

# **Embedding Indigenous Cultural Safety and Cultural Humility as a Culture of Practice in Health Research Institutions**

by

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## Ethics Statement

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- a. human research ethics approval from the Simon Fraser University Office of Research Ethics

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## **Abstract**

Health inequities between Indigenous people and other Canadians are rooted in colonization and perpetuated by racist and discriminatory health systems and practices. The lack of cultural safety in health care settings is known to block Indigenous people from critical health care and supports. The Truth and Reconciliation Commission's (2015a) Calls to Action #23 and #24 reflect the importance of advancing Indigenous cultural safety and cultural humility in health care systems including research institutions. Through adopting an Indigenous public health perspective centred on an Indigenous historical perspective of health, this capstone project examines the issue of Indigenous cultural safety and humility in a health research institution in British Columbia. Drawing on existing literature and six qualitative interviews, nine strategies to increase Indigenous cultural safety and cultural humility are analyzed against seven evaluative criteria. With the lens that advancing Indigenous self-determination over health and wellbeing including within the health research process is a necessary step for reconciliation and addressing health inequities, recommendations for individual health research institutions are provided along with considerations for policy implementation and next steps.

**Keywords:** Indigenous cultural safety; cultural humility; health research; health policy; Indigenous self-determination; Indigenous Public Health; anti-Indigenous racism.

## **Dedication**

I would like to dedicate this capstone project first and foremost to my children. My children are strong, funny, creative and smart young humans and I am grateful each and every day that their spirits chose me. Their confident claim of their identities as Ktunaxa and Syilx people are inspiring. I am honoured and proud to be their mother each and every single day. I would like to thank you two most of all.

To my fallen Indigenous sisters and brothers, I love each and every one you.

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## List of Acronyms

BC	British Columbia
BCCSU	BC Centre on Substance Use
CEIH	Centre for Excellence in Indigenous Health
CIHR	Canadian Institute of Health Research
FNHA	First Nations Health Authority
FNLC	First Nations Leadership Council
IBPA	Intersectionality-Based Policy Analysis
ICS&CH	Indigenous Cultural Safety and Cultural Humility
IRS	Indian Residential School
IRSSA	Indian Residential Schools Settlement Agreement
OCAP	Ownership, Control, Access, and Possession
PHSA	Provincial Health Service Authority
RCAP	Royal Commission on Aboriginal Peoples
TCPS	Tri-Council Policy Statement
TRC	Truth and Reconciliation Commission
UBC	University of British Columbia
UNDRIP	United Nations Declaration on the Rights of Indigenous People
VCH	Vancouver Coastal Health

## Executive Summary

It is known that Canada was built upon colonization and unequal power dynamics between Indigenous peoples and settler society. For Indigenous peoples in Canada, the legacy of colonialism is embedded in their daily lives, and it is still taking lives. Academics and government-mandated commissions have linked ongoing conditions of chronic inequality, political marginalization, and historical trauma to ongoing health inequities that are embodied by Indigenous peoples and communities. Health inequities between Indigenous people and other Canadians are further perpetuated by racism in the health care system. A lack of cultural safety and humility in health care settings manifests as racist health care experiences and are known to push Indigenous people away from accessing critical health care and supports. Furthermore, the practice of health research is rooted in western ideas of knowledge production and knowing, and frequently constructs Indigenous peoples in ways that create further stigma and marginalization. There is an opportunity for health research institutes to change their orientation and advance cultural safety and cultural humility in the health care systems and structures.

The Truth and Reconciliation Commission's (2015a) Calls to Action #23 and #24 reflect the importance of advancing Indigenous cultural safety and cultural humility in health care systems including research institutions. By adopting an Indigenous public health perspective centred on an Indigenous historical perspective of health, this capstone project examines the issue of Indigenous cultural safety and humility in a health research institution in British Columbia. Drawing on existing literature and six qualitative interviews, this project articulates five key components of cultural safety and humility. The importance of (a) truth telling about colonization; (b) fostering understandings of First Nations perspectives on health and wellness; (c) supporting Indigenous faces, content, and spaces; (d) advancing Indigenous self-determination; and (e) creating mechanisms for long-term self-reflection were all identified as key elements that promote cultural safety and humility.

Nine strategies to increase sustainable levels of Indigenous cultural safety and cultural humility were analyzed against those five criteria, in addition to considerations

related to cost and administrative complexity. Strategies included the following actions: (a) sign the First Nations Health Authority's Declaration of Commitment on Indigenous cultural safety and cultural humility and mandate staff to make a personal pledge to making change; (b) require all current and future staff to complete Indigenous cultural safety and cultural humility training; (c) require all staff and research affiliates to complete Indigenous public health training; (d) establish a senior leadership position for an Indigenous cultural safety and cultural humility lead to oversee all aspect of advancing cultural safety and humility efforts; (e) establish an Indigenous Research Board with power over research involving Indigenous peoples; (f) implement an Indigenous recruitment, hiring, and retention plan; (g) establish an Indigenous strategic partnership protocol agreement to provide a framework for continued collaboration between the health research organization and Indigenous partners; (h) establish a complaints mechanism for Indigenous staff, clients, and partners to provide feedback (positive or constructive) without fear or judgement or reprisal; and (i) integrate Indigenous cultural safety and humility into staff performance evaluation and employee orientation for new staff and research affiliates.

Based on the analysis of options against the evaluative criteria, it was determined that no one option alone addressed the key policy objective. In order to meaningfully advance cultural safety and humility, it is the recommendation of this analysis that all options be implemented in the long run. In the short run, options with the least administrative burden should be prioritized. Namely, having the institution sign the First Nation's Health Authority's (2015b) *Declaration of Commitment* to Indigenous cultural safety and cultural humility (ICS&CH), followed by implementing mandatory ICS&CH training, integrating ICS&CH performance measures into staff evaluations and onboarding, and initiating strategic partnerships with First Nations organizations and communities. Subsequently, an ICS&CH strategic lead should be hired and given adequate authority, oversight, and resources to implement a compressive institutional ICS&CH strategy. This position can then facilitate the development of an Indigenous Research Board and the establishment of Indigenous recruitment, hiring, and retention strategies. Once the Indigenous Research Board is in place, a complaints process can be established with the necessary oversight and enforcement mechanisms. In the long run, the institution should explore opportunities for having staff receive extensive Indigenous public health training. While this would be costly and administratively

complex to implement, this option is best positioned to support non-Indigenous staff and researchers to meaningfully reflect on colonization and how it has contributed to their positions of privilege at the expense of Indigenous peoples.

It is critical to emphasize that cultural safety and humility is an ongoing process and not something that can be achieved with the implementation of any specific or group of policies. While adoption of all the recommended options is expected to result in transformative organizational change, only Indigenous people who interface and interact with the institution can determine when it is culturally safe. It is also critical to emphasize that cultural safety is not a static concept and requires ongoing attention, reflection, resources, and commitment.

It is also important to acknowledge that there are limits to the contributions that individual research institutions can make to advancing cultural safety and humility in health systems and spaces. While it is expected that the recommended policy package will help reduce health inequities between Indigenous and non-Indigenous populations, broader social and structural changes are needed. Self-determination for Indigenous peoples in all areas of their lives is a pressing and necessary condition for health inequities to be fully addressed.

# **Chapter 1. Introduction**

There is an opportunity to influence a transformation in health research practices in British Columbia (BC) and throughout Canada. Although there is a proven capacity for generating quality research that positively influences public policy and clinical care (Barker, Goodman, & DeBeck, 2017; Dooling & Rachlis, 2010; Milloy et al., 2016) these institutions are predominantly non-Indigenous institutions, with few to no Indigenous staff, leadership, or researchers. Research institutions have developed themselves as experts on health issues that disproportionately impact Indigenous communities. These institutions are competing for research funding targeting Indigenous research priorities, thereby risking duplication of research undertaken by Indigenous health researchers and Indigenous organizations. Furthermore, non-Indigenous research institutions and researchers risk perpetuating race-based stereotypes of Indigenous communities, placing Indigenous research participants in unsafe situations (Damon et al., 2017) or harming potential strategic Indigenous partnerships. There is an opportunity for non-Indigenous research institutions to familiarize themselves with Indigenous self-determination and develop mechanisms for increasing internal capacity to carry out health research with a practice of humility.

## **1.1. The Rationale for Indigenous Cultural Safety and Cultural Humility**

For Indigenous peoples in Canada, the legacy of colonialism is embedded in their daily lives, and it is still taking lives (Hadland et al., 2015; Pollock, Mulay, Valcour, & Jong, 2016). Furthermore, racist stereotypes and a colonial narrative of history reinforce non-Indigenous peoples' beliefs that Indigenous people are undeserving of proper health care, culturally appropriate family interventions, or even justice as we have seen with the latest verdicts in the Colten Boushie or Tina Fontaine tragedies. In the context of health, racist health care experiences (Browne et al., 2011; Kurtz, Nyberg, Van Den Tillaart, & Mills, 2008; Levy, Ansara, & Stover, 2013) of Indigenous peoples have been linked to disengagement from care, a delay in care or even no care at all (Goodman et al., 2017). Under the current opioid crises, racist health care experiences and subsequent

disengagement (Goodman et al., 2017) from care is particularly poignant and underscores the urgent need for culturally safe care for Indigenous peoples.

Social, political, economic, and health inequities between Indigenous people and other Canadians are rooted in colonialism and perpetuated by racism. From an Indigenous public health perspective, the colonial foundation of Canada's health care system means that Indigenous people and communities typically do not receive adequate public policy responses to Indigenous public health issues that address colonization, racism or political marginalization, and Indigenous social determinants of health (National Collaborating Centre for Aboriginal Health, n.d.; Smylie, 2013; Willows, Hanley, & Delormier, 2012). In the larger context of truth and reconciliation in Canada, transformation of all parts of Canada's colonial infrastructure are being demanded by Indigenous people across the country (Bellrichard, 2018b; "First Nations Leaders Rally," 2018; National Inquiry into Missing and Murdered Indigenous Women and Girls, n.d.). In BC, transformation of the health care system is underway and Indigenous people and organizations are leading the change.

### **1.1.1. The Embodiment of Inequality**

It has been long established that Canada was built upon colonization and unequal power dynamics between Indigenous peoples and settler society. It is known that Canada systematically set out to destroy the political and social institutions of Indigenous people (Aboriginal Healing Foundation, 2004; Eshet, 2015). Land was seized, communities were moved, and movement of Indigenous peoples was restricted as they were politically marginalized, dehumanized, and pulled into a cash economy in which they were not intended to reap the benefits (Smith, 1993). Canada's colonial legacy are the state structures that continue to oppress Indigenous peoples and perpetuate systemic and administrative violence upon them (Canadian Human Rights Tribunal, 2017; Indian Act, 1985; John, 2017).

It is known that chronic conditions of inequality and trauma wear human bodies down (Reading, 2009). There is significant research on the embodiment of inequality by oppressed and marginalized peoples around the globe (Dussault, 1996a; Fassin, 2003; Howells, Lynn, & Sesepasara, 2017; Zuckerman, 2010); researchers have examined epigenetics and the intergenerational transmission of poor nutrition, lifestyle,



environment, and maternal care on offspring (Aguilar & Halseth, 2015; Human Early Learning Partnership, University of British Columbia, n.d.; Unternaehrer et al., 2015) and have found that childhood trauma was associated with non-fatal overdose (Lake et al., 2015). Research has shown that there is a higher prevalence and incidence of chronic pulmonary disease amongst Indigenous people in comparison to non-Indigenous people (Ospina et al., 2015). A recent study conducted found that although there is an overall lower incidence of cancer for status First Nations people in BC, there was a lower survival rate for most cancers (FNHA, 2017e). Examining the political, social, and economic conditions of stress and trauma in a society points to the unequal distribution of power and control that has been embodied by Indigenous peoples.

### **1.1.2. Health Research, Epistemological Violence and Contributions to Stereotypes**

The practice of health research is rooted in a western perspective of education and knowledge production and given power and preference by a colonial state. Understanding the origin of knowledge and how it is produced is key in advancing culturally safe health research institutes. “Epidemiology” is defined as the study of disease patterns and causes in a population and “biostatistics” as a branch of statistics that applies statistical methods to biological and health research (School of Population and Public Health, University of British Columbia, n.d.). Thomas Teo (2008) from York University describes epistemological violence, in the context of psychology, as the act of interpreting empirical data<sup>1</sup> that constructs the “other” (Indigenous peoples) as problematic, or inferior, with explicit or implicit negative consequences for the “other.” With regards to Indigenous people and communities, this has meant pathologizing individuals and ignoring their current and historical contexts. Problems of speculation and interpretation of data are a known limitation of empirical sciences. Collecting data is at the centre of health research, and how the data are contextualized and given meaning is rooted in a viewpoint that is informed by the researcher’s personal history, biases, assumptions, social location and settler origins thus risking the perpetuation of epistemological violence upon Indigenous people.

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<sup>1</sup> Referring to observations that are valid and reliable (Wilkinson, n.d.).

