



National Association
of Friendship Centres
Association nationale
des centres d'amitié

Urban Indigenous Forum: Addressing Systemic Racism in Healthcare

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In Friendship.



About NAFC

The National Association of Friendship Centres (NAFC) is a network of over 100-member local Friendship Centres (FCs) and Provincial/Territorial Associations (PTAs) across Canada. For more than fifty years, Friendship Centres have aided First Nations (status and non-status), Inuit, and Métis people living in urban environments, including rural, remote, and northern. Friendship Centres are Canada's most significant urban Indigenous service delivery infrastructure and are providers of culturally relevant programs and services to urban Indigenous community members.

Friendship Centres are grassroots organizations that provide services to all members of their respective communities, regardless of their legal status as an Indigenous person, and have done so since their inception. Last year, ninety-three Friendship Centres served approximately 1.4 million First Nations, Inuit, Métis, and non-Indigenous people across over 1200 programs in 238 buildings across Canada and employing over 2,700 staff.

These programs and services span a range of areas, including health, housing, education, recreation, language, justice, employment, economic development, culture, and community wellness. Friendship Centres are a lifeline for many Indigenous people living in urban environments. Today, approximately 50%-85% of the Indigenous population in Canada lives in urban communities (with over 1000 population). Friendship Centres are known within urban Indigenous communities for creating much-needed support structures that are not available anywhere else.

Background

On November 6, 2020, NAFC hosted an online forum on systemic racism in healthcare. Our goal with this forum was to honour urban Indigenous people's experiences in accessing our right to healthcare as well as the experiences of those who travel between on-reserve and northern communities to urban settings.

On September 28, 2020, Joyce Echaquan, a 37-year-old Atikamekw woman and mother of seven died in Centre hospitalier de Lanaudière, in Joliette, Quebec. The horrendous and degrading moments before Joyce Echaquan's death were captured by her via Facebook Live. Her bravery in capturing these harrowing moments called the world to bear witness to the deplorable racism, abuse and inhumane treatment Ms. Echaquan was subjected to prior to her death, all at the hands of healthcare workers entrusted and sworn to care for her.

This tragedy has led to raw outrage, grief and pain for Ms. Echaquan's family and friends, as well as hundreds of Indigenous communities nationwide. Deplorably, the racism Ms. Echaquan was subjected to is a common reality for many Indigenous persons accessing their right to healthcare. Our aim to address anti-Indigenous systemic racism in healthcare is supported by the Truth and Reconciliation Commission of Canada: Calls to Action, specifically call to action number eighteen:

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.¹

¹ Truth and Reconciliation Commission of Canada: Calls to Action (2015), p.2, retrieved online. Urban Indigenous Forum: Addressing Systemic Racism in Healthcare

Summary of Event

The Urban Indigenous Forum: Addressing Systemic Racism in Healthcare was a crucial first-step in acknowledging the efforts it will take to ensure Indigenous people can access their right to healthcare with dignity and respect, however, our work does not end here. It remains our view that an Indigenous-led and community-driven process is essential in the path forward and compiling this report to share with Indigenous, Federal, Provincial/Territorial governments, our Partners, and the Canadian public as a whole is our first call to action. In this report you will find comments and suggestions from participants of the forum that range from personal experience, experience of advocates, professionals, and allies.

During the forum, we discussed:

- The action that is currently happening on the ground in our communities,
- The role of urban Indigenous service providers in healthcare, and,
- Recommendations for moving forward to ensure that Indigenous peoples can access healthcare services with dignity, without fear and, free from discrimination.

The Event was moderated by Jocelyn Formsma, Executive Director, The National Association of Friendship Centres (NAFC). We were honoured to host such esteemed Indigenous professionals, and community members, with frontline experience that spans several decades:

Senator Yvonne Boyer – Senator, Senate of Canada; former Associate Director for the Centre for Health Law, Policy and Ethics at the University of Ottawa; former Canada Research Chair in Aboriginal Health and Wellness at Brandon University, is a leading authority on Indigenous health law and has worked in this area for several years. From her exceptional professional experience, Senator Boyer discussed forced and coerced sterilization in Canada. Drawing on a personal, family experience Senator Boyer highlighted the depravity and racism-laden experiences of Indigenous people accessing their right to healthcare. Senator Boyer discussed how current eugenics legislation underpins healthcare in Canada and places Indigenous people at significant risk of health harm. Senator Boyer advocated for informed consent and knowledge of rights when accessing healthcare and making healthcare decisions.

