Promoting Culturally Safe Care for First Nations, Inuit and Métis Patients

A Core Curriculum for Residents and Physicians

IPAC-RCPSC
Contents

Acknowledgments and Contributors ................................................................................................................................... i
Introduction ................................................................................................................................................................................ iii

Section A - For Facilitators

Facilitator preparation .............................................................................................................................................................. A-1
Teaching requirements .............................................................................................................................................................. A-3
Core Curriculum Learning Session Goals and Objectives ........................................................................................................ A-6
Session I – Quiz .......................................................................................................................................................................... A-7
Session II – Video and Reflection ............................................................................................................................................ A-35
Evaluation ..................................................................................................................................................................................... A-37

Section B - For Learners

Pre-Reading ................................................................................................................................................................................. B
Session Handouts ....................................................................................................................................................................... B

Section C - Resources

Readings and Resources ........................................................................................................................................................... C-1
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Introduction

Many First Nations, Inuit and Métis people have had negative experiences with the mainstream health-care system, often because of cultural differences between the patient or client and the health-care provider. There is a growing recognition that if the mainstream health-care system in Canada is to be effective in helping to improve the health of its First Nations, Inuit and Métis patients and clients, it must provide culturally safe care. In other words, health-care providers must take into consideration the social, political, linguistic, economic and spiritual realm in which their patient or client lives in order to communicate competently with him or her. A lack of culturally safe health services places First Nations, Inuit and Métis patients at risk, by dramatically reducing access to services.

The roots of cultural safety in the health-care system lie in the education of its health-care providers. The Indigenous Physicians Association of Canada (IPAC) and the Royal College of Physicians and Surgeons of Canada (RCPSC) have thus collaborated to produce this ‘Core’ training module for residents and physicians. The material has been developed by the IPAC–RCPSC Core Curriculum Development Working Group to guide learners to a higher level of understanding of pervasive and ongoing health disparities for Indigenous populations.

The material in this module is meant to be the first step in a long process. Each physician who uses the module, whether he or she is an educator or a trainee, will bring his or her own perspectives and experiences to the material. We hope that users will share their views of the material with us and suggest ways to improve it; their generosity will enrich the module for the benefit of those who come after them.

All of the material contained in this guide should be reviewed during a facilitators' training session or before facilitating your first session. It is also intended to be a reference for future sessions on Indigenous health. It is expected that you will most likely use the presentations and activities described here in each session that you facilitate.

Programs are encouraged to build on existing local resources and networks and engage with their local faculties (undergraduate, postgraduate or continuing medical education), or specialty societies to pool resources for funding and organizing interprofessional Indigenous events, such as lectures with invited speakers, cultural events and faculty development.
Facilitator preparation

Advance Preparation

Before facilitating this educational session, you will need to do the following:

1. **Put together a list of potential First Nations, Inuit and Métis community members** who might be willing and able to co-facilitate, participate in the session or act as a resource. Some national or local First Nations, Inuit and Métis organizations who may be able to assist with this include the Indigenous Physicians Association of Canada; Aboriginal Nurses Association of Canada; First Nations, Inuit and Métis student centres or institutes; regional friendship centres; the National Aboriginal Health Organization; Assembly of First Nations; Métis National Council; Inuit Tapiriit Kanatami; the Congress of Aboriginal Peoples and the Native Women’s Association of Canada.

2. **About three months** before the session, contact the First Nations, Inuit and Métis community members on your list to arrange their participation in the session.

3. **Arrange a pre-meeting** with the community member(s) and/or co-facilitator(s) to discuss session objectives and the workshop outline and to share your expectations of what the session will be like and what it will accomplish. **Update relevant slides, handouts and readings in this curriculum binder with provincial or regional data and any information on local First Nations, Inuit and/or Métis communities.**

4. **Distribute the pre-reading list** and resource list to the participants about 1–2 weeks before the session.

5. **Review all of the material you will be using.** Read the pre-reading material to ensure you are familiar with this topic. It is important that you are familiar with the materials and conversational questions. All required reading is included in this guide.

6. **Make copies of needed materials.** Ensure that sufficient copies of the handouts are available for each participant. DO NOT make copies of the slides, as these contain the answers to the quiz questions.

