CANADIAN FEDERATION OF NURSES UNIONS

BEYOND EQUITY:

Taking Action to Address Indigenous-Specific Racism in Nursing

Dr. Liquaa Wazni, RN, PhD
Dr. Lisa Bourque Bearskin, RN, PhD

Canadian Federation of Nurses Unions

The CFNU is Canada's largest nurses' organization, representing frontline unionized nurses and nursing students in every sector of health care — from home care and LTC to community and acute care — and advocating on key priorities to strengthen public health care across the country.

Land acknowledgement

From coast to coast to coast, we acknowledge the ancestral and unceded territory of all the Inuit, Métis and First Nations Peoples that call this land home. The Canadian Federation of Nurses Unions is located on the traditional unceded territory of the Algonquin Anishnaabeg People. As settlers and visitors, we feel it's important to acknowledge the importance of these lands, which we each call home. We do this to reaffirm our commitment and responsibility to improve relationships between nations, to work towards healing the wounds of colonialism and to improve our own understanding of local Indigenous Peoples and their cultures.

Published by

Canadian Federation of Nurses Unions
2841 Riverside Drive
Ottawa, ON K1V 8X7
613-526-4661
www.nursesunions.ca

ISBN
Print: 978-1-990840-39-5
Digital: 978-1-990840-40-1

CFNU project team

Research coordinator
Tyler Levitan

Project support
Oxana Genina, Corey Grist

Available in French translated by

Juliette Giannesini

CFNU Member Organizations

Registered Nurses' Union Newfoundland & Labrador
UNA United Nurses of Alberta
New Brunswick Nurses Union NBNU SINB Syndicat des infirmières et infirmiers du Nouveau-Brunswick
pei nurses
BC NURSES' UNION
Nova Scotia Nurses' Union
ONTARIO NURSES' ASSOCIATION
sun SASKATCHEWAN UNION OF NURSES
CNSA AEIC
Manitoba nurses Union A COMMITMENT TO CARING

Beyond Equity: Taking Action to Address Indigenous-Specific Racism in Nursing

We express our deep gratitude to the Indigenous Peoples of this land, whose knowledge, leadership and guidance continue to shape and transform Indigenous health care services. We uphold local Indigenous rights and responsibilities with profound respect across the territories where we live, work and learn. We commit to learning and acknowledging whose traditional territory we inhabit, recognizing that every part of what is colonially known as Canada exists on Indigenous traditional territory. We honour the Peoples whose historical and living relationships with the land continues to this day.
We extend our heartfelt gratitude to the Elders, both past, present and future, for they hold the memories, traditions, cultures and hopes for generations to come.

Authors

Liquaa Wazni, RN, PhD, Postdoctoral Fellow, University of Victoria

Mona Lisa Bourque Bearskin, RN, PhD, Beaver Lake Cree Nation, University of Victoria, CIHR Chair, Indigenous Health Nursing, BC

Holly Graham, RN, PhD, R. D. Psych., Thunderchild First Nation, Associate Professor, Department of Psychiatry, University of Saskatchewan, CIHR Chair, Indigenous Health Nursing, SK

Wanda Phillips-Beck, RN, PhD, Hollow Water First Nation, CIHR Indigenous Chair in Nursing, First Nations Health and Social Secretariat of Manitoba, Adjunct Professor, College of Nursing, University of Manitoba

Dr. Margot Latimer, Kjipuktuk (Halifax) Mi'kma'ki, Professor, Faculty of Health, Dalhousie University, CIHR Chair, Indigenous Health Chair in Nursing, NS

Dr. Blanchet Garneau, RN, PhD, white settler of French ancestry, Associate professor, Faculty of Nursing, Université de Montréal, CIHR Chair, Indigenous Health Nursing, QC

Jason Hickey, RN, PhD, Associate Professor, Faculty of Nursing, University of New Brunswick, CIHR Chair, Indigenous Health Nursing, NB

Table of contents

Presidents message

Nurses are tireless advocates for their patients, extending even beyond the confines of their workplaces. However, a fundamental issue of workplace – and broader societal – injustice that has never been adequately addressed by Canada's nurses is that of reconciliation with Indigenous Peoples. Indigenous nurses and patients continue to face systemic racism within the context of a settler colonial state, with a history as old as Canada of facing deplorable treatment in our health care systems.

That is precisely why the CFNU commissioned this timely report to coincide with our formal apology to Indigenous Peoples for nurses' role in these systems, along with a commitment to do better. As one of the country's leading voices in health care and the largest nurses' organization, it is our responsibility to pursue cultural safety and equitable access to care that is free from discrimination for Indigenous patients and clients, and anti-racist workplaces for our Indigenous nurse colleagues.

The CFNU has been working towards building a trusted advocacy role in justice for Indigenous Peoples since the appalling case of Jordan River Anderson from Norway House Cree Nation in Manitoba, who had been hospitalized since birth with a rare medical condition in Winnipeg. Governments failed to provide the care he needed based on jurisdictional squabbles over which level of government should have paid. What happened to Jordan and what continues happening to Indigenous Peoples facing systemic racism cannot persist.

The way forward for Canada's nurses is to apologize for our historical role and lack of sufficient action, and to continue our efforts to lay a strong foundation for future generations. We pledge to right these wrongs through meaningfully contributing to reconciliation, while being accountable to Indigenous Peoples and to our members. Our 2025 national convention is the site for these historic steps on this continuous journey.

I would like to thank Dr. Liquaa Wazni and Dr. Lisa Bourque Bearskin for producing this report. I would also like to thank the Indigenous Health Research Nursing Chairs who made important contributions to the writing. Finally, I would like to thank the CFNU team led by Tyler Levitan and our CFNU advisory committee members Brigitte Goar (ONA), Candi DeSousa (BCNU) and Marla Johal (MNU) for their guidance and wisdom.

I hope the report serves as an invaluable resource for educating our members and advancing the long overdue work of truth and reconciliation within the nursing and broader health care community in Canada. Let us move forward with determination and action.

In solidarity always,

Linda Silas, CFNU President

From the CIHR Indigenous Health Nursing Chairs

Tani'si, hello – on behalf of the six inaugural CIHR-funded Indigenous Health Nursing Research (IHNR) Chairs, we are grateful to support nurses in their journey through reconciliation, as we honour and uphold Indigenous health as a fundamental human right.

We value our deep relational connection to our home fires, with respect for all of Creation. We recognize that re-imagining a different future for nursing wellness begins with us, both individually and collectively, as a whole family. It is our shared responsibility to acknowledge that long before the colonization of Canada, Indigenous communities had well-established health knowledge and governance structures that sustained the health and wellness of their Peoples. We demonstrate our strong commitment to this future by serving local Indigenous communities and creating partnerships with universities, health authorities and health outreach programs. Indigenous nurses bring nursing close to the people's home fires, supporting an "earn as you learn" approach, through intergenerational mentorship initiatives that engage and uplift a new generation of nurses.

We practice transformational learning and experiential nursing education by advancing the Truth and Reconciliation Commission's Calls to Action #23 and #24.[5] We have advocated for nursing curricula to include Indigenous perspectives, histories and knowledge systems, while addressing systemic racism in health care. We continue to call for culturally safe learning environments, enhanced intergenerational mentorship initiatives and policy reforms that embed anti-racist legislation to advance decolonial health care.

Through our leadership and presence, we are strengthening the nursing profession's commitment to reconciliation and fostering a health care system that respects and upholds Indigenous rights. Over the past 50 years, our early nursing leaders paved the way with their unique ways of being, their distinct knowledge and their ability to adapt and respond to lived realities. We continue to show how the power of collaboration can create meaningful solutions to improve health care delivery, disease prevention, rehabilitative and palliative care and community wellness. We remain committed to dismantling systemic barriers to health care access. With bravery, courage, trust and curiosity, we bring together different perspectives to build inclusive values-based partnerships and sustainable solutions. We help to achieve better outcomes by generating wellness approaches that authentically support self-determining principles of care.

Our approach to health is different because it is infused with First Nations, Métis and Inuit values, languages and laws of relationality. We look beyond traditional models and embrace a holistic wellness approach for the future, taking an expansive view on the social, cultural and environmental contributors to health. We teach person-centred, community-focused and community-led care. We prioritize working alongside communities to ensure our work is responsive to the needs of the Peoples and health care providers who serve them.

Canada's public health care system is under immense pressure. Compounding challenges of workforce shortages, limited training opportunities, the ongoing mental health and toxic substance use crises, pandemic recovery and the urgent need to eradicate Indigenous-specific racism have all intensified. Our commitment to transforming this system remains unwavering. Helping nurses maintain healthy and active professional lives requires innovative solutions and interventions. We encourage a new, holistic approach that is centred on connection, community, collaboration and culture, as this is essential to bringing about systemic change in our health care system.

Our collaborative team is deeply engaged in developing a thriving community-focused health care environment that attracts and retains health professionals. Our team of Indigenous Health Nursing Researchers, nursing leaders, students and community champions explores collaborative practice models to improve patient outcomes, reduce errors, enhance patient safety and increase professional satisfaction. We are committed to cultivating and integrating cultural safety, humility and ways of knowing, while supporting Knowledge Holders, Healers and Helpers to advance local health knowledge systems. We move forward together, knowing that accelerating health research, creating meaningful partnerships and translating research into health impacts can contribute to changing a complex, systemic and colonial problem. It is our hope that we continue to learn and unlearn while upholding the rights of Indigenous Peoples to self-determination.

On behalf of the I-Chairs, we also want to hold up our hands to Dr. Liquaa Wazni, who led the writing of this report. Her leadership and unwavering commitment to making change are palpable, and she has become an invaluable member of our collective. In addition to our future leaders who contributed to our collective research, we are grateful to Dawn Googoo (We'koqma'q First Nation), Julie Francis (Eskasoni First Nation), S. Josée Lavallée (Manitoba Métis Federation's Bison Local), Michelle Padley (Métis Nation of BC), Christina Chakanyuka (NWT Métis Nation), Anne-Renée Delli Colli (Canadian settler, French ancestry) and Tania Turnbull (Scottish, English, Inuit and Innu ancestry).

This report contains key terms and concepts that are essential to understanding Indigenous health and health care transformation. To support clarity and ease of reference, important terms are shown in bold throughout the text. All bolded terms are defined in the **Glossary**. If you are using the **digital version** of this report, you can **click on a bolded term** to navigate directly to its definition in the Glossary.

We express our gratitude to the Canadian Federation of Nurses Unions (CFNU) for their financial contribution toward developing this discussion paper. We also acknowledge funding for the Indigenous Nursing Research Chairs Program, provided by the Canadian Institutes of Health Research – Institute of Indigenous Peoples' Health, with additional support from professional nursing organizations in our respective regions (e.g., resources, advocacy and partnership).

Êkosi pitamâ, that is it for now,
Mona Lisa Bourque Bearskin

1 Reconciling Indigenous health and transforming health care

To begin, we acknowledge the traditional custodians and stewards of these lands on which we live, benefit and prosper. From east to west, we pay our respects to the old ones, the **Knowledge Holders** and **Elders** past, present and emerging, understanding that this land is and always will be Indigenous lands, even though it is colonially known as Canada.

We recognize that future generations and those yet to be born will need to be cared for in ways that nurture relational obligations. We recognize ourselves as guests and descendants with inherent rights to ensure our responsibilities as good neighbours and to take care of the water, the air, the fire and the land, acting as stewards of humanity, and to be in service to our local Indigenous Peoples.

The legacy of **colonialism** in Canada continues to have significant impacts on how health care is provided and how it impacts health experiences and outcomes of **First Nations**,[237] **Métis**[1] and **Inuit**[2] Peoples. This discussion paper takes a closer look at what a **distinctions-based approach (DBA)**[3] means for health care providers and how it impacts **Indigenous Peoples'** health experiences and outcomes. In addition, we introduce key historical factors that have contributed to **Indigenous-specific racism** in health care, while upholding the unique rights, identities and health needs of First Nations, Métis and Inuit Peoples, and offer ideas for nurses to become culturally safe providers.

In collaboration with the Canadian Federation of Nurses Unions (CFNU), this resource represents our ongoing journey toward truth and **reconciliation** in nursing as called for in the **Truth and Reconciliation Commission's (TRC) Calls to Action.**[5] Each of us is committed to upholding the self-determining rights of Indigenous Peoples and recognizing distinct populations from a human rights perspective. As our nursing matriarchs, Knowledge Holders and Elders remind us, having the freedom to practice intellectually, culturally, spiritually and linguistically is the only way forward. This report draws on the extensive research and **lived experiences** of Indigenous Peoples' access to care and the voices of Indigenous nurses working within the health care system. Their wisdom offers a vision and a mission for meaningful transformation in health care that we embrace.

We envision a world where Mother Earth and Indigenous Peoples are healthy and vibrant as a result of honouring their right to receive safe and quality Indigenous health care. Where Indigenous communities lead healthy, vibrant lives with every breath, with every prayer, with every stitch and with every nurse.

Beyond equity

There is no denying that the current health care crisis is deeply affecting the health of Indigenous Peoples. It is also taking a toll on Indigenous nurses, many of whom face burnout, are leaving the profession, or are moving from the public to the private sector, such as travel agencies, thereby threatening the sustainability of our health care system. At the same time, many health care providers are uninformed or ill-equipped to address the complexities of Indigenous health, in which health care is rooted in **colonial structures.**[7] Upholding **Indigenous rights** requires an understanding that Canada is built on the suffering of Indigenous Peoples. Colonial laws, **treaties** and international policies shaped health systems in ways that made it illegal for First Nations to speak their languages, practice their laws and maintain relationships with their ancestral lands. These structures and policies continue to shape health care today, making it difficult for Indigenous Peoples to fully access and exercise their rights to health, land, language and **self-determination**.

The colonial forces disrupted Indigenous governance, education, health and knowledge systems that have long been sustained through **traditional Indigenous healing practices**, cultural protocols and kinship relations. This led to the erosion of families, destruction of communities and children stripped of their rights to learn from and care for one another. This attempted physical and cultural extinction failed. Today, we see the resurgence and revitalization of First Nations, Métis and Inuit Peoples from coast-to-coast-to-coast returning to their homelands, learning their languages and working to overcome the social, economic, spiritual and intellectual violence Indigenous Peoples still endure. **Colonial systems** continue to shape every level of the Canadian health care system, influencing how Indigenous Peoples' rights are acknowledged, respected and implemented in practice.

It has long been recognized that health care providers need to understand how culture and systems of oppression operate within health care systems.[8] Ramsden, a **Māori** nurse, explained that the significance of **cultural safety** emerged with the need to acknowledge the impact of colonization and understand the effects of ongoing colonization on Indigenous populations throughout the health care landscape. Ramsden defined cultural safety as an outcome of nursing care that empowers those who receive health care services with the right to express degrees of felt risk and define 'safety' when receiving care. Key to this transformation are the standards of practices of cultural safety and **cultural humility**, which guide providers to recognize, examine and challenge power dynamics, systemic inequities and personal biases.[9]

The time to move beyond equity is now. We have done extensive work in nursing to understand the difference between equality and equity. Equality means everyone is treated equally, which does not consider the social determinants of health, whereas equity focuses on addressing the barriers to receiving fair and just services. Therefore, transcending equity is not merely about distributing resources fairly. It also means removing power imbalances and barriers rooted in Eurocentric knowledge systems, while ensuring that Indigenous Peoples' rights are respected. This work requires dismantling colonial structures, upholding Indigenous self-determination, and centring Indigenous leadership and knowledge within an eco-health framework that recognizes the deep interconnection between human and ecosystem health. By focusing on truly equitable outcomes, we can create opportunities for Indigenous leadership to shape and lead a just, responsive and culturally safe health care system.

Furthermore, a decade has passed since the release of the TRC's Calls to Action,[5] yet progress on implementation remains painfully slow. Achieving true reconciliation requires more than equal or equitable policies; it demands a fundamental shift toward Indigenous-led health governance, policy transformation and the restoration of Indigenous self-determination in health care. As we enter a new era of health service delivery and truth-telling, we must transcend the constraints of colonial health systems and commit to systemic changes. This report is intended for a national audience, providing guidance for all licensed nurses in Canada, including registered nurses (RNs), licensed practical nurses (LPNs), registered psychiatric nurses (RPNs) and nurse practitioners (NPs), as well as other health care professionals.

A collective journey

This initiative emerges from CFNU's long-standing collaboration with Indigenous nurses and the Canadian Indigenous Nurses Association (CINA).[10] It also shares the collective journey of the six Indigenous Research Chairs in Nursing[11] and their teams of Indigenous Elders, Knowledge Holders, nurses, nursing students and patients, who bring critical insight and powerful stories of determination, strength, bravery, **resilience** and advocacy. Over the past five years, these Chairs have focused on improving access to culturally safe and inclusive education and care for Indigenous communities while promoting opportunities for Indigenous nursing students and leadership. Their efforts have been strengthened through collaborative partnerships with national organizations such as CINA, the Canadian Nurses Association (CNA)[17] and the Canadian Association of Schools of Nursing (CASN);[13] regionally with professional and regulatory bodies and nurses' unions; and locally with schools of nursing and community organizations. Notably, the Manitoba Chair[13] is the only Chair uniquely situated within a community-led organization, the First Nations Health and Social Secretariat of Manitoba.[15]

Representing regions across British Columbia, Saskatchewan, Manitoba, Quebec, Nova Scotia, and New Brunswick, the Chairs are deeply committed to uplifting Indigenous voices in practice, education, leadership and research. Their work examines Indigenous-led primary health care services, Indigenous wellness, authentic community partnerships, systemic discrimination and Indigenous-specific racism, revealing both the persistent challenges and the remarkable strengths of Indigenous Peoples in advancing culturally safe and people-oriented care. This collective research reinforces the need for relational, reciprocal, responsible and responsive service delivery tailored to the unique needs of respecting First Nations, Métis and Inuit Peoples. Together, we advance **Indigenous Health Nursing** as a specialty practice that integrates **Indigenous Knowledge Systems** and holistic healing approaches rooted in the cultural values of Indigenous Peoples. Central to this work are the relationships that connect Indigenous nurses, researchers and allies across Canada, New Zealand, Australia and the United States. Through these international collaborations, the Chairs have amplified First Nations, Métis and Inuit perspectives in global nursing discussions while promoting culturally grounded research, education, and intergenerational mentorship to drive meaningful systemic change.

This report is more than just an academic or professional endeavour; it is a living testament to the strength, wisdom and unwavering vision of Indigenous nurses and their communities. It carries their stories and voices, and it celebrates their leadership. Recognizing Indigenous health as a fundamental human right requires critical discourse and ethical spaces where Indigenous ways of being and knowing are respected and upheld. Our shared purpose is rooted in nurturing minds, deepening spiritual connections, sharing relational practices and carrying forward the responsibilities entrusted to us.

Indigenous nursing leaders: a tradition of bravery and advocacy

The question of who was "first" must be treated with caution and, ideally, broadened to reflect First Nations, Métis and Inuit epistemologies of caregiving, knowledge transmission and leadership in community health. Evidently, this undertaking requires a degree of time, diligence and insight that we may not be best positioned to offer at this time. However, for over 45 years, Indigenous nursing leaders who formed the Canadian Indigenous Nurses Association in 1975 have been at the forefront of advancing Indigenous Health Nursing and the first Indigenous health organization at a time when there were no others.[17] Trailblazers such as Edith Monture and Jean Goodwill were among the first recognized Indigenous nursing leaders in Canada.

Members of our BC Indigenous Health Nursing Research (BC-IHNR[185]) Wisdom Council, including Kétéskwew (Madeline Dion Stout), Judy Pelly, Mabel Horton, Rose Miller, Evelyn Voyageur, Doreen Spence, June Shackley, Marilyn VanBibber and so many more not listed here, have inspired and mentored generations of health providers. Originally from Kuujjuarapik, Quebec, Minnie Akparook was among the first Inuk nurses to practice in

Nunavik. Her path into nursing was marked by profound adversity, including forced relocation, attendance at a residential school and persistent **systemic racism**.[235] Despite repeated setbacks and institutional rejections, she was eventually accepted into a nurse's assistant program, through which she successfully transitioned into and completed her training as a registered nurse. It is important to note that, due to colonial records often failing to properly recognize Inuit women's roles, especially when they were not operating within Euro-Canadian credentialing systems, many Inuit women who provided care and healing were not formally acknowledged as nurses despite fulfilling critical health functions within their communities.

