Maawanji'idiwag

Meeting Together in a Good Way

Engaging the Truth and Reconciliation Commission (TRC), Missing and Murdered Indigenous Women and Girls (MMIWG) and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP): A Curricular Mapping Activity for the Ontario Primary Health Care Nurse Practitioner Program

This report has been made possible through funding from the Council of Ontario Universities.
Sky Woman – A Creation Story

Long before the world was created, there was an island in the sky inhabited by sky people. One day a pregnant sky woman drops through a hole created by an uprooted tree and begins to fall for what seems like eternity.

Coming out of darkness, she eventually sees oceans. The animals from this world congregate, trying to understand what they see in the sky. A flock of birds is sent to help her. The birds catch her and gently guide her down onto the back of Great Turtle. The water animals like otter and beaver have prepared a place for her on turtle's back. They bring mud from the bottom of the ocean and place it on turtle's back until solid earth begins to form and increase in size.

Turtle's back becomes Sky Woman's home and the plants she's brought down with her from Skyworld, including tobacco and strawberries, are her medicine. She makes a life for herself and becomes the mother of Haudenosaunee life, as we know it today.

We Acknowledge that our work and meetings are occurring on Indigenous Lands.

On February 14th, 2020 our journey began together on the traditional lands of the Atikameksheng Anishnawbek and Wahnapitae First Nation at Laurentian University.

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Preface

This report is intended to serve as a guide and framework for decolonizing and Indigenizing the PHCNP program curriculum. It speaks to and calls upon the reader to practice self-reflection. It has also been guided by elders and knowledge keepers as well as by the principles of cultural safety and humility. This work is quite timely and much needed and is being undertaken during Wet’suwet’en solidarity protests that have been occurring across Canada. The need for reconciliation with Canada’s First Peoples has been long overdue. Our goal is to contribute to improving our relationships with Indigenous Peoples by providing a PHCNP program that is aligned with the values and importance of reconciliation.
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1. Background - What brought us here?

Addressing the need for this report.

“Reconciliation is about forging and maintaining respectful relationships. There are no shortcuts.” Justice Murray Sinclair

On February 14, 2020 a team of elders and knowledge keepers, an Ontario PHCNP program student and nursing faculty in the PHCNP program met together at Laurentian University's Indigenous Sharing and Learning Centre. When meeting in a good way, expressed as Maawanji'idiwag in the Anishinaabe (Ojibwe) language, sweetgrass is needed. Sweetgrass in its braided form, speaks to our coming together, our intertwined relationships with each other and the land. Through storytelling we can connect our hearts which can often be emotional and harrowing. While passing around a braided sweetgrass strand, the group began with introductions and each took a turn speaking to their location on the land and to their relationship with Indigenous people. This is a time of great change, where the relationship with each other and the land has come to the fore. In this regard, it is fitting that we have begun this report with the creation story where the land is alive and full of life - an Indigenous way of being and knowing. As we met and wrote at the time of the Wet'suwet'en pipeline protests, we all felt challenged to reflect on our individual location with respect to the land, people and history and how this extends into all relationships.

In 2015 the final report of the Truth and Reconciliation of Canada (TRC) was completed. The report continues to resonate today as educational organizations throughout Canada are challenged to recognize and fulfil its Calls to Action. In 2016 and around the same time that the TRC was released, the Report on the Evaluation of the Aboriginal Content of the Ontario Primary Health Care Nurse Practitioner Program was completed. The research undertaken at that time evaluated courses through faculty perspectives framed through the lens of the Canadian Indigenous Nursing Association (CINA), previously the Aboriginal Nurses Association of Canada (ANAC) core competencies. These competencies include postcolonial understanding, communication, inclusivity, respect, Indigenous knowledge and mentoring and supporting students for success (ANAC, 2009a, p.5). Then in 2018, the National Inquiry into the Missing and Murdered Indigenous Women and Girls (MMIWG) released its final report, Reclaiming Power and Place. These two very important reports reflect human rights articles that can be found within the United
Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) which were endorsed by Canada in 2010. All of these reports and declarations have served as a guide to frame our discussions, review and ultimately guide the recommendations or better yet, the action calls that this report will bring forward.

Following the momentum of all the previously mentioned reports, this report seeks to build upon and establish a foundation for ongoing activities aimed at enriching the overall Ontario Primary Health Care Nurse Practitioner (PHCNP) Program curriculum. Under the Council of Ontario University Programs in Nursing (COUPN), the PHCNP program is offered through a consortium of nine Ontario universities including Lakehead, York, McMaster, Ottawa, Laurentian, Western, Windsor, Queens and Ryerson.

The TRC, the National Inquiry into the MMIWG and the UNDRIP reports and documents are of critical importance towards human rights and equity and are thereby essential to the nursing domains of leadership, education, practice and research. We have heard repeatedly that many faculty are unsure about how to interpret let alone incorporate the guidelines and calls to action from these reports into curricula. This report intends to serve as a guide and support faculty in incorporating culturally safe Indigenous content into the PHCNP program. In this respect, the reports and documents are prioritized as being of pivotal importance to the PHCNP program and its curriculum.

Four Sacred Medicines Tobacco, Sweetgrass, Sage, Cedar

CBC News. (2014). Elder Irene Young of Opaskwayak Cree Nation shares teachings on the four sacred medicines: https://www.cbc.ca/player/play/2687175159
1a) *The Sweetgrass Braid – honesty, sharing and kindness - a journey towards curriculum, learning and action*

Dr. Michelle Spadoni helps us to learn the significance and relationship of sweetgrass to our work:

_Sweetgrass— Lessons on rethinking curriculum and decolonizing learning_

Sweetgrass in many North American Indigenous communities is thought to be one of the four sacred medicines. Sweet grass is an interesting metaphor, for thinking about decolonizing learning/teaching practices. The plant itself gives out a sweet smell, a gift from mother earth, she offers us gentleness, love and kindness (Anishnawbe Health Toronto, 2000). The Elders tell us it is a reminder of what is at the heart of ‘good relations.’ A reminder of how to be with one another and with mother earth. Sweetgrass grows best in the sun, and well-watered meadows, but it thrives along ‘disturbed edges’ (Wall Kimmerer, 2013).

_The gifts of sweetgrass—thinking about colonizing and decolonizing learning_

When we think about decolonizing education, it calls us to re-think our very way of ‘being, doing, and knowing’ as educators (Cote-Meek, 2014). It also calls us to consider, within our own practice as well as curriculum issues of bias, power and privilege, what counts (or not) as knowledge and whose voices are heard (and whose voices are silenced). We are challenged to consider what knowledge (s) we privilege in curriculum, what content becomes forefront in the minds of our learners and teachers (remembering that we are all learners), and what content is banished to the ‘soft edges.’ Knowledge (s) that are glanced over in learner discussions, and how ‘soft edges’ are perceived by learners when intertwined with such concepts as epidemiology/pathophysiology/diagnostics and treatment. It is important to consider if our learners are ready to appreciate the connections.

It brings into question what we think we know, and what we do not know, and requires an acknowledgement of personal values, beliefs, and biases in relation to curriculum content.
and how we go about ‘teaching’ said content. It’s an opportunity to explore why it is that we find teaching certain areas of the curriculum challenging and others uncomfortable. Decolonizing education calls faculty to consider how we envision learners (their capacities, sensibilities and competencies) from novice to graduate, and how each level of development and professional formation differ. It is vital to consider which epistemological frameworks shape curriculum and teaching practice and consider if our approach in the classroom and clinical setting allow for other worldviews to be critically appreciated and useful in practice. Further consideration may be given to explore how content and learning objectives and outcomes are developed, designed, assessed, measured and evaluated in relation to Indigenous content and worldviews.

**With a focus on Indigenous content, diverse voices and wise practice, this exercise sought to consider and answer a number of questions in relation to the NP curriculum such as:**

How is Indigenous content taught and is it inclusive of voice and wise practices?

How are Indigenous people’s world view’s articulated in relation to colonizing and decolonizing teaching/learning approaches?

Are the voices of contemporary Indigenous NP’s present in curriculum content?

Where does Indigenous content appear in NP curriculum, how is it interwoven, is there a natural progression, what other forms of knowledge support Indigenous content?

What developmental level is the student at in relation to the specific Indigenous content being offered (for example: intergenerational trauma, medicines)?

How is content linked (or not) to issues of diversity, culture, power and privilege, racism, and intergenerational trauma?
We looked for clues in the current curriculum of whether or not the current design reflects decolonizing theoretical perspectives (humanism, relational perspectives, feminist theory, social location, intersectionality, and anti-colonial theory, Indigenous methodologies and paradigms).