An outcome of measuring health inequities is that researchers and governments are producing statistical portrayals of Indigenous peoples that reinforce what Natalie Clark (2016b) has termed as the “shock and awe tales” (p. 3) of the lives of Indigenous peoples. A look at any comments section of a news story online (Chapin, 2015; Houpt, 2015; Ombudsman CBC, 2018), social media (“Canada Investigates,” 2018; Paradkar, 2018; Roache, 2018) or even to the comments made by public government officials will attest to the pervasive nature of racist stereotypes among non-Indigenous Canadians (Bellrichard, 2018a; “Sen. Lynn Beyak,” 2018). There is a need to conduct research that does not further the discourse and construction of Indigenous peoples and communities as at-risk, vulnerable, inferior, criminalized or problematic and perpetuate further stigma and marginalization.

In the world of public policy and evidence-based decision making, how evidence is assembled and constructed matters; it is not only deeply political, but also influences the types of problems that are focused on and interventions that are identified and taken to address the issue in question. A shortage of Indigenous researchers with the specialized skill set that health research institutes look for means a gap in the types of solutions that will be identified, and thus a lack of Indigenous knowledge and ways of knowing informing health research and policy.

## **1.2. Indigenous Cultural Safety and Cultural Humility**

In BC, there is a commitment to create a health care environment free of racism and discrimination where Indigenous people feel safe when receiving health care (First Nations Health Authority [FNHA], n.d.-b). The concept of Indigenous cultural safety refers to a practice of fostering a health care climate where health care employees recognize the history of colonization and its impacts on Indigenous people (Provincial Health Services Authority, 2017). Cultural safety is about addressing the power imbalances inherent in the health care system (Gerlach, 2012; Greenwood, Lindsay, King, & Loewen, 2017). Cultural safety is seen as an outcome of encouraging a process of self-reflection among health care professionals and institutions to develop their understanding of personal and systemic biases (Gallagher, 2017). In BC, Indigenous cultural safety training includes the idea of fostering a sense of “humility” and humbly acknowledging oneself as a learner when it comes to understanding another’s experience (FNHA, n.d.-b).

### **1.2.1. Indigenous Cultural Safety and Humility in the Context of the Opioid Crises**

In August 2017, the FNHA (2017c) report of preliminary findings on overdose data and First Nations people in BC found that First Nations peoples are overrepresented in all overdose events and overdose deaths in BC. Experts acknowledge ongoing and historic colonization, trauma, and dispossession of lands and resources as contributing to the impacts of the overdose public health emergency for First Nations peoples in BC (FNHA, 2017d). The report describes “how racism and intergenerational trauma increases risk of problematic substance use and is a barrier to accessing health care services” (FNHA, 2017d, para. 5). Overdose data and reports by BC Coroners Service, BC Centre for Disease Control, BC Ambulance Service and BC Ministry of Health indicate that the Opioid crisis is worsening in BC and echoes an upwards trend that is being reported across the country. The ongoing opioid crises and fentanyl-related overdoses in Canada underscores an already urgent need for a culturally safer health care system for Indigenous people that requires system-wide transformation of all sectors of the health care system. Indigenous cultural safety and cultural humility play an important role in transforming health outcomes for Indigenous people in Canada.

## **1.3. Indigenous Public Health Perspective**

The policy analysis in this capstone adopts an Indigenous public health view centred on an Indigenous historical perspective of health to examine the issue of Indigenous cultural safety and cultural humility in a health research institution in BC. The Indigenous public health perspective in this analysis begins with the premise that racism and colonialism are key social determinants of health that manifest at all levels and processes throughout the health care system.

### **1.3.1. Research Question**

This capstone research project examines the following question: How can a health research institute increase levels of cultural safety and cultural humility within its organization? Although the research question guiding the project is intended to respond to the interests of the BC Centre on Substance Use (BCCSU), the recommendations are

applicable to other health research institutions generating health research that involves Indigenous people. The BCCSU was established in 2017 and receives ongoing operational funding by the Ministry of Health and is housed within Providence Health Care. At this time, BCCSU has not signed formal partnership agreements with FNHA and is in transition to becoming an independent organization and establishing their own human resource policies and information technology infrastructure. BCCSU is interested in examining how their organization might contribute to the advancement of cultural safety and humility within the province.

### **1.3.2. Applied Research**

This capstone project is applied research in that it seeks to answer a question about the contributions that a health research institution can make in advancing Indigenous cultural safety and humility in BC and to solve the real problem that racist health care experiences perpetuate inequitable health outcomes for Indigenous peoples in Canada. Rather than establishing or advancing a theoretical framework and making a contribution to the discipline of public policy, the purpose of this policy analysis is to contribute to real-world change.

### **1.3.3. Key Objective**

This project explores current practices in promoting Indigenous cultural safety and cultural humility (ICS&CH) in BC. The main objective is to identify policies and practices that may contribute to higher sustainable levels of cultural safety and cultural humility within an institution. While recommendations on advancing Indigenous cultural safety and humility are tailored to the BCCSU, findings are relevant for other research institutions in BC and beyond.

## **Chapter 2. Background**

### **2.1. Introduction**

In BC, First Nations<sup>2</sup> have advanced jurisdiction in Indigenous public health in pursuit of their vision for “healthy, self-determining and vibrant BC First Nations children, families and communities” (FNHA, n.d.-h, para. 1). This chapter provides an overview of the drivers and context of Indigenous cultural safety and cultural humility, including BC’s Indigenous health governance model (First Nations Health Council, 2011) and key stakeholder responses to the call for Indigenous cultural safety and humility in BC.

### **2.2. Drivers of Indigenous Cultural Safety and Humility in British Columbia**

#### **2.2.1. The Royal Commission on Aboriginal Peoples**

The Royal Commission on Aboriginal Peoples (RCAP) was established in the wake of the Oka crises in 1991. The Oka crisis is most notable for underscoring racial tensions in Canada as the Mohawk people took a 78-day stand to protect their traditional territory (Koenig & Obomsawin, 1993). The mandate of the commission was to study the evolution of relationship between Indigenous peoples, the Government of Canada and Canadian society as a whole (Library and Archives Canada, 2016).

After extensive research and consultation, the Commission issued a five-volume, 4,000-page report with 440 recommendations and an entire chapter on Canada’s Indian Residential School System in November of 1996 (Hurley & Wherrett, 1999). The report discusses why Indigenous people are entitled to equitable social, educational and health outcomes. The report argues that in the absence of a fundamentally different approach and new policies, the social and economic conditions of Indigenous people would remain more or less the same (Dussault, 1996b, p. 54). Volume three of the report provides comprehensive statistical documentation of the poor health and socioeconomic status of

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<sup>2</sup> “BC First Nations” refers to the First Nations communities whose traditional territories are geographically located in British Columbia.

Indigenous people in Canada and links health inequities to colonialism and the political and economic marginalization of Indigenous peoples.

The Commission raised awareness of the Indian residential school system and the devastating impacts of colonization on the health and wellbeing of Indigenous peoples in Canada. Furthermore, it has provided a benchmark for measuring Canada's progress and commitment on addressing the inequities faced by Indigenous people. While a few of the recommendations have been implemented in the last 20 years,<sup>3</sup> gaps in health outcomes for Indigenous people remain (Troian, 2016).

### **2.2.2. The United Nations Declaration on the Rights of Indigenous Peoples**

The *United Nations Declaration on the Rights of Indigenous People* (UNDRIP; United Nations, 2008) sets the minimum necessary threshold to meet international human rights standards for the treatment of Indigenous peoples. The declaration affirms Indigenous Peoples' basic human rights, including rights to self-determination, language, equality and access to all social and health services without discrimination. Furthermore, in Article 24, UNDRIP affirms that Indigenous peoples have an equal right to enjoyment of the highest attainable standard of physical and mental health (United Nations, 2008, p. 29). Although UNDRIP is not a legally binding instrument under international law, it underscores the need to address the political marginalization and oppression of Indigenous peoples by advancing their self-determination in all matters that affect their lives. UNDRIP was adopted by the General Assembly in September 2007 by a majority of 144 states in favour. Under the Harper Government, Canada was one of four countries that voted against UNDRIP signalling that Canada is a deeply entrenched colonial state unwilling to give up real or symbolic power to Indigenous people.

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<sup>3</sup> For example, the creation of the Truth and Reconciliation Commission, establishment of funding dedicated to healing from the residential school era, and the replacement of the Ministry of Indigenous and Northern Affairs with two departments responsible for implementing a new relationship with Canada and the other to provide services for non-self-governing communities in August 2017 (Government of Canada, 2018).

### **2.2.3. Truth and Reconciliation Commission of Canada Calls to Action**

The Truth and Reconciliation Commission of Canada (TRC) was established in 2008 under the Indian Residential Schools Settlement Agreement (IRSSA)<sup>4</sup> and was completed in 2015. The core functions of their mandate were to; research and document historical records; witness and preserve the experiences of Indian residential school (IRS) survivors; promote awareness and public education of Canadians about the IRS system and legacy; produce and submit a report including recommendations to the Government of Canada; and support commemoration of IRS students and families (TRC, n.d.; Resident Schools Settlement, n.d.).

In June 2015, the TRC (2015a) released their final report in a ceremony that included a speech from Chair Murray Sinclair who called on Canada to implement UNDRIP as a way to begin reconciliation. The report called for action in the areas of child welfare, education, language and culture, health, and justice to address the legacy of the IRS system (TRC, 2015a). Following the release, a private member's bill from New Democratic Party Member of Parliament Romeo Saganash calling on Prime Minister Harper to implement the UNDRIP was voted down by Conservative MPs ("PM Harper," 2015). At the time, National News reported Prime Minister Harper had stated that UNDRIP was "aspirational" and that signing onto UNDRIP was not necessary because Indigenous rights were already recognized in the constitution ("PM Harper," 2015).

Much like RCAP, the TRC (2015a) documented historical and colonial injustices and then linked ongoing social, education and health inequities of Indigenous peoples to their political marginalization. The TRC adopted UNDRIP as a framework (TRC, 2015b) for reconciliation between Indigenous and non-Indigenous Canada at all levels and across all sectors of Canadian society thereby affirming the stance that self-determination and equitable power dynamics between Indigenous people and Canada are key drivers for social change. After nearly a decade, Canada officially removed its

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<sup>4</sup> The Truth and Reconciliation Commission of Canada is one component of the Indian Residential Schools Settlement Agreement (IRSSA). The IRSSA is an agreement between the Government of Canada and approximately 86,000 Indigenous people who had attended the Canadian Indian residential school system between 1879 and 1996. The IRSSA compensation package included the Common Experience Payment, Independent Assessment Process, the TRC, commemoration, and health and healing services.

objector status to UNDRIP in May 2016 under Prime Minister Trudeau and is now a full supporter of the declaration, without qualification.

In the BC context, TRC (2015a) Calls to Action #23 and #24<sup>5</sup> have prompted the Centre for Excellence in Indigenous Health (CEIH) in partnership with the University of British Columbia (UBC) to bring forward the *2324 Indigenous Cultural Safety Interdisciplinary Learning Experience* (UBC, n.d., 2017a). The course targets students training for professions in health sciences. The course is delivered through a combination of online training and in-person workshops with plans to implement this as a mandatory course in all twelve-health science programs at UBC beginning Fall 2018. Training module topics include: tenets of cultural safety; Indigenous perspectives of history; social determinants of health; and health outcomes (UBC, 2017b).

### **2.3. Indigenous Health Governance in British Columbia**

Researchers have measured health inequities between Indigenous people and other Canadians, and tripartite and bilateral agreements have been signed between Indigenous leadership and levels of government to address those health inequities. In 2005, the “Kelowna Accord” (Patterson, 2006, p. 1), a series of agreements between Indigenous leadership, federal government, and the provinces and territories, produced a 10-year plan to “close the gap” (p. 1) between Indigenous and non-Indigenous Canadians. While the Accord stagnated soon after due to the incoming Harper Government failing to honour the agreement, it continued to move forward in BC.

In 2005, BC First Nations came together to achieve progress on title and rights and developed the *Leadership Accord* (Assembly of First Nations BC Region, First Nations Summit, & Union of British Columbia Indian Chiefs, 2005) affirming mutual respect and political unity thus establishing the First Nations Leadership Council (FNLC) in BC. The FNLC represented BC First Nations during the Kelowna Accord and agreed to a new relationship with the Province of BC to begin addressing the health and socioeconomic gaps, which existed for BC First Nations. The new relationship

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<sup>5</sup> Call to action #23 called “on 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 and provide cultural competency training for all health care professionals” (TRC, 2015a, p. 7).

Call to action #24 called upon “medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues” (TRC, 2015a, p. 7).



established common ground between BC First Nations and set the stage for a series of agreements with the Province and the Federal government that have resulted in the advancement of First Nations jurisdiction in health care planning, administration and governance that is the first of its kind in Canada (Assembly of First Nations BC Region et al., 2005).

This model of Indigenous health governance consists of four components: the First Nations Health Council advocating and supporting BC First Nations; the FNHA which assumed responsibility for federal health services previously delivered by the First Nations and Inuit Health Branch Western Region in 2013; the First Nations Health Directorates Association advising on FNHA policy direction and service delivery models; and the Tripartite Committee on First Nations Health responsible for enacting system change and developing a reciprocal accountability framework (First Nations Health Council, 2011, pp. 24–30). The FNHA is now responsible for planning, management, service delivery and funding of health programs, in partnership with First Nations communities in BC (FNHA, n.d.-a).