Regardless of the ongoing challenges, their leadership remains a testament to the fact that Indigenous health is fundamental to moving beyond health equity if any real change is to happen. For decades, Indigenous Peoples were barred from attending nursing schools, a restriction that only changed in 1960.[16] As Rose Miller so aptly put it, "We made the change." Their perseverance opened the door for future generations, who continue to lead with strength and vision. In the ongoing fight against colonial-style health care delivery, these early nursing leaders laid the foundation for today's urgent call to expand Indigenous nursing leadership roles, create grassroots evidence of Indigenous-led health care's benefits and implement on-the-ground solutions to address a range of health inequities from the bedsides to the boardroom.[16,17,18]

The key findings of the BC-IHNR[185] research highlight the many nurses who are taking a stand and speaking out against colonial structures that undermine Indigenous Knowledge Systems and community well-being. Nurses are advocating for culturally safe care, often at great personal and professional risk, while navigating systems that render them invisible or reduce their contribution to token efforts.[6] Many nurses talked about working in settings that are unwelcoming and hostile, where their advocacy is dismissed or penalized. Despite these challenges, they persist with resilience, carrying forward their vast knowledge, lived experience and ancestral gifts of healing, helping and caring for others as health professionals. One example of this resilience and leadership is the *Indigenous Leadership Circle* within the BC Nurses' Union (BCNU),[20] which is a unique initiative that offers a meaningful space for Indigenous nurses to come together, share knowledge and advocate for culturally safe practices within the profession.

Their vision of self-determination affirms that health and healing are defined by Indigenous Peoples and in alignment with their sociocultural and ecological realities. This is not a one-size-fits-all approach, as each nation and Indigenous group has its own language, customs and beliefs about health. Indigenous nurse leaders continue to reclaim health as a rights-based, truth-centred and strengths-oriented movement that honours collective acts of resurgence and resistance in reshaping health care and beyond. While recognizing the past contributions of

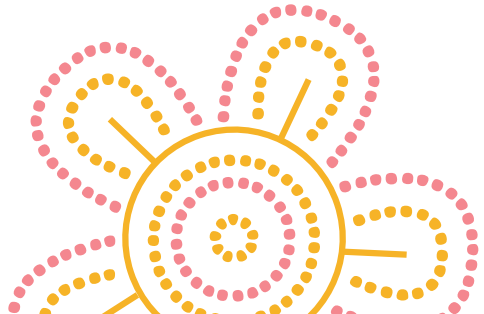
Indigenous nursing leaders, it is imperative that nursing professionals also engage in this work to dismantle systemic barriers, build mutual support and create opportunities for Indigenous Peoples to thrive. Their strength calls upon us to centre cultural safety, humility, equity and justice in our relational nursing practice, not just as an act of resistance but as a commitment to building something better.

Healing is a deeply personal act, and nursing as a political voice lies at the heart of this journey. The movement for meaningful change is growing, fueled by resilient Indigenous nurses and their allies. We aspire for all people to recognize Indigenous health as a human right, and we believe that critical discourse and ethical spaces are essential to advancing this understanding. Our shared purpose is rooted in nurturing minds, connecting to spirit, sharing relational practices and carrying forward the responsibilities entrusted to us. Indigenous nurses are not merely working within the system; they are reimagining it, calling for creating and leading models of care that honour Indigenous ways of being and knowing. However, to accomplish this, they need the right support and tools to navigate and challenge the colonial structures that still shape health care experiences today.

Changes cannot come from the top down; they must be led by Indigenous nurses themselves, supported by systems that recognize their authority, value their knowledge, and create space for self-determined and distinctions-based approaches to nursing education and care.

Despite the lingering effects of racism fatigue, our Peoples are strong and hold distinct traditional systems of care rooted in the land. Roots that make the baskets that hold our stories, carry our salmon, berries, and medicines to sustain our ancestral well-being and our right to health.

(Colleen Seymour, Tk'emlu'ps te Secwe'pemc[50])



Who are the original peoples?

According to section 35(1) of the *Canadian Constitution Act*, 1982, Indigenous populations are recognized as First Nations, Métis and Inuit Peoples.[21] They are the fastest-growing population in Canada, and collectively represent just under two million people, making up 5% of the national population. Among them, 58% identify as First Nations, 34.5% as Métis, and 3.9% as Inuit. The Indigenous population has increased by 9.4% since 2016, outpacing the non-Indigenous growth rate of 5.3%. Ontario has the largest Indigenous population (22.5%), and a significant proportion (25.4%) of Indigenous individuals are under 14 years of age. These trends highlight the resilience and resurgence of Indigenous Peoples.[22]

First Nations are very diverse and are often referred to as the original descendants who have lived on these lands since time immemorial, along with the Inuit, who are known as peoples of the Arctic. The Métis Peoples are another distinct population with a unique history that stems from the relational unions between the First Nations and European fur traders. They carry their own unique histories, languages, governance systems and cultural protocols.[23,24]

Indigenous ways of life are rooted in balance, interconnection and sustainability, shaping holistic approaches to health, education and governance that prioritizes collective well-being.[25] Before colonization, Indigenous nations thrived with complex political structures, extensive trade networks and advanced knowledge systems.[26,27,28] Their economies were built on reciprocity, sustainability and kinship that ensured land and resources were cared for and shared across generations.[29] Their knowledge of medicine, healing ceremonies and ecological conservation were passed down through oral traditions and lived experience, and sustained their communities for thousands of years.[39,31,32] Despite disruptions caused by colonialism, Indigenous Peoples have continually adapted and resisted, maintaining their languages, traditions and governance structures. Today, their knowledge systems continue to inform self-determining processes of governance, climate action and health interventions, offering invaluable wisdom for building a more just and sustainable future.[33,34]

Understanding treaties

Some of the earliest treaties remain central to confederation efforts in Canada and play a critical role in addressing systemic injustices. The treaty-making process was initially framed as a means for building respectful nation-to-nation relationships and defining responsibilities between Indigenous Nations and the **Crown**. In practice, it became a tool for the dispossession of Indigenous people from their land, the dismantling of their health support systems and the erosion of their **sovereignty** through **paternalistic** policies over time.[58] While early treaties, such as the *Peace and Friendship Treaties* (1701–1763), focused on coexistence and cooperation,[35] later negotiations of treaties often prioritized settler access to land and resources.[37]

The Royal Proclamation of 1763 was a turning point, as it formally recognized Indigenous land rights and established a legal recognition of First Nations Peoples for Treaty-making.[36] However, while some treaties were signed under extreme duress, vast areas of Indigenous land were never surrendered and remain unceded. The failure to honour the treaty commitments has had lasting consequences, leading to ongoing disputes over land, governance and health care. As a mere symbolic move, land acknowledgments serve as a reminder of these unfulfilled promises and the need for meaningful action toward reconciliation. Despite the formal recognition of Indigenous land rights, many subsequent treaties, including the *Numbered Treaties* (1871–1921), failed to deliver on promises of land, education, health care and other resources, leaving Indigenous communities marginalized.[38] More recent agreements, such as the *Nisga'a Treaty* (2000)[39] and the *Yukon Umbrella Final Agreement* (1993),[40] signal some progress in recognizing Indigenous sovereignty and resolving disputes over land and governance that will see the health of its Peoples. Although both historic and modern-day treaties and land claims are often portrayed as mutually beneficial, many commitments have not been honoured, reinforcing systemic violence that continues to harm Indigenous Peoples and their communities.

Health care is one of the most critical treaty obligations, yet many are unaware of the Medicine Chest Clause and that commitments remain unfulfilled. Long before Canada's public health care system existed, First Nations had well-established health systems rooted in the laws and languages of the land.[41,19,42,43] These systems supported thriving communities and reflected Indigenous knowledge and governance over health and well-being. This treaty commitment to health care is known as the Medicine Chest Clause in Treaty 6,[44] which is meant to ensure continued access to health care for Indigenous Peoples. However, like many other promises, it was not fully honoured. Instead, it

was later misrepresented and rewritten into legislative policies that prioritized assimilation over Indigenous rights.[45] As a result, Indigenous communities continue to face chronic underfunding of health care services, limited access to culturally safe and community-led care, and systemic barriers such as jurisdictional disputes
over health care responsibilities.

Federal involvement in Indigenous health care was never about upholding treaty obligations, but rather about settlers' concerns that poor Indigenous health conditions could pose a risk to public health.[42] This history highlights how public health reform in Canada became a tool of exclusion, contributing to ongoing inequities that Indigenous communities continue to face. Treaties are not merely historical documents but are living agreements that demand ongoing respect and action. Upholding these commitments is crucial for addressing historical injustices, advancing reconciliation, and building equitable nation-to-nation relationships that honour the rights and self-determining actions of Indigenous Peoples.[36]

2 Confronting the colonial health legacy

What is colonization?

Colonization is more than a large-scale movement of settlers; it is a process of dominance that continues to reshape the lives of Indigenous Peoples today.[45,46] Driven by **colonial ideologies**, it established what is known as "settler colonialism," a framework that allowed dispossession of Indigenous Peoples and the creation of legal and institutional structures that continue to marginalize and disadvantage them.[47] Colonization goes beyond physical displacement; it disrupts Indigenous ways of life, erases Indigenous sovereignty, language and cultural practices and reinforces social structures that perpetuate systemic power imbalances and inequities.[29,34] One of the most devastating outcomes is believed to be the introduction of "crowded type" pathogenic infectious diseases, such as smallpox, measles and typhoid brought by European settlers. Indigenous populations had no immunity to these diseases and suffered high mortality rates.[48] Beyond diseases, colonial policies forcibly removed Indigenous Peoples from their homelands through centralization, which meant relocating them to less desirable lands that threatened their survival.[46] This severed deep connections to the land, disrupting food systems, traditional medicines and cultural practices that had sustained them for generations.[49] These disconnections not only impacted immediate health and survival but also reshaped health care access and delivery, further entrenching colonial legacies within medical systems.

The infringement of the biomedical model on Indigenous Knowledge systems

Within this colonial context, Eurocentric health care systems have long marginalized Indigenous approaches to healing, which are holistic and community-based.[33,50] The dominance of the **biomedical model of care** reinforces systemic inequities by prioritizing pathology, standardized treatments and biological mechanisms of disease while dismissing the cultural, spiritual and social determinants of health. Indigenous Knowledge Systems view health as a balance of physical, mental, emotional, spiritual and communal well-being, grounded in thousands of years of ecological and cultural wisdom that prioritizes relationality and interconnectedness.[50,51] However, the **hegemony** of the biomedical model of care has denied and devalued these approaches and excluded Indigenous perspectives from policy and practice.[54]

The Indian Act and erosion of Indigenous rights (1876 – present)

The Indian Act of 1876 is one of the most colonial laws in Canada and was designed to **assimilate** Indigenous Peoples into settler society.[35] Rather than recognizing Indigenous nations as self-governing Peoples, the Act imposed a rigid, government-controlled system that stripped them of their autonomy, culture and land. It fractured family kinship ties, dismantled traditional governance systems, banned sacred cultural practices such as the **Potlatch** and **Sun Dance**, and imposed patriarchal structures that marginalized and discriminated against Indigenous women.[55,56,57] These imposed patriarchal structures disproportionately harmed Indigenous women as they lost their legal status, rights and connection to their communities if they married non-Indigenous or non-status men, and their children were denied Band membership (*Indian Act*, 1876).[58] This legislated "status" designation determined who was officially recognized as "Indian" under Canadian law, often excluding individuals from accessing their own community resources, **reserve land** or health care services. The Act also restricted the control of First Nations and Métis communities over land and resources, fostering economic dependency. It furthermore excluded Métis People as a distinct population.

The Act penalized those who sought higher education. Under its **enfranchisement** policy, Indigenous individuals lost their status if they obtained a university degree

or pursued professions such as law, medicine or the clergy.[58] This created significant barriers to nursing, where formal education was required for entry. Many Indigenous women who aspired to become nurses were forced to choose between their careers and their legal identity as First Nations women. For example, Edith Monture, a Mohawk nurse from Six Nations, was barred from Canadian nursing schools and had to pursue her education in the United States. There, she became the first Indigenous Canadian woman to gain the right to vote in a federal election.[59]

Over the years, the Act has been amended multiple times, yet its colonial framework persists.[58] The 1951 *amendment* removed bans on cultural practices and allowed Indigenous women to vote in band elections and attend university, but it failed to address systemic inequities. *Bill C-31* (1985) restored status to some First Nations women and their descendants who had lost it due to discriminatory policies. However, it introduced new barriers, such as the *Second-Generation Cut-Off Rule*, which still prevents many grandchildren of women who regained status under Bill C-31 from passing status to their own children if they have a non-status partner. This amendment also failed to retroactively restore status to descendants of women who married non-status men before 1951.[60] Subsequent efforts, such as the 2011 *Gender Equity in Indian Registration Act* and 2017 *Bill S-3*, were introduced to correct gender-based discrimination for women who lost status by marrying non-status men. While they restored status to more individuals, they left key gaps unresolved, particularly for pre-1951 cases, and continued to exclude many descendants through the *Second-Generation Cut-Off Rule*. These changes also did not dismantle the broader colonial framework of the *Indian Act*, which continues to perpetuate systemic inequities and undermines Indigenous sovereignty.[58] The Act still shapes policies that impact the lived experiences of First Nations, Métis and Inuit communities, often limiting Indigenous self-determination and equitable access to health services.

Although Inuit were not governed under the *Indian Act*, colonial policies and state interventions similarly destabilized Inuit kinship systems, gender roles and collective autonomy. The forced relocations of the mid-twentieth century were often justified by claims of national sovereignty and economic development. These relocations were implemented under conditions that exposed Inuit to starvation, dispossession and cultural rupture. They undermined traditional Inuit governance and authority within families and communities, particularly by imposing coercive forms of control that disregarded Inuit social structures and consent.[61] In addition, Inuit were subjected to a range of identity-based exclusions through the Eskimo Identification System, which was in effect from the 1940s to the 1970s. This system replaced Inuit naming practices with disc numbers, stripping individuals of their relational and cultural identities and agency.[62,63] In parallel, the large-scale slaughter of Inuit sled dogs, carried out by colonial authorities between the 1950s and 1960s, inflicted profound trauma and hardship on Inuit families. This violence severed their mobility, autonomy, subsistence practices and social cohesion.[63,64]

Residential schools (1880s–1996)

The Canadian Indian residential school system was a state-sponsored initiative that operated between the late 19th century and 1996 and was designed to coercively assimilate Indigenous children into a Eurocentric societal framework.[5] In 1920, the *Indian Act* was revised to force all Indigenous children into residential schools, giving the government the power to take them from their families, often by force.[66] Under the notorious directive from the Prime Minister of Canada, John A. McDonald, to "kill the Indian in the child,"[67] these institutions were rooted in colonial doctrines espousing racial and cultural supremacy and sought to eradicate Indigenous culture and identity.[71] As estimated by the federal government, approximately 150,000 Indigenous children were torn from their families and put into residential schools, where they were systematically forbidden from speaking their languages, practicing their cultures, or maintaining ties to their communities.[5]

Many of the children in residential schools suffered physical, emotional and sexual abuse, resulting in serious and intergenerational traumas that extended beyond survivors into successive generations.[5] The TRC documented the deaths of approximately 3,200 Indigenous children in these institutions, though the actual number is believed to be much higher, potentially exceeding 6,000, with many children still unaccounted for.[238] Conditions in those schools were characterized by neglect and systemic racism, with overcrowding, malnutrition, and inadequate medical and oral health care, leading to high mortality rates. Infectious diseases such as tuberculosis and influenza spread unchecked due to the lack of proper health resources and care.[95] Residential schools were also places of unethical medical research.[70] Children were subjected to nutritional experiments that, in part, were used to inform federal nutrition policies at the time, including aspects of Canada's Food Guide. These experiments often involved the deliberate withholding of essential nutrients, leaving children hungry, causing immediate harm and contributing to long-term health issues, including an increased risk for chronic conditions such as diabetes.[94] The residential school system, therefore, instilled a deep-rooted fear and distrust of education and health institutions, effects that continue to impact Indigenous communities today.

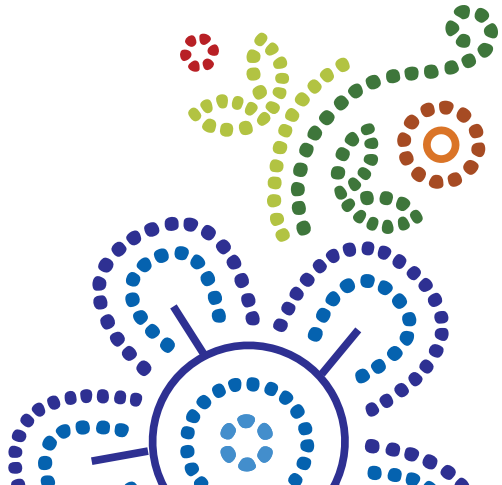
Nurses as part of the colonial health system played a significant role in the oppression of Indigenous Peoples. In residential schools, they were present in institutions where unethical medical experiments occurred and were often complicit in the neglect and abuse of Indigenous children. Many provided inadequate care and failed to advocate against the deplorable conditions that led to widespread illness and death.[72] By upholding assimilationist policies, nurses also contributed to the dismissal of Indigenous Knowledge Systems, perpetuated systemic racism and supported cultural erasure.[77] Today, the lack of widespread acknowledgement of this history in nursing education and practice reveals a gap in understanding the ongoing impacts of colonialism and in recognizing the profession's complicity in that legacy.[73]

Florence Nightingale, highly regarded as the founder of modern nursing, also contributed to the marginalization of Indigenous Peoples through her alignment with colonial ideologies.[76] While she transformed health care with her revolutionary ideas on sanitation and Western medical practices, her Eurocentric approach rejected Indigenous Knowledge Systems and perpetuated the perceived superiority of Western medicine over other medical systems.[77,78] Nightingale's influence on colonial health policies aligned with assimilationist agendas, displacing community-based Indigenous healing traditions in favour of dependence on Western institutions.[79] Furthermore, her emphasis on individual health responsibility overlooked systemic injustices created by colonialism, which included forced displacement, inadequate living conditions and exclusion from health care decision-making processes.[76,80]

While Florence Nightingale's legacy is celebrated annually on International Nurses Day (May 10),[82] her ties to colonialism have prompted some reflection. In 2020, the New Zealand Nurses Organization chose not to honour Nightingale, stating, "the historical figures whom we choose to venerate say a lot about who we are."[81] In Canada, Indigenous nurses have advocated for April 10 to be established as Indigenous Nurses Day in honour of Charlotte Edith Anderson Monture (1890–1996), the first Indigenous registered nurse in Canada and a First World War veteran. Born on the Six Nations Reserve near Brantford, Ontario, Monture's groundbreaking legacy continues to inspire Indigenous nurses today.[83]

In British Columbia, Rose Casper[84,85] of the St'at'imc Nation is recognised as the first Indigenous nurse in Western Canada. A graduate of the Kamloops Indian Residential School, she pursued further education and graduated from St. Joseph's School of Nursing in Victoria, BC, in 1955. Casper dedicated over 50 years of service to her home community of Shalalth, and her legacy continues through the Rose Casper Healing Centre,[86] which offers both traditional and contemporary wellness services.

As we reflect on the history of nursing, it is crucial to acknowledge and honour these contributions, ensuring that the stories of Indigenous nurses are fully integrated into the narrative of the nursing profession. We must right the wrongs of the past and create a more inclusive history that recognizes the impact of colonial caring approaches while celebrating the resilience and leadership of Indigenous nurses. One way to honour Indigenous nurses is to confront and address the systemic racism they have faced in their chosen profession.