Jennifer Brazeau – Executive Director, Centre d'amitié autochtone de Lanaudière located in Joliette, QC. Jennifer has been on the front lines of Indigenous community work for several years and discussed witnessing online the death of Ms. Echaquan and the follow-up work that she and the staff of the Friendship Centre did with the community as events unraveled. Ms. Brazeau explained how she organized her team to help manage the crisis for community members, supported Ms. Echaquan's family, and ultimately how they sought solutions to managing the aftermath of the incident. Responding to needs on the ground and ensuring that this does not happen again continue to be priorities, as described by Ms. Brazeau, and a piece of this response is opening a proximity clinic.

Édith Cloutier – Executive Director, Centre d'amitié autochtone de Val d'or in Val d'or, QC. She is also an esteemed member of the order of Canada and an NAFC board member. Ms. Cloutier discussed the positive results of Indigenous people taking charge of their health services. The social innovation occurring at the Val d'or Friendship Centre through the Minowé Clinic is aimed at creating accessibility to culturally relevant and safe health services and to create a sense of harmony for patients to ultimately improve the health conditions of Indigenous people. Ms. Cloutier explained the ways in which this wholistic approach to healthcare has already positively impacted the lives of Indigenous people within the Val d'or region. This model is not without its challenges and these were also discussed by Ms. Cloutier as areas for growth and strengthening the work done here as well as offering these observations for consideration in implementing similar services of social innovation across Canada.

Dr. Alika Lafontaine – Métis Physician with Alberta Health Services currently based out of Grande Prairie, AB. He is an Associate Clinical Professor, Lecturer at University of Alberta and has a history of considering issues of systemic racism in healthcare. Dr. Lafontaine discussed the unfortunate, “abnormal, norms” that have been created with respect to Indigenous healthcare and how Indigenous people have grown to tolerate exceptional amounts of harm. These norms, as discussed by Dr. Lafontaine, must change and to achieve this change he proposes a piece of the solution in the form of a method for reporting health harm. Dr. Lafontaine explains that Indigenous patients do not feel comfortable or safe reporting health harm and the consequences of this can literally be grave. He introduced the SafeSpacesNetwork initiative and announced that they were soon going to be piloting the initiative in partnership with the BC Association of Friendship Centres. SafeSpacesNetwork is an initiative to document interactions between Indigenous people and the health care system in a safe and supportive manner to ensure that Indigenous experiences with the healthcare system are documented.

Dr. Janet Smylie – Métis Physician and Director of Well Living House based out of Toronto, ON. Dr. Smylie is also a Research Scientist at St. Michael's Hospital, Physician, Professor at University of Toronto, has been working in public health for more than twenty-years and knows the urban landscape very well. Dr. Smylie discusses how the answers to Indigenous health lie within our communities as well as the challenge of transforming non-Indigenous health systems. Through a discussion of current examples of successful Indigenous-led health services in urban settings, Dr. Smylie demonstrated the incredible results of Indigenous health access and Indigenous governance models as they relate to health services. These are examples of how Indigenous health models also serve the entire broader community and demonstrates how better services can be created for our own communities while providing innovation in services offered to non-Indigenous people as well. Dr. Smylie discusses the importance of creating Indigenous-led spaces both within and without non-Indigenous spaces in order to avoid an apartheid type healthcare system in Canada.

Systemic Indigenous-Specific Racism in Healthcare

Anti-Indigenous racism in health care exists. Unfortunately, the current landscape of data specifically on urban Indigenous peoples is minimal, out-of-date and not a reflection of present-day urban Indigenous experiences² in addition to stories of Indigenous health in Canada not generally being authored by Indigenous peoples themselves.³ Without disaggregated data, Indigenous and non-Indigenous organizations alike are hard pressed to develop targeted programming to address issues of systemic racism. In essence, a systemic response is needed in order to address the systemic issue of Indigenous-specific racism in healthcare.