In November 2006, the Province of BC and the FNLC released the *Transformative Change Accord: First Nations Health Plan* (British Columbia Assembly of First Nations, First Nations Summit, Union of British Columbia Indian Chiefs, & Government of British Columbia, 2006), which included a requirement to increase cultural competency with health authorities (p. 10). In response to the need for culturally safe health care the Provincial Health Service Authority (PHSA) Indigenous Health program created and launched the *San'yas Indigenous Cultural Safety Training* (n.d.) certificate in 2010, another first of its kind in Canada (PHSA, 2017). San'yas online training attracts health care professionals who are already working in the health care system.

### **2.3.1. First Nations Health Authority: The Declaration of Commitment to Advancing Cultural Safety and Humility in BC and Partnership Building**

The FNHA is achieving progress in addressing the conflict between cultural ways of living and systemic policies through its partnerships. In 2014, they signed a Memorandum of Understanding with BC Coroners Service that resulted in a change in

policy for infant deaths (FNHA, 2014). FNHA has made a call for cultural safety in BC and in July 2015 provincial health leaders in BC including the (FNHA), the BC Ministry of Health, PHSA, and the five regional health authorities in BC signed the *Declaration of Commitment* (FNHA, 2015b). On March 1, 2017, all 23 health regulatory bodies in BC made a commitment to a safer health care system for First Nations and Indigenous people and also signed onto the declaration (College of Pharmacists of British Columbia, n.d.; FNHA, 2017a). Representatives of the regulatory bodies came together with the FNHA to participate in a Blanket Ceremony to honour the commitments made by the 23 partners and to begin cultural safety work in a good way (College of Chiropractors of British Columbia, n.d.). In September 2017, Providence Health Care, one of the largest Catholic health care organizations in Canada, also began a new partnership with the FNHA and signed the declaration (FNHA, 2017b).

The *Declaration of Commitment* on advancing cultural humility and cultural safety within health services includes three components; creating a climate for change; engage & enable stakeholders; and implement and sustain change (FNHA, 2015b). Accompanying the Declaration is the *#itstartswithme* campaign where individuals can make a personal pledge to make a difference and upload those to the FNHA (2016) website. The FNHA has developed a suite of resources and ideas for change to support their partners' commitments including the FNHA (n.d.-f) *Policy Statement on Cultural Safety and Humility* with recommendations that are applicable to partners; a series of twelve webinars that are available online at no cost (FNHA, n.d.-f); and two resource books on creating a climate for change and outlining key drivers and ideas for change (FNHA, n.d.-c, 2015a).

### **2.3.2 FNHA Policy Statement on Cultural Safety and Humility**

The *Policy Statement on Cultural Safety and Humility* developed by the FNHA (n.d.-f) outlines their position and views of cultural safety and humility and offers key recommendations to advance culturally safe health care systems. Recommendations include providing cultural safety and humility training, developing cultural safety policies and frameworks within organizations, establishing complaints processes and evaluation, integrating cultural safety into human resources policies and decisions, establishing physical environments that are culturally safe, establishing change in leadership approaches, and building meaningful partnerships with First Nations communities.

## 2.4. Research Ethics as an Insufficient Mechanism for Cultural Safety and Humility

Although there are guidelines in place for “ethical” research with Indigenous populations, it is not enough to assure cultural safety. There is clear power and influence inherent in health research institutions that are funding or conducting research. The Canadian Institute of Health Research (CIHR), Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada (2014) are the three federal research funding agencies guiding the ethical standards of conduct in research through the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS) since 1998. The granting agencies were created by Acts of Parliament, which define the areas of research funded by each agency and tasked with distributing research funding allocated by the Government of Canada. These funding agencies influence trends in health research topics and research practices through its funding mechanisms or establishment of research funding priority areas (Government of Canada, 2016). Acknowledging that research involving Indigenous peoples has typically been carried out by non-Indigenous researchers, the CIHR established the Aboriginal Ethics Working Group in 2004. The Aboriginal Ethics Working Group was tasked with drafting the *CIHR Guidelines for Health Research Involving Aboriginal People* (CIHR, 2013b). The guidelines were developed collaboratively and through consultations with Indigenous communities, researchers and members of research ethics boards provided feedback on the draft guidelines. In 2010, the guidelines contributed to the revised TCPS commonly referred to as TCPS2 (Panel on Research Ethics, 2018), which includes an entire chapter (Chapter 9) devoted to research involving Indigenous people. Respect for human dignity is a central value of the TCPS requiring “that research involving humans be conducted in a manner that is sensitive to the inherent worth of all human beings and the respect and consideration that they are due” (CIHR et al., 2014, p. 6). Respect for human dignity is expressed in the TCPS through three core principles: respect for persons, concern for welfare, and justice.

In “Policy Writing as Dialogue: Drafting an Aboriginal Chapter for Canada’s Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans,” Castellano and Reading (2010) argue that writing policy that applies to First Nation, Inuit and Métis peoples in Canada the necessity of engaging the affected population becomes central to

the undertaking. The article “reflects on the process of developing policy on research ethics from the perspective of authors of First Nation origin who are committed to enhancing the agency of Aboriginal peoples in processes that affect them” (Castellano & Reading, 2010, p. 2). Beginning with the launch of RCAP in 1992, the article provides an overview of the development of Indigenous research ethics in Canada leading up to the revision of TCPS and how they have informed chapter 9 TCPS2.

The CIHR (2017b) has developed the *Action Plan: Building a Healthier Future for First Nations, Inuit, and Métis*, which provides a roadmap of concrete actions to strengthen Indigenous health research in Canada. One of the actions commits to increasing its investments in Indigenous health research to a minimum of 4.6% (proportional to Canada’s Indigenous population) of CIHR’s (2017a) annual budget (amounting to \$46,000,000). While efforts have been made to improve research practices through the development of research ethics guidelines for research involving Indigenous populations, they are insufficient mechanisms for ensuring cultural safety and cultural humility.

## **Chapter 3. Methodology**

The study uses qualitative analysis to identify and understand how ICS&CH training facilitators and strategic leaders are working to advance such practices in their institutions. Knowledge sharing interviews are critical for informing the development of the policy evaluation framework and policy interventions that have the greatest potential to advance ICS&CH in a health research institution.

### **3.1. Knowledge Sharing Interviews**

Knowledge sharing interviews inform the development of strategies and an evaluation framework for potential strategies that assess the likeliness of each strategy to meet the key objective of this research study. During the period of January 31, 2018, to February 16, 2018, six semi-structured interviews with key staff working to advance ICS&CH were interviewed at the following organizations: the UBC CEIH; Vancouver Coastal Health (VCH); BC Ministry of Children and Family Development; Mount Pleasant Neighbourhood House, Vancouver; and the BCCSU. There were no criteria for exclusion. Interviews were 45 to 90 minutes in length, although a few exceeded this time.

The main research instrument was a qualitative interview guide. All interviews were digitally recorded, and transcribed and qualitative analysis was undertaken to identify themes emerging from the interviews. Audio files were transferred and stored on a password-protected computer and deleted from the recording device. An inductive approach to qualitative research and coding was based on themes emerging from the study of interview data. The Principal Investigator summarized data using themes that arose from the data in order to gain an understanding of the data. Themes arising from interviews inform the identification of measurement criteria for evaluating strategy outcomes, as well as inform identification of policies and practices that increase levels of ICS&CH within an organization.

## **3.2. Recruitment Methods**

Online research provided a preliminary identification of potential participants. Interviewees from government, university and non-profit organizations were approached using contact information that was readily available to the public. Referrals were also provided by key contacts.

As part of the informed consent process, participants were apprised that participation in the study was entirely voluntary and that they may withdraw from the study at any time in the research process. One participant requested to be given the opportunity to review how the interview data would be used prior to consenting to its inclusion in the capstone. No minors or captive populations were included in interviews.

## **Chapter 4. Results**

### **4.1. Key Themes Arising from Semi-structured Interviews**

The intent of the knowledge sharing interviews was to identify and evaluate policies and practices that contribute to higher sustainable levels of ICS&CH. The majority of the experiences shared by participants offer valuable insight into what constitutes sustainable cultural safety and humility training practices. The following themes emerged from the interviews and point towards common elements of ICS&CH that are developing in health care systems, universities, and government. To ensure participant anonymity, the codes Participant 01 through to Participant 06 are used to cite excerpts and quotes from interviews.

One limitation of this study is that findings reflect the experiences of Indigenous professionals who are working to advance ICS&CH within organizations in the Greater Vancouver area with the exception of one person who lives on Vancouver Island. The findings do not necessarily reflect the experiences and perspectives of Indigenous peoples working to advance ICS&CH elsewhere.

#### **4.1.1. “It’s about merging the heart and the head”: Confronting white privilege and coming to terms with settler identities**

Individuals shared their preference for shifting the focus away from Indigenous people and towards the training participants self-awareness of their own biases and the origins of their assumptions and privilege. This was seen as a way of addressing the history of colonization and encouraging non-Indigenous people to come to terms with settler identities. This was central to the process of encouraging cultural humility and acknowledging oneself as a learner:

You have to have a fuller understanding of the impacts of colonization and how they’re showing up today even though people think things are past, and how it is still going on today, and then how you sit with that injustice ... the humility piece is really being aware of self ... i.e. How am I bringing my awareness that my social work background in itself carries power and how has that power been used

in a negative way with Indigenous people for a long time. Am I working with that tension? I'm a nice person. I'm a good person. I'm doing good work and I also have this education that's been supported for hundreds of years.... To me that humility piece is knowing the tension, feeling that and being conscious of it and not ignoring it or pretending that it's not relevant. I could say "Oh, no. I'm not a social worker. I'm a therapist," which would be a blind spot. It would be me pretending that it's not a bias that I bring in. It's a piece of my identity [and social work]. (Participant 01)

Cultural humility requires a practice of self-reflection beginning with self-awareness at one's own social historical and geographical location. Shifting away from an Indigenous focus and making the training participant focused was a practice intended to prepare participants before delving into the history component of the training:

Before we even get into the history, they'll hopefully be self-reflective and know what they're bringing into the learning and have an examination of what their understanding is and where they may have gotten their information and their understandings about Indigenous people from. (Participant 02)

#### **4.1.2. "Making sure that the people who are leading are Indigenous": building culturally safe environments**

Through the knowledge sharing interviews, many participants identified that staff who were involved in cultural safety and humility training were Indigenous and their capacity to undertake this work was enhanced by their lived experience and identities as Indigenous people. One Indigenous community developer acknowledged that, in Vancouver, it is widespread that non-Indigenous organizations are trying hard to figure things out and determine the best way to do it. There was a sense that "there are lots of complications when it comes to that because there are a lot of people kind of racing to the front to be the ones that are leading this" (Participant 03).

Given the emotional nature of their work, a number of participants described the importance of having Indigenous colleagues when facilitating ICS&CH training. For example, teaching colonial history to non-Indigenous people is emotionally challenging work for both the Indigenous trainer and training participants and the presence of



Indigenous teams of people engaging in the work is an element of safety. “This work carries so much weight, we keep each other’s spirits up” (Participant 02).

The experience of cultural safety for facilitators and those engaged in the advancement of ICS&CH was foundational to their achievements. Interview participants reported the importance of the presence of Indigenous leaders, coworkers and Elders in providing a circle of support around their work. “I feel that it is very real and alive in my body, that feeling of, we know who we are” (Participant 04).

This same participant further described her initial experience with VCH, noting how her sense of safety increased when Indigenous leadership and staff came onboard:

I would not come here to Aboriginal Health for VCH because all of the Aboriginal Leads were non-Aboriginal except for one. I responded to that one lovely person all of the time with all of their requests, but, I didn’t feel personally comfortable in becoming part of a team that most.... How can you be a leader in Aboriginal Health when you are not Aboriginal? So, I resisted.... And then we had this beautiful person come in as the Executive Lead. (Participant 04)

#### **4.1.3. “It’s an Indigenous approach to be very careful about how we affect other people’s spirits”: Indigenous cultural safety for Indigenous trainers and leaders**

The importance of creating welcoming environments arose as a key element of safety for Indigenous facilitators, elders and community members. One participant who is an Indigenous Elder had this to say:

They opened up the new mental health building on the North Shore called the Oak Centre and they have the Carlyle Centre within that, which takes our youth. That entire team took [ICS&CH training] and they really took ownership of it and they welcomed us, Elders, to come. For us Elders, when I go into many of those places that have no idea what Indigenous cultural safety is, I have to do the education myself where I go. And it takes a lot of energy, a lot of strength away from me. When I go to Carlyle Centre I know I am going to be take care of and respected as Elder, as an Indigenous Knowledge Keeper. That they have respect

in place because they committed themselves to that training and own it.  
(Participant 4)

#### **4.1.4. “We are going to be human together in this”: Heart-centred work and lifelong learning**

One ICS&CH facilitator shared how she sees her work in facilitation as trying to get participants to embody ICS&CH as a way to live in their work environment. For her, ICS&CH training is about body knowledge and encouraging a practice of self-reflection. By encouraging training participants to embody ICS&CH, they are taught to listen to their body signal opportunities for implementing their ICS&CH training. Her work is about merging the heart and the head, and the lifelong practice of self-reflection is viewed as integral practice for encouraging the embodiment of ICS&CH training.