The "Sixties Scoop"

The "Sixties Scoop" is a reference to the widespread federal government apprehension policies of First Nations, Métis and Inuit children. While the term “60s” suggests a single decade in which children were removed from their families, this system spanned generations.[69,75,169] Child apprehension systems remain a significant source of historical and ongoing colonial harm. Often referred to as the "Millennium Scoop," it is considered a continuation of the Indian Residential School system in contemporary health and social services policy.[87]

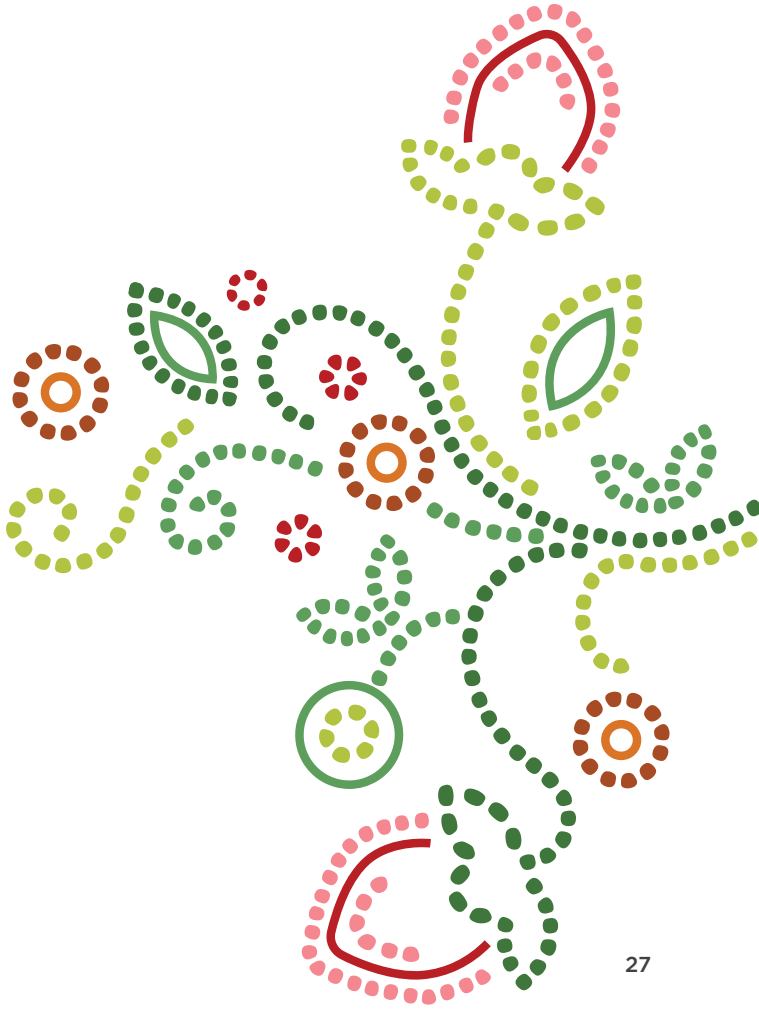
Despite decades of activism to reform child welfare systems, Indigenous children continue to be overrepresented in today’s foster care system. As of 2021, 53.8% of children under the age of 14 in foster care are Indigenous, while only 7.7% of the child population in Canada is Indigenous.[88] One particularly harmful contemporary practice has been the use of birth alerts, where hospitals and health care providers flag expectant Indigenous parents to child welfare authorities without their consent. While birth alerts were officially discontinued in many jurisdictions as of 2020, reports show that similar practices continue informally in some communities. These practices further erode trust in health care and contribute to the ongoing surveillance and apprehension of Indigenous children at birth.[90] Nurses work closely with Indigenous families and communities. Thus, it is important to acknowledge that the ongoing fear of child apprehension among Indigenous Peoples is significant. Establishing trust through processes that recognize personal and structural biases against Indigenous people is crucial in preventing further colonial harms in nursing practices.

Indian hospitals (1940s–1980s)

Like residential schools, a tragic legacy of pain and suffering remains from the establishment of 29 segregated “Indian hospitals” across the country,[16,91] which were introduced in the mid-20th century under the guise of addressing tuberculosis outbreaks in Indigenous communities. These hospitals primarily served to segregate Indigenous patients from mainstream health care. Inuit women were also disproportionately affected by the medical evacuations of the mid-twentieth century, during which many were separated from their families, sometimes indefinitely, to receive treatment in southern institutions. These policies routinely disregarded Indigenous social structures, subjected women to coercive sterilization practices and generated enduring intergenerational trauma.[19,92,103] Instead of reflecting a genuine commitment to Indigenous well-being, they embodied colonial violence and systemic racism. These facilities were notorious for being understaffed, underfunded and characterized by substandard care.[92]

They also became sites of invasive and unethical medical procedures, with many performed without any type of informed consent.[94,16] The trauma inflicted by these hospitals left lasting scars on individuals, families and communities, deepening mistrust in health care systems and contributing to ongoing health disparities.[96,19] Nurses in these hospitals were part of the oppressive system where they engaged in unethical practices, particularly in carrying out forced sterilizations of Indigenous women without informed consent.[97,98,99] Forced and coerced sterilization in Canada included the forcible sterilization of Indigenous women, which is a violation of international and national women's reproductive rights and laws.[100,101]

In 2021, the discovery of 215 unmarked grave sites at the former Kamloops Indian Residential School in Tk'emlúps te Secwépemc territory shocked many Canadians and renewed calls for accountability and reconciliation.[102] These graves stand as a harrowing testament to the systemic violence inflicted upon Indigenous children, many of whom never returned home. Families from this area immediately took responsibility for the children, to honour Estcwicwey (meaning the missing), and do not want to inscribe another number on these horrific acts of violence, as they continue to seek justice. Children buried in these unmarked graves often succumbed to untreated illnesses, malnutrition or outright mistreatment and abuse, underscoring the appalling conditions and neglect that pervaded the residential school system.[102] The discovery of these graves was a watershed moment in Canadian history, confirming what Indigenous communities had long asserted about the fates of children who were sent to these schools. The Tk'emlúps te Secwépemc emphasized that these children were buried without markers, names or records, reflecting the profound dehumanization inherent in the residential school system.[102] This tragic legacy highlights the urgent need for truth-telling, accountability and systemic reform to address these historical injustices and to honour the memory of those who were lost because of the residential school system.[71]



Navigating Indigenous health services in Canada: an overview

The health care delivery system for Indigenous Peoples in Canada is a complex network shaped by historical factors and varied governmental responsibilities. Essentially, the federal government plays a significant role through Indigenous Services Canada (ISC),[105] which funds and administers a broad range of public health services for **on-reserve** First Nations communities and Inuit living in designated regions. These ICS services are delivered through local health centres and nursing stations, which provide primary health care, preventive services, health education and supplementary health benefits, such as non-insured health benefits that fall outside standard provincial health coverage. While the Inuit as land beneficiaries and First Nations living on-reserve benefit from ISC-managed services, many others, including significant numbers of First Nations living **off-reserve**, rely on provincial or territorial health systems. Métis populations face unique challenges and often lack access to dedicated ISC programs and typically receive health services through provincial channels. These layers of complexity are illustrated in Figure 1, and they add to an already fragmented jurisdictional landscape in the division and provision of responsibilities between federal and provincial or territorial governments.

While ISC handles a significant portion of primary care and supplementary health benefits for on-reserve communities, Indigenous Peoples living off-reserve, whether First Nations, Métis or Inuit, often navigate multiple overlapping jurisdictions that interrupt the consistency of care.[104] A growing movement toward Indigenous self-governance, exemplified by models like the First Nations Health Authority in British Columbia,[221] is transferring control of health care to Indigenous communities, ensuring services reflect local cultural and social needs. However, colonial legacies, overlapping jurisdictions and fragmented funding continue to challenge efforts to create a system that fully honours the unique needs and self-determination of First Nations, Métis and Inuit peoples.

The following overview of First Nations and Inuit health service delivery highlights the various programs, services and infrastructure in the system. It is important for nurses to understand how Indigenous health services are delivered because gaps in this knowledge can lead to fragmented care, erode trust and result in unsafe practices for patients. While patients bear the greatest risk, nurses may also encounter ethical dilemmas, moral distress and potential professional consequences when care is compromised by jurisdictional complexities and systemic inequities.[104]

Overview of First Nations and Inuit health delivery

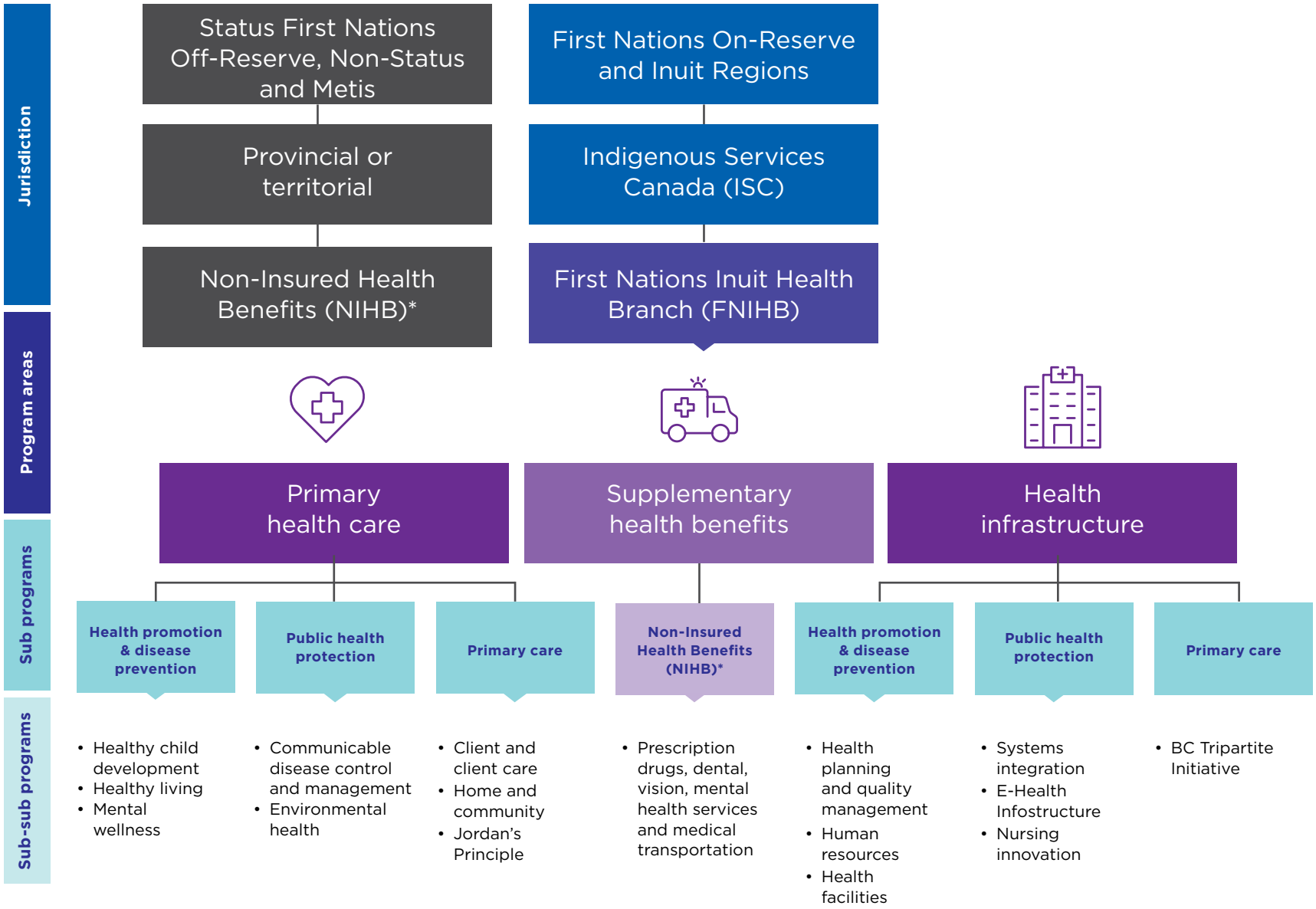


Figure 1: Overview of First Nations and Inuit health delivery[104]

* NIHB is delivered federally and is accessible to Status First Nations regardless of their geographic location within Canada.

Current health status of Indigenous Peoples in Canada

The health status of Indigenous Peoples in Canada is deeply tied to colonial history, systemic racism and long-standing social inequities. Indigenous communities continue to have high rates of chronic diseases such as diabetes, cardiovascular disease and respiratory conditions, alongside mental health challenges, substance use disorders and elevated suicide rates, particularly among youth.[141] Life expectancy for Indigenous Peoples remains lower than that of the non-Indigenous population, while maternal and infant mortality rates are disproportionately higher.[107] These disparities are not just statistics. They represent everyday realities of many Indigenous families and communities who are navigating daily challenges in a country with vast resources. Poverty, overcrowded housing, food insecurity and lack of access to clean drinking water continue to put Indigenous Peoples at greater risk. At the same time, systemic racism, discrimination and the exclusion of Indigenous Knowledges from health care systems make it harder to access the care they require.[107]

Addressing these disparities means going beyond awareness and recognition. It is a call for meaningful action. True changes happen when we invest in culturally safe, community-led health care, where Indigenous voices lead the way and traditional knowledge is respected as a fundamental part of well-being. It means upholding self-determination in federal and provincial policy and ensuring Indigenous communities have the power to shape their own health care systems.[108] Indigenous communities have long carried deep knowledge and strength in the areas of health and healing. However, lasting changes start with genuine listening, learning and commitment to actions, so that every Indigenous person, family and community can access culturally safe and equitable care.

> "Racism is not an accident. The system is not broken. It was created this way. And the people in the system are incentivized to stay the same."
>
> (Federal Health Minister Patty Hajdu, 2020)

Indigenous health disparities are sustained through Indigenous-specific racism

Systemic racism in nursing extends beyond individual **prejudice** as it is deeply embedded in systemic economic, political, social and cultural structures that uphold unequal power dynamics between white people and people of colour.[109] It manifests at multiple levels of systemic, institutional and interpersonal, each reinforcing the next and contributing to persistent health disparities for Indigenous Peoples.[112]

Indigenous-specific racism is rooted in colonial ideologies, laws and policies, such as the *Indian Act* and residential schools, that entrenched racial hierarchies that excluded Indigenous Peoples from decision-making and produced disparities across health care, education and housing.[110,113] Institutional racism is part of systemic racism as it is embedded in the policies, practices and structures of organizations and institutions (e.g., hospitals, universities and governments) and sustains racial disparities by limiting equitable access to resources, opportunities and leadership roles.[53] One example is discriminatory hiring practices that limit Indigenous representation in health care leadership and leave critical decisions about Indigenous health in the hands of those who may not fully understand or prioritize Indigenous perspectives.

Without Indigenous voices at the table, policies and programs often fail to reflect the needs and lived experiences of Indigenous communities. Another example is the unequal allocation of resources and biased triage protocols in emergency departments, which place Indigenous patients at lower priority.[111] Similarly, lack of interpretation services makes it difficult for patients to communicate symptoms, understand diagnoses or advocate for their care, especially when some Indigenous languages have no direct translation for concepts like pain.[114]

These structural barriers, combined with personal biases, often result in harmful assumptions such as accusations of drug-seeking behaviour and reluctance to provide appropriate treatment.[11] At the interpersonal level, racism appears in direct interactions between health care providers and Indigenous patients. This can range from overt discrimination to more subtle but equally harmful microaggressions, such as condescending communication, dismissing pain, or making inappropriate comments about identity.[116] These interactions are shaped by biases, stereotypes and power imbalances that have been reinforced through socialization and learned behaviors. Individuals absorb racial prejudices from media, family and societal norms, which influence how they interact with Indigenous patients. Institutional and structural factors further normalize these behaviors, as health care systems often deprioritize Indigenous perspectives and fail to provide culturally safe care.[117] As a result, many Indigenous patients report that their pain is frequently minimized or ignored.[114] This issue also affects Indigenous

children, who are more likely to experience pain from chronic conditions such as ear infection, but are less likely to be referred to specialists for proper treatment.[115] These behaviours can erode trust in health care providers, discourage Indigenous patients from seeking timely medical attention and result in delayed diagnoses and worsening health outcomes.[112]

If we are truly committed to reconciliation in Canada, we need to take a hard look at the laws, policies and structures that continue to uphold Indigenous-specific racism. This means unlearning harmful assumptions, relearning history and recognizing how both individual actions and systemic factors shape the experiences of Indigenous Peoples today.[119,236]

Understanding white supremacy, privilege and fragility in nursing

Indigenous-specific racism is sustained through **white supremacy**, a system that shapes social and political institutions to centre whiteness as the norm and treat Eurocentric perspectives as superior.[121,124] This dominance is embedded in health care, education and policy, where Indigenous voices, traditions and knowledge systems are often overlooked or dismissed. As a result, Indigenous patients frequently experience barriers to culturally safe care, and Indigenous health professionals remain underrepresented in leadership and decision-making roles, limiting their ability to influence the policies that affect their communities.

A key mechanism that reinforces this system is **white privilege**, which grants unearned advantages to white individuals while limiting opportunities for Indigenous people.[122,123] In nursing, this privilege manifests in hiring practices, clinical policies and education and care models that fail to reflect Indigenous approaches to health and healing.[124] Many nurses are unaware of their positional power and unintentionally reinforce systemic oppression in their daily practice, thus contributing to health care disparities.

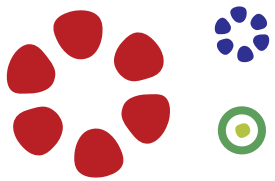
Even when these issues are acknowledged, **white fragility** acts as a barrier to meaningful change. As defined by Robin DiAngelo, white fragility refers to defensive reactions white individuals may have when they are confronted with discussions regarding racism, privilege, or systemic inequities.[125] In nursing, this can appear as resistance to anti-racism initiatives, denial of systemic bias, deflection of accountability, or dismissing the lived experiences of Indigenous patients and colleagues.[124,126] In nursing, resistance to anti-racism initiatives, dismissal of Indigenous colleagues' concerns and reluctance to acknowledge systemic bias create barriers to meaningful change.[126] Such defensiveness and reluctance to engage in uncomfortable conversations hinder effective dialogue, reconciliation, and systemic progress and change.[124,127]

Cultural safety and cultural humility

The combination of cultural safety and cultural humility creates health care environments where patients feel dignified and protected from discrimination and mistreatment.[128] The concept of cultural safety originated in Māori nursing practice in Aotearoa (New Zealand) to ensure that health care experiences align with patients' cultural identities and definitions of well-being.[8] Cultural safety requires health care providers to examine how systemic biases influence care interactions while advocating for meaningful reforms that address structural barriers that perpetuate racism and inequities.

Cultural humility complements this by recognizing that no individual can ever fully understand another culture. Instead of striving to master cultural knowledge, cultural humility encourages ongoing self-reflection, self-awareness and active engagement with communities to help address power imbalances between health care providers and patients.[128,129] It encourages health care providers to connect with patients with openness, respect and a willingness to learn, creating trusting, patient-centred relationships that honour individuals' values, identities and lived experiences. By embracing both cultural humility and cultural safety, health care providers can build trusting relationships, improve communication and deliver inclusive and responsive care. Practicing cultural humility allows providers to recognize and analyze their implicit biases while deepening their emotional understanding and reducing misconceptions about others. **Reflective practices** such as journaling and peer discussions can help health care providers identify areas for growth and refine their approach to patient care.

Reflexivity[129] and reflective practices are also essential to attaining cultural safety and humility as they help health care providers to continuously examine their identities, privileges, biases and social position within the health care system. Reflexivity goes beyond simple self-awareness and involves ongoing questioning on how personal beliefs, professional training, life experiences and broader systemic factors shape interactions with patients, particularly those from marginalized or underserved communities. Reflective practices, such as journaling, peer discussions and structured debriefing, provide a space for health care providers to process experiences, recognize areas for growth and refine their approach to patient care. By integrating cultural safety, cultural humility, reflexivity and reflective practices, health care providers can improve communication, foster trust and deliver care that is inclusive, responsive and rooted in **social justice**. These practices go beyond equity, ensuring that health care systems move toward sustained accountability, decolonization and meaningful systemic change.



Trauma-informed care and concern

Trauma-informed practice does not require becoming a health expert, but it is at the core of nursing values, which include doing no harm and protecting the public. By having basic knowledge of the impacts of trauma on the human body, our ethical responsibilities require daily activation of strategies aimed at reducing exacerbating trauma-related problems. Trauma-informed care is described as an organized approach to treatment that increases the safety of people by recognizing and responding to the effects of trauma.[130,131] Trauma involves any experience or multiple experiences across the life spectrum that overwhelm an individual's ability to emotionally cope with it.