First Nations, Inuit, and Métis people living in urban settings have multiple intersecting diversities that make up their respective identities. These diversities correspond with rights that are enshrined in both domestic and international law.

As people living with diverse identities, urban Indigenous people also experience multiple and intersecting challenges, due in part from (and at the very least, not alleviated by) their Indigeneity. In addition to experiencing racism and discrimination, urban Indigenous people generally experience higher rates of poverty, unemployment, precarious housing or no housing, violence, and overrepresentation in the

² “Urban Indigenous Wellness Report: A BC Friendship Centre Perspective”, BC Association of Aboriginal Friendship Centres (2020), p.11, retrieved online.

³ Dr. Allan, B & Dr. Smylie, J. “First Peoples, Second Class Treatment: The role of racism in the health and well-being of Indigenous peoples in Canada” (2015), p.2, retrieved online.

criminal justice system. These issues, which are all determinants of health, are further heightened for Indigenous children, youth, people with disabilities and Two-Spirit and LGBTQIA+ individuals.

Upholding rights and addressing the challenges of urban Indigenous people requires equally diverse supports and responses from multiple stakeholders. An important starting point for this process is to collect disaggregated data.

The Truth and Reconciliation Commission of Canada Call to Action number twenty-four states:

*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.*⁴

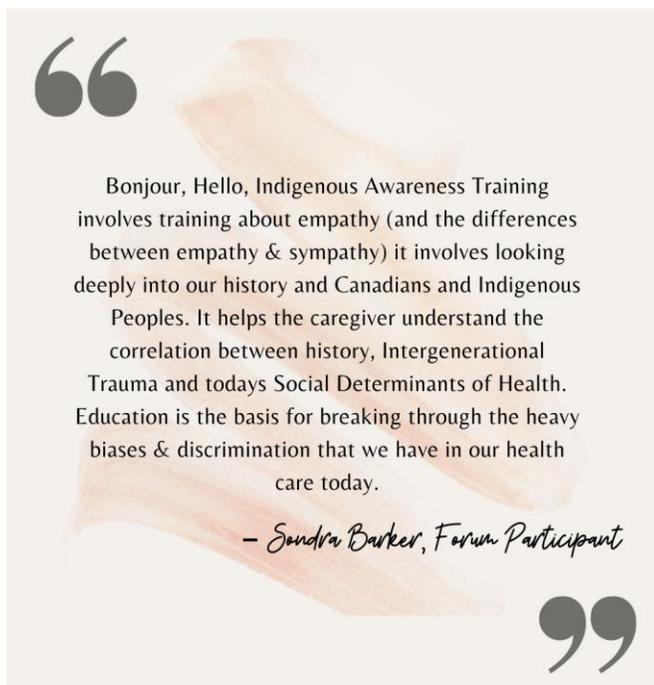
In the recent report, *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*, by Mary Ellen Turpel-Lafond, Ms. Turpel-Lafond states that widespread evidence of Indigenous-specific stereotyping, racism and discrimination do in fact exist in the B.C. health care system.

*“Indigenous people told us that they encounter racism and discrimination in the B.C. health care system, including stereotyping, unacceptable personal interactions and poorer quality of care. Many Indigenous people said they do not feel safe when accessing health care services and interacting with health providers – some noting that they “never” feel safe, and many sharing that they “always” have negative experiences. Indigenous women spoke up more than any other Indigenous people, and shared their particular feelings of unsafety.”*⁵

While *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care* was specifically addressing allegations of racism and discrimination within the B.C. healthcare system, the report’s findings echo much of what we, as Indigenous people, have experienced across Canada. The

contributing factors of racism and discrimination experienced by Indigenous peoples in general, let alone while accessing healthcare, are complex. Colonization, the *Indian Act 1876*, residential schools, sixties scoop, are all systems of oppression that have braided systemic racism into Canadian institutions as well as racist views of those that work within these institutions in various capacities.