ICS [Indigenous cultural safety] work isn't necessarily about making better doctors and nurses or social workers or healthcare professionals. It's all about being human. How are we going to be human together in this, so that we can see that it's not ok and make change. (Participant 01)

This same participant further states, “It's about body knowledge and a lot of the things that I'm trying to access is helping them anchor it into their system” (Participant 01).

Cultural humility “is about paying attention to being a lifelong learner” (Participant 06). ICS&CH training was viewed by another participant as providing foundational learning with the onus on participants to discover how they can put ICS&CH into practice in their professional work:

Facilitating has always been something that I've been drawn to and what my experience has been prior to coming here. When I came in, I asked myself “How do we make this a sustainable practice?” I think of it more as ceremony for us facilitators because what was happening was that it was very depleting to go out working with non-Indigenous people, trying to “educate” them and I hate that. That's not what we're doing. That's not what I hope we were doing, that's not the intention behind what we were doing. I really want to engage with people in more of a humanness experience. So, my human meets their human because I know we're all good people and I know of health care professionals, the very least want

to do good work. We do. So how do we give people the information so that they can enliven that for themselves in their practice? Not that I'm going to educate them and tell them how to do it, right? That's not my job. Their job is to figure that piece out. *My job is to help them engage with their compassion* [emphasis added], so that they can show up to figure out what that would look like for their practice. (Participant 01)

#### **4.1.5. “It’s important that Indigenous people are celebrated before they are analyzed”: Cultural appreciation & how history is taught— Indigenous historical perspectives and resisting the deficit approach to teaching history**

The idea of cultural appreciation and the value that is placed on *how* the history of colonization is taught was another theme that emerged in interviews. Participant 03 states, “Before [Indigenous people] are being labelled I think they should be celebrated for their history and their position in this place and that the [Indigenous] people are on their land, even if they are not in their own territory.”

A deficit approach to teaching history was viewed as pathologizing Indigenous people and communities and believed to reinforce cultural stereotypes that fuel ideas of racism: “The history is important but appreciation and developing an appreciation for Indigenous people is far more important” (Participant 03). This participant noted that in her work she uses art and technology as a medium for teaching Indigenous knowledge and encouraging cultural appreciation relying on principles founded on Indigenous values (Participant 03).<sup>6</sup>

The idea is that ICS&CH is more than just providing training. It needs to be coupled with an experience of Indigenous culture to deepen an understanding of what it means to be Indigenous and getting people to feel something that is not attached to that idea of history that makes people feel sad *for* Indigenous people. “It’s really frustrating that a lot of people still kind of look at us with puppy dog eyes because they feel sad for our history” (Participant 03).

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<sup>6</sup> The participant referenced the *Sixteen Guiding Principles for Creating a Sustainable and Harmonious World* developed by the Four Worlds International Institute (Lane, 2018).

A strength-based, or appreciation-based approach was believed to focus on how Indigenous communities were thriving prior to colonization and highlighted invaluable knowledge that could be shared today (i.e., plant technology, art). Focusing on the resiliency of Indigenous peoples today is another example of a strength-based approach that arose in knowledge sharing interviews. Indigenous historical perspectives of health began with stories of how strong and healthy Indigenous peoples were for thousands of years before colonization. This point was made through stories focused on resiliency and of how Indigenous people resisted systematic cultural genocidal government policies and hung on to many cultural teachings, knowledge, and ways of knowing.

#### **4.1.6. “You can only lead people as far as you have gone”: ICS&CH is modelled by leadership**

Interview participants described their ideas of what an organization that is acceptable enough to receive Indigenous people looks like, characteristics included: non-judgement, acceptance, compassion and a commitment to developing a foundational knowledge and appreciation for Indigenous people. Participant 03 discussed what she saw as “missed-understandings” that arise when researchers do not have foundational knowledge and appreciation for Indigenous people:

I think they come from a place of looking at Indigenous people as a deficit, something’s wrong, and they are supposed to be helping them.... It takes a long time for a person to build their foundation of capacity to have a good understanding of the historical context of what Indigenous people have gone through.... It’s really the leadership that has to ingrain in themselves a really strong foundation of understanding before they can pass that on to anyone else. ... If they don’t have that, how are they supposed to hand down knowledge to their Directors, Managers, Coordinators, Leaders, Programmers and front-line staff to ensure that they feel supported when they are serving Indigenous people.  
(Participant 03)

I think it takes time to example that you are doing it in a respectful way and that you build rapport with the community. I think it’s the Leadership that can really hand that down, that proper practice. That is not easy to do because to conduct yourself in a way that is respectful to Indigenous culture you have to go outside

of what is normal for you, which is learning all of our customs (i.e., like Elders go first, or even native humour) and understanding them. (Participant 03)

## **Chapter 5. Policy Criteria**

Based on background documents and findings from the knowledge sharing interviews, a set of seven criteria are identified and used to evaluate the potential strategies. The key objective in this policy analysis framework is to assess to what extent potential strategies are expected to increase sustainable levels of ICS&CH within a health research institution.

### **5.1. Philosophical Limitations of Policy Analysis Framework**

A typical chapter in a capstone policy analysis includes a section outlining how the policy analyst determines an appropriate response to the “policy problem” (or in this case, the policy opportunity) by evaluating a range of potential strategies against a set of evaluative criteria. The specifications of each criterion are usually presented along with their corresponding units of measure.

Bardach (2012), in *A Practical Guide for Policy Analysis*, states, “Of course, the most important evaluative criterion is whether or not the projected outcome will solve the policy problem to an acceptable degree” (p. 32). Bardach takes the position that by thinking of a policy story as having two inter-connected but separable plotlines, the analytic and the evaluative, subjectivity and social philosophy have freer play on whether we think a policy alternative is “good” or “bad” for the world. For Bardach, it is at this stage in the policy analysis that we are able to introduce societal values and philosophy.

The topic of inquiry in this capstone project is premised on the concept that Indigenous people get to decide if something or someone is “culturally safe” and furthermore, that a sense of cultural safety is firmly rooted in an Indigenous worldview and perspective on health and wellness. From this position, governments or agencies does not get to declare that they are now a “culturally safe” organization, Indigenous people will decide and tell them. There is tension between the holistic perspectives of Indigenous worldviews and the very practice of Bardach’s (2012) approach to policy analysis that requires the analyst to select, separate, and assess individual policy approaches and pit them against one another and identify the strategy that best stands

out and meets the policy objective. Of course, there is room in Bardach's framework to select a menu of strategies for a multi-pronged policy approach.

As a Ktunaxa policy analyst, I feel the limitations of Bardach's (2012) perspective of policy analysis. I am unsure how a policy analyst can meaningfully embed Indigenous values and philosophy within Bardach's policy analysis when the analytical framework feels reductionist and inherently rooted in a colonial worldview. I am curious about whether a non-Indigenous policy analyst can meaningfully "indigenize" a policy analysis framework? In spite of what I feel are philosophical limitations of Bardach's approach to policy analysis, this chapter outlines seven evaluative criteria that are subsequently applied to estimate the projected outcomes of potential policy approaches. This work is undertaken with the intention of injecting Indigenous values into Bardach's policy analysis framework.

## **5.2. Truth-Telling About Colonization**

As highlighted in the knowledge sharing interviews, ensuring that non-Indigenous staff in health research institutions understand colonization and their role as settlers is a critical foundation for ICS&CH. This criterion was conceptualized to evaluate whether the potential strategy increases awareness of the legacy of colonialism residing in current-day policies, practices, beliefs, and attitudes amongst non-Indigenous members of the health research institution, relative to other strategies. It also includes the extent to which a strategy facilitates non-Indigenous peoples to understand their role in colonization and how colonization has set up systems and structures that privilege settlers at the expense of Indigenous people. The rating scale is "high," "medium," or "low." A low score reflects that the strategy does not increase awareness amongst non-Indigenous staff and affiliates of the research institution, while a high score reflects that the strategy does. A score of low/med reflects that the strategy performs better than options rated low but not as well as options rated medium. Answers to the following questions guide the evaluation.

- Does the strategy increase non-Indigenous members' awareness of and centre Indigenous historical perspectives?
- Does the strategy increase awareness of the legacy of colonialism and its impacts amongst non-Indigenous members of the health research institution?

- Does the strategy support non-Indigenous peoples understanding of their role as Settlers and how colonization has benefited them and fostered their white privilege?

### **5.3. Fostering Understanding of First Nations Perspectives on Health and Wellness**

The concepts of cultural safety and cultural humility are rooted in a First Nations perspective of health and wellness. Before outlining this criterion, a brief comment on the importance of holistic perspectives on health and wellness and the importance of non-Indigenous peoples knowing about those perspectives is necessary. As suggested in the knowledge sharing interviews, cultural appreciation for First Nations perspectives on health and wellness by non-Indigenous peoples is expected to contribute to a higher perceived sense of cultural safety by Indigenous peoples. Closing the gap in health disparities and achieving optimal health and well-being of Indigenous peoples requires a health system that is inclusive and respectful of Indigenous perspectives of health and wellness. Fostering non-Indigenous peoples understanding of Indigenous perspectives on health and wellness is a key element in achieving an inclusive health care system that is culturally safe for Indigenous peoples.

This criterion considers the extent to which a strategy increases understanding and respect for First Nations worldviews and perspectives on health and wellness among non-Indigenous people in the health research institution, relative to the other strategies. The more that non-Indigenous people in the organization are aware of First Nations perspectives on health and wellness that in turn increases or fosters an environment more conducive to cultural safety for Indigenous people. This criterion does not evaluate whether a strategy is believed to encompass a First Nations perspective on health and wellness or if a strategy is believed to be “holistic.” The unit of measurement is based on whether Elders and Indigenous knowledge holders are involved in the strategy and are well positioned to share perspectives on health and wellness on key issues to the organization. The greater the extent, the greater the likelihood that non-Indigenous people will learn about Indigenous worldviews. The rating scale is “high,” “medium,” or “low.” A low score reflects that the strategy does not foster an understanding of First Nations perspectives on health and wellness relative to other strategies. A high score means that the strategies fosters an understanding among the



greatest estimated number of non-Indigenous staff and affiliates within the health research institution relative to other strategies. A score of 'low/med' reflects that the strategy performs better than options rated low but not as well as options rated medium. Similarly, a score of med/high reflects that the option performs better than options rated medium, but not as well as option rated high. The following questions help guide the evaluation for this criterion:

- To what extent does the strategy make space and room for Elder and Knowledge Holder involvement? Is there a mechanism in place to support that?
- Does the strategy create space for the knowledge of language, traditions, culture, and medicine that is passed down by Elders and Indigenous Knowledge Holders? To what extent are Indigenous practices integrated into the organization (i.e., administratively, research theories, and methods)?

#### **5.4. Indigenous Faces, Content, and Spaces**

One of the key themes that emerged from the knowledge sharing interviews was the importance of having Indigenous people lead ICS&CH efforts. Similar to this sentiment, cultural safety is supported when Indigenous people enter an organization and see that the staff include Indigenous people, content that the organization develops includes and reflects Indigenous materials, and spaces reflect Indigenous cultural practices. This criterion evaluates whether the strategy supports the inclusion of Indigenous faces, content, and spaces in the health research institution, as these are expected to support the perception of culturally safety by Indigenous peoples. It is important to emphasize that cultural safety is an evaluation that is solely determined by the experience and perspectives of Indigenous peoples. The criterion does not evaluate the perceived potential levels of safety by Indigenous peoples in the BC health care system or working within the organization. Rather, this criterion evaluates whether a strategy may potentially establish elements of safety that might increase an Indigenous individual's perceived sense of cultural safety. This criterion assesses a strategy, relative to the other strategies, for its likeliness to establish the following elements that are considered necessary (but not sufficient) elements of cultural safety:

- An increase in the number of Indigenous employees and research scientists in the health research institution.
- The extent to which Indigenous practices and Indigenized content is embedded into the organization's policies and practices.
- The institution's use of Indigenous spaces.

If a strategy is expected to establish an element of safety under a specific strategy then it is given a rating of "high," "medium," or "low." A low score means that the strategy does not meet the elements of this criterion, while a high score means the strategy performs well on this criterion relative to other strategies.

## **5.5. Long-Term Process of Self-Reflection**

The concept of cultural humility is founded on the notion of self-reflection and acknowledging oneself as a learner in ICS&CH. The criterion evaluates whether the strategy puts a tool or mechanism in place to foster and sustain a practice of personal and organizational self-reflection within the health research institution. This criterion does not attempt to evaluate potential increases in a sense of cultural humility among non-Indigenous employees. The unit of measurement is based on "high," "medium," or "low" and scoring is assessed on how well a strategy meets this criterion relative to the other strategies. A low score reflects that the strategy does not provide a mechanism to encourage the development of self-reflective practices by non-Indigenous employees or the organization. A high score reflects that the strategy provides a mechanism and increases both employee and organizational practices to a greater degree relative to other strategies, while a low score reflects that the strategies does not.

