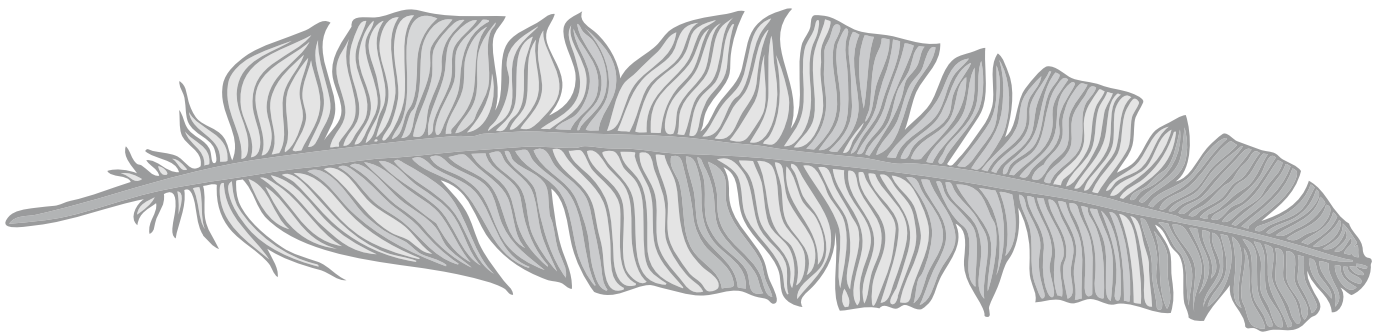

Emergency Response Systems and Services in Remote First Nations Communities in Northern Ontario

Authors: Orkin, A. M., VanderBurgh, D., Ritchie, S. D., Curran, J. D., & Beardy, J.. Derejko, K.S.

Remote and isolated First Nations populations in Canada face dramatically elevated morbidity and mortality from mental health and addiction problems, cardiovascular and respiratory diseases, diabetes and obesity, and infectious diseases, manifesting in an overall higher incidence of health emergencies[1]. Over 95,000 First Nations people live in 85 remote communities in Canada where federal nursing stations or clinics are the only source of local healthcare[2]. Furthermore, approximately 25,000 people in 29 remote communities rely on air transportation to access an emergency department[3]. In such remote and isolated communities, Health Canada reports that untrained laypeople usually deliver on-scene care in emergency situations.[4] This current approach to emergency care for First Nations is inadequate and inequitable. As such, there is urgent need to address the unique geographical, cultural and epidemiological circumstances in these remote communities, and a community-based approach provides a promising opportunity to have an effective, sustainable and scalable local care system that is founded on First Nations self-determination and self-governance.

Community-Based Emergency Care (CBEC) is one approach that can enhance the delivery of emergency care for remote First Nations. CBEC is a collaborative process between healthcare providers, health researchers, governance and policy-making organizations, and local First Nations community members[5]. CBEC focuses on training locals as first responders that can deliver essential features of quality emergency care in communities that lack formal paramedicine systems. Rather than recruiting professionals trained outside of First Nations communities, CBEC improves local capacity by giving training Community Emergency Health Workers (CEHW) with skills to recognize illness and injury, provide basic treatment, and focus on disease prevention and health promotion. CBEC is operated through First Nations governance institutions and delivered by local providers, contributing to a philosophy of self-determination that has been linked with positive health outcomes and is essential to the cultural vision of First Nations in Canada[5].

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1 Health Canada. First Nations Comparable Health Indicators. Available at: http://www.hc-sc.gc.ca/fniah-spnia/ diseases-maladies/2005-01_health-sante_indicat-eng.php# mortality. Archived by WebCite® at: http://www. webcitation.org/6Yh9PL49F (accessed May 21, 2015).

2 Office of the Auditor General of Canada. Access to health services for remote First Nations communities. Report 4,Spring 2015. Available at: http://www.oag-bvg.gc.ca/internet/docs/ parl_oag_201504_04_e.pdf. Archived by WebCite® at: http:// www.webcitation.org/6Yh1LKH5O (accessed May 21, 2015).

3 Glazier RH, Gozdyra P, Yeritsyan N. Geographic Access to Primary Care and Hospital Services for Rural and Northern Communities: Report to the Ontario Ministry of Health and Long-Term Care. Toronto: Institute for Clinical Evaluative Sciences; 2011.