7. **Set up the room.** Make sure you have all of the materials you will need and that the room is set up appropriately (see Figure 1). A U-shaped or round table is best for facilitating participant discussion. If you are using a voting system or team approach to the quiz, ensure that adequate space is available in the room.
Teaching requirements

Time required
- Approximately 3 hours

Materials required
1. This facilitator guide
2. PowerPoint presentation (CD Quiz)
3. Computer or laptop and digital projector
4. Internet Connectivity
   - Weblink or DVD copy of The Apology Video
   - http://www.ainc-inac.gc.ca/ai/rqpi/apo/index-eng.asp Contains links to videos of Prime Minister’s Apology, statements from House leaders; statements from leaders of the five National Aboriginal Organizations (NAOs)
5. Participant handouts:
   - Application Indian Residential School Independent Assessment Process
   - Transcript – The Apology Video (House of Commons Version)
6. Participant resource list
7. Pens or pencils and paper
8. Name tags (optional)

Suggested Initial room set-up:

![Facilitator(s)](image)

Figure 1

Suggested Initial room set-up:
Facilitating a Session

The facilitator is responsible for helping participants learn, stay engaged, and discuss and examine topics related to First Nations, Inuit and Métis health. Ultimately, the facilitator guides the process and ensures that each participant can determine one or more things they can do to better understand the issues related to First Nations, Inuit and Métis health, cultural competency and cultural safety.

**Set the context for the session.** Introduce yourself and answer any immediate questions participants might have. Review the main objectives of the session, and provide an overview of the structure and activities before you begin. You may also want to prepare a brief agenda if you plan on incorporating other topics or components into the session.

**Ask participants to introduce themselves,** if they don’t already know each other. Name tags may also be helpful if you have them available.

**Throughout the session,** the facilitator should do the following:

- Introduce each activity and its purpose.
- Provide clear, brief instructions for the activity.
- Create a sense of energy and enthusiasm within the group.
- Establish and maintain the group’s focus and momentum.
- Make sure everyone is participating.
- Create a safe learning environment.

It is important to remember that the group’s experience will in large part reflect the energy and enthusiasm of the leader of the session. The facilitator is key in making the discovery and learning of new ideas a fun and positive experience for all participants.

The progression of the workshop is largely dictated by the questions you ask. Your role as a facilitator is to let the session run its course. The group should be kept on time and on track, but conclusions should not be made for the participants.

The role of the facilitator(s) in this process is to **get participants talking;** therefore, the less talking done by facilitators, the better. Although facilitators and learners alike may be tempted to revert back to a conventional lecture format (whereby information is simply transmitted, stored and regurgitated), it must be emphasized that this would diminish the experience; the learning would be less rich and information harder for participants to retain and apply. This is particularly true given the components of this session that relate to attitudes.

Facilitators should always ensure to clarify concepts or questions for the group or to ask additional probing questions to make sure that all of the information and concepts are covered.
**Tips and Suggestions**

1. **Be an active listener.** It is important for the participants to see the involvement and interest of the facilitator(s). If session leaders appear to be uninterested or distracted, participants will feel less comfortable and will be less willing to participate fully.

   Active listening can be communicated by nodding your head as participants speak, maintaining eye contact with speakers, leaning forward in your seat, asking additional questions, etc.

2. **Keep the group focused.** It is important for the facilitator to keep the group focused on the conversation and questions. Try to avoid random conversations or tangential thoughts that lead the group away from the main learning objectives. If these occur, you can reread or reiterate the current question or activity.

3. **Maintain a lot of energy and enthusiasm.** Participants will match the energy level of facilitators and other participants in the session. Be sure to set the right amount of energy right from the beginning by smiling often, expressing interest in all opinions, using inflection in your voice, etc.

4. **Ask probing questions.** Sessions will result in much richer learning if facilitators ask questions that elicit more detailed responses. Whenever possible, try to avoid allowing participants one-word answers or opinions.

   Sample questions include:
   
   “What do you mean by that?”
   
   “Why do you think that is the case?”
   
   “Where might that have an impact?”
   
   “When do you think that would be so?”
   
   “How did you form that impression?”

5. **Encourage participation.** It is important to engage all participants in the session, recognizing that participants can engage in a variety of ways. Calling on individuals by name may help involve more reticent members. It is also important to be aware of and sensitive to differences in learning styles and relevant experiences or knowledge (or lack thereof) with First Nations, Inuit and/or Métis health issues.