The following questions guide the evaluation of each strategy:

- Does the strategy entail a mechanism for reflexive organizational practices and procedures?
- Does the strategy foster a climate for self-reflective employee practices amongst non-Indigenous members of the health research institution?

## 5.6. Indigenous Self-Determination

“If it’s true that we have been researched to death, maybe it’s time we started researching ourselves back to life” (RCAP, Aboriginal Researchers Workshop Facilitator, personal communication, September 24, 1992).

The stark reality is that research has been used as an instrument of oppression, imperialism and colonialism over Indigenous peoples. Furthermore, health inequities between Indigenous peoples and other Canadians are rooted in the unequal power dynamics that have been sustained since colonialism through present day systems of oppression (a few examples include the Indian Act, the criminal justice system, child welfare system, health care system).

In light of this, Indigenous peoples are steadily advancing jurisdictional control over data collection processes in their communities and asserting their Ownership, Control, Access and Possession (OCAP) over research and how their information is used. OCAP principles (First Nations Centre, 2015; First Nations Information Governance Centre, n.d.) have influenced Indigenous (Assembly of First Nations, 2009; FNHA, n.d.-d, n.d.-g) and non-Indigenous organizations (CIHR, 2013a, 2015; Indigenous People’s Health Research Centre, 2005), Indigenous communities (Nuu-chah-nulth Tribal Council Research Ethics Committee, 2008) and academics (Schnarch, 2004) in Canada alike in discussions and development of protocols for advancing Indigenous self-determination in the research process. Indigenous research and research protocols centre sovereignty and self-determination within frameworks for conducting ethical Indigenous research that emphasizes Indigenous research priorities (Assembly of First Nations, 2009; Donald, 2012; Kovach, 2009; Smith, 1999). Instead of research on and about Indigenous peoples, the criterion evaluates strategies for bringing about research by and for Indigenous peoples.

In this policy analysis, Indigenous self-determination is a key criterion for evaluation of potential strategies. This criterion evaluates strategies for their likeliness to promote strategies that support and promote Indigenous research ethics and advance Indigenous self-determination. Questions guiding the evaluation of strategies include:

- Does the strategy include a mechanism that promotes Indigenous research ethics?

- Does the strategy include a mechanism that advances Indigenous self-determination and instills accountability of researchers?

The unit of measurement is based on a score of “high,” “medium,” or “low.” A low score reflects that there is no mechanism in place at all and a high score reflects that the strategy includes a clear mechanism that supports Indigenous research ethics and self-determination.

## **5.7. Cost to Organization**

This criterion evaluates the cost of implementing a strategy relative to the other strategies available. The unit of measurement is based on a score of “high,” “medium,” or “low.” A low score reflects that there is an estimated high cost of the strategy relative to other strategies and a high score reflects that the strategy is relatively low cost relative to other strategies. Scores are based on estimating total resources needed to implement the strategy (honorariums, food, meeting spaces, event coordination, staff hours, cost of training, etc.) relative to other strategies.

## **5.8. Administrative Complexity**

This criterion considers the logistical aspects of implementing a strategy and includes a consideration of the complexity that is required to implement the strategy, relative to other strategies. The unit of measurement is based on “high,” “medium,” or “low.” A low score reflects the strategy is highly complicated relative to other strategies, while a high score reflects that the strategy is less complex relative to the other strategies. This criterion identifies less complex strategies that can be implemented quicker than other strategies. Complexity is assessed by estimating the total logistical coordination that is needed to implement the strategy relative to the other strategies.

**Table 5.1. Summary of policy criteria and measurements**

Criteria	Components of Criteria	Measure
Truth Telling about Colonization	<ul style="list-style-type: none"> <li>→ Awareness of Indigenous historical perspectives</li> <li>→ Awareness of the legacy of colonialism</li> <li>→ Recognition of Settler Identity and White Privilege</li> </ul>	High Medium Low
Fostering Understanding of First Nations Perspectives on Health and Wellness	<ul style="list-style-type: none"> <li>→ Extent of Elder and Knowledge Holder involvement</li> <li>→ Extent that Indigenous knowledge and practice is integrated into the organization</li> </ul>	High Medium Low
Indigenous Faces, Content, and Spaces	<ul style="list-style-type: none"> <li>→ Indigenous employees</li> <li>→ Indigenous practices and content</li> <li>→ Indigenous spaces</li> </ul>	High Medium Low
Long-term Process of Self-Reflection	<ul style="list-style-type: none"> <li>→ Reflexive organizational practices</li> <li>→ Self-reflective employee practices</li> </ul>	High Medium Low
Indigenous Self-Determination	<ul style="list-style-type: none"> <li>→ Promotes Indigenous research ethics</li> <li>→ Advances Indigenous self-determination</li> </ul>	High Medium Low
Cost to Organization	<ul style="list-style-type: none"> <li>→ Total resources needed relative to other strategies.</li> <li>→ Estimates can include honorariums, event/meeting coordination, staff hours, training, administrative</li> </ul>	High Medium Low
Administrative Complexity	<ul style="list-style-type: none"> <li>→ Relative to other strategies</li> <li>→ Total logistical aspects required to implement the strategy</li> </ul>	High Medium Low

## Chapter 6. Strategies and Evaluations

The following are a set of nine strategies related to advancing ICS&CH in a health research institution. These strategies have been identified and developed from the information collected through background research and knowledge sharing interviews. The FNHA's (n.d.-f) *Policy Statement and Key Drivers and Ideas for Change* (FNHA, n.d.-c) were particularly informative for identifying key actions to advance ICS&CH. The fundamental components of each strategy are outlined. Previously described evaluative criteria are applied in an assessment of each strategy (see the Appendix for a policy matrix summarizing evaluations).

**Table 6.1. Strategies**

Strategies	Description of Strategy
ICS&CH Declaration & Pledge	<ul style="list-style-type: none"> <li>• BCCSU Leadership to sign FNHA Declaration of Commitment</li> <li>• Leadership, staff and research affiliates pledge to #itstartswithme campaign</li> </ul>
Mandatory ICS&CH Training	<ul style="list-style-type: none"> <li>• Collaborate with CEIH to identify the best training mechanisms for staff to increase ICS&amp;CH</li> <li>• For current staff: In-person ICS&amp;CH training for (short run intervention)</li> <li>• For new hires: develop in-house ICS&amp;CH training Combination of online/in-person (short term) <ul style="list-style-type: none"> <li>○ Job descriptions and advertisements state that prior completion of ICS&amp;CH training is a mandatory skill and qualification (long term)</li> </ul> </li> <li>• Provide ongoing ICS&amp;CH training for staff, health researchers and leadership (e.g., Annual ICS&amp;CH Education Days)</li> </ul>
Mandatory Indigenous Public Health Training	<ul style="list-style-type: none"> <li>• Completion of Indigenous Public Health graduate certificate (or select courses)</li> <li>• Examples include: Research Ethics; Social Determinants of Indigenous Health; Indigenous Health Policy; Using Public Health Data in Indigenous Communities; and Mental Health Care and Delivery in Indigenous Communities.</li> </ul>
Establish Indigenous ICS&CH Strategic Lead	<ul style="list-style-type: none"> <li>• Create a leadership position for an Indigenous ICS&amp;CH Strategic Lead</li> </ul>

Strategies	Description of Strategy
Indigenous Research Advisory Board	<ul style="list-style-type: none"> <li>• Establish a research advisory board with an Elder, Indigenous youth reps and representation from local Indigenous communities               <ul style="list-style-type: none"> <li>○ Meaningful engagement, nothing moves forward without full approval</li> <li>○ Reciprocity – participants are meaningfully compensated for their time</li> </ul> </li> </ul>
Indigenous Recruitment, Hiring and Retention Strategy	<ul style="list-style-type: none"> <li>• Hiring committee includes an Indigenous staff/community member on hiring panel</li> <li>• ICS&amp;CH interview structure</li> <li>• Statement of preference for Indigenous candidates in job advertisements</li> </ul>
Strategic Indigenous Partnership Development	<ul style="list-style-type: none"> <li>• Identify strategic partnerships with FNHA, VCH, CEIH, key Community stakeholders, Urban Native Youth Association,</li> <li>• Develop a Strategic Partner Research Steering Committee</li> </ul>
Complaints Process	<ul style="list-style-type: none"> <li>• Develop mechanisms for Indigenous staff, clients, partners, etc. to provide feedback (positive or construction) without fear of judgment or reprisal               <ul style="list-style-type: none"> <li>○ Include requirement that BCCSU affiliated research must provide information on research consent forms that there are complaint mechanisms in place</li> </ul> </li> </ul>
ICS&CH Integrated into Staff Performance Evaluation and Orientation	<ul style="list-style-type: none"> <li>• ICS&amp;CH built into annual Employee Performance Evaluation</li> <li>• ICS&amp;CH self-evaluation tool for staff and leadership</li> <li>• Develop ICS&amp;CH Employee Onboarding</li> <li>• Hire Indigenous employee for a Human Resource position to oversee development and implementation of these processes</li> </ul>

*Note.* BCCSU = British Columbia Centre on Substance Use; FNHA = First Nations Health Authority; CEIH = Centre for Excellence in Indigenous Health; ICS&CH = Indigenous Cultural Safety and Cultural Humility; VCH = Vancouver Coastal Health.

## 6.1. Sign the Declaration of Commitment and Make a Pledge

This strategy entails two aspects: (a) having the health research institution sign the FNHA’s (2015b) *Declaration of Commitment to Advancing Indigenous Cultural Safety and Humility* and (b) mandating staff and research affiliates to make a personal pledge to the FNHA’s *#itstartswithme* campaign.

The FNHA's (2015b) *Declaration of Commitment to Advancing Indigenous Cultural Safety and Humility* would be signed in a witnessing ceremony with the FNHA. The signing of the declaration by the leadership of the health research institution serves the purpose of giving permission to its staff and research affiliates to make a personal change and work for system-wide change in health care. Signing the Declaration of Commitment to hardwire cultural safety and humility in the health system sends the signal that leadership at the institution are focused on taking concrete actions to support FNHA's vision of a culturally safe health system for First Nations and Indigenous people in BC. This sets the stage for an accountable relationship with FNHA and Indigenous strategic partners. The signing of the Declaration can take place on a day that includes an agenda of discussions from leadership and possibly FNHA on what this Declaration means for the organization and for Indigenous peoples in BC. On this day, the *#itstartswithme* campaign is initiated by the leadership of the health research institution modelling their own pledges of commitment in the witnessing ceremony. Mandating staff and research affiliates at the health research institution to make a pledge to the campaign establishes an important protocol and signals change in organizational culture and expectations to non-Indigenous members of the organization.

### **6.1.1. Evaluation**

Overall the strategy does not include an explicit mechanism for increasing non-Indigenous staff and research affiliates' awareness of Indigenous historical perspectives and the legacy of colonialism and recognition of settler identities and white privilege. There is a risk that mandating individual staff and research affiliates to make a pledge may become a symbolic gesture that is not sustained as a transformation in their professional practice. Additionally, it takes time for organizational changes to take effect and for staff and affiliates to take up the pledge and make time to reflect on the pledge, including actions such as viewing twelve FNHA webinars and resources on advancing cultural safety and humility. This strategy receives a score of *low/medium* with regards to truth telling about colonization.

With regards to fostering understandings of First Nations perspectives on health and wellness the option is rated as *low/medium*. The strategy does include a mechanism for ensuring Elder and Knowledge Holder involvement or for integrating Indigenous



knowledge into the organization. However, there is Elder and Knowledge Holder involvement in carrying out a witnessing tradition on the day the declaration is signed.

Although this strategy sets the stage for future organizational change it is not expected to increase the number of Indigenous faces, content and spaces in the organization as it does not provide a mechanism for that. The strategy receives a *low* score on this criterion.

Making a pledge alone does not ensure that employees are encouraging a long-term process of self-reflection. Individual and organizational self-reflection is a necessary part in establishing change in organizational culture and sustaining reflexive organizational practices. There is no mechanism encouraging and supporting staff and research affiliates as they work towards transforming their professional practice and identifying opportunities for change. With regards to establishing a long-term process of self-reflection, the strategy is scored *low*.

This strategy does not include mechanisms that promote Indigenous research ethics or advance Indigenous self-determination within the organization. It receives a *low* score on this criterion.

This strategy receives a *high* score with regards to cost to organization and administrative complexity. Relatively few resources are needed to implement this strategy and the event coordination necessary for signing the Declaration is relatively straightforward. This strategy is low cost and meets the recommendation of the FNHA (n.d.-f) *Policy Statement on Cultural Safety and Humility* that “It starts with me” (p. 17) is modelled by leadership.