Does the curriculum support the development of curious and creative, critical reflective practitioners?

In addition, there were other queries to consider in relation to decolonizing curriculum and teaching practice which included (but not limited to):

- What sorts of theories/philosophies underpin our teaching?
- What sorts of theories/philosophies create space to consider how we nourish and engage learners, spark their curiosity, gentleness of spirit, humility and introspection as they navigate spaces of uncertainty in relation to issues of racism, oppression, vulnerability, power and privilege (to name a few)?

**Sweetgrass—a perennial with a rich root system**

Sweetgrass thrives best in disturbed edges. Disturbed edges capture the tension filled space of reconciliation between Indigenous and Non-Indigenous people and reflects the unease nurse educators have with Indigenous content, whether they are Indigenous or Non-Indigenous. Mary Jane Logan McCallum, a historian from the University of Manitoba, studies the history of Indigenous nurses in Canada (i.e.: Indigenous Women, Work, and History, 1940-1980). In her studies’ she explores some of the key Indigenous nurse leader’s whose professional practice (clinical and academic) have informed contemporary Canadian healthcare. For example, we may learn from Jean Cuthand Goodwill. An RN, Jean was raised on the Little Pine First Nation Saskatchewan. She became one of Canada’s leading nurse advocates. In 1981 she became the “first Indigenous woman in the federal public service to be appointed special advisor to the minister of Nation Health and Welfare” (Cuthand, n.d., para 2). She was one of the original founders of the Registered Nurses of Canadian Indian Ancestry (RNCIA), now the Canadian Indigenous Nurses Association (Cuthand, n.d.). Jean Cuthand Goodwill and her colleagues in the early 1970’s identified the need to organize and advocate for the recruitment and retention of Indigenous nurses
with the end goal of improving Indigenous people’s access to education, and health care (McCallum, 2016). The formation of the RNCIA reflects a ‘turning point’ in Canadian nursing, and in the history of Canadian healthcare (McCallum, 2016).

As McCallum notes an important organizing principle for Aboriginal nurses was Indian Control since it is at the roots of self-determination and self-government in the field of healthcare for Indigenous people (McCallum, 2016). Moreover, Indian Control challenged the lack of consultation by governments in relation to Indigenous people in policy development (from healthcare to education and land claims). Further, Indian Control opens up a broader conversation about the significance of Indigenous people’s cultural and historical place in Canada, and the rights inherent within (McCallum, 2016). The echoes of Canada’s Indian Act, in relation to what McCallum notes as absence of ‘Indian Control’ can be found within the testimonies of those who came to share their stories publicly with the commissioners of the MMIWG Inquiry.

A passage of relevance surfaces in the MMIWG’s Report (2019) volume 1, A Reclaiming Power and Place, with Commissioner Qajaq Robinson’s reflection on rights in relation to power and place:

  The continued actions of our government to deny and infringe on human rights and Indigenous rights and the colonial, sexist and racist attitudes held by non-Indigenous peoples fails to reciprocate this welcome, respect and kindness you have shown me. Despite the numerous human rights laws and instruments the federal, provincial and territorial governments are bound by, and despite the recognition and affirmation of Indigenous rights in our Constitution, and the numerous court decisions calling for rights recognition and respect, this is not the reality for Indigenous Peoples, and especially Indigenous women, girls, and 2SLGBTQQIA people in Canada. (p. 9)

The truths shared within the pages of the National Inquiry hearing, tells the ‘thousands of stories—of acts of genocide,’ genocide empowered by colonial structures stemming from the “Indian Act, the Sixties Scoop, residential schools, breaches of human Indigenous rights, leading directly to the current increased rates of violence, death and suicide in Indigenous populations” (MMIWG’s
Report, 2019, p. 50). Ultimately, as Mary Jane Logan McCallum (2016) suggests Canada’s colonial structures have cemented Indigenous people’s continued:

Mistrust of health-care services, the suspicion of inferior treatment and structural anti-Indigenous racism, and the superficial, distant, medicalized, stop-gap response from Health Canada are common characteristics of the relationship between Indigenous people and health-care system. (The Indigenous Nurses Who Decolonized Health Care, para 1)

This is the context in which this report emerges in the complex web of colonization, racism, power and privilege, mistrust, and suspicion.

Colonialism is the attempted or actual imposition of policies, laws, mores, economies, cultures or systems and institutions put in place by settler governments to support and continue the occupation of Indigenous territories, the subjugation of Indigenous Nations, and the resulting internalized and externalized thought patterns that support this occupation and subjugation.

Colonialism is not to be confused with colonization. Colonialism is the ideology advocating colonization. Colonization generally refers to the process by which Europeans invaded and occupied Indigenous national territories.

(Historical Roots of NP Practice)

Given the complexity of graduate level NP education, relative to the expectations of accreditation bodies, and the needs of society, it is a challenge to map out a ‘socially accountable’ curriculum in a time of reconciliation. Contextually, NP programs in Ontario (through the consortium) have distinct relationships, that create a sense of responsibility to northern and Indigenous people (there is a historical origin to the NP program in Ontario, both legislatively, within the professional and health care system, and society in general).
Advanced Practice Nursing—*from the safe shores of history we look back to look forward*

Nurse historian Sioban Nelson (2009) suggests history is useful because there are stories which “it is wise not to forget—we should learn from the blunders of those who came before us and show some wisdom” (p. 781). Understanding the historical roots of NP practice with Indigenous people/communities is a means of learning about colonization in contemporary times and how we understand reconciliation in relation to curriculum. However, this means looking not only for roots in well-watered meadows, but in disturbed edges.

Looking for the Historical Roots of NP Practice in—well-watered meadows:

The historical roots of advanced practice nursing stem from the needs of society, weaving back to the early 1890’s when outpost nurses worked in isolated areas of the country (Northwest Territories, Labrador, and Newfoundland) providing maternal/child care, early efforts of controlling infectious diseases and managing chronic diseases and supporting people during their last days of life (Graydon & Hendry, 1977; Higgins, 2008; Kaasalainen et al., 2010; Staples, Ray, & Hannon, 2016). Nurses have stepped in to support healthcare in remote areas of Canada, where physicians are not always accessible. World War II nursing veterans, with their extensive field training, post combat, were funded to take additional training and education in the area of infection control (to manage the tuberculosis pandemic and psychiatric nursing) (Kaasalainen et al., 2010). Initial drivers of the NP role in Canada in the mid 1960’s and early 1970’s included: universal publicly funded medical insurance, physician shortage, the introduction of primary health care, and increased medical specialization (Kaasalainen, et al., 2010; Staples, Ray, & Hannon, 2016). NP’s became a means for addressing physician shortages in remote areas of the country that were chronically underserviced (Kasalainen et al., 2010). Kaasalainen et al (2010) captures the context of the 1960’s in a quote from an NP working in the Yukon:

> Historically, nurses have worked in an expanded capacity in remote regions of northern Canada out of necessity, so when health services were being regionalized in the north in the 1960s and they started looking for nurses to work up here, they initially looked at midwives from Britain because of the high birth rate and the aboriginal community and eventually, it just evolved that nurses had to take on many roles that were traditionally within the medical
realm, and doing things like suturing and reading x-rays and those types of things, and so we have evolved. We are almost, you could say, the first generation of NP (p. 38).

Looking for the Historical Roots of NP Practice—*in disturbed edges*

In the not so distant past, in the 1950’s many nurses working in the far northern areas of the country, and particularly those whose work included care of Indigenous people in Federal Nurses stations understood the complexity of their practice evolved from the dynamic nature of the patient population (Canadian Nurses Association, 1950). Their work ranged from community needs like midwifery; care of complex conditions and the containment of infectious diseases like tuberculosis. But, perhaps not as visible was how they practiced and delivered care to Indigenous patients/families and communities; indeed, the profession’s understanding of Indigenous people’s health and well-being was and continues to be shaped by legislative and socio/political forces. For example, the Canadian Nurses Association Journal (The Canadian Nurse) in the summer of 1950 published their August issue focused on the theme of *Nursing the Indian*. In the editor’s preface entitled *Between Ourselves* we obtain a glimpse into how the government’s articulation of Treaties and the Indian Act shaped how nurses in the 1950’s came to understand Indigenous people and their role as nurses:

*According to the best available estimates*, before the white man came to what is now known as Canada there were something over 200,000 Indians. Though the present population figure is considerably below that number, the population figure is considerably below that number, the popularly held opinion that the race is disappearing is not in accordance with facts. During the 20th century the trend has been upward with a gradual but fairly steady increase. Much of the credit for the improvement can be given to the health programs that have been sponsored by the Federal Government. Several hospitals are maintained by the Indian Affairs Branch for the exclusive use of the Indians (Canadian Nurses Association, 1950, p. 604).