As service delivery community hubs, Friendship Centres observe that the federal and provincial government’s approach to consultations only with Indigenous governing bodies has allowed urban Indigenous people to become “unseen” by current government policy approaches that results in inadequate resourcing for urban Indigenous services. Further, the federal government has not engaged an effective mechanism to be able to “see” and engage First Nations, Inuit and Métis



⁴ Truth and Reconciliation Commission of Canada: Calls to Action (2015), p.3, retrieved online

⁵ Turpel-Lafond, M.E., “In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care”, November 2020, p.31, retrieved online

who are urban-based or appropriately engage the organizations that work with them and serve them in decision making venues.

To meaningfully uphold rights and address the challenges of Indigenous people living in urban settings, the NAFC recalls, supports, and advances the findings of the National Inquiry into Missing and Murdered Indigenous Women and Girls final report that noted that implementing solutions (in this case the Report's Calls to Justice) must address, "*the needs of distinct Indigenous Peoples, and taking into account factors that make them distinct*" including but not limited to:

- Self-identification
 - First Nation
 - Inuit
 - Métis
- Geographical- or regional-specific information
 - North, South, East, West
 - Proximity to urban centres, oceans, water, and natural resources
 - Locations of traditional territories and homelands
 - Municipal, provincial, and territorial boundaries
- Residency
 - On-reserve/off-reserve
 - Rural/urban
 - Remote and northern
 - Communities and settlements
- A gendered lens and framework that ensures that impacts on women, girls, and 2SLGBTQIA individuals are considered.
- Understanding the differences and diversity among 2SLGBTQIA people
- Understanding that the needs, within communities of individuals, may not necessarily be the same.⁶

An intersectional approach with multiple stakeholders is required to appropriately measure experiences of urban Indigenous peoples within the healthcare system and to uphold the right to access health care with dignity and respect.

In addition to little-to-no disaggregated data available to support programming and policy positions to address Indigenous-specific systemic racism in health care, the multifaceted jurisdictional landscape plagues our interactions with the healthcare system. The debate over which level of government is responsible for Indigenous persons living within urban areas has impeded Indigenous peoples access to health services.

⁶ National Inquiry on Missing and Murdered Indigenous Women and Girls (2019). *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*, p. 172, retrieved online
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The issue of jurisdictional wrangling is compounded by complex Canadian legal systems that are intended to serve as a mechanism for redress once an individual has experienced racism and discrimination. Additionally, internal mechanisms of complaint within institutions tend to be modeled after colonial ideas of dispute resolution and appear to be more focused on preserving the institution as opposed to the rights and safety of patients. Indigenous people are subjected to working within a legal system that is historically oppressive for Indigenous peoples. Currently, there is no Indigenous specific ground of discrimination within provincially or federally regulated human rights law. Instead, an Indigenous person is required to apply to the respective tribunal within their province or territory, select several grounds of discrimination such as race, ancestry, creed and gender, and then make written submissions for each of the code grounds and explain how they relate to the unique circumstances of experiencing discrimination as an Indigenous person.

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I feel that one issue is the fact that there are several entities under the umbrella of Indigenous health. They fall under differing jurisdictions of federal, provincial, FN Health Authorities etc. Can this be amalgamated with existing infrastructure and a cooperative relationship be established as one entity? i.e. cost-sharing/funding arrangements etc.

– Gary George, Forum Participant

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The Truth and Reconciliation Commission of Canada Call to Action number twenty submits:

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.⁷

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A group of nurse colleagues and I have been discussing what can be done. We've thought about asking for accreditation standards to be revised, (and this can expand to Community Care Legislation requirements as well), asking colleges to require completion of cultural safety training, ensuring indigenous voices at leadership tables, and creating safe spaces for harm experiences to be reported and addressed were the ideas we thought of and I hear echoed here. Thank you for this session and for your work. We are all in this together.

– Sue Bartnik, Forum Participant

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Action that is Currently Happening on the Ground in our Communities

Since 2011, to improve the health and living conditions of Indigenous people, the Government of Quebec and the Val-d'Or Native Friendship Centre joined forces and expertise to create the Minowé Clinic allowing to build a culturally safe and renewed offer of frontline services for the Indigenous population of Val-d'Or. Édith Cloutier, Director of the Val-d'Or Friendship Centre is quoted by CBC, “Integrating frontline health services at the friendship centre is what has made the clinic successful...The purpose of that partnership with the CISSS (Integrated Health and Social Services Centres) is to increase access to health services, but also to address that

rupture of trust in the system.”⁸ This program not only provides direct access to health care practitioners but also provides direct access to other programs run out of the Friendship Centre and, combined, this approach is successfully filling a gap of inequalities in healthcare and is truly a systemic transformation.