**Table 6.2. Summary of evaluation for the ICS&CH Policy Statement, Declaration, and Pledge**

Criteria	Components of Criteria	Measure
Truth Telling about Colonization	<ul style="list-style-type: none"> <li>→ Awareness of Indigenous historical perspectives</li> <li>→ Awareness of the legacy of colonialism including recognition of Settler Identity and White Privilege</li> </ul>	Low/Medium

Criteria	Components of Criteria	Measure
Fostering Understanding of First Nations Perspectives on Health and Wellness	<ul style="list-style-type: none"> <li>→ Extent of Elder and Knowledge Holder involvement</li> <li>→ Extent that Indigenous knowledge and practice is integrated into the organization</li> </ul>	Low/Medium
Indigenous Faces, Content, and Spaces	<ul style="list-style-type: none"> <li>→ Indigenous employees</li> <li>→ Indigenous practices and content</li> <li>→ Indigenous spaces</li> </ul>	Low
Long-term Process of Self-Reflection	<ul style="list-style-type: none"> <li>→ Reflexive organizational practices</li> <li>→ Self-reflective employee practices</li> </ul>	Low
Indigenous Self-Determination	<ul style="list-style-type: none"> <li>→ Promotes Indigenous research ethics</li> <li>→ Advances Indigenous self-determination</li> </ul>	Low
Cost to Organization	<ul style="list-style-type: none"> <li>→ Total resources needed relative to other strategies.</li> <li>→ Estimates can include honorariums, event/meeting coordination, staff hours, training, administrative</li> </ul>	High
Administrative Complexity	<ul style="list-style-type: none"> <li>→ Relative to other strategies</li> <li>→ Total logistical aspects required to implement the strategy</li> </ul>	High

## 6.2. Mandatory ICS&CH Training

This strategy entails that all current and future staff and research affiliates receive ICS&CH training that is relevant to a health research institute. Providing in-person training to current staff is an immediate intervention that can be implemented in the short run and less costly in terms of time, coordination of time, and total staff hours needed to complete online training. In-person training can include the colonial origins of research, and what meaningful Indigenous collaboration in the research process looks like. With this strategy there is an opportunity develop a strategic partnership with the CEIH at UBC to collaborate and develop an in-house ICS&CH training program specific to health researchers. The strategy also includes an annual ICS&CH education day with mandatory participation of all staff, research affiliates and senior leadership.

Current practices in BC demonstrate a shift towards mandatory ICS&CH training for health science students in universities, physicians and surgeons, and new hires in Health Clinics in Vancouver. In the long run, this strategy entails that job descriptions and employment advertisements for health research institutions state that prior completion of ICS&CH training is a mandatory skill and qualification for employment thus supporting the CEIH and UBC initiative to meet the TRC Calls to Action 23 and 24 and “hardwire” ICS&CH into the BC health care system. This requirement supports societal demand for ICS&CH training in BC which may potentially encourage more universities to supply mandatory ICS&CH training for student health researchers as well as university staff and faculty thus contributing to system wide changes in BC’s health system including health research.

### **6.2.1. Evaluation**

Mandatory ICS&CH training of all non-Indigenous staff and research affiliates addresses many of the components of the Truth Telling about Colonization criterion; however, given the limited time and scope of training, it is unable provide a comprehensive understanding of how colonization has privileged settlers at the expense of Indigenous peoples and how colonization continues to reproduce these inequities in current policies and practices. This strategy, therefore receives a score of *medium/high* for this criterion.

With regards to fostering an understanding of First Nations perspectives on health and wellness the strategy is scored *medium* because the extent of Elder and Knowledge Holder involvement is time limited to the duration of the training. Additionally, this strategy does not guarantee that Indigenous knowledge and practices are integrated into individual employee and research practices and thus fully integrated into the organization. The strategy is not expected to increase the presence of Indigenous employees, Indigenous knowledge and content, or Indigenous spaces nor is a mechanism provided to support long-term self-reflective employee practices or reflexive organizational practices and processes. The strategy receives a *low* score on these two criteria. The option also does not include mechanisms that promote Indigenous research ethics or advance Indigenous self-determination within the organization, and therefore receives a *low* score for this criterion as well.

In the short run, the strategy is expected to be costly and with a high degree of administrative complexity. In the long run, cost will decrease and implementation will become less complex as current staff and research affiliates receive the training. It therefore receives a low and high score for both these criteria.

**Table 6.3. Summary of evaluation for the mandatory ICS&CH training**

Criteria	Components of Criteria	Measure
Truth Telling about Colonization	<ul style="list-style-type: none"> <li>→ Awareness of Indigenous historical perspectives</li> <li>→ Awareness of the legacy of colonialism including recognition of Settler Identity and White Privilege</li> </ul>	Medium/High
Fostering Understanding of First Nations Perspectives on Health and Wellness	<ul style="list-style-type: none"> <li>→ Extent of Elder and Knowledge Holder involvement</li> <li>→ Extent that Indigenous knowledge and practice is integrated into the organization</li> </ul>	Medium
Indigenous Faces, Content, and Spaces	<ul style="list-style-type: none"> <li>→ Indigenous employees</li> <li>→ Indigenous practices and content</li> <li>→ Indigenous spaces</li> </ul>	Low
Long-term Process of Self-Reflection	<ul style="list-style-type: none"> <li>→ Reflexive organizational practices</li> <li>→ Self-reflective employee practices</li> </ul>	Low
Indigenous Self-Determination	<ul style="list-style-type: none"> <li>→ Promotes Indigenous research ethics</li> <li>→ Advances Indigenous self-determination</li> </ul>	Low
Cost to Organization	<ul style="list-style-type: none"> <li>→ Total resources needed relative to other strategies.</li> <li>→ Estimates can include honorariums, event/meeting coordination, staff hours, training, administrative</li> </ul>	Low (short) High (long)
Administrative Complexity	<ul style="list-style-type: none"> <li>→ Relative to other strategies</li> <li>→ Total logistical aspects required to implement the strategy</li> </ul>	Low (short) High (long)

### 6.3. Mandatory Indigenous Public Health Training

This option entails staff and research affiliates complete a program similar to the Indigenous Public Health graduate certificate from the Indigenous Public Health Institute at UBC (UBC Faculty of Medicine, n.d.). The certificate would involve completing a

series of six intensive 1-week courses taught by leading Indigenous experts. They would cover core Indigenous public health competencies including research ethics, environmental health, health policy, and epidemiology and biostatistics through an Indigenous lens. Examples of select courses include: Social Determinants of Indigenous Health; Indigenous Health Policy; Using Public Health Data in Indigenous Communities; and Mental Health Care and Delivery in Indigenous Communities.

By mandating intensive Indigenous public health training there is an opportunity to develop a partnership with FNHA and the CEIH and work with them to identify a set of core competencies for health researchers. Core competencies are the essential knowledge, skills and attitudes necessary for the practice of culturally safe health research methods and analysis. They can serve as the basic building blocks of culturally safe health policy research. Furthermore, this step sets an industry standard in health research practices that may exert a societal influence on other post-secondary institutions to meet the TRC Calls to Action and provide mandatory ICS&CH education in their health research programs.

### **6.3.1. Evaluation**

This strategy is scored *high* for its potential to fully meet the components of the Truth Telling about Colonization criterion and fostering an understanding of First Nations Perspectives on Health and Wellness. However, this strategy scores *low* on all five remaining criteria. The strategy does not include explicit mechanisms that promote Indigenous research ethics or advance Indigenous self-determination within the organization; however, completion of selected courses enhances employee awareness of Indigenous research ethics. As the courses are time limited, they do not directly implement a mechanism for long-term self-reflection. Given the time commitment involved in the courses, the cost and administrative complexity are very high.

**Table 6.4. Summary of evaluation for Mandatory Indigenous Public Health Training**

Criteria	Components of Criteria	Measure
Truth Telling about Colonization	<ul style="list-style-type: none"> <li>→ Awareness of Indigenous historical perspectives</li> <li>→ Awareness of the legacy of colonialism including recognition of Settler Identity and White Privilege</li> </ul>	High
Fostering Understanding of First Nations Perspectives on Health and Wellness	<ul style="list-style-type: none"> <li>→ Extent of Elder and Knowledge Holder involvement</li> <li>→ Extent that Indigenous knowledge and practice is integrated into the organization</li> </ul>	High
Indigenous Faces, Content, and Spaces	<ul style="list-style-type: none"> <li>→ Indigenous employees</li> <li>→ Indigenous practices and content</li> <li>→ Indigenous spaces</li> </ul>	Low
Long-term Process of Self-Reflection	<ul style="list-style-type: none"> <li>→ Reflexive organizational practices</li> <li>→ Self-reflective employee practices</li> </ul>	Low
Indigenous Self-Determination	<ul style="list-style-type: none"> <li>→ Promotes Indigenous research ethics</li> <li>→ Advances Indigenous self-determination</li> </ul>	Low
Cost to Organization	<ul style="list-style-type: none"> <li>→ Total resources needed relative to other strategies.</li> <li>→ Estimates can include honorariums, event/meeting coordination, staff hours, training, administrative</li> </ul>	Low
Administrative Complexity	<ul style="list-style-type: none"> <li>→ Relative to other strategies</li> <li>→ Total logistical aspects required to implement the strategy</li> </ul>	Low

## **6.4. Establish an Indigenous ICS&CH Strategic Lead Position**

This strategy calls for establishing a senior leadership position for an ICS&CH Strategic Lead to oversee all aspects of the advancement of ICS&CH within the organization. The position would be responsible for coordinating the development and

implementation of an ICS&CH strategic plan, with priority areas under the strategic plan identified in collaboration with Indigenous partners for co-development of strategies to inform and foster cultural safety and humility with the health system including health research. It is important that the mandate and authority of this position is meaningful enough to support their role in building meaningful relationships with Indigenous Strategic Partners. Additionally, the role would be accountable for: ensuring Indigenous representation on related boards, committees and advisories; efforts to ensure a workforce that includes Indigenous people in staff positions, as research affiliates and are visible at all levels of the organization. Initiatives could include: establishment of Indigenous Research Advisory Board; development of employee performance evaluations and ICS&CH informed employee orientation for new hires; develop initiatives to recruit and retain Indigenous staff and research affiliates; and encourage Indigenous students to pursue opportunities in health policy research (e.g., offer student co-op positions and mentorship that develop the specialized research and analytical skill set required by the organization).

#### **6.4.1. Evaluation**

This strategy receives a *low* score with regards to truth telling, fostering an understanding of First Nations perspectives on health and wellness, and administrative complexity. Although establishing an ICS&CH Strategic Lead may have some potential to foster truth telling and increased understanding of First Nations perspectives on health and wellness by initiatives such as facilitating visits from First Nations communities, sharing traditional protocols, arranging conferences, and key leadership meetings on local First Nations lands, there are not formal mechanisms to advance these aims, so the option scores low. Furthermore, the ability of the strategic lead to execute these approaches is contingent upon the relative mandate, authority and accountability embedded in the position. Indeed, there is a high degree of administrative complexity required to determine the reporting and governance structure of this position. This is particularly complex given that health research institutions are comprised of independent academic research scholars whose institutions protect their academic freedom.

The strategy receives a score of *low/medium* on the criterion for Indigenous self-determination. An Indigenous strategic lead may potentially be able to establish mechanism that promotes Indigenous research ethics or advances Indigenous self-

determination if that task is mandated into the position but given the uncertainty the score is low/medium.

With regards to increasing Indigenous faces, content and spaces, long-term processes for self-reflection, and cost to the organization this strategy moderately outperforms the previous three strategies. The position does not explicitly increase the number of Indigenous employees in the organization but it does increase the presence of Indigenous face and spaces through activities described above. It, therefore, rates *medium* for increasing Indigenous faces, content, and spaces. Establishing an ICS&CH Strategic Lead could be a mechanism for long-term processes of self-reflection as this individual would be able to challenge staff and researchers to reflect on their actions and assumptions as settlers. It therefore receives a *medium* score for this criterion as well. The cost of this option is assessed as *medium* since it requires ongoing funding for the position and activities related to the position.

**Table 6.5. Summary of evaluation for an Indigenous ICS&CH Strategic Lead Position**

Criteria	Components of Criteria	Measure
Truth Telling about Colonization	<ul style="list-style-type: none"> <li>→ Awareness of Indigenous historical perspectives</li> <li>→ Awareness of the legacy of colonialism including recognition of Settler Identity and White Privilege</li> </ul>	Low
Fostering Understanding of First Nations Perspectives on Health and Wellness	<ul style="list-style-type: none"> <li>→ Extent of Elder and Knowledge Holder involvement</li> <li>→ Extent that Indigenous knowledge and practice is integrated into the organization</li> </ul>	Low
Indigenous Faces, Content, and Spaces	<ul style="list-style-type: none"> <li>→ Indigenous employees</li> <li>→ Indigenous practices and content</li> <li>→ Indigenous spaces</li> </ul>	Medium
Long-term Process of Self-Reflection	<ul style="list-style-type: none"> <li>→ Reflexive organizational practices</li> <li>→ Self-reflective employee practices</li> </ul>	Medium
Indigenous Self-Determination	<ul style="list-style-type: none"> <li>→ Promotes Indigenous research ethics</li> <li>→ Advances Indigenous self-determination</li> </ul>	Low/Medium
Cost to Organization	→ Total resources needed relative to	Medium



Criteria	Components of Criteria	Measure
	other strategies. → Estimates can include honorariums, event/meeting coordination, staff hours, training, administrative	
Administrative Complexity	→ Relative to other strategies → Total logistical aspects required to implement the strategy	Low

## 6.5. Establish an Indigenous Research Board

An Indigenous research board and accompanying ICS&CH protocols within a health research institution supports the ICS&CH of Indigenous peoples and communities in the research process and respects OCAP principles of Indigenous self-determination. In BC, the FNHA collaborates with the CIHR to identify and inform CIHR priority areas for research funding. Respecting the self-determination of Indigenous peoples in the research process is one way in which a health research institution can demonstrate its recognition, promotion and protection of the rights and freedoms of Indigenous people.