Later the author attempts to explain ‘Treaties’ and states:
Treaties were made with the various tribes whereby the Indians ceded to the Crown their aboriginal title and interest in the land. In consideration of this cession, the Federal Government promised certain benefits: adequate territory set aside as Indian reservations; cash grants made; annual payment annuities on a per capita basis—the “Treaty” money; assistance in agriculture. stock-raising, hunting, trapping, etc; the education of Indian children; facilities for health protection (Canadian Nurses Association, 1950, p. 604).

Subsequently, the understanding of the role of Treaties and the Indian Act was depicted as protective mechanisms. It is from this perspective that nurse Ivy Maison (1950) in her article *Nursing on Canada’s Rooftop* described an adult Indigenous man as:

“The Indian is an interesting and contradictory character. He is, by turns, likeable and exasperating, kindly and mean, sometimes cooperative and often just plain cussed, always childlike in his emotions and understanding and usually indolent. He loves attention and bandages—lots of both!” (Maison, 1950, p. 623).

Maison (1950) concludes nurses who wish to work in northern communities with Indigenous people “need a deep love of her own work and a liking for and understanding of a simple childlike people, whom she can help to better health and living conditions” (p. 625). Looking back, the narrative of Indigenous adults as ‘kindly and mean, plain cussed, childlike and indolent’ is at play in child welfare practices of removing Indigenous children from their homes, placing them in the foster care system: *The 60’s Scoop Generation* (Truth and Reconciliation Commission Final Report, 2015).

Mary McCann’s (1950) article *A Health Survey in the Far North* was published along-side Ivy Maison’s. Mary was a Public Health nurse working with the medical officer stationed at Ile a la Crosse and the public health nurse stationed in Buffalo Narrows. The nurses from Buffalo Narrows reported from their community visits “syphilis and tuberculosis appeared to rife among their people” (p. 626), thus, the origin of Mary’s health survey work. The best way to accomplish the survey was to tie the survey work to Treaty payments as it intersected two divisions of government tasks—treaty payments and the Department of Indian Affairs medical outreach program. The medical team accompanied the Treaty party, carrying out chest x-rays, smallpox vaccinations, and
blood samples for syphilis serology. A trade of sorts, treaty money in exchange for complying with the health survey examinations/assessments. In her writing Mary describes the details of her work, the people she meets, the places they stay. She also considers the roles of Residential Schools in the health and well-being of Indigenous children and concludes:

Each yearly holiday time the children are sent home with a new set of clothing they have made personally. One would think it impossible for these Indian children, after receiving several years of such fine education, to return to the reserve and fall into the backward and often unhealthful habits of their people. Yet many do seemingly forget all they have learned (p. 631).

Within Mary’s reflections, lies the tension that many Indigenous children experienced [echoed in the testimonies of Indigenous people in both the TRC (2015) and MMIWG (2019) Report], stripped of their families, language, culture, ways of life, they return to their communities, caught between worldviews. One can only imagine the trauma both children and parents experienced, as Indigenous ways of being and knowing were considered less than—“fall into the backward and often unhealthful habits of their people”, children were taught to reject their language, culture and ways of life in Residential Schools, they were taught to reject in many ways their families and communities (TRC Final Report, 2015; MMIWG, 2019).

The Brian Lloyd Sinclair Inquest (Provincial Court of Manitoba, 2010) is one of the most recent historical examples of how colonial practices within the healthcare system can create structural inequities, and differences in Indigenous people’s experiences of healthcare access and treatment. Brian Sinclair an Indigenous man spent the last 34 hours of his life unattended in an emergency department (ED). waiting to be treated for a bladder infection, that lead to septicemia and ultimately his death. He was described by people in the waiting room and various hospital staff as poorly dressed, smelly, and intoxicated. Informal practices and larger societal issues shaped to varying degrees how patients were triaged within the ED. For example, the department was unofficially a space for ‘shelter’ for people living homeless in Winnipeg’s low-income intercity core (the intercity area lacked sufficient shelter housing). Many people that interacted with Brian during his last 34 hours of life, assumed he was homeless. The Winnipeg Health Science Centre (HSC) ED in 2008 in part functioned as an unofficial shelter “for people to come in off the street
for medical treatment mostly, but also for warmth, shelter or food.” (Provincial Court of Manitoba, 2010, p. 58). Experts like Dr. Cook who gave testimony at the inquest, raised questions about how racism, social isolation and stigmatization may have played a role in Brian’s death (Provincial Court of Manitoba, 2010).

In-Between ‘well-watered meadows and disturbed edges’

It is from the safe shores of history, that we consider the roles both nurses and the profession play in enacting the Indian Act in relation to Residential Schools and the Sixties Scoop Generation. Moreover, what we know now as intergenerational trauma and ultimately genocide. The challenge as educators/practitioners’ is how we might re-think curriculum with the mindset of preparing NPs to consider the intersection of practice, health policy, and health intervention with a critical eye to the influences of colonial practices in contemporary healthcare. Thus, from the horizon of historical and contemporary shores, moving from the space of serving Indigenous people in isolated communities (1890’s) and the role nurses played in sustaining the colonial practices of the Indian Act in public health nursing in the 1950’s, and most recently the Brian Lloyd Sinclair (2010) inquest, are lessons. We must: “learn from the blunders of those who came before us and show some wisdom” (Nelson, 2009, p 178).

From blunders to wisdom—reflecting on Indigenous content, diverse voices and wise practices:

• navigating uncertainty, troubling practice, issues of power and privilege, equity and inequity, equality and inequality, beliefs and values, assumptions and biases;
• re-thinking approaches to learning that open the possibility of considering how one’s place in the world is interwoven into how one view’s their own personhood in relation to that of their patients; this can occur during self-reflection
• re-considering the significance of history (personal and collective) to ‘being well/unwell.’
• re-considering how the organizational, institutional, legislative, and ethical structures shape our practice and patient outcomes;
• reflecting on the significance of culture and language, politics and economy.
• Exploring the meaning of advocacy at the individual, community, professional and political level.
As nursing faculty:

- What is essential to sustaining your practice?
- What are your obligations and responsibilities?
- How do you want to ‘be,’ how do you understand your place in the world beyond the classroom, and what are your roots?
- What sorts of critical perspectives (intersectionality, postcolonial theory, gender-based theory) might we take up with learners/faculty so they can appreciate how institutional/government practices have the potential to preserve historically colonizing policies; shape in overt and/or nuanced ways inequitable and unjust healthcare practices that continue the legacy of the Indian Act?
- What sorts of practices in curriculum support learners and faculty in their quest to sustain ‘good relations’ with Indigenous peoples and communities?
1b) Connecting concepts: Cultural Humility and Cultural Safety

Concepts related to culture can be thought of as being interconnected and on continuum. For example, cultural awareness considers diversity, cultural sensitivity promotes respect for differences and cultural competence focusses on skills, attitudes and knowledge. Although there are varying perspectives, the emphasis in this report is to expand upon the meanings of cultural safety and humility as relevant to NP practice and education.

Moving towards cultural safety and humility links with the legacy of colonial power relations, recognizing assumptions and othering through a self-reflective lens. Health care providers perspectives of the “Other must therefore be interpreted within wider histories and relations of power that accrue from an individual’s past experiences, the wider social discourses that shape one’s interpretive lens, and the background knowledge that each brings to an encounter” (Browne, 2007, p. 2171). Consistent with the TRC, the National Inquiry into the MMIWG and UNDRIP, the concepts of cultural safety and humility also align with the more recent competencies for nursing.