⁷ Truth and Reconciliation Commission of Canada: Calls to Action (2015), p.3, retrieved online

⁸ *How Quebec's Minowé Clinic is Improving Indigenous Access to Health Care*, Ka'nhehs'io Deer, Canadian Broadcasting Cooperation (November 2020), retrieved online

Services offered through Minowé Clinic include:

- Health care services offered through a doctor, nurse practitioner and obstetrician,
- Social services are offered by social workers,
- Psychosocial services provided by a psychologist,
- Community Services are offered through community organizers, daycare workers and friendship centre staff, and,
- Traditional healing services.

The findings of the *Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Quebec: listening, reconciliation in progress*, the findings of the *Truth and Reconciliation Commission of Canada* combined with the death of Joyce Echaquan underscore the urgency of having health platforms for and by Indigenous peoples. Despite the success of the Minowé Clinic, the need for on-going and sustainable funding as well as recognition of this clinic (and others like it) by public health remains an issue. Regardless of these issues, the work is being done.

In October 2020, Mirerimowin, a proximity clinic, welcomed its first patients at Centre d'amitié autochtone de Lanaudière. Patients are required to make appointments at Mirerimowin, which operates two afternoons per month. If the clinic is not able to accommodate all appointments, Centre d'amitié autochtone de Lanaudière continues to fill service gaps by making every effort to aid in the form of accompaniment to appointments elsewhere. Ms. Brazeau explains that as of late November 2020, they still do not have enough support to hire a nurse or to purchase special medical equipment for the clinic, but the clinic is working to meet the basic needs of the community despite a lack of funding.

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As Friendship Centres we work in these communities everyday, we work with these community members. We are called to hospitals and hospices, we are called to help people in comfort and palliative care and we are called to long-term care facilities, families. We hold people's hands and we make sure people get to their appointments. There is a lot that we play in this role and there is a big piece that needs to be heard from that urban perspective.

– Jocelyn Formisano, Executive Director

of
NAFC

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These models work because it allows Indigenous people to feel safer when accessing health care that is directed by Indigenous people – it allows us to feel confident that we will be treated with dignity and respect and not be subjected to racism and discrimination.

Senator Yvonne Boyer is a member of the Senate Standing Committee on Human Rights that has been investigating forced and coerced sterilization with the objective of providing recommendations for future work. During the forum, Senator Yvonne Boyer explains that, “Within the 42nd parliament we were able to put together a short study on the forced and coerced sterilization of Indigenous women where we had some fantastic testimony come in. Now that we are starting the 43rd Parliament, we are looking at doing another [study] building on the first one and bring

more of an international focus of what is happening.”

Senator Boyer has worked tirelessly to bring the issue of coerced and forced sterilization to the forefront through her own work and through igniting conversations on the matter with partner organizations.⁹

⁹ Boyer, Y, *Our Fight Against Coerced and Forced Sterilization: The first step in eradicating this unspeakable crime is to listen and hear the voices of Indigenous women who have been sterilized* (May 2020), retrieved online

The Role of Urban Indigenous Service Providers in Healthcare

The answers to healthcare systems by and for our communities lay within our communities. As Dr. Janet Smylie discussed in our forum, the approach to Indigenous healthcare services in an urban context must be a dual approach of facilitation of Indigenous specific spaces within non-Indigenous organizations in combination with Indigenous specific clinics and services within Indigenous organizations. Without a dual approach we, as a country, run the risk of propelling the existing apartheid system for health services in Canada. Organizations such as Wabano Centre for Aboriginal Health, Anishnawbe Health Toronto and Minowé Clinic as well as other Indigenous clinics across the country are good models of urban Indigenous service providers because they build on Indigenous community strengths.