4 Health Canada, First Nations and Inuit Health Branch. Basket of Services Working Group Report: Professional Practices Advisory Committee. June 2013.

5 Reading CL, Wien F. Health Inequalities and Social Determinants of Aboriginal Peoples' Health. National Collaborating Centre for Aboriginal Health; 2009. Available at: http://www. nccah-ccnsa.ca/docs/social%20determinates/nccah-loppie-wien_ report.pdf. Archived by WebCite® at: http://www.webcitation.org/6YhEcakzP (accessed May 21, 2015).

CBEC began as a pilot project in Sachigo Lake between 2010 and 2013, and aimed to train community members as CEHWs through a customized, comprehensive, and culturally appropriate curriculum based on their communities emergency needs. [6] The pilot program had three phases: a site visit with researchers and community members to discuss needs and provide input; the delivery of a five-day CEHWs training course for participants to develop skills surrounding patient assessment, treatment and decision-making competencies specific to emergency situations; and the program evaluation phase following principles of participatory action research. Results from Sachigo Lake pilot were discussed between key stakeholders and First Nations community representatives at CBEC Roundtable meeting in Sioux Lookout. At this meeting, and the original vision and core principles were expanded and seven governing principles were developed to guide future implementation of CBEC. These principles include: community-based service and governance, sustainable service, local capacity-building, intergovernmental and intersectional collaboration, integration across emergency health services, integration across emergency health services, and excellence of care[7].

The results of the Roundtable meeting and formal evaluation indicate that that CBEC is a promising strategy to enhance the delivery of emergency care for remote First Nations[8]. Rather than displacing informal systems with standard paramedicine services, CBEC will enhance and support existing systems with the training and infrastructure needed to deliver excellent and accessible services while building local community capacity[9]. In addition to this, CBEC can create jobs, enhance community resilience, improve access to care, and save lives[10]. Like similar international initiatives, CBEC builds on a global evidence base demonstrating that local lay health providers can deliver essential culturally appropriate emergency care and transform community health for conditions ranging from physical trauma to mental health[11,12,13,14]. CBEC offers a new approach to address the current inadequacy in emergency response in remote First Nations communities, an approach that is desperately needed not only for the wellbeing of individuals who require urgent care, but for entire communities.

[6] Orkin A, VanderBurgh D, Born K, et al. Where there is no paramedic: The Sachigo Lake wilderness emergency response education initiative. PLoS Med 2012;9(10):e1001322.

[7] Orkin A, VanderBurgh D, Ritchie S, Fortune M. Community-Based Emergency Care: An Open Report for Nishnawbe Aski Nation. Thunder Bay: Northern Ontario School of Medicine, 2014. www.nosm.ca/cbec

[8] *Ibid*

[9] Orkin, A. M., VanderBurgh, D., Ritchie, S. D., Curran, J. D., & Beardy, J. Community-Based Emergency Care: A Model for Prehospital Care in Remote Canadian Communities. CJEM, 1-4.

[10] ^

[11] Kobusingye OC, Hyder AA, Bishai D, et al. Emergency medical systems in low-and middle-income countries: recommendations for action. Bull World Health Organ 2005;83(8):626-31.

[12] Jayaraman S, Mabweijano JR, Lipnick MS, et al. First things first: effectiveness and scalability of a basic prehospital trauma careprogramforlay first-respondersinKampala,Uganda.PLoS One 2009;4(9):e6955.

[13] Alaska Community Health Aide Program. Community Health Aide Program Standards and Procedures; 2015. Available at: http://www.akchap.org/resources/chap_library/CHAPCB_ Documents/CHAPCB_Standards_Procedures_Amended_ 2015-01-22.pdf. Archived at Webcite® at: http://www.webci tation.org/6c6k-KESTG (accessed October 7, 2015).

[14] Chamberlain S, Stolz U, Dreifuss B, et al. Mortality related to acute illness and injury in rural Uganda: Task Shifting to Improve Outcomes. PLoS One 2015;10(4):e0122559. doi:10.1371/journal.pone.0122559.