Cultural safety goes beyond the idea of cultural “appropriateness” and demands the incorporation of services and processes that empower Indigenous Peoples. The creation of cultural safety requires, at a minimum, the inclusion of Indigenous languages, laws and protocols, governance, spirituality, and religion. (p.173)

In addition, the new 2020 College of Nurses of Ontario (CNO) Registered Nurse competencies and the Canadian Council of Registered Nurse Regulators link with the definitions as set forth by British Columbia’s First Nations Health Authority in 2018:

**Cultural safety:**

An outcome based on respectful engagement that recognizes and strives to address the health care system’s inherent power imbalances. It results in an environment free of racism and discrimination, where people feel safe when receiving health care. (First Nations Health Authority, 2018)

**Cultural humility:**

Cultural humility is a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner regarding understanding another’s experience. (First Nations Health Authority, 2018)

The recent 2020 Entry to Practice Competencies for Registered Nurses adopt the conceptual framework for organizing competencies from the Royal College of Physicians of Canada. The Royal College of Physicians and Surgeons mapped Indigenous cultural safety values against the CanMEDS framework in the document entitled, *Examining ‘Cultural Safety’: Indigenous health values and principles as interpreted through the CanMEDS framework* (2015). The competencies
of medical expert, health advocate, scholar, professional, communicator, collaborator and manager were linked with Cultural safety / Consensus; Continuity, Openness, Distinctiveness, Evidence, Shared Research; Self-regulation, Transferability, Self-Reflection; Transparency, Respect, Accountability; Partnership, Access, Trust, Autonomy and Self-determination, Economy, Sustainability, Equity respectively (Indigenous Health Committee of the Royal College (IHC) and the Office of Research, Health Policy and Advocacy, 2019).

1.3 Uses principles of trauma-informed care which places priority on trauma survivors’ safety, choice, and control.

3.5 Incorporates the process of relational practice to adapt communication skills.

9.3 Engages in self-reflection to interact from a place of cultural humility and create culturally safe environments where clients perceive respect for their unique health care practices, preferences, and decisions.


In the CNO’s Competencies for Nurse Practitioners Entry-to-Practice which were revised in 2018, under the category, Client Care: Client Relationship Building and Communication, the competency states the NP will:

i. Provide culturally safe care, integrating clients’ cultural beliefs and values in all client interactions

   and

ii. Use relational strategies (e.g., open-ended questioning, fostering partnerships) to establish therapeutic relationships
As per the entry level competencies, Nurse Practitioners need to know how culturally safe practice transpires into daily practice. Faculty involved in teaching and learning with Nurse Practitioner students are required to self-reflect upon their assumptions and understanding of a colonial history.

In the Brian Lloyd Sinclair Inquiry (Provincial Courts of Manitoba, 2010), Indigenous physician Dr. Janet Smylie outlined the concept of cultural safety, drawing from the Indigenous Physicians Association of Canada articulation of cultural safety for undergraduate medical education, punctuating the critical differences between cultural safety, cultural competence, and cultural sensitivity:

**Cultural Safety:** refers to a state whereby a provider embraces the skill of self-reflection as a means to advancing a therapeutic encounter with First Nations, Inuit, Metis peoples and other communities including but not limited to, visible minorities, gay, lesbian, transgendered communities and people living with challenges. Self-reflection in this case is underpinned by an understanding of power differentials. For First Nations, Inuit and Metis communities, this power imbalance is unequal and can be seen as a residual element of colonization and act as a barrier to facilitating the health and healing for First Nations, Inuit and Metis citizens of Canada. Providers should be able to understand their own biases and prejudices and how racism might play a role while providing care to these diverse communities (Provincial Court of Manitoba, 2010, p. 172).

**Cultural Awareness:** “the acknowledgement of difference” (Provincial Court of Manitoba, 2010, p. 172).

**Cultural Sensitivity:** “recognition of the importance of respecting difference” (Provincial Court of Manitoba, 2010, p. 172).

Thus, while cultural sensitivity and competence focuses on learning about the culture, cultural safety directs healthcare providers to consider everyone (even themselves) as bearers of culture, requiring health professionals to reflect critically upon their own culture and lived experiences, values, beliefs, and attitudes, and acknowledge that these differences come to bear in visible and invisible ways in their practice with patients/families/communities and colleagues (Provincial Court of Manitoba, 2010).
In this respect, we can appreciate that teaching cultural safety is more complex than increasing awareness or learning sensitivity; it involves deepening respect for the full meaning of our history of colonialism, appreciating its impact on the health of Indigenous peoples, and translating this into a process of building relationships. (Guerra & Kurtz, 2017, p. 129)

Asking questions regarding the need for Cultural Safety and its importance may be addressed by both faculty and students when discussing the publicized cases of Michelle Labrecque and Brian Sinclair. Michelle Labrecque, who suffered from a fractured pelvis, was sent home with a prescription with a sketch of a beer bottle, circled with a slash through it. In the 2015 report, First Peoples, Second Class Treatment prepared for Wellesley Institute, Dr. Billie Allan and Dr. Janet Smylie, highlighted the role of racism and how it impacts the health and well-being of Indigenous peoples in Canada.

McCallum and Perry (2018) in their book entitled, Structures of Indifference: An Indigenous Life and Death in a Canadian City, describe the timeline, circumstances and interactions with staff people in the Winnipeg Emergency Department where Brian Sinclair’s waited for over 34 hours before dying.

On the afternoon of 20 September, a nurse practitioner saw Sinclair and noticed the basin he had been given after he vomited. She took this as a sign that someone else had attended to him and did not check if he needed care. Later in the day, she passed Brian Sinclair, whose head was slumped to the side. She assumed that he was sleeping, that someone had already taken care of him, and that he was just waiting for a bed in another area.

(McCallum & Perry, 2018, p.23)

The cases of Michelle Labrecque and Brian Sinclair convey the necessity of both of the interconnected concepts of cultural safety and cultural humility. The concepts in this regard may be considered as lifesaving as a defibrillator and dialysis. In the wake of these two senseless tragedies, The First Nations Health Authority in British Columbia began a feather campaign where all health care providers were encouraged to sign a declaration indicating their commitment to both cultural safety and humility:
1c) Student Testimonial

Society has come a long way when it comes to cultural safety and respect for one’s race, culture or ethnic background. However, the matter of stereotyping is still very much an issue and is often seen as a less threatening form of judgement. As a self-identifying Indigenous student, I have witnessed and experienced stereotyping. Despite educating people on Indigenous customs, people still perceive that all Indigenous students or Indigenous people receive everything for free; free schooling, free transportation, free housing or even financial loans for businesses requiring no repayment. Despite having paid out of pocket for my entire undergraduate degree, there are still several people who comment that they too could have had a successful career if they had everything paid for. These types of comments make it difficult for one to self-identify. It is difficult to come forward and self-identify in a setting where your race is often a popular topic that is frequently misunderstood and represented. Throughout the years, I have overheard some interesting discussions about why there is an increased risk for certain health conditions in the Indigenous population and people’s thoughts and opinions as to why this might be. It becomes increasingly difficult to self-identify after hearing some of these comments and discussions. For example, if you attend an online course, people cannot see what you physically look like and therefore, there may not be as much restraint in conversations as there would have been if they knew your background or could actually see you. People’s comments and stereotyping seem to stem from a lack of education or knowledge regarding ongoing inequalities and disparities for Indigenous Peoples. With a better understanding of the importance of cultural safety and the application of cultural humility, I am hopeful that this will result in an increase in cultural safe care being provided to Indigenous Peoples.

Jenna Bluteau, RN, NP – PHC Student, March 2020
1 d) Faculty Testimonial

Reflection is an essential skill when it comes to developing one’s cultural competence. This is especially the case for non-Indigenous individuals. Although I have worked with Indigenous Peoples and in First Nation communities for over 30 years, my understanding of cultural humility tells me that I will never fully know the culture but that’s ok. My experience has taught me that it is important to reflect upon my own personal values and beliefs and how this guides the way I view the world and others around me. The act of reflection becomes a lens through which we can situate ourselves in relation to others. It can help us to make sense and understand why we see things the way we do. It is important that we question our beliefs and ask ourselves if what we have come to accept as truth is in fact nothing more than a myth or a stereotype that we are unconsciously perpetuating as a result of ignorance or lack of knowledge and experience. The process of introspection and reflection can sometimes be challenging and lead us to uncover things about ourselves that might be surprising and perhaps even disturbing. I want to assure you that this is entirely normal and acceptable and the only way that we can truly uncover our own biases. In order to become culturally competent individuals, educators, and practitioners we must understand and incorporate the principles of cultural safety and humility. For us to develop and deliver a curriculum that is culturally safe, we must all engage in the process of reflection. The framework being proposed in this report can serve as a guide to us all.

Dr. Roger Pilon, PhD, NP-PHC-PHCNP Program Faculty-March 2020
In this first section we have provided some context, encouraged self-reflection and introduced some key concepts for consideration that can assist us with decolonization.

We will demonstrate the link between some of the key reports and documents that were introduced earlier and how they can help to inform and improve our curriculum when it comes to the care of Indigenous Peoples.