We are learning of the level of violence inflicted on Indigenous bodies and lifeways – beginning prior to conception and long after death – known as intergenerational trauma.[132] In this context, the perpetual harm and persistent human indignities experienced in everyday life are exacerbated during epidemics such as COVID and the opioid crisis. It is important to note as well that the nurses' experience of receiving harm and witnessing harm and violence in the workplace on a frequent and sometimes daily occurrence is of growing concern.[133] These impacts of trauma show up vicariously in different ways, such as a person experiencing avoidance, fear, hyperarousal, shame, mistrust and anger when triggered by events or PTSD. Through the eyes of Indigenous Peoples, trauma-informed care and concern are critical to healing from the colonial forces that have wreaked havoc on so many lives. It is time to move away from these intentional policy-driven agendas and return to Indigenous eco-wellness practices that are deeply ingrained in the bodies of Indigenous Peoples.[135,136] The reclamations of traditional health knowledge systems and services of **Healers** and **Helpers**, who hold a deep understanding of the human impact on forest families, water people, sky beings and plant relatives, are vital to our continued freedom and existence.[26,136,137]

To sustain the road to wellness, all nurses must ask themselves: What have I learned? What is my story of reconciliation? How do I take care of myself, others and the land I live on? To ground these concepts in the lived experiences of First Nations, Métis and Inuit Peoples, we share the story of Brian Sinclair, a 45-year-old Anishinaabe man whose preventable death in a Winnipeg emergency room illustrates real-world consequences of systemic racism and neglect. His experience highlights the ongoing impacts of colonialism for both Indigenous and non-Indigenous nurses working within these systems. The case study that follows introduces Brian Sinclair's story and explores key themes, such as cultural safety, systemic racism and practical solutions within health care systems, while promoting understanding and respect for Indigenous knowledge, experiences and traditional healing practices.

Case study 1: Brian Sinclair

On September 19, 2008, Brian Sinclair, a 45-year-old Anishinaabe man from Sagkeeng First Nation in Manitoba, sought care for a bladder infection caused by a blocked catheter at Winnipeg's Health Sciences Centre Emergency Department (HSC-ED). A nurse at a community health centre had referred him to HSC-ED, providing him with a letter outlining his condition and arranging transportation via taxi.[138] Video footage revealed that after briefly interacting with a triage aide, Sinclair moved his wheelchair to a visible corner of the waiting room, expecting to be called for care. Over the next 34 hours, he remained in the waiting area, visibly unwell, yet he was ignored. Several staff members made assumptions that he was intoxicated or homeless and simply seeking shelter.

During this time, Sinclair vomited multiple times and concerned bystanders alerted security. However, no medical staff intervened. On the evening of September 20, other patients again expressed concern about his condition, but it wasn't until after midnight that a security guard checked on him, discovering he was unresponsive. Attempts at resuscitation were unsuccessful, and Sinclair was pronounced dead at 12:51 AM on September 21, 2008. His death was caused by acute peritonitis, resulting from an untreated bladder infection. Toxicology reports confirmed that no drugs or alcohol were in his system, refuting the assumptions made by staff. There was little documentation on the events leading up to Sinclair's death other than the video footage, which reveals how he was treated while trying to access medical care.[138]

The legal system's response

According to the *Out of Sight* report that was created by the Brian Sinclair Working Group to examine his tragic death, the legal system's focus needed to be on the ongoing systemic anti-Indigenous racism in health and legal systems.[138] The investigation started in 2010 and concluded in 2012, and, unfortunately, no one was held accountable for Brian Sinclair's death; rather, it was to be used as an educational case to 'learn' from. Police did not investigate Sinclair's death until his family pressured authorities; when Sinclair's family requested a retrial or for the Crown's decision to be publicly made, all requests were denied. The health care system and legal system failed Brian Sinclair.

The Brian Sinclair Working Group

According to the *Out of Sight* document, the Brian Sinclair Working Group was developed to conduct an inquest into how systemic racism contributed to Brian Sinclair's death and the subsequent inquest. The group's goal is to combat Indigenous-specific racism in health care and improve patient care for Indigenous communities. They have used public forums, presentations and published materials to bring attention to these critical issues.[138]

Inquest proceedings: the inquest aimed to uncover the facts surrounding Brian Sinclair's death and recommend preventive measures. Initially, there was a call for a public inquiry into the treatment of Indigenous people within the health care system, but Manitoba's government denied the

request. The inquest was conducted in two phases. The first, spanning 34 days with 74 witnesses, examined the circumstances of Sinclair's death, highlighting staff biases and assumptions. However, staff denied seeing Sinclair and dismissed racism as a factor, claiming equal treatment for all patients. The second phase, lasting 13 days with 9-10 witnesses, focused on HSC-ED's triage process, care delays and staffing levels, deviating from the original mandate. This shift occurred despite no issues affecting the 150 other patients treated that same weekend.

Next steps and recommendations

There is a clear objective for future work focused on addressing racism and discrimination in the health care system. The inquest highlighted the need to address racism and discrimination in health care. Recommendations include the following.[138]

- A national anti-racism policy across all health care systems.
- Provincial or territorial health departments implementing anti-racism plans with progress reporting.
- Zero-tolerance policies against racism in unions and professional organizations.
- Anti-racism curricula in health professional schools, increased Indigenous representation and cultural safety training.

Reflexive questions

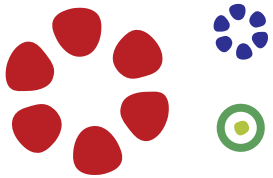
- What organizations or structural factors might make it difficult for nurses to advocate for and implement practice changes that reduce racism? Why and what meaning does this have for you?
- Which nursing practice standards could have addressed this situation, and why is it important to adhere to them when delivering care to Indigenous patients?
- Is there significance in using an inquest versus a public inquiry? What are the advantages and disadvantages in the case of Brian Sinclair?
- How could training in anti-racism, cultural safety and cultural humility have helped to prevent the death of Brian Sinclair?
- Do you think these recommendations are adequate toward addressing the relevant needs of the Indigenous population?
- What are some examples of how these recommendations can be implemented, or are they already implemented elsewhere?
- How can recommendations, such as those generated from the *Out of Sight* document, be shared more widely in schools of nursing, nursing leadership and health systems?

Brian Sinclair's tragic death is not an isolated incident. It reflects how personal biases continue to shape Indigenous health today. From the *Indian Act* to residential schools and Indian hospitals, systemic racism remains deeply embedded in health care. Indigenous nurses have long been at the forefront of change, challenging these injustices and advocating for culturally safe care. True transformation requires more than recognition. It demands action, accountability and Indigenous leadership in health governance. In addition, participating in these inquiries and systemic change initiatives can impose significant emotional and time burdens on communities. The next section explores pathways to systemic change and **decolonization** in health care.

3 Structural and systemic health transformation efforts

Reforms have emerged in response to international violations of Indigenous calls for action. This section will provide an overview of key initiatives and examine progress on major frameworks that emphasize the integration of Indigenous healing practices and culturally safe health care. The analysis will highlight both advancements and ongoing gaps between acknowledgment and tangible action in promoting cultural safety and humility.

> "This history is not your fault. But it is absolutely your responsibility."
>
> Nikki Sanchez[142]



Key initiatives

United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)[4] was initially rejected but subsequently adopted by the United Nations General Assembly on September 13, 2007, recognizing and promoting both the individual and collective rights of Indigenous Peoples around the world. The declaration asserts the rights of Indigenous Peoples to self-determination, culture, land, education, health and economic development. Developed in response to centuries of colonization, marginalization and systemic oppression, UNDRIP calls for proactive measures to safeguard and protect Indigenous communities. By affirming the rights to self-determination, it helps Indigenous Peoples define their political status, drive economic growth and preserve their cultural identity. Overall, UNDRIP provides a framework for governments, institutions and organizations to advance the rights of Indigenous Peoples in accordance with international human rights standards.

The Declaration consists of 46 articles that are organized into key themes.[4] At its core, self-determination affirms the right of Indigenous Peoples to autonomy and control over their political, social and economic systems. Cultural rights ensure the protection and preservation of Indigenous languages, traditions and spiritual practices.

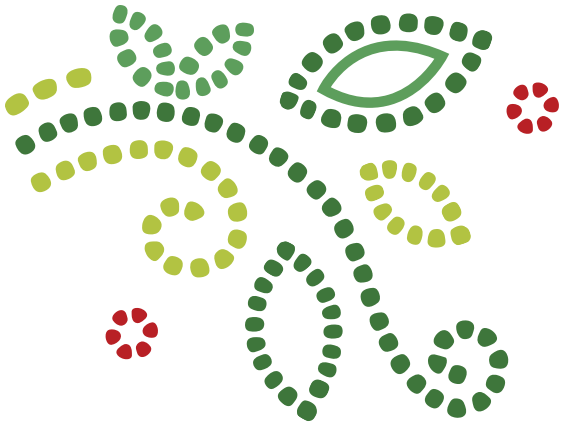
Articles on land and resources recognize the rights of Indigenous communities to their traditional territories and resources for cultural and economic survival. The health and well-being theme highlights the right to access traditional medicines, health practices and equitable health care. Education supports the right of Indigenous Peoples to establish and govern their educational systems that reflect cultural values and knowledge. Finally, the principle of participation ensures Indigenous Peoples have a voice in decisions affecting their lives, reinforcing their sovereignty and self-determination. UNDRIP's international scope provides a strong basis to promote the global recognition and protection of Indigenous rights. It serves as an important tool for advancing justice for Indigenous communities worldwide. In 2021, Canada took an important step toward reconciliation by adopting the *United Nations Declaration on the Rights of Indigenous Peoples Act (UNDRIP Act)*[239] into law. This legislation commits Canada to aligning its laws with UNDRIP and working with Indigenous Peoples to develop an action plan for its implementation. Although guided by international agreements, Canada has also developed its own policies that respond to the distinct inequities experienced by First Nations, Métis and Inuit Peoples in this country.

Truth and Reconciliation Commission (TRC) Calls to Action

The Truth and Reconciliation Commission (TRC),[5] chaired by Senator Murray Sinclair, was established in 2008 under the Indian Residential School Settlement Agreement and mandated by the Supreme Court of Canada. In 2015, TRC released 94 Calls to Action that documented the experiences of residential school survivors and outlined a roadmap to address both past and ongoing impacts of the residential school system in Canada. These multi-sectoral Calls to Action involve all levels of government, health organizations, post-secondary institutions, professional and advocacy bodies such as nursing unions and associations, faith-based organizations, media and the corporate sector, outlining a path forward for upholding the rights of Indigenous Peoples and advancing reconciliation across key sectors of health, education, justice and child welfare.

In health care, Calls to Action 18–24 specifically focus on reducing health disparities, ensuring equitable funding for Indigenous health services and integrating traditional healing practices. The overall aim is to promote Indigenous self-determination, equity and improved health outcomes. For example, Call to Action #24 requires that all medical and nursing schools in Canada include training on Aboriginal health issues, such as the legacy of residential schools, treaties and Indigenous rights. This call has driven education reform in health care programs nationwide. These calls stress the importance of providing culturally safe care, increased Indigenous representation in health care professions and anti-racism training to address biases.[120]

The TRC emphasizes that truth-telling is an essential step toward establishing a foundation for trust, accountability and meaningful reconciliation. Achieving reconciliation in the nursing profession requires ongoing, intentional, and intergenerational transformation. As the Honourable Murray Sinclair reminds us, reconciliation requires active participation, continuous learning and a willingness to reshape our thinking and relationships, laying the foundation for true healing and systemic change. In nursing, this means engaging deeply with Indigenous communities, critically examining our practices and embracing new approaches that centre Indigenous Knowledges and cultural safety.[195]



"[R]econciliation is a process which is building.
It's not a spectator sport. It involves everybody.
And everybody is implicated in it, whether you like it or not.
You are either for it or you are against it. No neutrality exists here.
And when you think about it, you have to understand it.
And understanding it is part of the education process.
And understanding the implications it has for you
is part of the challenge that we also need to face.

And all of that has to do with knowledge.
All of that has to do with dialogue as well, and developing
consensus and agreement about where we're going to go
as a country...
We have to talk about what kind of relationship we're going to
have going forward. And that means we have to think differently.
We have to think better..."

The Honourable Murray Sinclair, Senator and Chief Commissioner of the TRC, in remarks delivered at the Tommy Douglas Institute at George Brown College in Toronto, Ontario, on May 28, 2018

Missing and Murdered Indigenous Women and Girls (MMWIG)

The National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG)[144] was launched to investigate the systemic causes of violence against Indigenous women, girls and **2SLGBTQQIA+** people in Canada and to provide recommendations for justice and accountability. The final report documented horrific accounts of violence experienced by Indigenous women and girls, and exposed the deep failures of policing, the justice system, child welfare and health care in protecting Indigenous lives. The inquiry revealed how colonialism, systemic racism and state inaction have allowed race-based **genocide** to persist rather than be prevented. Although Indigenous Peoples represent approximately 5% of Canada's population, or over 1.8 million people,[106] Indigenous women and girls account for 28% of female homicide victims and are 12 times more at risk of being murdered or going missing.

The Calls for Justice issued by the inquiry demand urgent action, yet many remain unmet. For example, Call for Justice 3.2 calls for adequate, stable, equitable and ongoing funding for Indigenous-centred and community-based health and wellness services that are accessible and culturally appropriate. The Calls for Justice provide guidance for addressing systemic racism and actualizing systemic change.[144] However, since the report's release in 2019, there has been a concerning lack of engagement and response from higher education institutions.

Nursing professionals are encouraged to understand the impact of colonization, oppression and violence on Indigenous Peoples. Engaging with the MMIWG Report offers an opportunity for all Canadians to understand more about the legacy of systemic racism in Canada and its impact on community health and wellness. For example, the fastest growing incarcerated population in Canada is women, and 50% of those women self-identify as Indigenous.[144] This foundation of knowledge, which encompasses an understanding of the ongoing impacts of systemic racism, colonization and violence, is essential for nurses. Later, we will explore cultural safety and humility, providing practical approaches for delivering safe, harm-reducing, equitable and patient-centred care.

Key responses

Jordan's Principle

Jordan's Principle is a Canadian policy that was named in honour of Jordan River Anderson, a young boy from Norway House Cree Nation.[142] Jordan spent his entire life in the hospital due to prolonged disputes between federal and provincial governments over who would fund his care[89,142]. He passed away in 2005, never having lived in his family home. His tragic case exposed systemic failures in addressing the needs of First Nations children and galvanized an advocacy campaign led by the Assembly of First Nations (AFN)[145] and the First Nations Child and Family Caring Society (FNCFCS).[146] Through the strong voices of nurses who cared for Jordan, and with the

Manitoba Nurses Union's support, the Canadian Federation of Nurses Unions (CFNU) became active advocates for Jordan's Principle. These efforts led to the formal recognition of Jordan's Principle as a child-first, needs-focused initiative.[147,142]

The Canadian Human Rights Tribunal (CHRT) in 2016 mandated the full implementation of Jordan's Principle, ruling that First Nations children were being discriminated against due to funding delays and inequitable access to essential services.[148] Therefore, all First Nation children residing on or off reserves, when necessary, benefit from access to appropriate services of health care, social support and educational system assistance.[89] Jordan's Principle informs the provision of services at the level of the individual child, by taking into consideration the cultural, social and economic contexts.[149] Guided by principles of self-determination, cultural relevance and holistic care, the principle draws on frameworks such as the Touchstones of Hope, which prioritize Indigenous-led solutions and systemic change.[150,151]

Joyce's Principle

Joyce's Principle was born from the tragic death of Joyce Echaquan, an Atikamekw woman and mother of seven, who sought care at the Joliette Hospital in Quebec on September 28, 2020, for severe stomach pain.[152] While in the hospital, Joyce suffered from verbal abuse and discriminatory treatment by health care staff, a horrifying reality she captured in a live-streamed video shortly before her passing. Her last moments, which went viral on social media, exposed systemic racism in the health care system and sparked outrage and calls for change across the country.[152]

In response, the Council of the Atikamekw of Manawan and the Atikamekw Nation Council developed Joyce's Principle[152] to ensure Indigenous Peoples have access to high-quality and culturally respectful health care. This principle reinforces the integration of traditional Indigenous knowledge, equitable treatment and mandatory anti-racism training for health professionals. It also calls for legislative reform and increased Indigenous representation in health care governance, aiming to address systemic racism and create a system that respects and values all patients equally.[4,152]

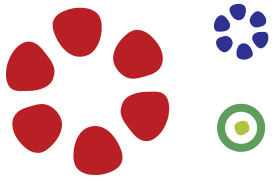
Both Jordan's Principle and Joyce's Principle shed light on systemic racism and are important tools in the broader effort to decolonize the Canadian health care system. This case will be explored further in Case Study 3 within *Section 4: Actionable and Applicable Strategies.*

In Plain Sight

The *In Plain Sight* report[113], published in 2020, was driven by the mounting evidence that Indigenous Peoples in British Columbia's health care system face systemic racism and discrimination. Prompted by countless stories of mistreatment, including high-profile tragedies like the death of Joyce Echaquan in Quebec, this report set out to identify actionable steps for real, lasting change.[152] The report revealed widespread prejudice, inadequate

integration of Indigenous traditional health practices and an under-representation of Indigenous leadership in health care governance. In doing so, it calls for immediate reform to embed cultural safety and anti-racism into health care policies, integrate Indigenous knowledge and practices and hold health authorities accountable for equitable care delivery.

In Plain Sight underlines the role and responsibility of nurses and other health care providers in creating culturally safe and respectful environments. By aligning its recommendations with the UNDRIP and provincial legislation such as the *Declaration on the Rights of Indigenous Peoples Act* (DRIPA),[239] this report hopes to inform systemic health transformation in ways that ensure that Indigenous Peoples receive equitable, dignified and culturally responsive care.



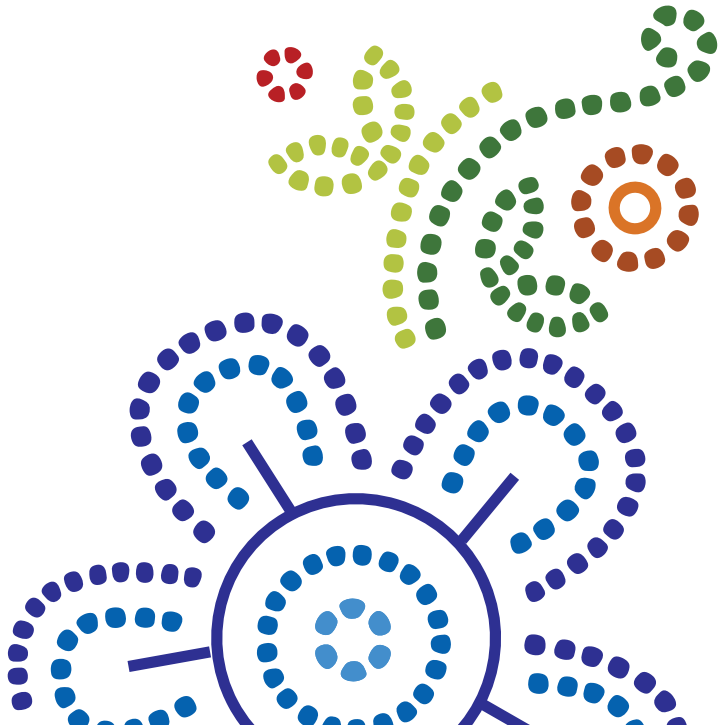
Distinctions-based approach to improving Indigenous health

In Canada, distinctions-based practices have been introduced to address Indigenous-specific racism in health care by recognizing the unique rights, histories and cultural contexts of First Nations, Métis and Inuit Peoples.[153,154] This approach acknowledges that Indigenous groups are not homogenous but rather possess distinct identities, governance structures and health needs that require tailored solutions rather than generalized approaches. Distinctions-based models strive to provide culturally safe care that aligns with community-specific values and traditions, while ensuring active participation of Indigenous people in shaping health care policies. Efforts to implement distinctions-based approaches in health care stress collaboration, education and systemic reform. Some initiatives focus on integrating Indigenous knowledge systems, including data and relevant health statistics,[155] while others work to enhance Indigenous governance in health care policy and research so that programs respond to each community's distinct priorities.[156] However, critiques caution that distinctions-based models may inadvertently fragment Indigenous health services, leading to inconsistencies in access to care and reinforcing colonial administrative categories that divide rather than unify Indigenous communities for broader systemic change.[157] Others raise concerns about whether funding and implementation will be equitable, emphasizing the need for Indigenous-led governance to ensure meaningful and lasting impact.[158]

Indigenous health nursing specialties (IHNS)

Indigenous health nursing is recognized as a unique and distinct body of knowledge in nursing, with specific knowledge, skills and attributes that stem from the voices and experiences of Indigenous nurses.[159,160,234] Nurses are claiming their collective Indigenous voices to guide nursing practice, education, and governance in ways that are rooted in Indigenous kinship, laws, languages and the lands from which they originate. Nurses value and respect the inherent rights of Indigenous Peoples to self-determine how care is designed and delivered in their communities, ensuring that it reflects Indigenous values and addresses community-specific needs.[161] Advancing IHNS involves culturally respectful care that adopts relational and stewardship principles, including traditional healing practices, respecting cultural protocols and addressing social determinants of health specific to Indigenous populations. Allies have an important role in supporting IHNS by listening, learning and sharing accountability and by actioning change. This means being willing to engage in uncomfortable conversations and acknowledging the colonial and racist systems that persist; systems we may not have created but that we continue to benefit from. While this process can be painful for many, it is necessary for adopting Indigenous health as a human right and advancing it as a social and restorative practice.