Boiling over: A closer Look at Drinking Water Advisories in First Nations Communities in Ontario

Author: Lindsay P. Galway (Department of Health Sciences, Lakehead University)
Academic Editors: Jayajit Chakraborty, Sara E. Grineski and Timothy W. Collins

Water is a key determinant of human health and ecosystem function and has immense spiritual and cultural significance for many First Nations peoples[1] . According to the World Health Organization, "(w) ater is the essence of life and human dignity"[2] (p. 3). Given the central role of water in protecting and promoting all aspects of health and wellbeing, access to safe and reliable drinking water and sanitation has been designated a human right. Currently, access to safe and reliable drinking water is commonplace for most Canadians and Canada is considered a nation defined by its plethora of water resources. Safe and reliable drinking water however, is denied to many First Nations peoples across the country[3]. The number of water-borne infections in First Nations communities is an alarming 26 times higher than the Canadian national average [4](while people living on reserves are 90 times more likely to have no access to running water compared to other Canadians[5]. This inequality highlights a priority public health and environmental justice issue in Canada that is interconnected to underlying social, political, and economic marginalization and overarching disadvantage faced by First Nations peoples of Canada.

This research presents a cross-sectional study designed to describe trends and characteristics of Drinking Water Advisories, herein referred to as DWAs, in First Nations Drinking water systems in Ontario issued between 1 January 2004 and 31 December 2013 and reported by Health Canada. DWAs are considered preventative measures issued to protect the public against potential health threats from drinking water supplies and can be issued for a range of reasons including problems with drinking water equipment or microbiological contamination[6]. Health Canada utilizes three types of drinking water advisories: ***boil water, do not consume***, and ***do not use advisories***[7],[8] depending on the circumstances.

In this analysis, the DWA trends and characteristics were used as a proxy for reliable access to safe drinking water, among First Nations communities in the province of Ontario. Visual and statistical tools were used to summarize the advisory data in general and temporal trends, as well as characteristics of the drinking water systems in which advisories were issued.

1 Baird, J.; Plummer, R.; Dupont, D.; Carter, B. Perceptions of water quality in First Nations communities: Exploring the role of context. *Nat. Cult.* 2015, *10*, 225–249

2 Brundtland, G.; Mello, S. Foreward. *In The Right to Water*; World Health Organization: Geneva, Switzerland, 2003

3 Boyd, D. No taps, No toilets: First Nations and the constitutional right to water in Canada. McGill Law J. 2011, 157, 81

4 Basdeo, M.; Bharadwaj, L. Beyond physical: Social dimensions of the water crisis on Canada's First Nations and considerations for governance. Indig. Policy J. 2013, 23, 1–14

5 Morrison, A.; Bradford, L.; Bharadwaj, L. Quantifiable progress of the First Nations water management strategy, 2001–2013: Ready for regulation? Can. Water Resour. J. 2015, 40, 1–21

6 Health Canada. *Drinking Water Advisories in First Nations Communities in Canada: A National Overview 1995–2007*; Health Canada: Ottawa, ON, Canada, 2009.

7 Murphy, H.M.; Bhatti, M.A.; Harvey, R.; McBean, E.A. Using decision trees to predict drinking water advisories in small water systems. J. Am. Water Works Assoc. 2016, 108, 109–117.

8 Environment and Climate Change Canada. Environmental Indicators—Drinking Water Advisories in Canada. Available online: https://www.ec.gc.ca/indicateurs-indicators/default.asp?lang=en&tn=2C75C17A-1 (accessed on 15 December 2015).

Overall, 402 advisories were issued during the study period, leading to a total of 118,307 advisory days. The average advisory duration was 294 days and strikingly 14% of such DWA days were in effect for more than one year. Most advisories were reported in summer months where microbial activity is more rampant due to higher temperatures. Equipment malfunction was the most commonly reported reason for issuing an advisory. Nearly half of all advisories occurred in drinking water systems where additional operator training was needed.

This study shows that access to safe drinking water is not reliable within First Nations communities across Ontario; it is sporadic in most cases and chronically unavailable in far too many. Researchers studying other marginalized and disadvantaged communities within developed nations have come to similar conclusions regarding the need to move beyond technical fixes and account for the role of social and ecological factors within the realm of water provision, safety, and quality (e.g.,[9,10]). The findings underscore that the prevalence of DWAs in First Nations communities must be addressed, focusing initially on priority water governance issues of fragmentation and source water protection.