Dr. Alika Lafontaine stated during our forum, “Patients just don’t want to be harmed anymore. Patients want to come to a medical encounter and have a good relationship with their provider. They don’t want to have to depend on the layers between them in order to have persons who have power to give them space to ensure that their care is centred on them, that they can direct it, that they get to make choices.” Creating Indigenous spaces both within Indigenous organizations as well as within non-Indigenous organizations – and having those spaces led by Indigenous people is essential to ensuring patients feel safe when accessing care. Without these spaces being supported and created, we run the risk of Indigenous people continuing to avoid health care due to fear of racism, and then fear of reprisal for reporting the discrimination.

The Truth and Reconciliation Commission of Canada Calls to Action include specific calls to action for Indigenous service providers:

Call to Action 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 priority¹⁰

In addition to supporting and creating Indigenous spaces for health care, it is also important to support an accessible mechanism for reporting harm that patients experience while accessing services. Supporting a mechanism for reporting harm that lies outside of health care institutions itself and instead is within the hands of patients, effectively shifts the burden of complaint making. Within the SafeSpacesNetwork Dr. Lafontaine explained that complaints are always anonymous – unless the complainant would like to be named, experiences are tracked and anonymous follow-up from health systems is available, the system tracks patterns of experiences, allows industry professionals to also share their experiences, and finally, anonymous service users and anonymous industry professionals can validate patterns to ultimately make better decision and support patients in avoiding harm.

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We are assaulted and then we are assaulted again by the system. Indigenous organizations need to be given the capacity to step in, support and advocate for victims. The reason why this is a standard occurrence is because victims do not have the strength or resources to take it where it needs to go.

– Christina Coolidge, Forum Participant

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¹⁰ Truth and Reconciliation Commission of Canada: Calls to Action (2015), p.3, retrieved online
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Hi there-wondering if people who work in Human Resources should be invited to the tables when racism occurs in healthcare. What policies and procedures do they have in place that all staff are to follow when they see and witness racism occurring? Then have an external person look and review these and see if it holds people accountable. In my experience sometimes complaints/ concerns get stopped with the paperwork. Definitions of systemic racism also needs to be in documents so there is no question of not knowing what this means. Meegwetch for sharing your experiences.

– Dee Thomas, Forum Participant

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Conclusion

First and foremost, the NAFC would like to thank our panelists for dedicating their life’s work to contributing to improved health circumstances for Indigenous peoples in Canada. Additionally, we would like to thank our forum participants who participated with respect and provided profound insight regarding their personal experiences as well as those of their loved ones and offered thoughtful recommendations for how we can move forward together. The NAFC knows that we are only one piece of the puzzle in advancing reconciliation and addressing systemic racism in health care. It is our position that hospitals, medical schools, governments, and the health care system as a whole need to make concrete and accountable steps for fundamental changes and to work with Indigenous people to achieve these changes. Only through accountability and system-

wide interventions will we achieve better health outcomes for urban Indigenous populations and improve health outcomes for Indigenous people.

We, as well as the rest of the country, have witnessed the grave consequences of allowing systemic racism to persist unchecked and the results of addressing it in the ways it has been addressed in the past. We support the work that is currently being done within our communities and implore provincial and federal governments to examine that work to witness its efficacy and in turn provide sustainable funding to expand these programs at a national level.

Recommendations

In part, as a result of this forum and our ongoing work, the NAFC believes that to advance work in improving health care outcomes and addressing racism in health care for urban Indigenous people:

1. Implement SafeSpacesNetwork nationally. The NAFC is well positioned to facilitate the role out of this platform to reach Indigenous people directly. This is a simple step to begin tracking and mapping instances of racism and discrimination which would allow us to create policy positions to address the issues. The NAFC has a well-established, reliable network that is poised to achieve this.
2. Implement a national program to fund health navigators placed in Friendship Centres and other urban Indigenous organizations as a harm reduction measure while continuing to work on systemic change.
3. Fund Jordan’s Principle workers to be made available at Friendship Centres and other urban Indigenous organizations nationally. This would support Indigenous families and children in accessing safe health care as well as assist families with navigating the complex jurisdictional landscape when seeking care for their children.
4. Develop a national urban Indigenous health framework to map out a continuity of services for Indigenous people that fully considers their intersectionalities and residencies to ensure that no one is left behind.

All of which is respectfully submitted.