6. **Be aware of body language and facial reactions.** Both verbal and non-verbal reactions will convey meaning to the learners. Appearing and remaining neutral and non-judgmental will facilitate the learners’ growth and understanding.

7. **Don’t allow individuals to dominate the session.** Some participants may, either intentionally or unintentionally, dominate the discussions in such group sessions. Avoid this when possible by calling on others for responses.

8. **Ensure participants do most of the talking.** It is also important that participants talk to and engage with one another. Support them in the process of coming to their own conclusions based on the information presented and through their discussion, but avoid telling participants what they should think or do. Again, the less talking done by the facilitator(s), the better. Also, avoid filling silences; do not be uncomfortable with silence.

   It might be noted that some Indigenous cultures consider silence a valued component of any conversation; it may be a time to think and enjoy another person’s company.
Core Curriculum Learning Session
Goals and Objectives

Goal
Learners will gain a better understanding of the historical, political and cultural issues that impact the health of Indigenous peoples in Canada.

Objective 1:
Learners will understand the connection between the historical and current government practices and policies towards First Nations, Inuit and Métis Peoples and the related impacts on their social determinants of health, access to health services and intergenerational health outcomes.

Objective 2:
Learners will, through a process of self-reflection, identify, acknowledge and analyze their own cultural values or considered emotional responses to the many diverse histories, cultures, world views, values, and contemporary events relating to First Nations, Inuit and/or Métis people.
Section A

Core Curriculum in First Nations, Inuit and Métis Health

Session I

Presentation
Answer Key and Facilitator's Notes

Quiz
"20 Questions"

"What you thought you knew about Indigenous Peoples."

Core Curriculum in Indigenous Health
March 2009

Quiz: Answer key
Time required: 90 minutes
Question 1

Approximately how many Indigenous people are there living worldwide?

A. 175 million  
B. 50 million  
C. 300 million  
D. 450 million  
E. 200 million

Answer: C (300 million)

It is estimated that there are between 300 and 350 million Indigenous people worldwide, living in 72 different countries.

It is important to note that the definition of "Indigenous" is contentious. This session will use the UN’s definition of Indigenous people as:

"the inheritors and practitioners of unique cultures and ways of relating to other people and to the environment. Indigenous peoples have retained social, cultural, economic and political characteristics that are distinct from those of the dominant societies in which they live."

This question highlights the significant number of Indigenous people living worldwide.
Question 2

In Canada how many groups are recognized as Indigenous?
A. 2
B. 4
C. 1
D. 3

Answer: D (3)

The Constitution Act, 1982, refers to the Indigenous people of Canada as “aboriginal peoples” which it defines as including Indian, Inuit and Métis peoples.

Although “Indian” is a legal term, it is more common now to use First Nations.
There are three legal categories for the status of a First Nations person:

1. **Registered**: meets the federal legal definition of “Indian” and is listed on the Indian Register
2. **Non-registered**: either does not meet the legal definition of Indian OR has not applied to be included on the Indian Register
3. **Treaty**: registered with a band that has signed a treaty with the Crown

Canada’s Constitution explicitly recognizes Aboriginal and treaty rights of Aboriginal peoples.

1. Registered First Nations on reserves and Inuit in communities: The federal government is responsible for primary health care and in-hospital services, and provinces and territories are responsible for public health.
2. Non-registered First Nations (most off-reserve or urban registered First Nations and Inuit and all Métis): Provinces and territories are responsible for health care.
3. Non-Insured Health Benefits (NIHB) is a program providing extended medical coverage (similar to private health insurance) for registered First Nations and Inuit only.

This question is important because it is the starting point for discussion about different jurisdictional responsibilities and policies that affect access to care for Aboriginal people in Canada (e.g., coverage under NIHB; inclusion in health data linkages for health status).
How many Aboriginal languages are spoken in Canada today?

A. 11  
B. 50  
C. 23  
D. 64  
E. 72

Answer: B (50)

50 Aboriginal languages from 11 language families are currently spoken in Canada. Dialects may exist within each language.

According to the Census, Cree, Inuktitut and Ojibway are the three most common Aboriginal language groups in Canada.