Currently, the management of water and the provision of drinking water are divided between Indigenous and Northern Affairs Canada (INAC), Health Canada, and Environment and Climate Change Canada (Environment Canada prior to 2016) and First Nations communities themselves[11]. Government departments consult and offer advice and funding for the water and wastewater systems and then First Nations communities are responsible for the delivery of water to community members as well as the design, maintenance, and operation of the water systems. It has been claimed in numerous panels on the state of drinking water in First Nations communities that "(t)hese arrangements are neither comprehensive nor easily deciphered; most critically, there are numerous gaps and a lack of uniform standards, as well as enforcement and accountability mechanisms"[12].

Addressing water-related issues and improving access to safe and reliable drinking water in Canada's First Nations communities also necessitates more explicit attention to source water protection at the watershed scale[13]. Research has found that there needs to be consolidated efforts upstream to protect the watershed and drinking water sources since water quality and quantity are impacted by off-reserve activities such as resource extraction, forestry practice and agriculture[14].

Inadequate access to safe and reliable drinking water among First Nations peoples is a priority public health and environmental justice issue. The problem will likely persist without enhanced monetary and infrastructural investments as well as multi-faceted and integrated efforts focusing on improving water governance and source water protection at the watershed level. Although the solutions remain complex, water is an integral part of health and wellbeing and must be a national priority to decrease DWAs across First Nations communities in all of Canada.

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9 Hargrove, W.; Juárez-Carillo, P.; Korc, M. Healthy Vinton: A health impact assessment focused on water and sanitation in a small rural town on the U.S.-Mexico border. Int. J. Environ. Res. Public Health 2015, 12, 3864–3888

10 Korc, M.E.; Ford, P.B. Application of the Water Poverty Index in border Colonias of West Texas. Water Policy 2013, 15, 79–97.

11 White, J.P.; Murphy, L.; Spence, N. Water and Indigenous peoples: Canada's paradox. Int. Indig. Policy J. 2012, 3, 3.

12 Indian and Northern Affairs Canada. Report of the Expert Panel on Safe Drinking Water for First Nations; Indian Affairs and Northern Development: Ottawa, ON, Canada, 2006; Volume 1.

13 MacIntosh, C. Testing the waters: Jurisdictional and policy aspects of the continuing failure to remedy drinking water quality on First Nations reserves. Ottawa Law Rev. 2008, 39, 63–97.

14 Phare, M.-A.S. Denying the Source: The Crisis of First Nations Water Rights; Rocky Mountain Books Ltd.: Surrey, BC, Canada, 2009.

Welcoming Future Generations: Culturally safe and competent care throughout the ceremony of birth

Authors: Denise Booth and Claire Dion Fletcher, RM

Aboriginal women and families have a complex and long history of losing autonomy of our bodies and how we choose to bring new life into the world. The Toronto Birth Centre (TBC) located in downtown Toronto, on the ancestral lands of the Wendat, Haudenosaunee confederacy and Anishinabe Nations, is a community-based health care facility that offers women a third option for a safe, family-centred place to give birth. The TBC as an organization operates within an Indigenous Framework, and promotes culturally safe care. The TBC strives to ensure that every Aboriginal family that chooses the TBC for labour and delivery are supported throughout pregnancy and birth. Families have the right to informed choice, while being supported and encouraged to reclaim their cultural teachings and ceremonies surrounding pregnancy, labour, birth and parenting.

Toronto Birth Centre

The Toronto Birth Centre is a midwifery and Indigenous-led organization, governed by a nine member volunteer board of directors. The Board of Directors is made up of two-thirds Registered Midwives and a majority self-identified Aboriginal members. The TBC has two advisory councils, the Midwives Council and the Community Council. To ensure representation of Aboriginal voices from different stages of the life cycle a Knowledge Keeper and Youth Member are a part of the Community Council and are non-voting members on the Board of Directors.

The TBC purpose is to achieve optimal health and wellness for the whole community through culturally centred care, education and research that supports the practice of Aboriginal midwifery in its fullest scope, both culturally and professionally. The TBC vision is to build a space where women, families and communities can access culturally safe birthing care.

The TBC has four core values that guide our policies and practice: self determination, equity, dignity and justice.