Indigenous Peoples hold the wisdom to identify their own paths to wellness for themselves, their families, communities and Nations. They have the knowledge and the expertise, but allies play an integral role in supporting meaningful change. Sometimes, the most important thing allies can do is listen deeply and take thoughtful immediate action. It's about supporting each other while at the same time challenging the systems of power and privilege. This process demands actively resisting domination and oppression while advancing Indigenous rights and sovereignty over every aspect of our humanity.



Key focus areas

- **Culturally relevant care**: IHNS honours Indigenous values and beliefs without taking ownership of them. Settler nurses do not need to learn what Indigenous traditional medicine contains, where to find it, or how to use it. Instead, they should create a culturally safe space where patients feel comfortable expressing their health care preferences. This means listening with respect, avoiding assumptions and supporting access to Indigenous Healers, Knowledge Holders or cultural liaisons when requested. Even if Indigenous traditional healing is not mentioned, nurses should remain aware that historical barriers may prevent disclosure. Advocacy for policies that accommodate Indigenous traditional practices, engaging in continuous learning about cultural safety and centering Indigenous-led care decisions are essential for meaningful and respectful health care interactions.

- **Self-governance**: IHNS calls for Indigenous-led nursing frameworks and standards that allow Indigenous nurses and their organizations to have the choice to define and regulate their own professional standards, practices and ethical guidelines. This autonomy helps care to be community-driven rather than externally imposed.

- **Education and training**: Advancing IHNS requires nursing education programs that are designed by and for Indigenous people to integrate Indigenous knowledge systems, languages and pedagogies. These programs equip nurses to deliver culturally safe care distinct to their communities' needs and strengthen local leadership. Education and training under IHNS also challenge Western-centric approaches and emphasize cultural humility and Indigenous self-determination.

- **Policy influence**: IHNS reinforces the need for Indigenous voices in health care policy at the local, regional and national levels. Systemic reform is essential to ensure that health care programs meaningfully address the distinct health challenges of First Nations, Métis and Inuit Peoples and are guided by Indigenous leadership.

- **Indigenous health research**: IHNS prioritizes community-driven, Indigenous-led research that centres Indigenous knowledge generation, translation and application. These approaches are rooted in Indigenous methodologies to contribute to a body of knowledge that is relevant, respectful and beneficial to Indigenous communities.

These findings are crucial to the advancement of Indigenous health nursing[185]. However, we acknowledge the essential role of non-Indigenous health providers in this collaborative work. Allyship is a way of being in relationship and involves people whose advantaged or disadvantaged status is not due to racialized identity but rather tied to their belonging to the dominant groups that hold system-level power and status. It is these individuals who are willing to act against systemic racism and oppression by neutralizing the power of providers.

There are many forms of allyship, and it is often the vulnerable group that determines if, in fact, you are an ally versus someone reacting to a deplorable situation with words of concern, while holding up their social justice flags. The test of allyship lies in the actions one takes, not in merely recognizing the right thing to do.

> "The greatest test of your professionalism will be your ability to apply your knowledge in a practical way, to put yourselves at the service of those communities and individuals whose need is greatest."
>
> (Jean Goodwill, RN, LLD[162])

Considering the ongoing reports, recommendations and calls to action, we still find ourselves working in a system that has not afforded Indigenous Peoples the dignity and respect they deserve. In health care, every patient's story is a testament to the system's strengths and its shortcomings. This case study is based on the true story of Keegan Combes of Skwah First Nation,[163] whose tragic death highlights the devastating consequences when health care systems fail.

Case study 2: Keegan Combes

Keegan's story is not just a narrative of loss but a crucial lesson for health care professionals to recognize and combat Indigenous-specific racism and systemic negligence. Keegan Combes was a 29-year-old Indigenous man residing in the Skwah First Nation community. Living with disabilities and being non-verbal, Keegan depended on an Indigenous caregiver, a Métis woman who provided dedicated care to Indigenous communities. Their bond was integral, especially in navigating Keegan's interactions with the health care system. One afternoon, Keegan's caregiver discovered him at home in a distressing state; he was slumped over, incoherent and covered in vomit. When emergency responders arrived at the scene, they seemed reluctant to take Keegan, stating that they "knew" him. It was only after Keegan's caregiver advocated on his behalf that he was taken to the emergency department by ambulance.

At the emergency department, Keegan presented with ongoing symptoms. A physician ordered laboratory tests that later revealed severe metabolic acidosis and toxic methanol levels. As Keegan's condition worsened, another physician noted that Keegan's liver enzymes were "elevated" and suggested discharging him despite his deteriorating symptoms. Keegan's caregiver insisted that he remain at the hospital. At this juncture, the provider proposed adding a do-not-resuscitate (DNR) order to Keegan's file, although this was not directly

related to discharge planning. The suggestion left his caregiver feeling that Keegan's life was being devalued and that he was only being seen for his disabilities rather than his medical needs. While medical orders for Keegan's neurological assessment were neglected by his nurse, Keegan's health continued to decline overnight. The nurse failed to report the serious and significant changes in his symptoms. Keegan was also restrained for several hours due to restlessness and attempts to get out of bed, though proper documentation and monitoring were not performed.[163]

In the morning, Keegan's caregiver called for an update on his condition. She was called back to receive the news that Keegan had been intubated and was transferred to the ICU unit, being told to get to the hospital as soon as possible. At the ICU unit, a new practitioner discussed the possibility that Keegan had ingested methanol. Tragically, Keegan passed away ten days later. His death was a direct result of the delayed diagnosis and inadequate treatment of methanol poisoning, compounded by dismissive and culturally unsafe care. Throughout his hospital stay, Keegan's worsening symptoms and his caregiver's concerns were continually dismissed, leading to improper, negligent and culturally unsafe care that ultimately caused his preventable death.[163]

Key focus areas

- **Systemic racism and bias**: Implicit biases related to Keegan's racial identity, culture and disabilities significantly influenced the quality of care he received. The initial reluctance of emergency responders to transport him and the inappropriate suggestion of a DNR order reflect underlying systemic racism and bias.

- **Communication failures**: There were multiple instances of miscommunication among health care staff and between providers and Keegan's caregiver. Important information, such as the severity of his condition and the need for further testing, was not effectively communicated, exacerbating his health issues.

- **Neglected caregiver concerns**: Keegan's caregiver, who is also a nurse, repeatedly had her insights and concerns dismissed by the health care providers. This neglect undermined her ability to advocate effectively for Keegan's care, contributing to delays in appropriate treatment.

- **Delayed diagnosis**: Despite laboratory results indicating severe metabolic acidosis and methanol toxicity, a formal diagnosis was not communicated, and further essential tests were not ordered promptly. This critical delay in diagnosing methanol poisoning was pivotal in Keegan's preventable death.

Reflexive questions

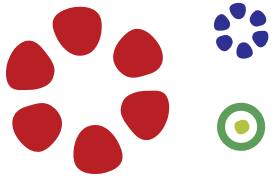
To deepen your understanding and enhance meaningful discussions, consider the following prompts. Each prompt is designed to encourage critical thinking and reflection on the systemic issues highlighted by Keegan's case.

- What factors do you think contributed to the mistreatment and neglect of Keegan? What implicit biases were at play?
- How do you think Keegan's death could have been avoided? What trauma-informed interventions could have been applied? How do the standards of cultural umility apply in this scenario?
- What can we take forward and learn from Keegan's story? What do we need to know? In what ways can we address Indigenous-specific racism in the health care setting?

4 Actionable and applicable strategies

This section presents pragmatic strategies to eliminate Indigenous-specific racism and enhance cultural safety for Indigenous communities across the nursing areas of practice, policy, education and research. These strategies offer real-world solutions for health care providers across diverse settings in Canada, aiming to support everyday nurses and leaders. The discussion highlights practical solutions, showing how nurses can address racism, advocate for culturally safe environments and support the integration of Indigenous knowledges into health care.

Additionally, it will underline the importance of recognizing and challenging white privilege and promoting reforms within health care systems to better serve Indigenous communities, whether through policy changes, improved education and training, or research initiatives centred on Indigenous perspectives. The aim of this section is to raise awareness, encourage reflexive practice and inspire actionable change in health care service delivery.



Decolonizing health care: shifting the power by centring Indigenous Knowledge

Decolonizing health care is a transformative process that seeks to dismantle colonial legacies by addressing systemic inequities deeply rooted in Western-centric ideologies. It means acknowledging historical harms, questioning and disrupting dominant frameworks and structures that have long marginalized Indigenous values, rights, identities and traditions.[165,166] Decolonization in health care means moving away from colonial frameworks and toward care models that honour Indigenous values, rights, cultural identities, knowledge systems, traditions and practices while acknowledging historical injustices. This process exposes and disrupts dominant ideologies and power structures while centring marginalized voices across all levels of the health care system.[34] Decolonization promotes healing, equity and cultural safety through its focus on the social, cultural, economic and political determinants of health.[139] As Cora Weber-Pillwax reminds us, decolonization is not a single event but a sustained commitment that must move beyond theory and into action. In nursing, this means actively supporting Indigenous self-determination, building respectful partnerships and moving beyond symbolic gestures toward real, meaningful collaboration.[164]

> "Decolonization is not merely a concept. It evokes and stimulates earth- and people-shattering consequences on a daily basis."
>
> (Cora Weber-Pillwax)[164]

An ongoing commitment to decolonizing nursing practices is important, as these actions underpin self-determination and self-governance while building mutually respectful partnerships rooted in rights, responsibilities and accountability.[143] **Tokenism** must be replaced with meaningful and sustained engagement with Indigenous Peoples and their vibrant, resilient communities, whose sovereignty and traditional knowledge must be upheld and celebrated. Adopting a distinctions-based approach to providing health care services is one step towards decolonizing nursing and improving the health outcomes for First Nations, Métis and Inuit Peoples.

Knowledge production about marginalized persons should come from those with lived experience, which requires a shift from *speaking for* to *speaking from* experience.[167] Working with Indigenous Healers, Helpers and health professionals who are incorporating Indigenous rights in collaboration with local land and language teachers generates new possibilities for public health and professional health leadership. This needs to be threaded throughout our nursing careers; this is not a one-time session, but a lifelong commitment to taking better care of our world. Recognizing that we are part of more than just a human world helps bring attention to the environmental injustices that have plagued Indigenous Peoples since the beginning of colonization. This perspective also affirms the rights and cultural significance of Indigenous traditional knowledge in nursing, offering valuable guidance for future generations of nurses.[168] A partnership between academic institutions, Indigenous communities and health care organizations will further ensure that nursing practices and education are informed by an Indigenous perspective, advancing respectful, relational, culturally responsive and safe care practices.[52] Such partnerships that centre Indigenous perspectives can ensure that Indigenous leaders, Knowledge Holders and community members are at the forefront of shaping health care structures, systems and service delivery.

> "We are in need of a paradigm shift, where mpahi kayas (deadly past, colonization) has to be shifted to wapatikewsiwin (grassroots evidence) and naskomowina (on-the-ground solutions)."
>
> Madeleine Dion Stout[18]

It is time to move beyond "performative" reconciliation (actions that lack meaning) and embrace it as a genuine call to systemic transformation, recognizing that the problem lies in addressing only the visible "tip of the iceberg". It is not enough to be "not racist," as anti-racism efforts must go beyond passive non-racism to actively dismantle inequitable structures through policy reforms, institutional changes and cultural shifts. True systemic change and meaningful social justice reform require confronting the deeper, unseen layers of

systemic inequities that continue to shape health care and education. Addressing systemic racism must go beyond culture to recognize its roots in human rights and ensure equitable access to health care. As stated in UNDRIP, "Indigenous Peoples have the right to maintain and strengthen their distinct political, legal, economic, social and cultural institutions, while retaining their right to participate fully, if they so choose, in the political, economic, social and cultural life of the state."[170] This is a framework that calls for more than symbolic gestures; it calls for actionable plans for decolonization that place cultural safety as a fundamental human right, and centres Indigenous sovereignty, self-determination and holistic health practices. By addressing the systemic racism embedded in health care and education, we can create equitable systems that respect and uplift Indigenous ways of knowing, doing and being.

The health care system needs to implement action to address Indigenous-specific racism through systemic and structural policy reform. This must be combined with cultural safety and humility practices to promote action that takes us beyond equity.[9,120] Cultural safety programs and workshops, Indigenous leadership development, intergenerational mentorship programs and communities of practice support ongoing learning and accountability.[120,53] Likewise, engaging in critical reflexive practice can lead to insights and understandings arising from new perspectives gained in the iterative process. Anchored in the IHN Ethical Framework,[173] Padley and colleagues examine the unique aspects of Indigenous nurse mentorship. The IHN Ethical Framework outlines key competencies, including Indigenous worldviews, decolonial understanding, respect, inclusivity, relationships, knowledge gardening, mentoring and student advocacy.[172] Interwoven within intergenerational Indigenous nurse mentorship are the IHN principles of relevance, relationality, respect, reciprocity, transparency and responsibility.[172,173]

Addressing racism through actionable initiatives

CPR RACISM framework

The CPR RACISM framework, developed by Dr. Holly Graham,[174] emerged in response to the persistent and systemic Indigenous-specific racism experienced by First Nations, Métis and Inuit Peoples in health care settings across Canada. Dr. Graham, a Nêhiyaw (Cree) nurse, scholar and advocate, created the framework through her work in both academic and clinical environments, drawing on her experiences working with Indigenous clients and mentoring Indigenous nursing students. It was developed as a relational and practical tool for nurses and health care providers seeking clear guidance on how to recognize, respond to and disrupt racism in real time. The framework is rooted in ethical care, cultural humility and advocacy, drawing inspiration from cardiopulmonary resuscitation (CPR), a familiar and life-saving practice, to signal the urgency and immediacy of responding to racism. Each letter in "CPR RACISM" represents an actionable step that providers can take in their day-to-day practice.[174]

- **Call out**: it requires nurses to get involved by helping to focus on the behavior and not the h ealth care provider.
- **Plan and practice**: prepare intervention strategies in advance to build confidence and minimize hesitation in addressing racism.
- **Review chart, speak to the client and assess the client**: perform an independent review of the client's condition through ethical and unbiased care.
- **Review treatment plan**: question treatment approaches neutrally to uncover potential biases and explore better options.
- **Allyship and advocacy**: commit to continuous education on anti-racist practices and actively support Indigenous communities.
- **Check with the client**: reassure clients with simple but empathetic phrases, creating a safe and respectful environment.
- **Intervene**: encourage bystander intervention, especially among students, to navigate power dynamics.
- **Speak up**: raise systemic concerns with unit managers or clinical educators, seeking support from mentors when needed.
- **Model safe nursing care**: practice trauma-informed care to ensure safety, trust and compassion in patient interactions.

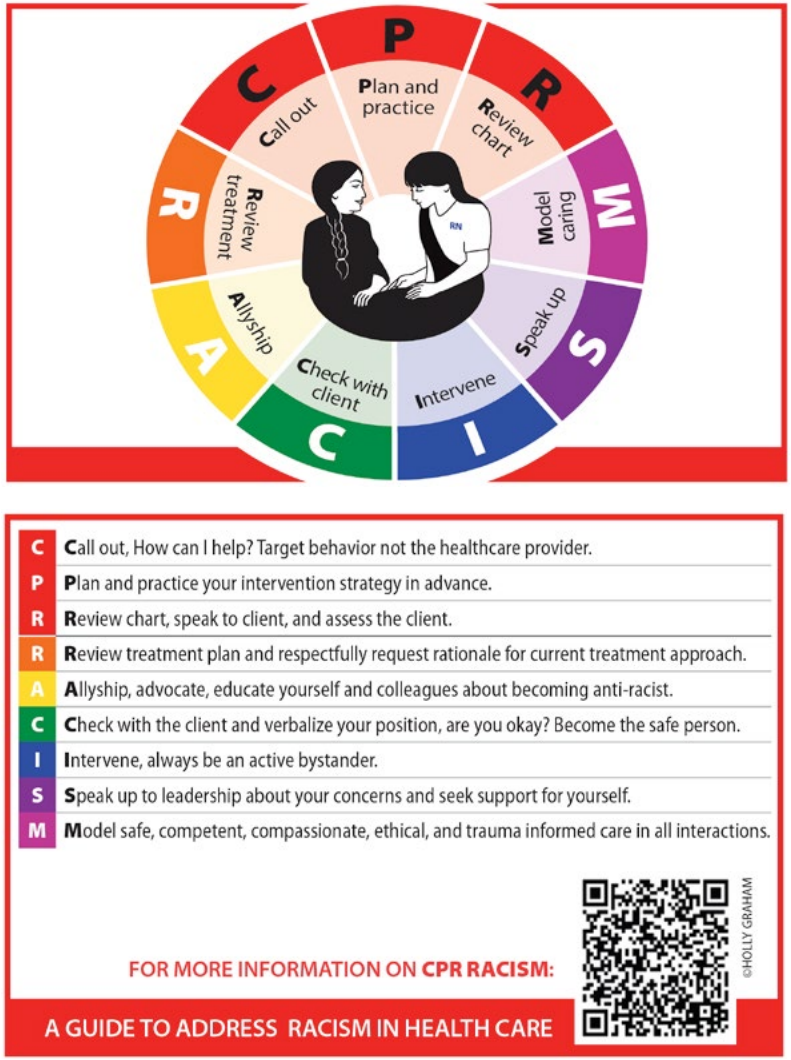


Figure 2: CPR RACISM framework[174]

The CPR RACISM framework offers practical and real-world strategies that fit naturally into the nursing processes, including assessment, diagnosis, planning, implementation and evaluation. By tackling racism directly, it enhances the ability of health care providers to deliver safe, ethical and culturally safe care for First Nations, Métis and Inuit clients. This framework serves as a crucial link, translating broader anti-racist principles into actionable steps that practitioners can use during daily practice.

British Columbia practice standard

Heightened awareness about cultural safety and Indigenous-specific racism has resulted in significant reform in British Columbia's health care regulatory landscape. One of the most notable changes is the passing of the *Health Professions and Occupations Act* (HPOA)[175] on November 24, 2022. Under the revised act, all regulated health professions are now required to streamline the process for regulating new professionals, support reconciliation, implement anti-discriminatory standards of care and integrate transparent accountability measures for public safety. These measures include the appointment of key oversight roles, such as a Superintendent Director of Discipline.[176]

The British Columbia College of Nurses and Midwives (BCCNM) has embarked on a long journey toward reconciliation, with its commitment over the past five years to eliminate Indigenous-specific racism as commendable. Recognizing and acknowledging colonial harm is not easy. The new regulations and standards set out by regulatory bodies as the minimum standards for culturally safe and trauma-informed nursing care are timely. This reminds us of the important work ahead for all nurses. For example, the BCCNM's six standards for cultural safety, cultural humility and anti-racism practice address key concepts that include the following.[120]

- **Self-awareness**: Nurses are required to critically question their own values, beliefs and assumptions to assess how these influence their practice.
- **Education and training**: Continuous learning is emphasized to enhance understanding of Indigenous histories, cultural contexts and the impacts of colonialism. This standard encourages nurses to seek out education and training opportunities that broaden their awareness and improve their ability to provide culturally informed care.
- **Anti-racist practice (taking action)**: Nurses are directed to act by helping colleagues identify and eliminate racist attitudes, language or behavior; supporting clients, colleagues and others who experience or report acts of racism; and reporting incidents of racism to leadership or the relevant health regulatory college.
- **Creating safe health care experiences**: Nurses are directed to treat clients with empathy by acknowledging the client's cultural identity, listening to and seeking to understand the client's lived experiences, treating clients and their families with compassion and being open to learning from the client and others.

- **Care for a client holistically**: Nurses are directed to care for a client holistically, considering their physical, mental/emotional, spiritual and cultural needs, and to facilitate the involvement of the client's family and others (e.g., community and Elders, Indigenous cultural navigators and interpreters) as needed or requested.

- **Person-led care (relational care)**: Nurses are instructed to respectfully learn about the client and the reasons they have sought health care services; to engage with clients and their identified supports in order to identify, understand, and address the client's health and wellness goals; to actively support the client's right to decide on their course of care; and to communicate effectively with clients.