Source: [http://www.ainc-inac.gc.ca/ab/fna/fna1_e.html](http://www.ainc-inac.gc.ca/ab/fna/fna1_e.html)

This question increases awareness. Learners should be aware of the language and/or dialect spoken by Indigenous people in their geographic area.
Many First Nations communities have an associated non-reserve community, which may have a significant Métis population (resulting from legislation in the Indian Act preventing non-status people from living on reserve).
Question 5

On September 13th, 2007, the United Nations General Assembly adopted the Declaration on the Rights of Indigenous Peoples. Which country or countries voted against the declaration?

A. United States
B. Canada
C. Australia
D. New Zealand
E. None of the above
F. All of the above

Answer: F (All off the above)

The US, Canada, Australia, and New Zealand were the only four votes against the UN declaration.

The declaration outlaws discrimination against Indigenous peoples and promotes their full and effective participation in all matters that concern them. It also ensures their right to remain distinct and to pursue their own priorities in economic, social and cultural development.

Most of the rights included in the declaration are enshrined in other human rights treaties already adopted by Canada including the rights to cultural development, health and freedom from discrimination.


This declaration took decades to write and pass. One major area of contention was the phrasing of the word “peoples” vs. “people” (“peoples” indicates the collective rights of a group). Canada’s rationale for not signing the declaration was that some of its items contradicted Canada’s Charter of Rights.

Western ideology places the rights of the individual over the rights of groups, and health has been viewed as an individual right. Learners should be asked to comment on this dichotomy of world views.

The Assembly of First Nations (AFN), along with other groups, has continued to lobby to have Canada ratify the declaration.
Question 6

On May 28th, 1918, women citizens of Canada were granted the right to vote in federal elections. The complementary right to stand for election to the House of Commons was granted in 1919; and women were officially deemed “persons” and eligible for senate appointments in 1929.

In what year did all Canadian Aboriginal peoples receive federal voting rights?

A. 1960  
B. 1950  
C. 1918  
D. 1929  
E. 1972

Answer: A (1960)

The federal franchise was extended, without qualification, to all First Nations people in 1960. Inuit people had received federal voting rights Previous to that, in 1950, At the provincial level, non-status Aboriginals received voting rights starting in BC in 1949 and ending with Québec in 1969.

This question demonstrates that, until recently, First Nations people did not have the right to vote (late baby boomers were the first to gain franchise rights).

Marcia Anderson, current president of the Indigenous Physicians Association of Canada, stated,

“My generation was the first in my family in which we had the right to vote when we reached the age of majority.”

Learners should be encouraged to think about the implications of this, in the context of understanding past government approaches and policy.
Question 7

Quinine, the first effective treatment for malaria, was discovered by...

A. Romans  
B. Quechua Indians  
C. The British  
D. Yanomamo  
E. The Kayapo

Answer: B (Quechua)

The Quechua-speaking Incas of the Andes used a tree bark called quina–quina to treat malaria. Following its use by a Jesuit Brother, the bark quickly became one of the most valuable commodities shipped from Peru to Europe.

80% of the world’s people depend on Indigenous knowledge for health and security.

25% of prescription drugs contain active ingredients derived from Indigenous knowledge of plants.

Annual market revenue of pharmaceuticals derived from medicinal plants used by Indigenous peoples exceeds $43 billion USD.

Note: Credit – and profits – for such pharmacologic therapies are rarely shared with Indigenous peoples. There are significant concerns around intellectual property rights as pharmaceutical companies continue to mine Indigenous knowledge of medicinal plants. ¹

¹ Hill, D.M., PhD, Traditional Medicine in Contemporary Contexts; Protecting and Respecting Indigenous Knowledge and Medicine; National Aboriginal Health Organization March 19, 2003, p. 16
The first case of smallpox in Mexico was reported in 1520. During the next century, the disease reduced the population in Mexico and Central America from 20 million people to:

A. 10.3 million  
B. 1.2 million  
C. 400,000  
D. 6.5 million  
E. 3.1 million

**Answer: B (1.2 million)**

Smallpox, which is related to cowpox, devastated indigenous populations throughout the Americas. One count indicates that smallpox reached the Peigan in 1764, with further epidemics in 1837 and 1868.

In the plains at the time of contact, there were an estimated 200,000 Indigenous Peoples, which then declined to about 75,000 at the lowest due to many factors, including outbreaks of influenza in 1717 and 1834, devastating smallpox epidemics in 1782 and 1837, and a measles outbreak in 1846–7.