Indigenous Framework

Toronto's Aboriginal midwives were committed to creating a space that ensured the policies, procedures and governance of the birth centre were built on a foundation of an Indigenous Framework. Since the beginning of the visioning of the Toronto Birth Centre there has been much community involvement. The vision for the TBC was developed through many gatherings of Toronto's Aboriginal community, talking circles were held with the support of Elders, Knowledge Keepers and academics to ensure the TBC would meet the needs of the community. The Indigenous Framework informs all aspects of the TBC, the framework includes nurturing healthy and reciprocal partnerships, integrating opportunities for leadership and capacity building into general operations, and establishing clear roles and responsibilities for all people who are involved with the TBC. Itapisinowin, a Cree word that represents an Indigenous worldview, reminds us that all worldviews can vary from community to community, nation to nation and person to person. We also acknowledge and respect the sacredness of life, kinship relationships, the interconnectedness of creation and our roles and responsibilities to the natural world. The TBC promotes the Rights of Indigenous peoples and our collective roles and responsibilities, as taught to us in our teachings as well as enshrined in the Canadian Constitution, the Ontario Human Rights Code and the UN Declarations on the Rights of Indigenous Peoples. This means that we acknowledge our histories, the legacies of colonization, and the impacts that colonization has on not just Indigenous peoples, but all people who live on Turtle Island.

Aboriginal midwifery

In Ontario, midwives who are Aboriginal may be either Aboriginal Registered Midwives or Aboriginal Midwives. The Regulated Health Professions Act, 199, includes exemptions for Aboriginal healers and midwives and the Midwifery Act, 1991 includes an exception for Aboriginal Midwives. These provisions enable Aboriginal midwives who provide traditional midwifery services within their communities to use the title Aboriginal Midwife. Currently in Canada there are 3 formal community-based training programs. Under the exemption clause, Aboriginal Midwives are midwives that are recognized and regulated by their communities according to standards established by their communities. Registered Midwives may also be Aboriginal, Aboriginal Registered Midwives are midwives who have completed a university-based midwifery program and who are recognized and regulated by the College of Midwives of Ontario according to standards established by the College. All Aboriginal midwives, whether registered or working under the exemption are health professionals that are deemed to have the required skills to provide safe care to their communities. The TBC is supportive of all Aboriginal midwives' right to practice midwifery fully in the ways of our ancestors.

Aboriginal midwives are primary health care providers that care for women and babies throughout pregnancy, birth and for six weeks postpartum. Some Aboriginal Midwives may also provide well-woman care beyond six weeks postpartum. Aboriginal midwives have knowledge of and offer a range of practice related to traditional and contemporary midwifery services. Aboriginal midwives have an important role in the provision of education to individuals, families and the community, this may include things such as, individual teachings to a family about pregnancy and birth, teaching a prenatal classes and providing education to midwifery students in either a community-based or university-based program. Aboriginal midwives are also recognized by many community members as the keepers of ceremonies surrounding pregnancy, birth, infants, children and youth.

Culturally safe care at the TBC

The Toronto Birth Centre provides an Indigenous space, from the cedar tree out front, to the artwork in the centre, to the names of the birth rooms, to waiting rooms that invite family in, the TBC is designed by midwives for birth, for families and for ceremony. The TBC creates a space where Aboriginal people feel comfortable to birth in the

way that they would like, with the people they would like present and with the ability to include traditions, ceremonies and medicines. The TBC is place where Aboriginal knowledge, cultures and ceremony is respected and celebrated.

The TBC provides not only a culturally safe space for Aboriginal people to give birth, but also a space for Aboriginal midwives to work. Reproductive rights include not only the right to have access to the birth and health care that we want, but also for our people to revitalize Aboriginal midwifery in our communities and lead the way in providing reproductive health in a culturally safe way. The TBC provides a space for this, where Aboriginal midwives can practice the ways we always have, and where we can share our teachings and ceremonies with clients, with families and with each other.

The TBC also offers a variety of programming, increasing the opportunity for traditional knowledge sharing. This has included teachings about traditional medicines, family centred celebrations, workshops, Biindige a'maazo (he/she comes in singing) and naming ceremonies to name a few. The cultural programming at TBC not only promotes

a respect for Aboriginal knowledge, but also marks the TBC as an urban space where people can come to reclaim and celebrate some of their cultural teachings and ceremonies. The linking of cultural events and teachings to a healthcare setting highlights the importance of culture and ceremony to the health and well-being of Aboriginal people. The TBC provides experiential learning opportunities, it is a safe place to support self-awareness, make connections, and learn new understandings from another's perspective. Working within cross cultural relationships the TBC helps to create a network of allies – there is an expectation at all levels of the organization for ongoing development of knowledge, attitudes, behaviours and skills to reflect cultural competencies and building of environments that are supportive of cultural safety for Aboriginal clients and families.