2. Linking the health-related Action Calls with the literature and curriculum.

The ensuing section offers a literature review pertaining to the health-related Calls to Action (TRC), Calls to Justice (MMIWG) and UNDRIP articles. There are two sections. In section 2a, all health-related Calls to Action (TRC), Calls to Justice (MMIWG) and UNDRIP articles are listed. In section 2b, the contents of the reports themselves and the related nursing and health literature as linked with NP practice, education, research and leadership are addressed and summarized. As the TRC was released in 2015, most of the literature searches involved the time period from 2015 to 2020.

The following diagram provides a visual representation the health-related Calls to Action (TRC), Calls to Justice (MMIWG) and UNDRIP articles that are expressed together as Action Calls. The Action Calls are threaded through the literature review and summary, analysis and mapping and overall curriculum and PHCNP courses.
2a) Action Calls

Truth and Reconciliation Commission of Canada's Calls to Action

18: We call upon the federal, provincial, territorial and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

19: We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.
20: In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off reserve Aboriginal peoples.

21: We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority. and,

22: We call upon those who can effect change within 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.

23: We call upon all levels of government to: Increase the number of Aboriginal professionals working in the health care field. Ensure the retention of Aboriginal health-care providers in Aboriginal communities. Provide cultural competency training for all health-care professionals

24: We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

55: We call upon all levels of government to provide annual reports or any current data requested by the National Centre for Reconciliation so that it can report on the progress towards reconciliation. The reports or data would include, but not be limited to: .... Progress on closing the gaps between Aboriginal and nonaboriginal communities in a number of health indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.
National Inquiry into the Missing and Murdered Indigenous Women and Girls’ Calls to Justice -

3.1 We call upon all governments to ensure that the rights to health and wellness of Indigenous Peoples, and specifically of Indigenous women, girls, and 2SLGBTQQIA people, are recognized and protected on an equitable basis.

3.2 We call upon all governments to provide adequate, stable, equitable, and ongoing funding for Indigenous-centred and community-based health and wellness services that are accessible and culturally appropriate, and meet the health and wellness needs of Indigenous women, girls, and 2SLGBTQQIA people. The lack of health and wellness services within Indigenous communities continues to force Indigenous women, girls, and 2SLGBTQQIA people to relocate in order to access care. Governments must ensure that health and wellness services are available and accessible within Indigenous communities and wherever Indigenous women, girls, and 2SLGBTQQIA people reside.

3.3 We call upon all governments to fully support First Nations, Inuit, and Métis communities to call on Elders, Grandmothers, and other Knowledge Keepers to establish community-based trauma-informed programs for survivors of trauma and violence.

3.4 We call upon all governments to ensure that all Indigenous communities receive immediate and necessary resources, including funding and support, for the establishment of sustainable, permanent, no-barrier, preventative, accessible, holistic, wraparound services, including mobile trauma and addictions recovery teams. We further direct that trauma and addictions treatment programs be paired with other essential services such as mental health services and sexual exploitation and trafficking services as they relate to each individual case of First Nations, Inuit, and Métis women, girls, and 2SLGBTQQIA people.

3.5 We call upon all governments to establish culturally competent and responsive crisis response teams in all communities and regions, to meet the immediate needs of an
Indigenous person, family, and/or community after a traumatic event (murder, accident, violent event, etc.), alongside ongoing support.

3.6 We call upon all governments to ensure substantive equality in the funding of services for Indigenous women, girls, and 2SLGBTQQIA people, as well as substantive equality for Indigenous-run health services. Further, governments must ensure that jurisdictional disputes do not result in the denial of rights and services. This includes mandated permanent funding of health services for Indigenous women, girls, and 2SLGBTQQIA people on a continual basis, regardless of jurisdictional lines, geographical location, and Status affiliation or lack thereof.

3.7 We call upon all governments to provide continual and accessible healing programs and support for all children of missing and murdered Indigenous women, girls, and 2SLGBTQQIA people and their family members. Specifically, we call for the permanent establishment of a fund akin to the Aboriginal Healing Foundation and related funding. These funds and their administration must be independent from government and must be distinctions-based. There must be accessible and equitable allocation of specific monies within the fund for Inuit, Métis, and First Nations Peoples.

**UN Declaration on the Rights of Indigenous Peoples**

Article 24 of the states:

1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.

2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.
2b) Literature review: providing context.

We began this report with a creation story, expressing the cultural connectedness and relationship with the land. Elder presence within Indigenous communities is essential to overall health and well-being. Communities benefit where elders provide the Seven Grandfather teachings of wisdom, love, honesty, respect, humility, bravery and truth. NPs whose work support elders to stay at home within their communities and families are providing an essential service to all. Elders are central to the TRC Call #22 and UNDRIP article 24 #1 where healing and medicinal traditions are prioritized.

Kyoon-Achan (2018) et al., explains strength-based approaches involving elder interpretations of the medicine wheel. Although it is beyond the limits of this work to express the full multitude of meanings associated with the medicine wheel, it is important to consider some of the central themes. Balance is considered the centre that links with all spheres, emotional, mental, spiritual and physical. Communal and relational bonds within communities and between families are strengthened through ceremonies, gatherings, feasts and powwows essential to healing. The activities bring elders and community people together to listen and support each other, essential to holistic health.

The First Nations Perspective on Wellness from the British Columbia’s from the First Nation Health Authority is a tool that supports a holistic vision of wellness:
TRC’s calls #18 and #24 directly speak to nursing education and about how history has impacted Indigenous health and why this is a priority. Volume 1 of the Final Report of the TRC provides an in-depth account of the residential school system and the devastating loss of life of the children who were taken from their homes and forced to attend them. Justice Murray Sinclair in Volume 1 of the TRC explains that this history and its repercussions involves all who live and work in Canada.

Reconciliation also is not an Aboriginal problem. It is about creating a relationship of mutual respect as was promised in the Royal Proclamation of 1763 and in the assurances given at, and reflected in, the many Treaties signed between the Crown and Canada’s Aboriginal people, most since Confederation. All people in Canada, including newcomers, have a role in this relationship-building process. While we may not all share a past connected to the residential schools, we share a future. We must all call for an ongoing process of reconciliation, regardless of political affiliation, cultural background, or personal history (TRC, Volume 1, p. VIII).
From this understanding, it is vital to learn about history and the loss of lands which also meant a loss of a way of living that provided health in all spheres – mental, physical, emotional and spiritual. In this regard it is important for NPs to understand the historical significance of the terms including the Doctrine of Discovery and Terra Nullius as explained in Volume 1 of the TRC. The Doctrine of Discovery meant that lands were considered unhabituated even though Indigenous people had lived there prior to contact. Terra nullius is a Latin word meaning land belonging to no one and was utilized by Europeans to gain sovereignty over lands (TRC, 2015).

Given the history concerning domination and displacement of Indigenous people to often remote and isolated areas, there is a need to emphasize access to healthcare. Indeed, NPs have their roots in outpost nursing, providing Advanced Nursing Practice in isolated communities throughout Canada’s north. Horrill et al. (2018) suggests a postcolonial over a biomedical perspective that understands the social determinants of health concerning accessibility through historical, social and political influences. It is important to stress that colonization has been identified as a key determinant of health for Indigenous Peoples (Reading & Wien, 2009; Greenwood et al., 2015; Reading, 2015). Biomedical approaches consistent with neoliberalism and egalitarianism speak to individualistic focuses where health is considered through a reductionistic lens as the absence of disease. Postcolonial theories draw attention to factors such as race, gender and poverty and their intersectional relationships rather than the degree of service provision.