Because these were “virgin epidemics” Indigenous people were particularly susceptible. In diseases like smallpox with a high mortality rate the population did not develop immunity, and secondary effects like low fertility rates further decimated the population.

The low fertility rate was a result of the increasing deaths among adults due to infectious diseases. ²

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The Indian Act forms the basis for federal jurisdiction on reserves (lands reserved for Indians). One complicating issue is how provincial public health acts are applied on reserves.

In general, public health acts will apply, except where they are inconsistent with First Nations law, or Aboriginal or treaty right, or to the extent that any provision would regulate the use of or right to property on reserve.

A recent controversial example of this dichotomy is the institution of smoking bans in public places – a provincial law that is not enforceable on reserve unless the band makes a bylaw enforcing it.

Question 9

In what year was the Indian Act officially legislated in Canada?

A. 1867  
B. 1900  
C. 1891  
D. 1876  
E. 1922

Answer: D (1876)

The first Indian Act was passed by Parliament in 1876; since then, numerous amendments have been made to the act. The present act was passed in 1951, but its provisions are still rooted in colonial ordinances and royal proclamations.

Source: http://www.ainsic-inac.gc.ca/qc/csi/ind_e.html
The act dictated Aboriginal registration and non-registration, enfranchisement, land ownership, education policies, (e.g. enforced compulsory attendance at residential schools for all Aboriginal youth) the last residential school closed in Saskatchewan in 1996.

In the prime minister's statement of apology regarding residential schools, parts of which will be viewed later, in one statement he refers to an infamous quote that describes the intended effect of the schools: to be to “kill the Indian in the child.”

Question 10

In what year was the Indian Act amended to make residential school attendance compulsory for all First Nations children ages 7–15 years?

A. 1886
B. 1900
C. 1920
D. 1934

Answer: C (1920)

The written federal policy was to assimilate First Nations children by educating children away from family and community.
Question 11

The written federal policy was intended to assimilate First Nations children by educating children away from family and community. Canada’s residential school policy therefore, met one of the United Nations definitions of genocide:

A. True
B. False

Answer: A (True)

One of the five actions that constitute genocide is the forcible removal of children from one population to another, which the 1920 Indian Act gave Indian agents the power to do.

Some have called this ‘cultural genocide’ or ‘the American Indian Holocaust.’
The 1948 Geneva Convention defines genocide as any one of the following acts committed with intent to destroy, in whole or in part, a national, ethnic, racial or religious group, as such:

a) Killing members of the group
b) Causing serious bodily or mental harm to members of the group
c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction on a whole or in part
d) Imposing measures intended to prevent births within a group
e) Forcibly transferring children of the group to another group

The article “Rethinking Cultural Genocide under International Law: Human Rights Dialogue” by David Nersessian (Cultural Rights, spring 2005) explains why “forcible transfer of children” was identified in the Geneva Convention but explicit statements about cultural genocide were removed.
Question 12

What was the highest number of residential schools to operate in Canada (including those run by the church)?

A. 35
B. 80
C. 62
D. 95

Answer: B (80)

The first school opened in 1840, and the number of schools reached a peak of 80 in 1930. After that numbers decreased because of disease outbreaks, fires, and other reasons.

The last Canadian government and/or Church-run residential school closed its doors in 1986.

Some residential schools have been re-established under Aboriginal administration and leadership in several communities not having senior high education available (e.g. Frontier Collegiate, Cranberry-Portage, MB; Blue Quills First Nations College, Saddle Lake, AB)

Nineteen different schools operated in Manitoba.

The last school in Manitoba that operated under the former policy closed in 1980.
Question 13:

What percentage of Aboriginal children attended residential schools?

A. 10%
B. 25%
C. 40%
D. 62%
E. Unknown

Answer: E (unknown)

The exact number for First Nations, Inuit and Métis is not known. In the FNRHS 39% of First Nations adults over 45 years of age had attended for an average of 6 years.

This question is intended to help learners understand the scope of the problem.

FNRHS = First Nations Regional Health Survey
Question 14

Which of the following were conditions in the residential schools?

A. Students were separated from their siblings.
B. Students were punished for speaking Aboriginal languages.
C. Students were at risk for malnutrition and infectious diseases.
D. A high proportion suffered various forms of abuse.
E. All of the above.