This strategy calls for the establishment of an Indigenous Research Board with a composition that includes Elders and Knowledge Keepers, Indigenous youth representation (e.g., Urban Native Youth Association), representation from Indigenous communities accessing local services (e.g., Western Aboriginal Harm Reduction Society), and Indigenous Strategic Partners. The Research Board must have the authority to be involved in meaningful engagement in the research process, whereby no research projects affiliated with BCCSU move forward without approval by the Indigenous Research Board. This strategy includes providing meaningful compensation for board representatives and for Indigenous people who consent to share knowledge with affiliated research projects. In her experience working with Indigenous community groups who are approached often by University researchers one interview participant talked about the burden of asking Indigenous people to give when they have so little to give and stressed the importance of mutual reciprocity. Mutual reciprocity was a value stressed by another interview participant that was an Elder.

### 6.5.1. Evaluation

Under this option, Indigenous informed research practices are embedded in the organization. While this strategy does not perform well relative to other strategies under the first two criteria for truth telling and fostering understandings of First Nations perspectives on health and wellness (*low*), and only moderately on the third criterion of supporting Indigenous faces, content, and spaces (*medium*), it scores very *high* with regards to establishing a long-term process of self-reflection by research affiliates and staff. The cost of compensating Indigenous people for their time and participation in the Research Board and for participating in research projects to the organization is rated *medium* as it is more costly relative to other options focusing on Indigenous recruitment, establishing a complaints process or integrating ICS&CH into employee performance evaluations.

This policy establishes a clear mechanism for promoting Indigenous research ethics and advancing Indigenous self-determination in the research process and scores *high* on this criterion. Establishing an Indigenous Research Board with power in combination with a mechanism for accountability (i.e., an accompanying complaints process) very clearly signals a shift in organizational culture to staff and research affiliates. The inclusion of Indigenous partners, Indigenous community organizations and Indigenous knowledge holders in the approval of research projects affiliated with the organization meaningfully positions Indigenous as co-investigators thus establishing an equal power dynamic between Indigenous people and non-Indigenous researchers. Establishing the structure and governance for this board, as well as maintaining sufficient membership and involvement would be administratively complex, and therefore receives a *low* score on this criterion.

**Table 6.6. Summary of evaluation for Indigenous Research Advisory Board**

Criteria	Components of Criteria	Measure
Truth Telling about Colonization	<ul style="list-style-type: none"> <li>→ Awareness of Indigenous historical perspectives</li> <li>→ Awareness of the legacy of colonialism including recognition of Settler Identity and White Privilege</li> </ul>	Low

Criteria	Components of Criteria	Measure
Fostering Understanding of First Nations Perspectives on Health and Wellness	<ul style="list-style-type: none"> <li>→ Extent of Elder and Knowledge Holder involvement</li> <li>→ Extent that Indigenous knowledge and practice is integrated into the organization</li> </ul>	Low
Indigenous Faces, Content, and Spaces	<ul style="list-style-type: none"> <li>→ Indigenous employees</li> <li>→ Indigenous practices and content</li> <li>→ Indigenous spaces</li> </ul>	Medium
Long-term Process of Self-Reflection	<ul style="list-style-type: none"> <li>→ Reflexive organizational practices</li> <li>→ Self-reflective employee practices</li> </ul>	High
Indigenous Self-Determination	<ul style="list-style-type: none"> <li>→ Promotes Indigenous research ethics</li> <li>→ Advances Indigenous self-determination</li> </ul>	High
Cost to Organization	<ul style="list-style-type: none"> <li>→ Total resources needed relative to other strategies.</li> <li>→ Estimates can include honorariums, event/meeting coordination, staff hours, training, administrative</li> </ul>	Medium
Administrative Complexity	<ul style="list-style-type: none"> <li>→ Relative to other strategies</li> <li>→ Total logistical aspects required to implement the strategy</li> </ul>	Low

## 6.6. Indigenous Recruitment, Hiring, and Retention Strategy

This strategy entails three elements: (a) establish a hiring committee with an Indigenous representative on the hiring panel (potentially a strategic partner could fulfill this role), (b) establish protocols for a culturally safe interview structure, and (c) include a statement of preference for Indigenous candidates in job advertisements. With this strategy there is an opportunity to work with local universities (e.g., UBC and Simon Fraser University) to develop strategies to strengthen Indigenous research capacity development from undergraduate to postdoctoral levels. Strategies could focus on creating mentorship and research opportunities for Indigenous students and attract recruitment of Indigenous students into a career in health research. By establishing a health policy research field that demands ICS&CH training and Indigenous Public Health education, as well as provides opportunities for those students, would support

universities in a collective effort to advance ICS&CH into the health care professional and health research post-secondary education systems.

### 6.6.1. Evaluation

This strategy scores the highest in terms of establishing a clear mechanism for increasing Indigenous employees and increasing Indigenous practices and Indigenized content and therefore receives a *high* score on this criterion. Furthermore, the cost to the organization is low relative to other options and so a *high* score is given for cost. Implementation of this strategy is administratively complex and requires a degree of coordination and oversight, so it receives a *low* score on this criterion. The option also does not establish a mechanism for promoting Indigenous research ethics or advance Indigenous self-determination so receives a *low* score for this criterion as well.

It should be noted that the overall low score of this option is misleading as promoting indigenous faces, content, and spaces is critical for establishing an Indigenous network to support the emotional and challenging task of advancing Indigenous cultural safety. Indigenous people are needed to meet the components of increased Indigenous practices and Indigenized content within the organization. The presence of an increased number of Indigenous employees within an organization support cultural safety for Indigenous employees as well as for Indigenous community members with whom the organization is interacting. Furthermore, this strategy supports the success of other strategies (i.e., Indigenous Research Board, Complaints Process, development of ICS&CH employee onboarding).

**Table 6.7. Summary of evaluation for Indigenous Recruitment, Hiring and Retention Strategy**

Criteria	Components of Criteria	Measure
Truth Telling about Colonization	<ul style="list-style-type: none"> <li>→ Awareness of Indigenous historical perspectives</li> <li>→ Awareness of the legacy of colonialism including recognition of Settler Identity and White Privilege</li> </ul>	Low

Criteria	Components of Criteria	Measure
Fostering Understanding of First Nations Perspectives on Health and Wellness	<ul style="list-style-type: none"> <li>→ Extent of Elder and Knowledge Holder involvement</li> <li>→ Extent that Indigenous knowledge and practice is integrated into the organization</li> </ul>	Low
Indigenous Faces, Content, and Spaces	<ul style="list-style-type: none"> <li>→ Indigenous employees</li> <li>→ Indigenous practices and content</li> <li>→ Indigenous spaces</li> </ul>	High
Long-term Process of Self-Reflection	<ul style="list-style-type: none"> <li>→ Reflexive organizational practices</li> <li>→ Self-reflective employee practices</li> </ul>	Low
Indigenous Self-Determination	<ul style="list-style-type: none"> <li>→ Promotes Indigenous research ethics</li> <li>→ Advances Indigenous self-determination</li> </ul>	Low
Cost to Organization	<ul style="list-style-type: none"> <li>→ Total resources needed relative to other strategies.</li> <li>→ Estimates can include honorariums, event/meeting coordination, staff hours, training, administrative</li> </ul>	High
Administrative Complexity	<ul style="list-style-type: none"> <li>→ Relative to other strategies</li> <li>→ Total logistical aspects required to implement the strategy</li> </ul>	Low

## 6.7. Strategic Indigenous Partnership Development

This strategy entails establishing an Indigenous strategic partnership protocol agreement to provide a framework for continued collaboration between the health research institution and Indigenous partners. This strategy meets the FNHA policy recommendation on cultural safety and humility to build meaningful partnerships with First Nations communities for co-development of strategies and services to inform and foster cultural safety within the health system (FNHA, n.d.-f, p. 18).

### 6.7.1. Evaluation

This strategy scores *low* with regards to truth telling about colonization and fostering an understanding of First Nations perspectives on health and wellness as it provides not direct mechanisms for that. In terms of increasing Indigenous employees, increasing integration of Indigenous practices and Indigenized content or availability of Indigenous spaces, establishing a long-term process for self-reflection, or supporting self-determination this strategy is scored *low/medium* relative to other strategies. While no clear mechanism is established that promotes Indigenous research ethics or advances Indigenous self-determination, a relationship with Indigenous partners that is built on mutual accountability and respect for human dignity, establishes a potential point for collaboration on those criteria.

Relative to other strategies this option includes *moderate* time costs to establish and maintain partner relationships and is *moderately* more administratively complex to implement. Accountability of partnerships and working collaboratively requires a degree of oversight and coordination of resources and personnel.

**Table 6.8. Summary of evaluation for Strategic Indigenous Partnership Development**

Criteria	Components of Criteria	Measure
Truth Telling about Colonization	<ul style="list-style-type: none"> <li>→ Awareness of Indigenous historical perspectives</li> <li>→ Awareness of the legacy of colonialism including recognition of Settler Identity and White Privilege</li> </ul>	Low
Fostering Understanding of First Nations Perspectives on Health and Wellness	<ul style="list-style-type: none"> <li>→ Extent of Elder and Knowledge Holder involvement</li> <li>→ Extent that Indigenous knowledge and practice is integrated into the organization</li> </ul>	Low
Indigenous Faces, Content, and Spaces	<ul style="list-style-type: none"> <li>→ Indigenous employees</li> <li>→ Indigenous practices and content</li> <li>→ Indigenous spaces</li> </ul>	Low/Medium
Long-term Process of Self-Reflection	<ul style="list-style-type: none"> <li>→ Reflexive organizational practices</li> <li>→ Self-reflective employee practices</li> </ul>	Low/Medium

Criteria	Components of Criteria	Measure
Indigenous Self-Determination	<ul style="list-style-type: none"> <li>→ Promotes Indigenous research ethics</li> <li>→ Advances Indigenous self-determination</li> </ul>	Low/Medium
Cost to Organization	<ul style="list-style-type: none"> <li>→ Total resources needed relative to other strategies.</li> <li>→ Estimates can include honorariums, event/meeting coordination, staff hours, training, administrative</li> </ul>	Medium
Administrative Complexity	<ul style="list-style-type: none"> <li>→ Relative to other strategies</li> <li>→ Total logistical aspects required to implement the strategy</li> </ul>	Medium

## 6.8. Complaints Process

This strategy entails developing a mechanism for Indigenous staff, clients, partners, and so on, to provide feedback (positive or constructive) without fear or judgement or reprisal. Research affiliates are already subject to internal institutional and university research ethics approvals processes. This strategy builds on those and establishes a requirement that to maintain affiliate membership with the health research institution, the affiliated researcher must include information on all research consent forms explaining that there are additional complaint mechanisms in place for Indigenous research participants. This aspect of the strategy sends a powerful signal about the research culture at the organization. Furthermore, the strategy signals the organization's willingness to adopt the FNHA policy recommendations on ICS&CH and demonstrate the organization's willingness to demonstrate accountability and ongoing reflective practices.

### 6.8.1. Evaluation

While scoring *low* on a number of criteria, notably on administrative complexity given that governance and accountability could be complicated to establish, this option scores *high* in terms of establishing a mechanism for supporting long-term process of

self-reflection at the individual and organizational level. The strategy is *low* cost relative to other strategies and requires less time, staff hours, and resources to implement. If combined with an Indigenous Research Board this option has the potential to advance Indigenous self-determination in the health research landscape in BC if established in the context of building mutually respectful and accountable relationships with Indigenous partners. It therefore receives a *medium* score for self-determination. It is expected that a formal complaint mechanism for staff might help with retention of Indigenous employees thereby moderately supporting the Indigenous faces, content, and spaces criterion.