In Canada, jurisdiction over the provision of healthcare for some Indigenous peoples has been contested for decades between federal and provincial levels of government, resulting in jurisdictional uncertainties and disputes that are ongoing. Healthcare services may be provided by the federal government, provincial government, or local Indigenous community depending on multiple factors. Consequently, many Indigenous peoples must cross these jurisdictional ‘borders’ to access appropriate health care—borders which are neat in theory, but messy and ambiguous in reality. (Horrill et al., 2018, p. 4)

The catastrophic implications of jurisdictional dispute are epitomized by Jordan’s Principle. Jurisdictional barriers are also expressed in TRC calls # 20 and #21, Calls to Justice #3.1, #3.2, #3.6, #3.7 and UNDRIP article 24 # 2. In memory of Jordan River Anderson, Jordan’s Principle,
was passed in 2007. The principle asserted the necessity to provide health care for Indigenous children irrespective of jurisdictional borders. Jordan's Principle is explained further:

Where a jurisdictional dispute arises between two government parties (provincial/territorial or federal) or between two departments or ministries of the same government, regarding payment for services for a Status Indian child which are otherwise available to other Canadian children, the government or ministry/department of first contact must pay for the services without delay or disruption. The paying government party can then refer the matter to jurisdictional dispute mechanisms. In this way, the needs of the child get met first while still allowing for the jurisdictional dispute to be resolved. (First Nations Child & Family Caring Society of Canada)

Dr. Cindy Blackstock, Executive Director, First Nations Child and Family Caring Society of Canada is an advocate for Indigenous children and Jordan’s Principle. She explains the discrepancy, “[f]or example, a child off reserve in Canada with a disability would receive as many mobility devices as medically required, whereas a child on reserve can only receive one mobility device every 5 years and is ineligible for electric wheelchairs (Blackstock, 2015, p.97). Dr. Cindy Blackstock furthers learning of the history that has bearing on present circumstances. For instance, she explains the work of Dr. Bryce who in 1922 publicized the alarming death rate of children forced to live in the schools to the Canadian government. Despite Dr. Bryce’s efforts no actions were taken (Blackstock, 2015). Judge Murray Sinclair describes the actuality of a much higher death rate in the documentations within the TRC. Sexual abuse, the banishment and punishment for practicing culture or speaking an Indigenous language resulted in mass psychological traumatization that filters through all health interactions between Indigenous people and health care today.

Jurisdictional disputes are apparent with the care of elderly Indigenous people. Services may be underutilized due to racist and discriminatory experiences with healthcare and a lack of affordability. Elders are considered vital to Indigenous communities and are highly respected for their knowledge, wisdom and ability to speak Indigenous languages. It can be extremely challenging for communities with inadequate funding to provide the complexity of services to enable seniors with health issues including dementia to stay home in their communities (Halseth, 2018). Furthermore, diabetes has resulted in an increased occurrence of Chronic Kidney Disease
(CKD) and End Stage Renal Disease (ESRD). In some communities, frail and elderly individuals with ESRD are required to travel long distances to receive dialysis or even move to urban areas where dialysis is provided. The elders are then separated from their families, communities, language and cultural ways of being and knowing. A bureaucratic process often impedes adequate health care:

This includes who pays for services if they are accessed off-reserve; the lack of programs and services available for Métis and non-status Indians that are available to First Nations on reserve and Inuit, like home care and continuing support programs; as well as delays or denied approvals for medicine, supplies and medical travel due to underfunding, excessive restrictions, and highly bureaucratic processes associated with the NIHB program. The Supreme Court of Canada’s (2016) landmark decision that Métis and non-status Indians are the responsibility of the federal government and the Truth and Reconciliation Commission’s (2015) Calls to Action facilitate a reconsideration of existing policies and requirements for these programs. (Halseth, 2018, p. 21)

Kim (2019) further addresses colonialism as a social determinant of health that perpetuates policies resulting in overcrowded and insufficient housing, isolation and poor accessibility to health care resources and food insecurity. Chronic diseases including diabetes and mental health have become epidemic in such circumstances. In addition, the present pandemic of coronavirus disease 2019 (COVID-19) preys on situations where overcrowding and poor health predominate.

Valerie Monague, Elder and Knowledge Keeper of the Beausoliel First Nation addresses the relationship between health services and accessibility:
Intergenerational or multi-generational trauma is widespread as a result of the history of residential school and the sixties scoop. The sixties scoop involved another large group of children being placed outside of their Indigenous families and communities. The denigration of family, community, language and culture compounded widespread traumatization manifested as poor mental health, addictions and an increase in chronic diseases. TRC Call #19 and Calls to Justice #3.3, #3.4 and #3.5 specify the need to address trauma, mental health and chronic diseases. Reading (2015) explains if:
“we search deeper still for the determinants responsible for shaping these conditions, we discover the root of the problem—a colonial structure-fashioned from the centralization of Aboriginal peoples into remote communities and reserves, the oppressive nature of the Indian Act, the damaging legacy of residential schools, racial discrimination in social environments and the labour market, as well as lack of public or private investment in economic development for Aboriginal communities” (p. 11).

Understanding behaviours that stem from experiences of trauma and violence is essential for all health care providers including NPs. The EQUIP Health Care (2017) resources, Trauma-and Violence-informed care (TVIC) builds upon trauma-informed care to involve systemic and interpersonal violence. This is highly relevant to histories shaped by residential schools and sixties scoop where intergenerational trauma has impacted upon the behaviour of subsequent generations. TVIC involves concepts which include harm reduction and cultural safety. The TRC Calls to Action, MMWIG Calls to Justice and UNDRIP all contend with cultural safety.

With its focus on structures of power, inequalities, colonialism and racism, cultural safety is an imperative concept within education (Churchill et al., 2017). From the First Nations Mental Wellness Continuum Framework released in 2015 by Health Canada cultural safety is described as involving a paradigm shift. It comprises thoughtful introspection upon history, culture and the structural power relationships within organizations that shape care. It implicates a means of continual self-reflection and organizational development encompassing the whole system to meaningfully and respectfully engage Indigenous people. Like a mirror reflecting concernedly upon the consequences of power relationships, cultural safety acknowledges systemic intolerance to change.

Cultural safety training of healthcare staff is pivotal to the heart health of Indigenous women. The stories of Elders revealed a shared experience of misdiagnosis and mistreatment by healthcare professionals. One Elder shared her story of being taken to hospital and being given antibiotics for what was assumed to be an infection when in fact she was having a heart attack. Despite insisting that the treatment was wrong, her concerns were dismissed, and the misdiagnosis had serious consequences for her. Other stories of mistreatment and racism involved healthcare providers making assumptions about
substance use (e.g. alcoholism) as the cause of illness rather than providing an adequate medical assessment, or forcing an Elder to be discharged and take a taxi home in the middle of the night because no family member could provide transportation despite the Elder expressing safety concerns due to a history of being assaulted. Cultural safety in healthcare also extends to food and nutrition, as one Elder described being forbidden by hospital staff from bringing traditional food like salmon for hospitalized community members. (Conklin et al., 2019, p.9)

Cultural safety furthers action against racism that is harmful to all people. Racism limits participation with health care as well adversely effects the degree of Indigenous representation in all sectors and the likelihood that Indigenous students will complete postsecondary education. In allyship, there are efforts to change systemic racism and foster meaningful respectful relationships. Susan Manitowabi, in the 2020 Pressbook, *Historical and Contemporary Realities: Movement Towards Reconciliation*, offers a perspective of allyship:

White settlers, because of their white skin privilege, are often in positions where they can lend their power to others taking on the role of powerful allies to the less advantaged people of the world. Being an ally requires that one listens more and forms meaningful relationships with Indigenous people. These relationships must be maintained and nurtured in order for greater understanding and learning to occur. This can be challenging given the history of colonialism, but it is not impossible. (Manitowabi, The Role of Allyship in Moving Towards Reconciliation, 2020)

Addressing the specific related health TRC Calls to Action, MMWIG Calls to Justice and UNDRIP through the preceding literature summary sets the stage for the following sections of this report. The learning concerning the meaning of relationship and land through an Indigenous lens, jurisdictional issues including Jordan’s Principle, access to health care, the legacy of residential schools and the sixties scoop, TVIC and cultural safety and interrelated concepts are significant to NP education and practice.
3. Analysis and mapping.

What we considered:

The Aboriginal Nurses Association of Canada (ANAC) now the Canadian Indigenous Nurses Association developed core competencies with the Canadian Association of Schools of Nursing (CASN) and the Canadian Nurses Association (CNA) for nursing education in 2009 in the document entitled, *Cultural Competence and Cultural Safety in Nursing Education, A Framework for First Nations, Inuit and Metis Nursing*. The core competencies include:

- post-colonial understanding,
- communication,
- inclusivity,
- respect,
- Indigenous knowledge and Mentoring and
- supporting students for success

Indeed, the core competencies were devised through a cultural safety framework with an emphasis on relationality (ANAC, 2009). Cultural safety within education fosters relationality where students feel safe and respected in voicing perspectives. This approach supports Indigenous students' participation and self-identification. Engaging in classrooms where Indigenous ways of knowing are discussed and prioritized and through learning the ongoing impact of colonialized history, is a necessary priority for all educators (ANAC, 2009; National Aboriginal Health Organization, 2008).