Reclamation of birth ceremonies

Pregnancy, birth and parenting have always been important in Aboriginal community life, as such, they were targeted by colonial and assimilationist policies meant to destroy Aboriginal culture. Being born in a place that is safe, supported by Aboriginal midwives, surrounded by friends and family, allows babies to be born within their cultural and ceremonial traditions in a supportive and loving environment which promotes well-being from the very beginning of life. The TBC provides a safe space for the reclamation of birth ceremonies and the celebration of Aboriginal cultural identity and expression-the foundations of health and well-being of future generations is being formed at TBC every day.

Community Healing Murals for Youth Empowerment: Cedar and Gold Mural Projects

Authors: Jessica Barudin and Vince Dumoulin (Cedar and Gold)

Mural art created by Indigenous youth is a celebration of the survival of Indigenous knowledge. That was the feeling we shared following the completion of the Community Healing Mural project in the 'Namgis First Nation community of Alert Bay, British Columbia. The Cedar and Gold Mural program blends traditional Indigenous culture with contemporary art and elements of graffiti, hip hop and restorative justice to promote safe spaces and learning opportunities for youth.

Capacity Building and Empowerment

Artist-in-residence, Vincent Dumoulin loves the vibrancy and collective energy from the youth – who are curious about their own creativity and not shy to express themselves when they discover the appropriate vehicle to do so. Vincent shares the similarities between traditional Indigenous art and the graffiti sub-culture with its origins in hip hop to connect with the youth. He opens up about how he turned his life around by developing his artistic skills and finding a pro-social creative outlet.

These mural projects enable collaboration with the children, educators, parents, Elders, cultural leaders and artists to work harmoniously. School curriculum and traditional approaches are integrated in with the mural making. This encourages youth to explore new skills and methods of self-expression, including sharing in circle, sketching, painting, singing and dancing. They also have the ability to re-create and convey their interpretation of these values and experiences through writing, speaking and documenting through photo and video. Responsibility and skill-development is a by-product to the painting of the walls.

Art + Language: a powerful duo

Indigenous culture is integrated in every aspect of the production, even before the mural concept development. This involves an opening from an Elder to share a prayer and stories, followed by circle sharing and sharing sketching activities, where youth assisted by artistic mentors to explore creating different expressions through symbols, colors and images.

Language is a focal point of the mural program because in each original language, there exists meaning and teachings (Rathwell & Armitage, 2016). Indigenous values are embedded within the language and we integrate the school curriculum with traditional knowledge throughout the program.

Mural Program Impact

- Pride and empowerment through strengths-based learning
- Cultural sharing and transmission of language / traditional values
- Multigenerational learning and healing
- Building capacity and social cohesion through the process of mural making
- Community beautification

The Cedar and Gold Mural program integrates culturally restorative practices that build on the sacredness of teachings and culture. This program of art and art making has the ability to bridge knowledge across generations and cultures. It is a form of healing that creates positive synergies and resilience amongst the participants. Inspire youth in your school and community and connect with us to launch a Cedar and Gold Mural Program!

Cedar and Gold

Cedar and Gold creates culturally-rooted health and wellness programming for Indigenous communities, organizations and professional allies across Turtle Island. Our programs integrate teachings from Indigenous knowledge and modern research to promote balance in body, mind and spirit. For more information, visit www.cedarandgold.ca or e-mail: Jessica@cedarandgold.ca[1]

In this project, the concept for the mural was inspired from the language and original art forms of the Kwakwaka'wakw, including ovoids and the trout-head design and modernized in the form of letters from the alphabet to spell out the word 'Maya'xala', a Kwak'wala word that means respect – a way of being that shows respect to one self, family and all of creation.

[1] Rathwell, K. J., and D. Armitage. 2016. Art and artistic processes bridge knowledge systems about social-ecological change: An empirical examination with Inuit artists from Nunavut, Canada. Ecology and Society21(2):21.