- **Strength-based and trauma-informed**: Nurses are directed to work with clients to incorporate their personal strengths in support of achieving their health and wellness goals. They must recognize the potential for trauma, whether personal or intergenerational, and adapt their approach thoughtfully and respectfully, including seeking permission before engaging in assessments or treatments. Nurses are also instructed to acknowledge that colonialism and trauma may influence how clients view, access and interact with the health care system.

Implementing accountability measures to combat racism in health care

Effective accountability mechanisms are essential tools in addressing racism within health care. Systemic accountability ensures that health care organizations and professionals are held responsible for their actions and the harm inflicted on Indigenous Peoples and their communities.

Key strategies

- **Mandatory reporting and tracking**: Establishing official incident reporting platforms is crucial for documenting, tracking and reviewing incidents of racism in health care. To encourage reporting without fear of retaliation, mechanisms such as anonymous reporting tools, dedicated hotlines and internal grievance systems should be implemented. British Columbia's *In Plain Sight* report[113] recommends such platforms to increase transparency and improve institutional responsiveness to racism-related complaints.

- **Cultural safety audits**: Routine cultural safety audits can help health care organizations identify gaps in policies, training and patient care. These audits assess adherence to cultural safety standards and provide

actionable insights for improvement. The *San'yas Indigenous Cultural Safety Program*, developed by the Provincial Health Services Authority (PHSA) of British Columbia,[177] offers frameworks to guide organizations in conducting these evaluations and embedding culturally safe practices into their operations. As an online evidence-informed initiative, San'yas is designed to build awareness of Indigenous-specific racism, colonial history and systemic inequities in health care.

- **Independent oversight bodies** play a crucial role in ensuring accountability by conducting impartial investigations into racism complaints and systemic issues. These entities provide recommendations, oversee policy compliance and promote Indigenous participation in health care governance structures. However, it is essential to avoid placing a disproportionate burden on the same Indigenous individuals to engage in these oversight roles. Several existing models demonstrate the effectiveness of independent oversight:

- **The British Columbia College of Nurses and Midwives (BCCNM)** has implemented an Indigenous Care Concerns & Complaints process, which allows Indigenous patients to self-identify when filing complaints, ensuring a culturally safe, trauma-informed review process.[178]

- **The Indigenous Primary Health Care Council (IPHCC)** in Ontario works directly with health care organizations to enhance Indigenous governance, policy compliance and oversight within health services, promoting cultural safety and accountability in patient care.[179]

- **The College of Physicians and Surgeons of Ontario (CPSO)** has introduced an Indigenous-specific complaints process to review racism-related cases and integrate Indigenous-specific racism training into health care regulation.[180]

The following initiatives highlight how independent oversight mechanisms can be embedded within health care institutions to investigate racism complaints, strengthen policy adherence and promote Indigenous leadership in governance structures.

- **Performance reviews and penalties**: Accountability at the individual level can be reinforced by integrating anti-racism metrics into employee performance evaluations. Health care professionals who fail to adhere to cultural safety and anti-racism standards may be required to undergo retraining, face disciplinary actions or, in severe cases, be subject to employment termination. Policies aligned with the TRC Calls to Action emphasize the necessity of such measures to hold health care providers accountable.[5]

- **Professional development training**: Institutional accountability is strengthened when health care organizations commit to ongoing education and professional development in anti-racism and cultural humility. Continuous training on systemic bias prevention, Indigenous health perspectives and cultural safety can help health care professionals remain informed and proactive in addressing racism within their practice.

- **Public reporting and transparency**: Health care organizations must uphold transparency by regularly publishing reports on racism-related incidents and institutional initiatives. Public disclosure of these reports fosters accountability, demonstrates commitment to systemic change and strengthens trust with Indigenous communities.

- **Leadership accountability in policy implementation**: Health care leaders must move beyond policy creation to ensure anti-racism measures are actively enforced. This requires ongoing training, clear accountability structures and regular evaluation to embed cultural safety and Indigenous health equity into daily practice. Leadership must be held responsible for addressing systemic barriers and ensuring meaningful, sustained change.

The experiences of Indigenous Peoples in health care continue to be marked by racism, neglect and mistreatment, often with devastating consequences. Without enforceable accountability mechanisms, transparent oversight and Indigenous-led governance, these injustices will continue. Systemic change requires a commitment from all levels of policymakers, health care leaders and frontline providers to dismantle discriminatory policies and uphold the rights, dignity and well-being of Indigenous patients.

Case study 3: Joyce Echaquan

On September 28, 2020, Joyce Echaquan, a 37-year-old Atikamekw woman from Manawan, Quebec, sought care at the Centre hospitalier de Lanaudière in Joliette due to severe stomach pain.[181] Joyce, a mother of seven, had a history of heart issues and other health conditions. She was admitted to the hospital the day before her death, expressing concerns about her treatment and her deteriorating health condition. Joyce used her phone to livestream a video on Facebook, capturing the neglect and racism she endured from hospital staff. The video revealed staff members making degrading remarks about her, suggesting that she was only seeking attention, making assumptions about her intelligence and lifestyle, and dismissing her distress. Her cries for help were ignored, and she was left unattended as her condition worsened. Joyce passed away on the morning of September 28, 2020. The coroner's report later confirmed that her death was preventable, and systemic racism played a significant role in the substandard care she received.

The legal system's response

Following Joyce's death, Coroner Géhane Kamel led an investigation into the circumstances surrounding her treatment.[181] In her report, she confirmed that Joyce's death resulted from a failure of the health care system, fueled by deeply rooted systemic racism. The report

emphasized that Joyce Echaquan was not adequately monitored or treated with the necessary urgency despite clear signs of distress. No criminal charges were laid against the hospital staff involved, but two employees were fired. The provincial government acknowledged the tragedy but refused to recognize systemic racism within Quebec's health care system, despite evidence presented in the coroner's report. This refusal created tension between the Atikamekw Nation and the Quebec government, as calls for justice and meaningful change continued.

- The Joyce's Principle initiative: as the document explains in the previous section, the Atikamekw Nation developed Joyce's Principle, which calls for mandatory cultural safety training for health care professionals, accountability measures and systemic changes to ensure Indigenous patients receive respectful and appropriate care. Although the federal government has supported the initiative, the Quebec government has yet to adopt it officially.[182] The CFNU endorsed Joyce's Principle at its 2021 national convention.[183]

- Inquest proceedings: the coroner's inquest examined Joyce's final hours, revealing failures in patient care, racial bias among health care workers and a lack of appropriate medical intervention. Géhane Kamel concluded that Joyce Echaquan was treated with prejudice and that her death was directly linked to systemic racism.

Despite these findings, the Quebec government continues to deny the existence of systemic racism within its institutions. However, Indigenous leaders, health care advocates and human rights organizations have used the coroner's report to push for systemic reforms.

Next steps and recommendations

Joyce Echaquan's death has become a catalyst for demanding justice and equity in health care for Indigenous Peoples. The coroner's report and Joyce's Principle provide clear recommendations, including the following.[181]

- **Recognition of systemic racism**: Governments and health care institutions must acknowledge the presence of systemic racism and commit to dismantling discriminatory practices.

- **Cultural safety and anti-racism training**: Mandatory training for health care professionals must be introduced to improve awareness, address biases and ensure Indigenous patients receive safe and appropriate care. This training must be rooted in anti-racism and decolonization, explicitly naming systemic discrimination and colonial power structures. It should be guided by Indigenous perspectives and include mechanisms to evaluate accountability and meaningful change in practice.

- **Increased Indigenous representation**: More Indigenous health care workers, patient advocates and advisory boards are required to oversee health care policies and practices.

- **Legislative changes**: Joyce's Principle must be implemented at the provincial/territorial and federal levels to guarantee Indigenous Peoples' right to safe and equitable health care.

The legacy of Joyce Echaquan's story continues to fuel advocacy efforts, urging systemic reforms to ensure Indigenous patients receive the dignity, respect and care they deserve.

Reflexive questions

- What role do you, as a nurse, play in either perpetuating or disrupting systemic racism and colonial power structures in your workplace, and what specific actions have you taken to ensure Indigenous patients are treated with dignity and respect?
- What trauma-informed care approaches would help in reducing trauma? What is vicarious trauma, and how, as a nurse, do you manage this stressor?
- How has your nursing education and institutional training prepared or failed to prepare you to recognize and address Indigenous-specific racism in clinical settings? What changes are needed in education and policy?
- What barriers exist within your unit or organization that may prevent health care staff from intervening when witnessing racist or unsafe care, and what supports are needed to make cultural safety a shared responsibility?
- In light of the CPR RACISM framework and considering Joyce Echaquan's experience, what specific strategies can you implement in your daily nursing practice to interrupt racism in the moment and contribute to a culturally safe and accountable care environment?

Educational reconciliation

In education, it is common to hear that nurses often distance themselves from advocacy and systemic change, partly due to gaps in nursing education and also due to the challenges of addressing issues of power.[14] Nursing programs have long failed to prepare nurses for socio-political roles, particularly in advocacy.[184] For meaningful progress, nursing must genuinely reflect the voices, experiences, values and languages of Indigenous Peoples and their communities in ways that are authentic and meaningful. This learning cannot be shaped by academic institutions alone; all health organizations and health leadership must make this commitment. We need to be reminded that nursing is more than patient care; it is about relationships, identity and the strength that comes from being deeply connected to your own critical self-awareness and understanding that the natural world is a fragile resource. Recognizing that the Earth's body (land) is inextricably interwoven with the human body (culture) reaffirms the importance of Indigenous languages, knowledge systems and holistic perspectives in health care. In this context, it is important to note that the Canadian Institutes of Health Research (CIHR) funded six Chairs in Indigenous Health Nursing Research (I-Chairs) in 2019 to explore social, economic and cultural determinants of health while promoting Indigenous holistic practices. These relationships and connections are key for the resilience, belonging and well-being of Indigenous health nursing professionals.

As primary sites of professional development, nursing schools play a critical role in training the largest cohort of health care professionals. They bear the responsibility of teaching non-Indigenous people about racism and how white fragility can inhibit relational practice. By doing so, they can help administrations, faculty and students gain the knowledge, skills and critical reflexivity needed to provide respectful and culturally safe care in their professional environments. The following sections outline practical strategies for achieving these goals.

Pathways of learning: Indigenous ways of being, knowing and doing

One way to ensure that Indigenous Knowledge Systems are authentically represented in nursing is by actively engaging Indigenous Elders, Knowledge Keepers and community members as mentors and teachers. Their involvement deepens students' understanding of Indigenous worldviews, values and relational approaches to care, enhancing their ability to provide people-centred and culturally safe care.[31,68] Storytelling, land-based learning and community engagement honour Indigenous ways of knowing and challenge Western-centric paradigms in health care education, resulting in a more inclusive approach to learning.[31] By placing Indigenous voices, rooted in place and personhood, at the centre of education, curriculum design becomes more aligned with and responsive to the lived realities, cultural priorities and self-determined goals of Indigenous communities.

Revising nursing education to confront colonial history, systemic racism, Indigenous health inequities, power imbalances and institutional discrimination, this approach leads to more equitable health care outcomes and is therefore critical for meaningful change. Integrating mandatory anti-racism and Indigenous cultural safety training throughout nursing programs prepares future nurses to provide care that acknowledges and respects Indigenous patients' cultural identities. Engaging students with realistic case studies and simulations that expose anti-Indigenous racism and model culturally safe care strengthens critical thinking and empathy, preparing them to identify and address discrimination in real-world clinical settings. Reflexivity exercises can help students examine personal biases and cultural identities and build the self-awareness they need to provide culturally safe care. Additionally, incorporating Indigenous health, history and rights into nursing ethics and policy courses provides the essential socio-political context necessary to advocate for Indigenous patients and uphold the principles of cultural safety.

Pathways of accountability

Providing continuous professional development on anti-racism, Indigenous health and cultural safety ensures that faculty stay informed about best practices, enabling them to effectively model and teach these principles. Establishing accountability structures for faculty engagement with anti-racism principles, such as regular

self-assessments and peer evaluations, encourages ongoing reflection and improvement in delivering culturally safe education. Equally important are clear policies for addressing racism experienced by Indigenous students, faculty and patients, ensuring that incidents are handled promptly and effectively and creating a safe and inclusive environment for everyone. Developing partnerships with Indigenous organizations to co-develop and co-evaluate anti-racism initiatives ensures strategies are both culturally appropriate and effective, resulting in more meaningful outcomes. Finally, implementing mandatory reporting and response mechanisms for incidents of racism within nursing programs promotes transparency and accountability, which are essential components of a culturally safe educational setting.

Support network

Creating opportunities to learn from the people we provide service to is invaluable. We require more clinical placements in Indigenous communities or Indigenous-led health organizations to provide nurses with practical experience in delivering culturally safe care, while deepening their understanding of community-specific health needs. Training preceptors in anti-racism and cultural safety ensures these clinical mentors model culturally safe practices, preventing the perpetuation of biases and creating supportive learning environments. Finally, establishing anonymous reporting systems for racism witnessed during clinical placements protects both students and patients, reinforcing accountability and continuous improvement in clinical settings.

Creating safe spaces and support networks for Indigenous nursing promotes a sense of belonging and helps them navigate the challenges unique to their health care experiences. Offering scholarships and funding opportunities to increase Indigenous representation in nursing programs reduces financial barriers, thereby enhancing diversity in the nursing workforce. Finally, recognizing and uplifting Indigenous research, methodologies and ways of knowing within the academic framework enriches the learning environment and ensures diverse perspectives are included in nursing education. One of the most powerful ways to strengthen this support is through intergenerational mentorship. Having a trusted mentor who can understand their struggles, share wisdom and provide guidance is important in reshaping nursing education. It also empowers Indigenous nurses and students in navigating oppressive systems that are often unwelcoming and isolating. Formal intergenerational mentorship programs that pair Indigenous students with Indigenous nurses and Knowledge Holders can create environments that nurture professional growth, resilience and leadership as students gain confidence and reassurance that they are not alone in their journey. Future efforts should include land-based learning opportunities, such as practicums in traditional territories and immersion in Indigenous healing practices[68] to strengthen cultural identity and enrich nursing education. Recognizing Indigenous Peoples as experts in health and well-being is essential to advancing health sovereignty and embedding Indigenous ways of knowing into health care.

Globally, there is growing recognition that systemic racism is a significant factor in education. There is a clear link between what is modeled and what is learned in the nursing school experience, which carries forward into the health care practice environment. In 2023, the Canadian Association of Schools of Nursing (CASN) acknowledged the harm caused to Indigenous Peoples and issued an apology, committing to address anti-Indigenous racism within nursing education.[194] One of the most well-known Indigenous Cultural Safety Training initiatives has been the San'yas Indigenous Cultural Safety Training Program, developed in 2008 under the direction of the Provincial Health Services Authority (PHSA) in British Columbia.[177] This focus on cultural safety training was initiated by the Canadian Indigenous Nurses Association in the early 2000s and promoted by national organizations. San'yas provides health care professionals with interactive exercises and reflective activities that focus on colonialism, systemic racism and Indigenous cultural safety. Originally launched in British Columbia, the program has since expanded to Ontario and Manitoba, where it has been adapted to address province-specific histories and challenges in health care and social services.[177]

In 2012, the Indigenous Cultural Competency Training (ICCT)[186] program was initiated at the Ontario Federation of Indigenous Friendship Centres (OFIFC)[187] to develop essential competencies for understanding how to build effective partnerships with Indigenous people. The ICCT program imparts crucial lessons by integrating four interrelated educational segments covering colonial management, the implementation of the *Indian Act*,[58] the operations of residential schools and treaty development. In Manitoba, the Indigenous Research Chair in Nursing with First Nations Health and Social Secretariat of Manitoba (FNHSSM)[188] has taken a proactive stance in dismantling systemic racism in health care to ensure First Nations Peoples receive equitable, culturally safe care. A key initiative in this effort is the training program *Disrupting Anti-Indigenous Racism: Moving Beyond Cultural Sensitivity in Health Care*.[189] Developed by a dedicated team of FNHSSM staff, this 8- to 10-week training is designed for health care providers to confront and disrupt ingrained biases and discriminatory practices, particularly targeting the transmission of harmful stereotypes from preceptors to trainees. Through this training, participants engage in a transformative learning process that focuses on understanding the historical and ongoing effects of colonization, using reflexivity to challenge personal biases, and equipping providers with practical tools to identify and combat racism. By embedding these principles into health care education and professional development, the FNHSSM continues to lead the way in addressing Indigenous-specific racism, fostering accountability and advocating for systemic change in the health care system. Similarly, the Rady Faculty of Health Sciences' office of Anti-Racism and office of Equity, Access and Participation[190] are leading work to set standards for anti-racism and social justice through online educational resources and opportunities for students, faculty and health care providers.

National reforms

In 2021, the Government of Canada established September 30 as the National Day for Truth and Reconciliation, a federal statutory holiday to honour survivors of residential schools, their families and communities.[191] This day serves as a public acknowledgment of Canada's colonial history and the need for collective reflection, education and accountability. In the health sector, it has become a focal point for initiatives, workshops and campaigns aimed at addressing Indigenous-specific racism and advancing reconciliation through culturally safe care. Observing this day reflects a growing national commitment to truth-telling and the ongoing work needed to transform systems in partnership with Indigenous Peoples.[191] In 2023, CASN collaborated with the I-Chairs and Indigenous Services Canada to launch a national virtual workshop series for nursing faculty.[195] These workshops, co-designed with Knowledge Keepers, Elders and Indigenous nursing students, covered topics such as Indigenous-specific racism, cultural humility and safety and systemic change in nursing education. The spring 2023 series attracted 500 participants, with bilingual sessions planned. Pre- and post-workshop evaluations showed that 93% of participants gained new insights, and 69% were highly satisfied with the sessions.

Expanding the workshop series nationally to include faculty, health leaders, clinical instructors or receptors and policymakers across all provinces and territories will strengthen its impact. Offering sessions in multiple languages will also improve accessibility and inclusivity. To sustain progress, robust monitoring and evaluation systems are needed to tackle TRC Calls to Action implementation in nursing education. Collaborating closely with Indigenous communities, Knowledge Keepers and organizations will help these initiatives align with Indigenous values and priorities. Additionally, ongoing equitable funding from federal and provincial governments is essential to support and expand health care initiatives that advance anti-racist practices. Canadian health care institutions, unions, professional organizations and educational bodies are increasingly recognizing the need to address Indigenous-specific racism. Notable initiatives include the following.

- **Canadian Federation of Nurses Unions (CFNU)**. For the last 20 years, the CFNU has been a champion of CINA and its members. The CFNU has been committed to educational work and has highlighted at its biennial conventions the issue of Indigenous-specific racism in health care and health disparities among Indigenous people in Canada, including a joint statement with the Manitoba Nurses Union in 2015 in support of Jordan's Principle,[240] an educational workshop at its convention in 2017, an endorsement of Joyce's Principle at its convention in 2021, and an educational live webinar on confronting anti-Indigenous racism in health care for its members and the broader public in 2021. Its member organizations, provincial nurses' unions, have done educational work of their own on this issue over the years, as well. Additionally, CFNU member organization, British Columbia Nurses' Union (BCNU), issued an apology to Indigenous Peoples and re-affirmed its commitment to a genuine and just process of reconciliation in 2022.[192]

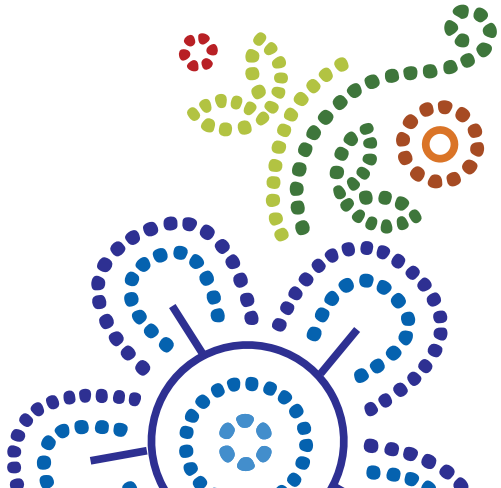
- **Canadian Nurses Association (CNA)**. In 2021, the CNA introduced the Nursing Declaration Against Anti-Indigenous Racism, asking all health care providers to commit to eliminating Indigenous-specific racism in nursing and health care. The CNA's *Code of Ethics for Registered Nurses* highlights cultural safety, ethical care and advocacy, urging nurses to build respectful relationships, address social determinants of health and challenge discriminatory practices.[193]

- **Canadian Association of Schools of Nursing (CASN)**. As the accrediting body for nursing education in Canada, CASN integrated anti-racism standards into nursing accreditation in response to the Truth and Reconciliation Commission's Call to Action #24.[5] These standards require all nursing programs to include training on Indigenous health, colonization, Indigenous rights and anti-racism. CASN also established the Anti-Racism in Nursing Education Working Group to advance anti-racism and cultural competency in nursing education.[194,195,196]

- **Canadian Nursing Students' Association (CNSA)**. The CNSA has had an Indigenous caucus for many years and, over the years, has passed resolutions and position statements at its conventions, acknowledging colonialism in our health care system and working toward cultural safety for clients through the nursing student experience in Canada.[197]

- **Health Standards Organization (HSO)**. In collaboration with the CNA, HSO developed a standard for Indigenous Cultural Safety and Humility to enhance health care environments for Indigenous patients. This standard focuses on training, fostering respectful engagement and ensuring health care practices align with Indigenous rights.[198]

The Government of Canada has committed to eliminating anti-Indigenous racism in health systems nationwide. Between October 2020 and January 2023, four National Dialogues on Indigenous-Specific Racism in Health Care were convened,[36] bringing together governments, health system partners and Indigenous health organizations to discuss actionable measures. These discussions have informed policies and funding allocations aimed at enhancing culturally safe health care services across the country.[36] While progress varies by province and territory, several regions have initiated systemic reforms, which are detailed in the following section.