Bartlett et al. (2007) developed a process framework for decolonizing research that includes rationalizing, enabling, facilitating, experiencing and accepting. Although considered as process within research the steps are of interest to an educational framework where within the current time period much attention has been given to decolonizing and indigenizing education. Within the
process of decolonizing, rationalizing may specifically be guided by Indigenous people including elders (Bartlett et al., 2007). In enabling, the Indigenous communities within proximity to the educational settings could be engaged in a participatory approach where students are immersed in Indigenous learning of traditional approaches to health. Facilitating may emphasize relationship building with Indigenous communities. Experiencing specifically addresses Indigenous protocols that may involve traditional protocols of smudging and gifting. Accepting may focus on building capacity for both Indigenous and non-Indigenous educators where the latter develops knowledge and ability to further learning within an Indigenous paradigm (Bartlett et al., 2007).

The following diagram offers an inclusive depiction that represents incorporating both the ANAC (2009) core competencies as well as the Bartlett et al. (2007) process framework towards addressing the TRC Calls to Action, MMWIG Calls to Justice and UNDRIP within the PHCNP program. Through both an Indigenous and non-Indigenous faculty team, PHC NP student and elders we sought to address the PHCNP program goals, course outcomes, supportive learning materials, as well as the various formative and summative assessment tools and methods.

Given the seventeen recommendations from the 2016 report (Appendix A), our work is now further guided by the MMWIG Calls to Justice released in 2019. Indeed, the resources available continue to flourish in this regard. For instance, in 2018 the pressbooks, Pulling Together: A guide for Indigenization of post-secondary institutions. A professional learning series, was made available. This resource is an excellent resource for educators interested in learning more about what decolonizing and indigenizing curricula may mean. For example, in Pulling Together: A
Decolonization is a component of Indigenization, because it means challenging the dominance of Western thought and bringing Indigenous thought to the forefront. Indigenization is part of reconciliation, because it involves creating a new relationship between Indigenous and non-Indigenous people. But these processes have important distinctions. Most notably, reconciliation is primarily a settler responsibility, and decolonization must be led by Indigenous people. In addition, the emotional work of reconciliation is different from that of Indigenization and decolonization, which have less of a focus on making amends for past traumas, and a greater focus on mainstreaming Indigenous thought. (BCcampus, Section 1: Understanding Indigenization, 2018).

Indigenization is also emphasized as not simply converting a Westernized process into an Indigenous one. Instead both are to be recognized as distinct ways of knowing that may coexist to further learners. “Therefore, we recommend that you use the word Indigenization cautiously and take care not to use it when Indigenous content is simply added to a course or when something Western is replaced with something Indigenous” (BCcampus, Section 1: Understanding Indigenization, 2018). As Indigenous knowledge, language and culture is particular to each geographic region the process of Indigenization will also range depending on the specific tribal community and people.

Another important consideration is an awareness of the role and importance that Indigenous traditional practices and medicines play for many Indigenous Peoples. Over the last two decades there has been an increase awareness and use of traditional practices within many health care settings (Maar & Shawande, 2006). As a result, it has become important, now more than ever, to consider how traditional practices and medicines can co-exist with Western medicine. Allen et al. (2020) contend that “emerging evidence suggests that Indigenous-led health service partnerships improve holistic (inclusive of mind, body, emotion and spirit) health outcomes for Indigenous Peoples, as well as access to care, prevention uptake and adherence to care plan” (p. E208).

Awareness and openness to Indigenous ways of knowing and being are also essential components to providing culturally competent and safe care.
In the following sections of this report, the culmination of our discussions with elders, faculty and student perspectives as aligned with previous sections of this report merge with the Action Calls identified in section 2a. This unfolds in section 4a where at the macro level the whole curriculum is addressed followed by the micro PHCNP course level in section 4b.

4a. Merging Action Calls with the whole curriculum

During the meeting that took place on February 14th, 2020, our group of community Elders and Knowledge keepers, PHCNP student and faculty discussed and deliberated many ideas and needs related to our task of furthering and mapping the curricular as per the Action Calls listed in section 2a.

We recognized that the National Inquiry into the MMIWG emphasizes the needs of lesbian, gay, bisexual, transgender, queer, questioning, intersex, pansexual, 2-spirited, asexual, and allies (LGBTQQIP2SAA) throughout the Calls to Justice.

In addition, we discussed the importance for all faculty and students, both Indigenous and non-Indigenous to develop safe places for dialogue to discuss sensitive experiences including experiences of stereotyping and racism. In this respect we also discoursed the need for all to engage in learning regarding cultural safety and humility, Indigenous ways of being and knowing - strength-based approaches that promote healing and revitalization of traditional ceremonies, healing practices and language.

1. All PHCNP program faculty, students and health care providers will engage in cultural safety and humility learning outcomes that:

- address the needs and care for LGBTQQIP2SAA
- further mental health care including TVIC
- connect the legacy of colonialism, history and systemic racism upon overall health and wellbeing
- prioritize respectful learning of Indigenous knowledge systems and traditional health practices
Action Calls: TRC Calls to Action #19, 22, 24; National Inquiry of MMIWG Calls to Justice #3.1,3.3,3.4,3.5; UNDRIP Article #24 – 1.

2. Faculty and students to participate in learning regarding jurisdictional limitations to accessibility:
   - including Jordan’s Principle
   - Non-Insured Health Benefits (NIHB) program – issues and limitations
   - Funding for the adequate provision of programs and services

   Action Calls: TRC Calls to Action #20, 21, 24, 55; National Inquiry of MMIWG Calls to Justice #3.1,3.2,3.3.4,3.5; 3.6: UNDRIP Article #24 – 2

3. Develop strategies to support the recruitment and retention of Indigenous NP students:
   - to self-identity
   - seek culturally safe resources for emotional, spiritual, mental and physical support
   - engage in clinical placements within Indigenous communities and community development initiatives (for both Indigenous and non-Indigenous students)

   Action Calls: TRC Calls to Action #19, 22, 24; National Inquiry of MMIWG Calls to Justice #3.1,3.2,3.4,3.5; 3.6: UNDRIP Article #24 – 1; 2

4. Further Indigenous approaches to NP research through:
   - Ownership, Control, Access and Possession (OCAP®) training
   - Funding for Indigenous led initiatives with NP students and faculty that contribute to cultural safe NP practice, education, research and leadership with the overall goal of making impacts upon improving Indigenous health and wellbeing.

   Action Calls: TRC Calls to Action #18, 21, 55; National Inquiry of MMIWG Calls to Justice #3.2,3.4,3.7
4b. Weaving within PHCNP courses

The 7 core courses of the PHCNP program include Roles and Responsibilities, Pathophysiology, Advanced Health Assessment Diagnosis I and II, Therapeutics I and II and the Integrative Practicum. Nine Ontario universities offer the courses including Lakehead, York, McMaster, Ottawa, Laurentian, Western, Windsor, Queens and Ryerson. The core PHCNP courses are offered as part of a graduate level nursing degree where students are required to take additional courses through their respective universities offering theoretical and research foundations or at a post-Master’s diploma level for those who already have a graduate nursing degree. With regards to this report, only the 7 core courses of the PHCNP program listed above were considered in relation to the health related TRC Calls to Action, MMWIG Calls to Justice and UNDRIP articles.

Appendix B provides course and learning outcomes and activities mapped with interlinking *Action Calls* as listed in Section 2a of this report. Through a summative analysis we broadly looked at course and module learning outcomes. Formatively we addressed specific assignments, case studies and quizzes within individual courses. It is anticipated that this report may lead to many more creative opportunities within the individual courses.

5. Process to implement the *Action Calls* for our curriculum in a good way Maawanji'idiwag.

Underpinning this collaborative effort were our meetings with Elder and Knowledge keepers, a PHCNP student and faculty vested and allied with Indigenous communities. Coming together in a good way, Maawanji'idiwag and guided by the sweetgrass braid weaving honesty, sharing and kindness is of vital importance to implementing all action calls.

A critical component to this work is to continue our ongoing efforts through our committee of committed faculty and students, elders and knowledge keepers. This committee could provide and engage in various initiatives as aligned with the Action Calls and initiatives. This may include:
Maawanji’idiwag Meeting Together

- Assisting faculty to develop curricula
- Keeping abreast of educational resources to share
- Developing resources specific to PHCNP programs
- Engaging in research initiative to further develop evidence informed resources

In addition, there is a plethora of resources already in existence. Some of these have been identified in the previous report (See Appendix A). The Indigenous Cultural Safety (ICS) training programs and KAIROS blanket exercises for all faculty and students are meaningful towards implementation of all action calls.