Answer: E (all of the above)

These aspects (among others) contributed to what have been described as the four fundamental harms of residential schools:

- physical and consequent emotional harm;
- educational harm;
- loss of culture and language; and
- harm to family structures.
Four fundamental harms caused by residential schools

Review the Application for the Indian Residential School Independent Assessment Process (a 20-page form used to document harm from residential schools): www.residentialschoolsettlement.ca/IAP_form.pdf

Note the checklist that includes:

- verbal abuse
- racist acts
- threats
- violence
- sexual abuse
- humiliation
- degradation

Each page provides the number for a 24-hour crisis line.

Learners should begin to think and see how this might affect individual, family and community health, keeping in mind how recent were the closures of the last residential schools.

These harms led to what is called “intergenerational harm,” “intergenerational trauma” or “intergenerational effects.”

A primary example of this perpetual suffering is the ongoing outcomes of parenting and early childhood development:

- Those attending residential schools failed to learn good parenting and coping skills.
- Those who were abused learned to continue the cycle of abuse.
- Those who lost coping skills turn to drugs and alcohol to escape the ongoing torment; often leading to child neglect and exposure to such high-risk behaviours.

Before moving on to the next question, share the two quotes shown on the next two slides about the effects of residential schools, which are taken from the 1996 Royal Commission on Aboriginal Peoples. They more clearly illustrate the links between policy and outcome.

The first quote highlights a personal story of abuse that cycled down generations following the grandfather’s experience of abuse at residential school.

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“One good example is my grandpa. His education was up to grade 2, I think. From what my father tells me there was a lot of abuse going on. A lot of name-calling, a lot of put-downs with the priest toward the kids. For every little thing they got the whip. My grandpa grew up with that, and he learned that, then he used it on his kids. Then my father used it on us.”

(Anonymous)

“When you talk about things like addiction and family abuse, elder abuse, sexual abuse, suicide and all the different forms of abuse we seem to be experiencing, it’s all based on the original violence….churches and governments made us believe that the way we are today is the Dene way. It isn’t. That is not the Dene culture.”

Roy Fabian, Hay River NWT
Question 15

If you compare the percentage of First Nations people who consumed alcohol in the past year with the percentage of the general population who did so, it would be:

A. Higher
B. Lower
C. The same

Answer: B (lower)

<table>
<thead>
<tr>
<th></th>
<th>First Nations</th>
<th>Non–First Nations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>69.3%</td>
<td>82.0%</td>
</tr>
<tr>
<td>Females</td>
<td>61.7%</td>
<td>76.5%</td>
</tr>
<tr>
<td>Combined</td>
<td>65.5%</td>
<td>79.3%</td>
</tr>
</tbody>
</table>
Alcohol consumption over past year: the first column compares alcohol consumption among men (69% vs. 82% in the general population), the second column among women (62% vs. 77%), and the last column both sexes combined (66% vs. 80%).

This point should highlight how common stereotypes affect our thinking. How do these stereotypes form? Even when the stereotypes are not malicious, how might they affect care?4

Note: Data on registered First Nations people are easier to find than data on non-registered First Nations, Inuit or Métis people, so we are often unable to report or use statistics on the health of the other Indigenous populations. This has to do with how health information is collected and generated.

Section A | Question 16

Question 16

If you compared the percentage of First Nations adults who are heavy or binge drinkers with that of the general population it would be:

A. Higher
B. Lower
C. The same

Answer: A (Higher)

Approximately 6.2% of adults in the general population report heavy drinking on a weekly basis compared with 10.2% of First Nations females and 20.9% of First Nations males.

How might this fact change
- Our assumptions?
- Our clinical judgment?
- Our clinical interviews?
- Our programs to address alcohol intake?
Question 17

If you compare the rates of sexual abuse between women in the general population and Aboriginal women, among Aboriginal women the rates are:

A. Higher
B. Lower
C. The same

Answer: A (higher)

Among the general population 51% report at least one instance of physical or sexual abuse.

Among Aboriginal women under 18 years of age, 75% report at least one instance of sexual abuse, and in 25% the first instance occurred at younger than 7 years of age.

Note: The statistic for the general population refers to sexual and physical abuse combined. The statistic for Indigenous women refers to sexual abuse only.