**Table 6.9. Summary of evaluation for complaints process**

Criteria	Components of Criteria	Measure
Truth Telling about Colonization	<ul style="list-style-type: none"> <li>→ Awareness of Indigenous historical perspectives</li> <li>→ Awareness of the legacy of colonialism including recognition of Settler Identity and White Privilege</li> </ul>	Low
Fostering Understanding of First Nations Perspectives on Health and Wellness	<ul style="list-style-type: none"> <li>→ Extent of Elder and Knowledge Holder involvement</li> <li>→ Extent that Indigenous knowledge and practice is integrated into the organization</li> </ul>	Low
Indigenous Faces, Content, and Spaces	<ul style="list-style-type: none"> <li>→ Indigenous employees</li> <li>→ Indigenous practices and content</li> <li>→ Indigenous spaces</li> </ul>	Low/Medium
Long-term Process of Self-Reflection	<ul style="list-style-type: none"> <li>→ Reflexive organizational practices</li> <li>→ Self-reflective employee practices</li> </ul>	High
Indigenous Self-Determination	<ul style="list-style-type: none"> <li>→ Promotes Indigenous research ethics</li> <li>→ Advances Indigenous self-determination</li> </ul>	Medium
Cost to Organization	<ul style="list-style-type: none"> <li>→ Total resources needed relative to other strategies.</li> <li>→ Estimates can include honorariums, event/meeting coordination, staff hours, training, administrative</li> </ul>	High
Administrative Complexity	<ul style="list-style-type: none"> <li>→ Relative to other strategies</li> <li>→ Total logistical aspects required to implement the strategy</li> </ul>	Low

## 6.9. ICS&CH Integrated Into Staff Performance Evaluation and Orientation

This strategy calls for embedding cultural humility into organizational human resource policy as an annual administrative practice. This option includes three elements: (a) standardizing an employee performance evaluation, (b) setting in place a culture for staff and leaders to reflect on how they are personally working to identify

areas for transformation and application of their ICS&CH training, and (c) ICS&CH informed employee onboarding for new hires that is relevant to a health research institution.

Self-reflection and self-awareness is at the centre of developing cultural humility. Developing competency in the practice of self-reflection is not something that can be easily measured. Interview participants shared practices that included the use of surveys and feedback forms following ICS&CH training. While the use of performance measurement tools does not guarantee heart level embodiment of ICS&CH training it can be an effective tool for promoting organization change in culture and lifelong learning. This strategy includes the use of self-evaluation forms after ICS&CH training and annual employee performance evaluations that include self-identified work plan goals to increase individual knowledge of ICS&CH and identify opportunities to apply ICS&CH training in personal professional practice. Measuring outcomes is harder than measuring outputs. In most qualitative interviews and current practices, the standard practice for measuring an outcome of change in a staff member's perspective of ICS&CH included completion of employee self-evaluation tools. The output of this strategy is that 100% of staff are required to practice self-reflection as an operational requirement. This strategies encourages a culture of self-reflection amongst staff, which is the outcome or consequence of this output.

Employee orientation to the research institution for new hires is typical human resource practice. This strategy calls for the development of an employee onboarding that is ICS&CH informed. Content areas of employee onboarding information may include guidelines for application for Indigenous research funds, Indigenous research-related protocols of the organization and partners, awareness of Indigenous partnerships and what that means, and identifying opportunities for research collaboration with Indigenous strategic partners.

### **6.9.1. Evaluation**

This strategy seemingly stands out for scoring higher in nearly all criteria but two. The extent to which Indigenous self-determination and Indigenous faces, content and spaces are increased is *low* relative to other options. This option is relatively simpler to implement and scores *high* in terms of costs to the organization. There is a *higher* payoff

in terms of establishing a long-term process for self-reflection and increasing levels of cultural humility within a health research institution for a relatively smaller investment compared to other strategies. Furthermore, this strategy answers the call by FNHA for the development of ICS&CH measures.

**Table 6.10. Summary of evaluation for ICS&CH integrated into staff performance evaluation and orientation**

Criteria	Components of Criteria	Measure
Truth Telling about Colonization	<ul style="list-style-type: none"> <li>→ Awareness of Indigenous historical perspectives</li> <li>→ Awareness of the legacy of colonialism including recognition of Settler Identity and White Privilege</li> </ul>	Medium
Fostering Understanding of First Nations Perspectives on Health and Wellness	<ul style="list-style-type: none"> <li>→ Extent of Elder and Knowledge Holder involvement</li> <li>→ Extent that Indigenous knowledge and practice is integrated into the organization</li> </ul>	Medium
Indigenous Faces, Content, and Spaces	<ul style="list-style-type: none"> <li>→ Indigenous employees</li> <li>→ Indigenous practices and content</li> <li>→ Indigenous spaces</li> </ul>	Low
Long-term Process of Self-Reflection	<ul style="list-style-type: none"> <li>→ Reflexive organizational practices</li> <li>→ Self-reflective employee practices</li> </ul>	High
Indigenous Self-Determination	<ul style="list-style-type: none"> <li>→ Promotes Indigenous research ethics</li> <li>→ Advances Indigenous self-determination</li> </ul>	Low
Cost to Organization	<ul style="list-style-type: none"> <li>→ Total resources needed relative to other strategies.</li> <li>→ Estimates can include honorariums, event/meeting coordination, staff hours, training, administrative</li> </ul>	High
Administrative Complexity	<ul style="list-style-type: none"> <li>→ Relative to other strategies</li> <li>→ Total logistical aspects required to implement the strategy</li> </ul>	Medium

## Chapter 7. Recommendations

This project focused on the problem of a lack of cultural safety in health care settings, which is known to push Indigenous people away from critical health care and supports. In response to the TRC's (2015a) Calls to Action #23 and #24 that highlight the importance of advancing Indigenous cultural safety and cultural humility in health care systems, this capstone project drew on existing literature and six qualitative interviews to articulate five key components of ICS&CH: The importance of (a) truth telling about colonization, (b) fostering understandings of First Nations perspectives on health and wellness, (c) supporting Indigenous faces, content and spaces, (d) advancing Indigenous self-determination, and (e) creating mechanism for long-term self-reflection were all identified as key elements the promote cultural safety and humility.

Nine strategies to increase Indigenous cultural safety and cultural humility were analyzed against those five criteria, in addition to considerations related to cost and administrative complexity. Based on the analysis of options against the evaluative criteria, it was found that the projected outcomes of individual strategies do not meet the key objective of achieving higher sustainable levels of cultural safety and cultural humility within a health research institute to an acceptable degree. No one single strategy fully satisfies the key criteria. What does stand out is the interconnected relationship between the strategies to support and uphold their collective capacity to satisfy the key value lying at the heart of the policy objective. For example, establishing a complaints process provides data for measures of cultural safety while employee performance evaluations provide data for measuring humility (FNHA, n.d.-f, p. 16). These mechanisms support an institutional commitment to evaluation, public reporting, and continuously improving cultural safety and answer the FNHA's (n.d.-f) call for the development of measures on ICS&CH (p. 16). To discourage the potential tokenism of ICS&CH training and the risk that such training can become a one-time ticking of a box, complementary strategies that embed ICS&CH as a culture of practice are needed. Actions such as annual employee performance measurement and establishing Indigenous Research Board help achieve this.

It is the recommendation of this analysis that all options be implemented in the long run. In the short run, options with the least administrative burden should be

prioritized. Namely, having the organization sign the FNHA's (2015b) ICS&CH declaration, followed by implementing mandatory ICS&CH training, integrating ICS&CH performance measures into staff evaluations and onboarding, and initiating strategic partnerships with First Nations organizations and communities. Subsequently, an ICS&CH strategic lead should be hired and given adequate authority, oversight, and resources to oversee a comprehensive organizational ICS&CH strategy. This position can then facilitate the development of an Indigenous Research Board, and the establishment of Indigenous recruitment, hiring, and retention strategies. Once the Indigenous Research Board is in place, a complaints process can be established with the necessary oversight and enforcement mechanisms. In the long run, the organization should explore opportunities for having staff receive extensive Indigenous public health training. While this would be costly and administratively complex to implement, this option is best positioned to support non-Indigenous staff and researchers to meaningfully reflect on colonization and how it has contributed to their positions of privilege at the expense of Indigenous peoples.

It is critical to emphasize that cultural safety and humility is an ongoing process and not something that can be achieved with the implementation of any specific or group of policies. While adoption of all the recommended options is expected to result in transformative organizational change, only Indigenous people who interface and interact with the institution can determine when it is culturally safe. It is also critical to emphasize that cultural safety is not a static concept and requires ongoing attention, reflection, resources, and commitment.

It is also important to acknowledge that there are limits to the contributions that individual research institutions can make to advancing cultural safety and humility in health systems and spaces. As noted in the beginning of this capstone, for Indigenous peoples in Canada, the legacy of colonialism is embedded in their daily lives, and it is still taking lives. While it is expected that the recommended policy package will help reduce health inequities between Indigenous and non-Indigenous populations, broader social and structural changes are needed. Self-determination for Indigenous peoples in all areas of their lives is a pressing and necessary condition for health inequities to be fully addressed.

## Chapter 8. Reflections On The Philosophical Limitations of Policy Analysis

As an Indigenous policy analyst, it was evident that the process of selecting, separating, and assessing individual strategies and evaluative criteria is informed by my interconnected identities as a mother, an academic, community advocate, and by my Ktunaxa, Syilx, Chinese, and English heritage. My identification and interpretation of the background research, interpretation of results, and evaluative analysis is deeply embedded in my intersecting identities. “Injecting” an Indigenous worldview into Bardach’s (2012) policy analysis framework through the selection of evaluative criteria does not bring the practice of policy analysis under the control or influence of Indigenous people/or values or otherwise “Indigenize” Bardach’s analytical framework in a meaningful way. The “criteria” or “value” of the concept of “Indigenous self-determination” in this analysis is deeply political and rooted in an anticolonial advancement of Indigenous jurisdiction in the field of public health (and health policy research). This is at the heart of Indigenous health governance in BC.

Moving away from a linear approach to policy analysis, academics have developed a methodology and framework through an iterative participatory process for advancing understandings of differential impacts of health policies through an intersectionality-based policy analysis (IBPA) framework to advance equitable health outcomes (Hankivsky et al., 2014). Although IBPA is effective at foregrounding (Muntinga, Krajenbrink, Peerdeman, Croiset, & Verdonk, 2016; Rudrum, Oliffe, & Brown, 2017; Woodgate et al., 2017; Zehbe, Wakewich, King, Morrisseau, & Tuck, 2017) complex contexts of health and social problems, the IBPA framework falls short on advancing Indigenous self-determination. Natalie Clark, a scholar of Welsh, Irish and Métis heritage has contributed her unique approach to Indigenous methodologies that inform her Indigenous intersectionality-based approach to community based participatory research projects (Clark, 2012). Clark (2016a) has challenged conventional intersectionality scholarship by foregrounding anti-colonialism and Indigenous sovereignty/nationhood. In “Red Intersectionality and Violence-Informed Witnessing Praxis for Indigenous Girls,” she challenges the very conventions of academic writing styles as she moves between first and third person, poetic to academic, and from

personal to political analysis following the inspiration of Gloria Anzaldúa's writing style that brings to life the theory they speak of (pp. 47–48). Her resistance to “conventional” writing styles highlights history, politics and power that underlie the theories, methods, validity and scope of knowledge production.

In this analysis Bardach's (2012) framework is effective at prioritizing a strategy for implementing all of the strategies in phased approaches. While some strategies are complicated and costly, others are relatively simple with relatively low cost. Furthermore, the analysis informs points of collaboration with Indigenous strategic partners and a place to begin discussions of what a mutually respectful and accountable relationship looks like.

Finally, an examination of the philosophical limitations of Bardach's (2012) framework revealed an intertwined story of the analytic and the evaluative. It is a story of policy analysis and research as well as Indigenous self-determination (personal and political) and the political currents running through public policy. Researchers and research institutions have had hundreds of years to develop their capacity and expertise in Indigenous health research and public policy within a colonial framework of governance. There must be Indigenous people and leaders advancing and achieving a real shift in power dynamics in an anticolonial framework focused on addressing health inequities. While the IBPA framework is a critical analytical framework that goes a step beyond Bardach's model, it is still rooted in a western perspective of pedagogy and knowledge production. Indigenous self-determination in the research process and public policy process demands Indigenous ontologies, epistemologies and methodologies to strengthen the foundation for a real shift in power. Acknowledging white privilege and settler identities that lay at the heart of the success of non-Indigenous health research institutes and opening space for Indigenous self-determination and Indigenous ways of knowing would demonstrate meaningful cultural appreciation of Indigenous knowledge and contribution to the world.

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# Appendix: Evaluation Matrix

Evaluation Matrix	ICS&H Declaration & Pledge	Mandatory ICS&H Training	Mandatory Indigenous Public Health Training	Establish Indigenous ICS&H Strategic Lead	Indigenous Research Board	Indigenous Recruitment, Hiring and Retention Strategy	Strategic Indigenous Partnership Development	Complaints Process	ICS&H Integrated into Performance Evaluations & Staff Orientation
Truth Telling about Colonization	Low/ Medium	Medium/ High	High	Low	Low	Low	Low	Low	Medium
Fostering First Nations Perspectives on Health and Wellness	Low/ Medium	Medium	High	Low	Low	Low	Low	Low	Medium
Indigenous Faces, Content, and Spaces	Low	Low	Low	Med	Med	High	Low/ Medium	Low/ Medium	Low
Indigenous Self-Determination	Low	Low	Low	Low/ Medium	High	Low	Low/ Medium	Med	Low
Long-term Process of Self-Reflection	Low	Low	Low	Med	High	Low	Low/ Medium	High	High
Cost to Organization	High	Low (short) High (long)	Low	Med	Med	High	Med	High	High
Administrative Complexity	High	Low (short) High (long)	Low	Low	Low	Low	Med	Low	Medium