Please see the Core Online ICS Training Courses:


Please see KAIROS Canada the Blanket Exercise Video:

https://www.kairoscanada.org/the-blanket-exercise-video

The willingness of faculty to participate in such activities and demonstrate how their specific courses including learning outcomes and activities relate to cultural safety and humility and the health-related Action Calls and initiatives is of paramount importance. Sustaining this initiative requires all to have a personal commitment to reconciliation.
Conclusion

Through a time of unprecedented change, strife and unrest it is truly amazing how this committed and dedicated team of nursing faculty, students and Elders and Knowledge Keeper came to together to meet in a good way, - Maawanji'idiwag. Our heartfelt connectedness to this work is profoundly meaningful and we know the work will not end with this report and must continue.

In the spirit of reconciliation, our relationship building with everyone to be involved in preparing our future health care providers is of the highest priority. It is only through this enduring work and resilience that we can move forward in order to ensure the well-being of all and our future generations.

In closing we are turn to the health-giving and cleansing properties of the sacred medicine cedar where in such times of great suffering we always return to the healing traditions of our ancestors.

We wish to thank and acknowledge the Council of Ontario University Programs in Nursing (COUPN) and the Ontario Primary Health Care Nurse Practitioner Programme. Without this support our report would not have been possible.

The North represents the winter. It represents the slowing of the physical life. This is the direction of reflection, and represents the stage of Elders. It is where we prepare for our journey into the next life. The North is where we remember all the aspects of our lives, and use what we have learned to pass it on to the next generation. The gift of cedar helps us in this direction as it cleanses the body and soul. It also helps nurture the body to prepare for its journey to the next cycle.

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Appendix A

Recommendations from the 2016 Report on the Evaluation of the Aboriginal Content of the Ontario Primary Health Care Nurse Practitioner Program

1. Include course goals and objectives pertaining to the Truth and Reconciliation Commission of Canada and Calls to Action.
2. Include course goals and objectives pertaining to the United Nations Declaration on the Rights of Indigenous Peoples.
3. Continue to prioritize Indigenous learning and knowledge within course frameworks, curriculum planning committees, accreditation and evaluative / quality measures.
4. Create space within courses for interactive critical discussions between faculty and students to further postcolonial understanding regarding health disparities, inequities, colonization, and historic trauma and to foster a social justice perspective.
5. Offer opportunities for course faculty to partake in focus groups / interactive discussion to further develop approaches to foster Indigenous learning.
6. Conduct evaluative research to determine the extent of NP student learning as per the Truth and Reconciliation Commission of Canada and Calls to Action.
7. Incorporate contextual Indigenous learning experiences within clinical and practicum experience.
8. Engage students in role-play or simulation to exemplify cultural safety where NP care fits with the recipient’s values or cultural way of being.
9. Develop Indigenous practical online activities for both faculty and students to explore and learn about cultural safety and humility. An example of this includes the resources offered through Culturally Connected- culturallyconnected.ca; https://culturallyconnected.ca/practice/rachel-caroline/
10. Update course materials to incorporate the term Indigenous
11. Regularly involve Indigenous elders, traditional persons, health care providers and educators to facilitate Indigenous learning.
12. Develop partnership with CINA and University Indigenous services to further recruit Indigenous NP students, faculty or mentors.

13. Involve NPs who care for Indigenous populations to be involved as tutors, preceptors etc. to facilitate Indigenous contextual experiences for students.

14. Apply NP CNO standard and CNA NP core competencies to case studies that represent common scenarios that may occur within Indigenous contexts.

15. Create a forum link accessible to both faculty and staff for sharing of Indigenous resources.

16. Encourage and provide incentives for faculty and students to engage in Indigenous Cultural Training (ICS) as available at: http://www.sanyas.ca/training/ontario

17. Support initiatives that foster learning and respect for Indigenous languages and awareness of the importance of language revitalization to community health and well-being.
## 4b. PHCNP courses.

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<thead>
<tr>
<th>Course Name</th>
<th>Summative</th>
<th>Formative</th>
<th>Aligned with Action Calls:</th>
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<tbody>
<tr>
<td>Roles and Responsibilities</td>
<td>Course Outcomes: Distinguish and voice the relevance of the Final Report of the Truth and Reconciliation Commission of Canada (2015), the National Inquiry into the Missing and Murdered Indigenous Women and Girls (MMIWG) and United Nations Declaration on the Rights of Indigenous Peoples to NP practice, education, research and leadership. [Rationale: In line with the CNO’s Competencies for Nurse Practitioners Entry-to-Practice (2018) under the category, Client Care: Client Relationship Building and Communication, the competency states the NP will provide culturally safe care, integrating clients’ cultural beliefs and values in all client interactions and use relational strategies.] Learning Outcomes for Module 11 may include the National Inquiry into the Missing and Murdered Indigenous Women and Girls (MMIWG) and include cultural safety and humility into the heading and content of module 11.3.</td>
<td>Include quiz questions addressing cultural safety, humility, Trauma-and Violence-informed care. (TVIC).</td>
<td>TRC Calls to Action #s 18, 19, 20, 22, 23, 24; Calls to Justice - National Inquiry into the MMIWG 3.1, 3.2; UNDRIP Article #24 –1.</td>
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<tr>
<td>Pathophysiology</td>
<td>Learning Outcomes #3 and #4 may include the history of colonization in addition to epidemiological, geographic disease patterns, environmental and occupational factors that influence disease progression.</td>
<td>Assignment or discussion forum - Describe the history of colonization in relationship to pathophysiological mechanisms, environmental factors and chronic diseases.</td>
<td>TRC Calls to Action #s 18, 19, 20, 21, 22, 24</td>
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<tr>
<td>Advanced Health Assessment Diagnosis I</td>
<td>Course Outcomes: Align with the CNO’s Competencies for Nurse Practitioners Entry-to-Practice Revised 2018. Under the category, Client Care A, Client Relationship Building and Communication, the competency states the NP will provide culturally-safe care, integrating clients’ cultural beliefs and values in all client interactions and use relational strategies.</td>
<td>Module 1 – Learning outcome – Consider both cultural safety and humility in addition to cultural competence. 1.4: Consider linking with Indigenous Determinants of Health housing, education, unresolved land issues and poverty. <a href="https://www.nccih.ca/docs/determinants/RPT-TransformingRealitiesSDOH-EN.pdf">https://www.nccih.ca/docs/determinants/RPT-TransformingRealitiesSDOH-EN.pdf</a> Case Study #2 Consider essentializing cultural stereotypes for example not all Indigenous people avoid eye contact. Consider a cultural safety versus a culturally sensitive approach. Case Study #3 Consider a question addressing systemic racism and cultural safety issues that impact on participation in health care. 1.9 Seminar – Include dialogue and discussion regarding colonialism and overall impacts and how to address including allyship concepts</td>
<td>TRC Calls to Action #s 18, 19, 20, 21, 22, 24; National Inquiry into the MMIWG Calls to Justice #s 3.1, 3.2, 3.3, 3.4, 3.6, 3.7</td>
</tr>
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| Advanced Health Assessment Diagnosis II | Module 4 – Prenatal Case #4 - Consider including cultural approaches, involvement of elders, colonial impact on diabetes, accessibility to culturally safe care including Jordan’s Principle.

9.6 Case #1 Consider incorporating colonization, inequity in accessibility and funding health care, Educating for Equity (E4E) Care Framework: [https://guidelines.diabetes.ca/cpg/chapter38#sec5](https://guidelines.diabetes.ca/cpg/chapter38#sec5) |

| Therapeutics I and II | Course Learning Outcomes may include:
- Recognize traditional health, healing practices and Indigenous languages with respect to the current realities concerning Indigenous health.
- Articulate the impact of colonization on mental health and diabetes in relation to TVIC and E4E respectively.
- Address the significance of cultural safety within the therapeutic relationship.

Develop Clinical Therapeutic Care Plans for, by and with Indigenous contexts to include Indigenous ways of knowing and being.
- Establish case studies and exam questions in relation to Indigenous traditional health and awareness of the legacy of colonialism upon health status, accessibility and funding.

TRC Calls to Action #22 and UNDRIP article #1 and MMWIG Calls to Justice 3.3, 3.4 and 3.5: UNDRIP Article #24 –1, 2. |
| Integrative practicum | Demonstrate PHCNP practice within an Indigenous setting focusing on cultural safety and humility, Indigenous healing traditions in tandem with western approaches. | Create a learning plan for NP practice that focuses on incorporating the health related TRC Calls to Action, MMWIG Calls to Justice and UNDRIP articles. | TRC Calls to Action #22 and UNDRIP article #1 and MMWIG Calls to Justice 3.3, 3.4 and 3.5: UNDRIP Article #24 –1, 2. |