Simard, E., & Blight, S. (2011). Developing a culturally restorative approach to Aboriginal child and youth development: Transitions to adulthood. First Peoples Child & Family Review, 6(1), 28-55.

Chronic Wasting Disease

CHRONIC WASTING DISEASE UPDATE

The Assembly of First Nations (AFN) is providing some important information on an environmental health issue that is affecting, deer, elk, and in some cases, moose. Chronic Wasting Disease (CWD) is a disease that affects the nervous system of species in the deer family (cervids) and is fatal to these animals. In an effort to create awareness for First Nations, AFN will be developing communication materials to educate First Nations communities about CWD. Some quick facts on CWD are included on the next page of this Bulletin.

As of this date, there is no scientific evidence that CWD can be transmitted to humans. It is recommended, however, that an animal that has been affected with CWD or any tissue from an affected animal not be used or consumed by humans.

CWD cases are currently limited to the provinces of Saskatchewan and Alberta. Many First Nations communities rely on hunting for both sustenance and ceremonial use that could put First Nations at greater risk of exposure to CWD. The AFN is working towards developing resources to inform First Nations and raise awareness about CWD to assist in avoiding any potential risk, and to ensure First Nations are included in ongoing efforts to address this issue.

The AFN is mandated to engage in this work through Resolution no. 70/2010, First Nation-controlled Awareness, Training & Surveillance Program for Chronic Wasting Disease. As set out in the resolution, the AFN will work with concerned First Nations to develop and strengthen First Nation wildlife and human health programs, including those dealing with Chronic Wasting Disease.

Quick Facts on Chronic Wasting Disease (CWD):

- Chronic wasting disease (CWD) is a fatal nervous system disease known to naturally infect white-tailed deer, mule deer, black-tailed deer, moose and elk.
- At this time there is no scientific evidence to suggest that CWD in deer and elk can be transmitted to humans. However, it is recommended that any tissue that may have come from a CWD-infected animal not be used or consumed by humans.
- Animals with CWD may show a number of different signs as the disease slowly damages their brain, which may include: excessive salivation, lack of coordination, paralysis, separation form the other animals in the herd and weight loss.
- CWD was first detected in Canada on a Saskatchewan elk farm in 1996. Since then the disease has been detected elsewhere in Saskatchewan, with a few cases in Alberta.
- CWD is transmitted directly and indirectly through environmental transmission, it should be noted that there is no evidence that CWD can be transmitted to other species outside of cervids.
- CWD is usually confirmed by testing of tissue from the affected animal after it is dead.
- Currently CWD is a reportable disease under the Health of Animals Act and all cases must be reported to the Canadian Food Inspection Agency, resulting in immediate investigation.

First Nations Clients: *You Have the Right t*

There has been an increasing understanding of the vital role that cultural safety and competency plays in building trusting relationships with health professionals and in improving health outcomes. The **Truth and Reconciliation Commission** (TRC) of Canada "call[s] upon the federal government to recognize, respect, and address the distinct health needs" of First Nations and for all levels of government to "provide cultural competency training for all health-care professionals." The TRC also calls on the Canadian health-care system to "recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients."

You have a right to culturally safe care. If you feel that a doctor has exhibited discriminatory or inappropriate behaviour, it is your right to file a complaint against that doctor. Each province or territory has a mechanism to file an official complaint, leading to an investigation. If you have had or encounter any negative experiences with doctors and decide to submit a complaint in writing, the following details should be included:

- your name, address, postal code, and phone number;
- the name(s) of the medical doctor(s);
- a description of your complaint;
- the date(s) the event(s) occurred;
- the name of any hospital involved;
- the name and address of any other person who may have information to support your complaint; and
- Your signature, to validate the claim.

The following contacts are specifically for submitting complaints about doctors. Other healthcare professions (dentists, nurses, etc.) are similarly bound by ethical standards via their own governing institutions and complaints must be submitted to the appropriate institution.

www.afn.ca

BRITISH COLUMBIA

The College of Physicians & Surgeons of British Columbia website, **www.cpsbc.ca**, has a formal complaint form that may be submitted online or by mail.

Telephone: 1-604-733-7758

College of Physicians & Surgeons of British Columbia
300–669 Howe Street
Vancouver BC V6C 0B4

ALBERTA

The College of Physicians & Surgeons of Alberta website, **www.cpsa.ca**, has a formal complaint form that must be signed and mailed.