Provincial and territorial reforms

Prince Edward Island: Health PEI has developed a summary of Indigenous health resources and trainings for service providers, offering cultural safety tools and inclusive practice guidelines to support respectful and informed care for Indigenous patients.[199] The Mi'kmaq Confederacy of PEI and the Native Council of PEI also play key roles in ensuring that Indigenous communities have access to culturally appropriate health and wellness services. In addition, the province launched its first Anti-Racism Action Plan (2023–2028) to address systemic racism, including anti-Indigenous racism, across health, education and public service sectors.[200]

Newfoundland and Labrador: Since 2020, the province has supported Indigenous-led health research and reform through the Research Exchange Group on Indigenous Health, which promotes community-based solutions rooted in traditional knowledge and equitable partnerships.[201] A Ministerial Committee on Anti-Racism works to review legislation and lead public education efforts.[202] In St. John's, a Community Action Plan co-developed with Indigenous partners aligns with the TRC and UNDRIP, while initiatives like Community Justice Connect support access to justice and address systemic racism.[203]

Alberta: In 2019, Alberta ended the use of birth alerts, a child welfare practice that allowed authorities to flag expectant parents without their knowledge or consent. This practice was recognized as a discriminatory child welfare practice that disproportionately affected Indigenous families, aligning with national recommendations to eliminate systemic racism in child apprehension.[204] Indigenous communities in the province, including the Paddle Prairie Métis Settlement and Sturgeon Lake Cree Nation, have continued to advance wellness and healing initiatives. Some of these efforts were originally supported by the Aboriginal Healing Foundation and are now sustained through community leadership and support from provincial programs.[205]

Yukon: Launched in 2019, Yukon's *Putting People First* strategy sets out 76 recommendations to transform health and social services into a more integrated, person-centred system. Core to the reforms are cultural safety, trauma-informed care and the inclusion of Indigenous perspectives through co-governance with First Nations. Demonstrating a commitment to respectful care, health authorities now include Indigenous language names, such as Shäw Kwä'ą in Southern Tutchone.[206]

Northwest Territories: The Government of the Northwest Territories (GNWT) has partnered with Indigenous governments to enhance cultural safety and accessibility within the health and social services system. Key initiatives include mandatory cultural safety and Indigenous-specific racism training for all health care staff, the promotion of Indigenous languages in health settings and efforts

to build a representative workforce that reflects the territory's largely Indigenous population. In 2022–2023, the GNWT also established a Cultural Safety and Anti-Racism (CSAR) Unit to lead system-wide efforts to address systemic racism, with a specific focus on anti-Indigenous racism.[207,208,209]

Nunavut: Nunavut's Department of Health incorporates Inuit Qaujimajatuqangit (IQ), Inuit traditional knowledge, into service delivery, promoting culturally grounded and community-led care.[210] In 2023, mandatory cultural safety training was introduced for physicians relocating to Nunavut, enhancing their understanding of Inuit history, values and health care experiences.[211] Additional educational resources exist, such as Indigenous cultural orientation and safety to support providers in delivering respectful and effective care.[212]

Saskatchewan: Registered nurses are mandated to adhere to practice standards that emphasize cultural safety and ethical care.[171] These standards are designed to ensure health care professionals are equipped to provide respectful and culturally appropriate services to Indigenous patients. However, ongoing monitoring and evaluation are needed to assess the impact of these policies on patient outcomes.

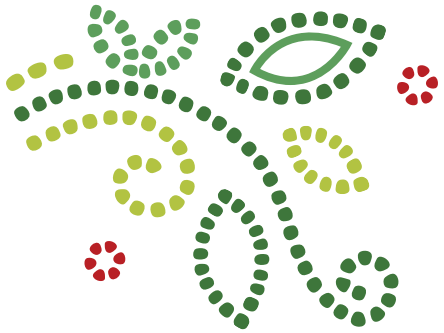
Quebec: While the Quebec government has not fully adopted Joyce's Principle, both the Quebec College of Physicians and the Fédération interprofessionnelle de la santé du Québec (FIQ) have publicly urged the province to formally acknowledge systemic racism and to collaborate with Indigenous organizations to develop culturally safe health care policies. FIQ endorsed Joyce's Principle at a previous convention and reiterated their call for government action following the 2022 provincial election.[213,214,215]

Ontario and Manitoba: Both provinces have introduced cultural competency training programs for health care providers aimed at reducing biases and improving care for Indigenous patients.[216,217] These initiatives prioritize collaboration with Indigenous leaders and communities to ensure that reforms are guided by lived experience and traditional knowledge, though continuous evaluation is required to determine their effectiveness.

British Columbia: Following the 2020 *In Plain Sight* report, which detailed pervasive Indigenous-specific racism in BC's health care system, the province has undertaken significant measures to implement the report's 24 recommendations. In November 2022, the *Health Professions and Occupations Act* (Bill 36)[175] received royal assent, introducing anti-discrimination provisions to strengthen responses to Indigenous-specific racism and enhancing the cultural safety of health care services. A 24-month progress update in 2023 highlighted ongoing efforts, including the establishment of the *In Plain Sight* Task Team to oversee the implementation process.[113]

Nova Scotia: In 2022, the province passed the *Dismantling Racism and Hate Act*,[219] mandating a provincial strategy to address systemic hate, inequity and racism. This strategy responds to community feedback and addresses concerns raised by underrepresented and underserved communities, such as the Mi'kmaw and Persons of Indigenous Descent.

New Brunswick: Although provincial-level change has been slow, New Brunswick's Indigenous Health Nursing Research Chair has worked closely with Indigenous community partners to support grassroots initiatives, including new Indigenous nursing outreach and wellness services, language revitalization, cultural diversity training, restorative justice, and the design and construction (currently underway) of an Indigenous healing centre.[218]



Support for community-driven and Indigenous-led initiatives

Engaging Indigenous communities and their leaders in health care initiatives is important for ensuring that these efforts align with their unique needs and priorities. Working together with Indigenous health organizations builds partnerships that allow the development of health care strategies that are grounded in Indigenous values and practices.[134] Adequate funding provides a necessary foundation for addressing systemic disparities while creating health equity by enabling communities to design, implement and sustain culturally appropriate policies.[220] Governments at both the federal and provincial levels should allocate specific funding for Indigenous-led initiatives, including traditional healing practices, promoting cultural safety and addressing systemic racism.

First Nations Health Authority

A prime example of effective Indigenous governance is the First Nations Health Authority (FNHA) in British Columbia.[221] Established in 2013 through a historic transfer of health services from the federal government to First Nations leadership, the FNHA is the first and only province-wide Indigenous-led health authority in Canada. It was created to ensure that Indigenous communities have greater control over their own health care systems.[221]

This shift represents a step toward self-determination in health care, recognizing the importance of culturally relevant and community-driven approaches.

The FNHA operates with a focus on holistic wellness, traditional healing practices and culturally safe care. Unlike mainstream health systems, which often impose standardized models of care, the FNHA works directly with First Nations communities to design programs that reflect their unique needs and cultural values. These initiatives include mental wellness programs, land-based healing practices, harm reduction strategies and the integration of Indigenous knowledge into health care services.[134] By placing Indigenous governance at the centre of health care decision-making, the FNHA serves as a model for other regions seeking to decolonize health services. Its approach demonstrates the effectiveness of Indigenous-led health care systems in addressing systemic inequities, reducing barriers to care and ensuring services align with the distinct cultural and spiritual needs of First Nations people.[9,222] The FNHA's work highlights the importance of self-determination in achieving health equity and serves as an example of how Indigenous leadership can transform health care in Canada.

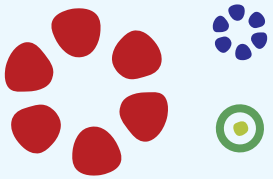
Snapshot of Indigenous health nursing leadership

Tajikeimɨk – Mi'kmaw health and wellness organization is a newly developed First Nations self-governing organization in Nova Scotia, exemplifying how Indigenous-led health care governance can improve health equity, cultural safety and self-determined health care solutions for Mi'kmaq communities.[223] In Mi'kma'ki, the unceded and ancestral lands of the Mi'kmaq, Tajikeimɨk is leading a transformation in health services by taking control of the design and delivery of health and wellness programs, with the aim of providing the Mi'kmaq of Nova Scotia with high-quality, culturally safe and holistic approaches to care.[224] A critical component of this transformation is the education of health care providers about Indigenous knowledge and worldviews to improve cultural safety and health outcomes. One key initiative in this effort is *To Know Better Is to Do Better: Translating Indigenous Knowledge to Health Practice,* an Indigenous-led cultural safety curriculum developed in partnership with Dalhousie University and IWK Health.[224] This program is actively being piloted across Nova Scotia to equip health care professionals with the skills and understanding needed to provide culturally safe care.[225]

Office of L'nu Nursing

The Office of L'nu Nursing[226] was established through the L'nu Nursing Initiative, which was developed under the Chair held by Dr. Margot Latimer and brought to life through ongoing proposals submitted in partnership with Tajikeimɨk. Partnerships with the province and nursing schools in Nova Scotia were essential in making this initiative a reality. Now under the leadership of Tajikeimɨk, Office of L'nu Nursing is operated and managed by the Mi'kmaw people. It is led by a director and has the capacity for four Mi'kmaw/Indigenous Nurse Education Specialists (MINES),[227] who support and operate out of the nursing schools across the province. The MINES are Mi'kmaw nurses who bring their experience and wisdom to support both prospective and current L'nu nursing students. The aim of the office is "to create a sustainable, supportive and safe environment for L'nu nursing students, fostering cultural understanding and empowering Mi'kmaq/L'nu students in their nursing education."[226] Through mentorship, culturally relevant resources and a network of peers and allies, the initiative empowers Mi'kmaq/L'nu students to thrive in a field that has not always reflected their unique perspectives and experiences. Another focus is on building a strong sense of community by connecting and celebrating the successes of Mi'kmaq nurses currently working across Nova Scotia.[226]

Demonstrating their commitment, the Research Nova Scotia's research investment initiative funded a research project titled "Etuaptmu'k W'loti: Using Mi'kmaw Knowledge to Create Health & Wellness Solutions".[228] The award initiative, co-hosted by Tajikeimɨk and IWK Health, represents an important milestone towards self-determination in Mi'kmaw health research. It is expected to improve Indigenous health outcomes in Nova Scotia, particularly through culturally safe education for health profession students and practicing clinicians, as well as the development of a cultural safety toolkit with indicators at the community, clinician, organizational and system levels.[228,225] Beyond these major initiatives, Tajikeimɨk also hosts several other culturally grounded programs focused on high-quality, culturally safe and holistic approaches. These programs include Nuji-Apoqnmuet,[229] Msɨt Mijua'ji'jk[230] and Mi'kmaq Cancer Care,[231] as well as the Mi'kmaq Indigenous Nurse Education Specialists role under the L'nu Nursing Initiative.[232]



In closing

Our network of CIHR Indigenous Nursing Research Chairs across Canada, along with a growing number of Knowledge Holders, Elders, students and staff, has been engaged in community-based research over the past five years as we collectively work toward advancing anti-Indigenous racism and reconciliation across nursing education, practice and policy in Canada. During this critical time in Canadian history, positive change can be realized by moving forward together in reconciliation with Indigenous populations. All nurses have the capacity for leadership, which includes developing knowledge related to cultural humility, cultural safety, conflict mediation, human rights and Indigenous-specific racism, as well as advocating for cross-jurisdictional Indigenous health care rights and sustainable holistic health care services.

The preventable deaths of Brian Sinclair, Joyce Echaquan and Keegan Combes expose the profound consequences of unchecked Indigenous-specific racism within Canadian health care. These tragedies show how colonial legacies, policy failures and inequitable power structures continue to create unsafe and life-threatening conditions for Indigenous patients. Despite existing equity measures and frameworks, the gap between Indigenous access to health care and health outcomes as compared to settler access and health outcomes continues to widen because the systems have yet to meaningfully dismantle oppressive structures that perpetuate these stark disparities.

Truth and Reconciliation is not an endpoint but a necessary foundation to address the intergenerational impacts of residential schools, forced assimilation and other forms of colonial violence. Real change demands a shift in power dynamics, dismantling oppressive frameworks and centring Indigenous Knowledges, worldviews, pedagogies and healing practices into mainstream health care. Equally important are robust mechanisms of accountability and strategies to address Indigenous-specific racism, enabling nurses and health care leaders to call out discriminatory practices, reshape organizational cultures and reinforce culturally safe environments. Moving beyond equity will require more time. However, moving forward we need Indigenous leadership at all levels of health care, supported by sustained commitment and transparent governance. This includes reimagining nursing to reflect Indigenous perspectives, promoting land-based learning and prioritizing community-driven solutions. Only by honouring the lived realities, rights and expertise of Indigenous Peoples can Canada advance from performative gestures of reconciliation to genuine systemic reform that ensures every Indigenous person receives the respect, dignity and high-quality care they rightfully deserve.

References

1. Métis Nation of Ontario. (n.d.). *Culture and heritage*. https://www.metisnation.org/about-the-mno/culture-heritage/

2. Inuit Tapiriit Kanatami. (n.d.). *The national voice for Inuit in Canada*. https://www.itk.ca/national-voice-for-communities-in-the-canadian-arctic /

3. Government of British Columbia. (2024, September). *Distinctions-based approach. Declaration on the Rights of Indigenous Peoples Act*. https://www2.gov.bc.ca/gov/content/governments/indigenous-people/new-relationship/united-nations-declaration-on-the-rights-of-indigenous-peoples/distinctions-based-approach

4. United Nations. (2007). United Nations declaration on the rights of Indigenous peoples (UNDRIP). https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf

5. Truth and Reconciliation Commission of Canada. (2015). *Honouring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada*. https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Executive_Summary_English_Web.pdf

6. Bourque Bearskin, M. L., Seymour, M. S. L. C., Melnyk, R., D'Souza, M., Sturm, J., Mooney, T., & Bell, B. (2024). Truth to action: Lived experiences of Indigenous healthcare professionals redressing Indigenous-specific racism. *Canadian Journal of Nursing Research*. Advance online publication. https://doi.org/10.1177/08445621241282784

7. Canadian Nurses Association. (2024, February 29). *Latest health workforce data confirms CNA's predictions of critical nursing shortages* [Press release]. https://www.cna-aiic.ca/en/blogs/cn-content/2024/02/29/latest-health-workforce-data-confirms-cnas

8. Ramsden, I. (2002). *Cultural safety and nursing education in Aotearoa and Te Waipounamu* [Unpublished doctoral dissertation]. Victoria University of Wellington. https://ir.wgtn.ac.nz/items/f23b0721-a705-404b-b5cf-7c4fb9c6c115

9. First Nations Health Authority. (2016). *#itstartswithme: FNHA's policy statement on cultural safety and humility*. https://www.fnha.ca/documents/fnha-policy-statement-cultural-safety-and-humility.pdf

10. Canadian Indigenous Nurses Association. (2019). *About us*. https://indigenousnurses.ca/about

11. Canadian Institutes of Health Research. (n.d.). *Indigenous research chairs in nursing*. https://www.researchnet-recherchenet.ca/rnr16/vwOpprtntyDtls.do?prog=3033&language=E

12. First Nations Health Authority & British Columbia Ministry of Health. (2024). *First Nations population health and wellness agenda: First interim update, 2024*. Retrieved from https://www.fnha.ca/Documents/FNHA-PHO-First-Nations-Population-Health-and-Wellness-Agenda-First-Interim-Update-2024.pdf

13. Canadian Association of Schools of Nursing. (2024, April). *Addressing the Truth and Reconciliation Calls to Action in nursing education workshop series*. https://www.casn.ca/2024/04/addressing-the-truth-and-reconciliation-calls-to-action-in-nursing-education-workshop-series/

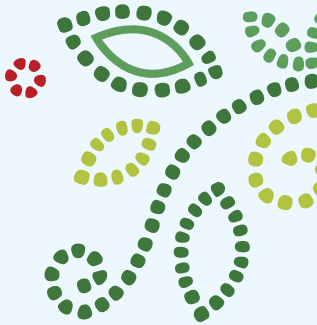
14. Phillips-Beck, W. (2020). *Indigenous research chair in nursing* [First Nations Health and Social Secretariat of Manitoba]. https://www.fnhssm.com/ichair

15. First Nations Health and Social Secretariat of Manitoba. (2025). *Indigenous research chair in nursing*. https://www.fnhssm.com/ichair

16. Lux, M. K. (2016). *Separate beds: A history of Indian hospitals in Canada, 1920s–1980s*. University of Toronto Press.

17. Canadian Indigenous Nurses Association. (2016). *The Indigenous nurse: Celebrating 40 years*. https://myrnao.ca/sites/default/files/attached_files/CINA%20NEWSLETTER%20-%20Spring%202016.pdf

18. Dion Stout, M. (2012) Ascribed health and wellness, Atikowisi miýw-āyāwin, to achieved health and wellness, Kaskitamasowin miýwāyāwin: shifting the paradigm. *The Canadian Journal of Nursing Research*, 44(2), 11-14.



19. Meijer Drees, L. (2013). *Healing histories: Stories from Canada's Indian hospitals*. University of Alberta Press.

20. British Columbia Nurses' Union. (2024). *Indigenous leadership circle*. https://www.bcnu.org/about-bcnu/human-rights-and-equity/indigenous-leadership-circle#:~:text=The%20Indigenous%20Leadership%20Circle%20offers,representative%20from%20each%20BCNU%20region

21. The Canadian Encyclopedia (2023, November). First Nations in Canada. *The Canadian Encyclopedia*. https://www.thecanadianencyclopedia.ca/en/article/first-nations#:~:text=First%20Nations%20is%20a%20term,First%20Nations%20people%20in%20Canada

22. Government of Canada. (n.d.). *Highlights from the 2021 census*. https://www.sac-isc.gc.ca/eng/1690909773300/1690909797208

23. Devine, H. (2004). *The people who own themselves: Aboriginal ethnogenesis in a Canadian family*, 1660–1900. University of Calgary Press.

24. Gabriel Dumont Institute of Native Studies and Applied Research. (2009). *The Virtual Museum of Métis History and Culture*. https://www.metismuseum.ca/

25. Battiste, M., & Henderson Youngblood, J. (2000). *Protecting Indigenous knowledge and heritage* Purich.

26. Borrows, J. (2016). *Freedom and Indigenous constitutionalism*. University of Toronto Press.

27. Ermine, W. (1995). Aboriginal epistemology. In M. Battiste & J. Barman (Eds.), *First Nations education in Canada: The circle unfolds* (pp. 101–112). UBC Press.

28. Aikman, S., & King, L. (2012). Indigenous knowledges and education. *Compare: A Journal of Comparative and International Education*, 42(5), 673–681.

29. Battiste, M. (2004, May 29). *Animating sites of postcolonial education: Indigenous knowledge and the humanities* [Plenary address].

30. Kimmerer, R. W. (2013). *Braiding sweetgrass: Indigenous wisdom, scientific knowledge and the teachings of plants. Milkweed Editions*.

31. Littlebear, R. (2000). Jagged worldviews colliding. In M. Battiste. (Ed.). *Reclaiming Indigenous voice and vision* (pp. 77-85). UBC Press.