At younger ages the perpetrator is often a family member. How does this fact link to the intergenerational impacts of residential schools?
Question 18

The suicide rate among non-Aboriginal Canadian men aged 15–24 years is 24 per 100,000. What is the rate for Aboriginal men of the same age group?

A. 58 per 100,000
B. 94 per 100,000
C. 37 per 100,000
D. 126 per 100,000
E. 153 per 100,000

Answer: D (126 per 100,000)

Suicide rates among Aboriginal youth in Canada are five to six times higher than that of non-Aboriginal youth.

This question highlights the problem of suicide among First Nations, Inuit and Métis populations. How might this problem link to health policy and residential schools?
Question 19

Roughly how much higher is the suicide rate among all Aboriginal people compared with the general population?

A. 3 times as high  
B. 6 times as high  
C. 9 times as high  
D. 12 times as high

Answer: A (3)

<table>
<thead>
<tr>
<th></th>
<th>Canadian</th>
<th>First Nations (On Reserve)</th>
<th>Inuit (Nunavut)</th>
<th>Métis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Expectancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>82</td>
<td>77</td>
<td>70</td>
<td>n.a.</td>
</tr>
<tr>
<td>Male</td>
<td>76</td>
<td>69</td>
<td>68</td>
<td>n.a.</td>
</tr>
<tr>
<td>IMR (per 1,000)</td>
<td>5.3</td>
<td>8.0</td>
<td>15</td>
<td>n.a.</td>
</tr>
<tr>
<td>Deaths by suicide</td>
<td>13</td>
<td>28</td>
<td>79</td>
<td>n.a.</td>
</tr>
</tbody>
</table>
The table indicates differences in life expectancy, infant mortality and deaths by suicide. Again notice the lack of data on Métis populations. Mortality data are well known to be underestimated for First Nations and Inuit people; differences are actually larger than what is shown here. It is important to recognize that there is diversity among the three groups of registered First Nations, Inuit and Métis. At least one study shows that even within the First Nations community, suicide rates vary dramatically community to community with markers of “cultural continuity.”

Question 20

The Government of Canada apologized to Aboriginal people for the residential school system on what day?

A. May 12, 2007  
B. June 11, 2008  
C. September 10, 2007  
D. June 21, 2008

Answer: B (June 11, 2008)

The federal apology took place on June 11, 2008. It was the first time national Aboriginal political leaders were allowed to sit and address parliament. Leaders from the Assembly of First Nations, Métis National Council, Inuit Tapiriit Kanatami, the Congress of Aboriginal Peoples and the Native Women’s Association of Canada participated.

This question provides a link to the next session in the workshop.

AFN = Assembly of First Nations  
MNC = Métis National Council  
ITK = Inuit Tapiriit Kanatami  
CAP = Congress of Aboriginal Peoples  
NWAC = Native Women’s Association of Canada
In order to be culturally competent and in order to provide culturally safe care for First Nations, Inuit and Métis People, physicians must understand the cultural, historical and political issues that have impacted and continue to affect the health of Indigenous peoples in Canada.
Lesson Title:
Understanding how history – specifically the residential school experience and the 2008 Apology by the Prime Minister – affects the health of Canada’s Indigenous Peoples today.

Lesson Objective
Through a process of self-reflection, identify, acknowledge and analyze one’s own cultural values or considered emotional response to the many diverse histories and contemporary environments (geography, cultures, world views, values, epistemology…) of First Nations, Inuit and Métis peoples and respectfully offer opinions.

Time: 90 minutes

Learning Objectives: As a result of attending this session, learners will

1. Gain accurate knowledge about the Canadian residential school experience and how its impact on First Nations, Inuit and Métis culture and health.

2. Discuss the rationale for The Apology from the Government of Canada to the Indigenous population.

3. Describe the different perspectives of the Indigenous population based on the responses from Canada’s Indigenous leadership.

4. Propose ways in which health care professionals can help to remove barriers and improve health care services and delivery to Indigenous patients.

Preparation:

1. Facilitators will need to view the video *The Apology* in its entirety. Copies of transcripts (included) should be distributed to all learners ahead of the session with instructions to review and reflect specifically on the key responses from the national Indigenous leaders.

2. The facilitator will show the video segments of the apology by the Prime Minister and statements by other party leaders in the House of Commons. The facilitator will lead a group discussion on the key responses from the national First Nations, Inuit and Métis leaders.