Telephone: 1-800-661-4689

College of Physicians & Surgeons of Alberta
2700 – 10020 100 Street NW
Edmonton, AB T5J 0N3

SASKATCHEWAN

The College of Physicians and Surgeons of Saskatchewan website, **www.cps.sk.ca**, has a formal complaint form that must be signed and mailed.

Telephone: 1-800-667-1668
E-mail: **complaints@cps.sk.ca**

Complaints Department - College of Physicians and Surgeons of Saskatchewan
101 - 2174 Airport Drive
Saskatoon, SK S7L 6M6

MANITOBA

The College of Physicians & Surgeons of Manitoba website, www.cpsm.mb.ca, has a formal complaint form that may be submitted via e-mail or signed and mailed.

to Culturally Competent and Safe Care!

Telephone: 1-877-774-4344
E-mail: **complaints@cpsm.mb.ca**

The College of Physicians & Surgeons of Manitoba.
1000 – 1661 Portage Ave
Winnipeg MB R3J 3T7

ONTARIO

The College of Physicians & Surgeons of Ontario website, **www.cpso.on.ca**, has a formal complaint form that can be filled out online.

Telephone: 1-800-268-7096 ext. 603

QUEBEC

The Collège des médecins du Québec website, **www.cmq.org**, has a formal complaint form that may be submitted by mail or in person. You may also mail a letter detailing your experience.

Telephone: 1-514-933-4787

Inquiries Division - Collège des médecins du Québec
Office 3500
1250, René-Lévesque Boulevard West
Montreal, QC H3B 0G2

NEW BRUNSWICK

The College of Physicians and Surgeons of New Brunswick accepts signed, mailed letters of complaint.

Telephone: 1-800-667-4641

Dr. Ed Schollenberg, Registrar
College of Physicians and Surgeons of New Brunswick
One Hampton Road, Suite 300
Rothesay, NB E2E 5K8

NOVA SCOTIA

The College of Physicians and Surgeons of Nova Scotia website, **www.cpsns.ns.ca**, has a formal complaint form that may be submitted by mail or in person.

Telephone: 1-877-282-7767

College of Physicians and Surgeons of Nova Scotia
Suite 5005 - 7071 Bayers Road
Halifax, NS B3L 2C2

PRINCE EDWARD ISLAND

The College of Physicians and Surgeons of Prince Edward Island accepts signed, mailed letters of complaint.

Telephone: 1-902-566-3861

College of Physicians and Surgeons of Prince Edward Island
199 Grafton Street
Charlottetown, PE C1A 1L2

NEWFOUNDLAND AND LABRADOR

The College of Physicians and Surgeons of Newfoundland and Labrador website, **www.cpsnl.ca**, has a formal complaint form that must be signed and mailed.

Telephone: 1-709-726-8546

College of Physicians and Surgeons of Newfoundland and Labrador
120 Torbay Road W100
St. John's NL A1A 2G8

YUKON

The Yukon Medical Council website, **www.yukonmedicalcouncil.ca**, has a formal complaint form that must be completed online.

Telephone: 1-867-667-3774
E-mail: **ymc@gov.yk.ca**

NORTHWEST TERRITORIES

The College of Physicians & Surgeons of Alberta is responsible for the complaints of residents of the Northwest Territories. The College of Physicians & Surgeons of Alberta website, **www.cpsa.ca**, has a formal complaint form that must be signed and mailed.

Telephone: 1-800-661-4689

College of Physicians & Surgeons of Alberta
2700 – 10020 100 Street NW
Edmonton, AB T5J 0N3

NUNAVUT

Patient Relations under the Government of Nunavut is responsible for handling complaints about medical professionals. "You can submit your concerns verbally – in person, via telephone, in writing – email, posted letter, or by completing a standardized downloadable form" obtainable at **www.gov.nu.ca/health/information/patient-relations**.

Telephone: 1-867-975-5703
E-mail: **patientrelations@gov.nu.ca**

Territorial Manager of Patient Relations,
Office of Patient Relations
Department of Health
P.O. Box 1000, Station 1000
Iqaluit, NU X0A 0H0

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55 Metcalfe Street
Suite 1600
Ottawa, ON K1P 6L5
www.afn.ca