3. Universities and programs are urged to establish a partnership with the local community (via Native Friendship Centres, local First Nation community, Métis settlement, etc.) to help identify and recruit resource persons (i.e., people with skills to help with healing process or facilitate the talking circles, elders to open/close, people to share stories of residential school).

4. It is recommended to have several community resource people (if possible First Nations, Inuit and Métis with a balance of gender), so that each small group can have a resource person to assist in their discussions.

5. Facilitators should arrange to meet with community resource people (co-facilitators) prior to the session.

6. Facilitators should become familiar with the local university Indigenous student organization and/or First Nations, Inuit and Métis support services.

7. Facilitators should become familiar with the school’s curriculum resources relating to Indigenous peoples.
Section A

Class Methodology

Introduction (10 minutes)

1. Opening Session (opening prayer or welcome words from elder/community person who will co-facilitate the session).
2. Welcome and introductions
3. Review discussion topic – The Apology Video (Transcript distributed for pre-reading)
   a. Question learners on the significance of The Apology “Why was such a declaration needed?”
   b. Look for two or three responses from the learners

Main Activity (25 minutes)

1. Introduce and view The Apology video
2. Highlight key questions:
   a. What was the basis of government policy, as represented by the residential school policy at that time? Has that changed?
   b. What specific impacts to Indigenous people and communities are mentioned?
   c. What impacts to health, either direct or indirect, are mentioned?
   d. What emotional responses did you have to watching the video?
   e. Did your emotional reaction (or lack of one) surprise you?
3. Identify learners to read aloud selected responses from the leaders of the five National Aboriginal Organizations (NAOs).

Small Group Discussions (45 minutes):

How does the residential school experience and apology affect the health of the First Nations, Inuit and Métis Peoples of Canada?

a. Four groups identified by topic/population
   i. First Nations
   ii. Inuit
   iii. Métis
   iv. Indigenous Women
b. Group recorder collects responses from each group member
c. Oral summary back to group
d. Feedback to learners from facilitator and/or elder or co-facilitator.

Conclusion (10 minutes)

1. Ask for any final reflections from the learners. Allow as many comments as time permits.
2. Instructor thanks elder and community resource people; emphasize how history has impacted on the health of the Indigenous people of Canada and how knowing this is a key aspect of being able to provide culturally safe care.
3. Closing prayer or words.

Follow-up activities

1. Organize an evening talking circle for the students with community members to learn more about the local indigenous culture.
2. Partner with the university Indigenous student organization or service to:
   a. Hold a film night as an informal learning opportunity
   b. Invite an elder, and/or residential school survivors to a school talk
3. Distribute a list of books and videos on the accurate history of Indigenous peoples in Canada for learners to view.
Evaluation

Proposals for Evaluation of Learning
Facilitators and learners should allow time for reflection exercises, and appropriate wrap up at the completion of the session.

Reflection Exercise:
- Large group circle for initial reflections
- Smaller circles to discuss and report back:
  - How might the residential school experience and the Prime Minister's apology affect the health of a First Nations, Inuit or Métis person today?
    - reference gender
    - intergenerational
    - determinants of health
    - rural and urban

Other proposed evaluation strategies:
- Portfolio and Written reflection
  - Learners select one item from session for inclusion in portfolio. This may include their most informative reading, surprising statistic, quote or other phrase/article which best represents the learning experience.
  - Learners will write and submit to the facilitator a 300-word reflection on the item chosen for the portfolio, indicating the significance.
Resources
IPAC RCPSC Curriculum Project Core Curriculum Working Group Resources List

Learners are to select one or two references to read under each topic area identified below to be read prior to the workshop.

Facilitators should familiarize themselves with all references.

Health Policy and Health Services


Cultural Competency


Cultural Safety


**History and Colonialization and Aboriginal Health**


**General resources:**

Adelson, N., ’*Being Alive Well*: Health and the Politics of Cree Well-Being (Anthropological Horizons) University of Toronto Press (September 1, 2000) 160 pages


**Additional Resources**


Chartrand L, Logan T, Daniels J. Métis History and Experience and Residential School in Canada, Aboriginal Healing Foundation, Ottawa, Ontario (2006)


Redwood-Campbell, L., MacDonald, W.A., and Moore, K., Residents’ exposure to aboriginal health issues. Survey of family medicine programs in Canada, Canadian Family Physician, 45 p325.