32. Simpson, L. B. (2011). *Dancing on our turtle's back: Stories of Nishnaabeg re-creation, resurgence and a new emergence*. Arbeiter Ring Pub.

33. Greenwood, M., de Leeuw, S., Lindsay, N. M., & Reading, C. (Eds.). (2018). *Determinants of Indigenous peoples' health: Beyond the social* (2nd ed.). Canadian Scholars' Press.

34. Bourque Bearskin, M. L. (2023). Decolonization: The what, why, and how: A treatise on Indigenous nursing knowledge. *Nursing Philosophy*, 24(3), e12430. https://doi.org/10.1111/nup.12430

35. Government of Canada. (2013). *Peace and Friendship Treaties (1725–1779)*. Crown-Indigenous Relations and Northern Affairs Canada. https://www.rcaanc-cirnac.gc.ca/eng/1360937048903/1544619681681

36. Government of Canada. (2024). *The Royal Proclamation of 1763*. Crown-Indigenous Relations and Northern Affairs Canada. https://www.rcaanc-cirnac.gc.ca/eng/1370355181092/1607905122267

37. Crosby, A. W. (1972). *The Columbian Exchange: Biological and Cultural Consequences of 1492*. Greenwood Publishing Company.

38. Miller, J. R. (2009). *Compact, Contract, Covenant: Aboriginal Treaty-Making in Canada*. University of Toronto Press

39. Nisga'a Lisims Government. (2000). *Nisga'a Treaty*. https://www.nisgaanation.ca/government/nisgaa-treaty/

40. Council of Yukon First Nations. (1990). *Yukon Umbrella Final Agreement*. https://www.cyfn.ca/agreements/umbrella-final-agreement/

41. Obomsawin, R. (2007, March). *Traditional medicine for Canada's First Peoples*. https://lfs-indigenous.sites.olt.ubc.ca/files/2014/07/RayObomsawin.traditional.medicine-1.pdf

42. First Nations Health Authority. (2025). *Our history, our health*. https://www.fnha.ca/wellness/wellness-for-first-nations/our-history-our-health

43. Daschuk, J. (2013). *Clearing the plains: Disease, politics of starvation, and the loss of Indigenous life*. University of Regina Press.

44. Craft, A., & Lebihan, A. (2021). The treaty right to health: A sacred obligation. National Collaborating Centre for Indigenous Health.

45. Alfred, G. T. (2009). Colonialism and state dependency. *Journal of Aboriginal Health*, 5(2), 42–60. https://www.researchgate.net/publication/242591149_Colonialism_and_State_Dependency

46. Government of Canada. (2018). *The arrival of the Europeans: 17th century wars*. https://www.canada.ca/en/department-national-defence/services/military-history/history-heritage/popular-books/aboriginal-people-canadian-military/arrival-europeans-17th-century-wars.html

47. Wispelwey, B., Osuagwu, C., Mills, D., Goronga, T., & Morse, M. (2023). Towards a bidirectional decoloniality in academic global health: Insights from settler colonialism and racial capitalism. *The Lancet Global Health*, 11(9), e1469–e1474.

48. Newman, M. T. (1976). Aboriginal New World epidemiology and medical care, and the impact of Old World disease imports. *American Journal of Physical Anthropology*, 45(3), 667–672.

49. National Collaborating Centre for Indigenous Health. (2019). *Social Determinants of Health-Access to health services as a social determinant of First Nations, Inuit and Métis health*. https://www.nccih.ca/docs/determinants/FS-AccessHealthServicesSDOH-2019-EN.pdf

50. Seymour, C., Bourque Bearskin, M. L., Wazni, L., Melnyk, R., Rose Hunter Porter, N., & Padley, M. (2023). Moving beyond ignorance and epistemic violence: Indigenous health nurses' response to systems transformation. *Healthcare Papers*, 21(2), 35–41.

51. Ahenakew, C. (2011). The birth of the “windigo”: The construction of Aboriginal health in biomedical and traditional Indigenous models of medicine. *Critical Literacy: Theories & Practices*, 5(1), 4–11.

52. Allen, L., Hatala, A., Ijaz, S., Courchene, E. D., & Bushie, E. B. (2020). Indigenous-led health care partnerships in Canada. *CMAJ, 192*(9), E208–E216. https://doi.org/10.1503/cmaj.190728

53. Browne, A. J., Varcoe, C., Lavoie, J., Smye, V., Wong, S. T., Krause, M., Tu, D., Godwin, O., Khan, K., & Fridkin, A. (2016). Enhancing health care equity with Indigenous populations: Evidence-based strategies from an ethnographic study. *BMC Health Services Research*, 16, 544.

54. Garcia-Vázquez, A. I. (2017). Indigenous Medical Tradition and Biomedical Tradition: A Historical Relation of Hegemony. *Advances in Social Sciences Research Journal*, 4(3), 201–214. https://journals.scholarpublishing.org/index.php/ASSRJ/article/view/2766/158

55. La Violette, F. E. (1973). *The struggle for survival*. University of Toronto Press.

56. Cole, D., & Chaikin, I. (1990). *An iron hand upon the people: The law against the Potlatch on the Northwest Coast*. Douglas & McIntyre.

57. Pettipas, K. (1994). *Severing the ties that bind: Government repression of Indigenous religious ceremonies on the prairies* (Vol. 7). University of Manitoba Press.

58. Government of Canada. (1985). *Indian Act, R.S.C., 1985, c. I-5*. https://laws-lois.justice.gc.ca/eng/acts/i-5/

59. Conn, H. (2023, October 17). Edith Monture. *The Canadian Encyclopedia*. https://www.thecanadianencyclopedia.ca/en/article/charlotte-edith-anderson-monture

60. Fiske, J. A., & George, E. (2007). Bill C-31: A study of cultural trauma. In J. P. White, E. Anderson, W. Cornet, & D. Beavon (Eds.), *Aboriginal policy research: Moving forward, making a difference* (Vol. 5, pp. 53–73). Thompson Educational Publishing.

61. Pasternak, S., & Groves, T. (2025). *RCMP and Inuit relocation*. National RCMP Heritage Centre. https://rcmpheritage.ca/rcmp-history/indigenous-peoples/rcmp-and-inuit-relocation/

62. Osborne, S. (2023). Inuit disc numbers. *The Canadian Encyclopedia*. https://www.thecanadianencyclopedia.ca/en/article/inuit-disc-numbers

63. Roberts, A. B. (1975). Eskimo identification and disc numbers: A brief history. Social Development Division, Department of Indian and Northern Affairs. https://publications.gc.ca/collections/collection_2017/aanc-inac/R5-303-1975-eng.pdf

64. Government of Canada. (2025). Government of Canada's apology for the Nunavik dog slaughter. Crown-Indigenous Relations and Northern Affairs Canada. https://www.rcaanc-cirnac.gc.ca/eng/1732300419996/1732300456676#s2

65. Michelin, O. (2019). Canadian Inuit dog. *The Canadian Encyclopedia*. https://www.thecanadianencyclopedia.ca/en/article/canadian-inuit-dog

66. Davin, N. F. (1879). *Report on industrial schools for Indians and half-breeds* [Davin Report]. https://dev.nctr.ca/wp-content/uploads/2021/01/Davin-Report.pdf

67. Adams, D. W. (1995). *Education for extinction: American Indians and the boarding school experience, 1875–1928*. University Press of Kansas. https://kansaspress.ku.edu/9780700629602/

68. Gone, J. P. (2016). Alternative knowledges and the future of community psychology: Provocations from an American Indian healing tradition. *American Journal of Community Psychology*, 58(3–4), 314–321. https://doi.org/10.1002/ajcp.12046

69. Sinclair, R. (2016). The Indigenous child removal system in Canada: An examination of legal decision-making and racial bias. *First Peoples Child & Family Review, 11*(2), 8–18. https://fpcfr.com/index.php/FPCFR/article/view/310/260

70. Mosby, I. (2013). Administering colonial science: Nutrition research and human biomedical experimentation in Aboriginal communities and residential schools, 1942–1952. *Histoire Sociale/Social History*, 46(1), 145–172. https://doi.org/10.1353/his.2013.0015

71. Milloy, J. S. (1999). *A national crime: The Canadian government and the residential school system, 1879–1986*. University of Manitoba Press.

72. Burnett, K. (2010). *Taking medicine: Women's healing work and colonial contact in Southern Alberta, 1880–1930*. UBC Press.

73. Symenuk, P. M., Tisdale, D., Bearskin, D. H. B., & Munro, T. (2020). In search of the truth: Uncovering nursing's involvement in colonial harms and assimilative policies five years post Truth and Reconciliation Commission. *Witness: The Canadian Journal of Critical Nursing Discourse, 2*(1), 84–96. https://doi.org/10.25071/2291-5796.51

74. Blackstock, C. (2016). The complainant: The Canadian human rights case on First Nations child welfare. *McGill Law Journal, 62*(2), 285–328. https://doi.org/10.7202/1040049ar

75. Blackstock, C. (2019). Indigenous child welfare legislation: A historical change or another paper tiger? *First Peoples Child & Family Review*, *14*(1), 5–8. https://fpcfr.com/index.php/FPCFR/article/view/367

76. D'Antonio, P. (2022). What do we do about Florence Nightingale? *Nursing Inquiry*, *29*(1), e12450. https://doi.org/10.1111/nin.12450

77. Stake-Doucet, N. (2020, November 5). The racist lady with the lamp. *Nursing Clio*. https://nursingclio.org/2020/11/05/the-racist-lady-with-the-lamp/

78. Helmstadter, C., & Godden, J. (2016). *Nursing before Nightingale, 1815–1899*. Routledge. https://www.routledge.com/Nursing-before-Nightingale-1815-1899/Helmstadter-Godden/p/book/9781138248885

79. Nelson, S., & Rafferty, A. M. (Eds.). (2011). *Notes on Nightingale: The influence and legacy of a nursing icon*. Cornell University Press. https://www.cornellpress.cornell.edu/book/9780801476112/notes-on-nightingale/

80. Reverby, S. M. (1987). *Ordered to care: The dilemma of American nursing, 1850–1945*. Cambridge University Press.

81. Croakey. (2020, May 12). NZ Nurses Organisation: Why we aren't celebrating Florence's birthday. *Croakey Health Media*. https://www.croakey.org/nz-nurses-organisation-why-we-arent-celebrating-florences-birthday/

82. International Council of Nurses. (n.d.). *International Nurses Day*. https://www.icn.ch/how-we-do-it/campaigns/international-nurses-day

83. Alexander, K. (2019). Charlotte Edith Anderson Monture. *National Women's History Museum*. https://www.womenshistory.org/education-resources/biographies/charlotte-edith-anderson-monture

84. Interior Health. (2024). In this together: Protecting knowledge keepers. https://www.interiorhealth.ca/stories/in-this-together-protecting-knowledge-keepers

85. Hogan, P. St'at'imx. (2013). Nurse Rose Casper retires after 50 years of service. *Spirit*. https://www.fnha.ca/WellnessSite/SpiritMagazineSite/SpiritMagazine/Spirit_Winter_2013.pdf

86. Rose Casper Healing Center – Tsal'alhmec Aboriginal Health Services. (n.d.). https://interior-west.pathwaysbc.ca/programs/2555

87. Hahmann, T., Lee, H., & Godin, S. (2024, April). Indigenous foster children living in private households: Rates and sociodemographic characteristics of foster children and their households. *Statistics Canada*. https://www150.statcan.gc.ca/n1/pub/41-20-0002/412000022024001-eng.htm

88. Indigenous Services Canada. (2025). *Reducing the number of Indigenous children in care*. First Nations Child and Family Services. https://www.sac-isc.gc.ca/eng/1541187352297/1541187392851

89. First Nations Child & Family Caring Society. (2023). *Jordan's Principle*. https://fncaringsociety.com/jordans-principle

90. Ontario Ministry of Children, Community and Social Services. (2020). *Policy directive: CW 005-20 – Ceasing the practice of birth alerts in Ontario*. https://www.ontario.ca/document/child-protection-service-directives-forms-and-guidelines/policy-directive-cw-005-20-ceasing-practice-birth-alerts-ontario

91. Government of Canada. (2025, March 19). *Final agreement reached to resolve Hardy class action*. Crown-Indigenous Relations and Northern Affairs Canada. https://www.canada.ca/en/crown-indigenous-relations-northern-affairs/news/2025/03/final-agreement-reached-to-resolve-hardy-class-action.html

92. Geddes, G. (2017). *Medicine unbundled: A journey through the minefields of Indigenous health care*. Heritage House Publishing Co.

93. McCallum, M. J. L., & Lux, M. (2022). Medicare versus medicine chest: Court challenges and treaty rights to health care. In E. W. Jones, J. Hanley, & D. Gavrus (Eds.), *Medicare's histories: Origins, omissions, and opportunities in Canada* (pp. 103–130). University of Manitoba Press.

94. Woolford, A. (2015). *This benevolent experiment: Indigenous boarding schools, genocide, and redress in Canada and the United States*. University of Nebraska Press.

95. Kelm, M. E. (1999). British Columbia First Nations and the influenza pandemic of 1918–19. *BC Studies*, (122), 23–48.

96. Drees, L. M. (2010). Indian hospitals and Aboriginal nurses: Canada and Alaska. *Canadian Bulletin of Medical History*, 27(1), 139–161. https://doi.org/10.3138/cbmh.27.1.139

97. Stote, K. (2015). *An act of genocide: Colonialism and the sterilization of Aboriginal women*. Fernwood Publishing.

98. Leason, J. (2021). Forced and coerced sterilization of Indigenous women: Strengths to build upon. *Canadian Family Physician*, 67(7), 525–527. https://doi.org/10.46747/cfp.6707525

99. Boyer, Y. L. R., & Leggett, R. (2022). Forced sterilization: A malicious determinant of health. In M. Greenwood, S. de Leeuw, & N. M. Lindsay (Eds.), *Introduction to determinants of First Nations, Inuit, and Métis peoples' health in Canada* (pp. 37–50). Canadian Scholars.

100. Ryan, C., Ali, A., & Shawana, C. (2021). Forced or coerced sterilization in Canada: An overview of recommendations for moving forward. *International Journal of Indigenous Health*, 16(1), 275–290.

101. Standing Senate Committee on Human Rights. (2022, July). *The scars that we carry: Forced and coerced sterilization of persons in Canada – Part I/*. The Scars that We Carry: Forced and Coerced Sterilization of Persons in Canada - Part II

102. Tk'emlúps te Secwépemc. (2021). *Press release*. Office of the Chief, Kamloops Indian Band. https://tkemlups.ca/wp-content/uploads/05-May-27-2021-TteS-MEDIA-RELEASE.pdf

103. Lux, M. (2017). Indian hospitals in Canada. *The Canadian Encyclopedia*. https://www.thecanadianencyclopedia.ca/en/article/indian-hospitals-in-canada

104. Bourque Bearskin, D., Bourque Bearskin, M. L., Jakubec, S. L., & Loader, V. R. (in press). Indigenous public health transformation. In M. Sedgwick & K. D. McCullough (Eds.), *Preceptorship in Canadian nursing education*. Canadian Association of Schools of Nursing.

105. Indigenous Services Canada. (2021). *Indigenous Services Canada departmental plan 2021–22*. Government of Canada. https://publications.gc.ca/collections/collection_2021/sac-isc/R1-105-2021-eng.pdf

106. Statistics Canada. (2021). *Census profile, 2021 census of population*. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E

107. Reading, C., & Greenwood, M. (2015). Structural determinants of Aboriginal peoples' health. *Determinants of Indigenous peoples' health* (pp. 1–15).

108. Webb, D. (2022). *Indigenous health in federal, provincial, and territorial health policies and systems*. National Collaborating Centre for Indigenous Health. https://www.nccih.ca/Publications/Lists/Publications/Attachments/10401/2023-01-09-RPT-Indigenous-Health-FTP-policies-and-systems-EN-web.pdf

109. Feagin, J. R. (2006). *Systemic racism: A theory of oppression*. Routledge/Taylor & Francis Group.

110. Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., … Gee, G. (2015). Racism as a determinant of health: A systematic review and meta-analysis. *PLOS ONE, 10*(9), e0138511. https://doi.org/10.1371/journal.pone.0138511

111. McLane, P., Barnabe, C., Mackey, L., Bill, L., Rittenbach, K., Holroyd, B. R., Bird, A., Hely, B., Janvier, K., Louis, E., & Rosychuk, R. J. (2022). First Nations status and emergency department triage scores in Alberta: A retrospective cohort study. *Canadian Medical Association Journal, 194*(2), E37–E45.

112. Allan, B., & Smylie, J. (2015). *First peoples, second class treatment: The role of racism in the health and well-being of Indigenous peoples in Canada*. Wellesley Institute.

113. Government of British Columbia. (2020). *In Plain Sight: Addressing Indigenous-specific racism and discrimination in BC health care*. Vancouver, BC: Ministry of Health. In-Plain-Sight-Full-Report-2020.pdf

114. Latimer, M., Simandl, D., Finley, A., Rudderham, S., Harman, K., Young, S., MacLeod, E., Hutt-MacLeod, D., & Francis, J. (2014). Understanding the impact of the pain experience on Aboriginal children's wellbeing: Viewing through a two-eyed seeing lens. *First Peoples Child & Family Review, 9*(1), 22–37. View of Understanding the Impact of the Pain Experience on Aboriginal Children's Wellbeing: Viewing Through a Two-Eyed Seeing Lens

115. Health Canada. (2020). *Working together to better understand, prevent, and manage chronic pain: What we heard* (Canadian Pain Task Force Report: October 2020). Government of Canada. https://www.canada.ca/content/dam/hc-sc/documents/corporate/about-health-canada/public-engagement/external-advisory-bodies/canadian-pain-task-force/report-2020-rapport/report-2020.pdf

116. Goodman, A., Fleming, K., Markwick, N., Morrison, T., Lagimodiere, L., & Kerr, T. (2018). "They treated me like crap and I know it was because I was Native": The healthcare experiences of Aboriginal peoples living in Vancouver's inner city. *Social Science & Medicine, 178*, 87–94.

117. Cameron, B. L., Plazas, M., Salas, A. S., Bearskin, R. L., & Hungler, K. (2014). Understanding inequalities in access to health care services for Aboriginal people: A call for nursing action. *Advances in Nursing Science, 37*(3), E1–E16. https://doi.org/10.1097/ANS.0000000000000039

118. Roxburgh, S., & Sinclair, M. (2024). Colonial constructions: Systemic racism in child welfare practice. *Journal of Social Work, 24*(1), 3–20.

119. Wilson-Raybould, J. (2022). *True reconciliation: How to be a force for change*. McClelland & Stewart.

120. British Columbia College of Nurses and Midwives. (2022). *Practice standards: Indigenous cultural safety, cultural humility, and anti-racism*. https://www.bccnm.ca/RN/PracticeStandards/Pages/CulturalSafetyHumility.aspx

121. DiAngelo, R. (2011). *White fragility. International Journal of Critical Pedagogy, 3*(3), 54–70.

122. McIntosh, P. (1988). *White privilege and male privilege: A personal account of coming to see correspondences through work in women's studies* (Vol. 189). Wellesley College, Center for Research on Women.

123. Johnson, H. B., & Shapiro, T. M. (2013). Good neighborhoods, good schools: Race and the "good choices" of White families. In A. R. Doane & E. Bonilla-Silva (Eds.), *White out: The continuing significance of racism* (pp. 175–189). Routledge.

124. Lavelle, B. & Harding, L. (2022). How Indigenous-Specific Racism is Coached into Health System. In A. Gebhard, S. McLean, & V. St. Denis (Eds.), *White benevolence: Racism and colonial violence in the helping professions*. (pp.18-30). Fernwood Publishing.

125. DiAngelo, R., & Dyson, M. E. (2018). *White fragility: Why it's so hard for White people to talk about racism*. Beacon Press.

126. Hantke, S., St. Denis, V. & Graham, H. (2022). Racism and antiracism in nursing education: confronting the problem of whiteness. *BMC Nursing* 21, 146 (2022). https://doi.org/10.1186/s12912-022-00929-8

127. Came, H., & Griffith, D. (2018). Tackling racism as a "wicked" public health problem: Enabling allies in anti-racism praxis. *Social Science & Medicine, 199*, 181–188. https://doi.org/10.1016/j.socscimed.2017.03.028

128. First Nations Health Authority. (2025). *Cultural safety and humility*. https://www.fnha.ca/what-we-do/cultural-safety-and-humility

129. Dawson, J., Laccos-Barrett, K., Hammond, C., & Rumbold, A. (2022). Reflexive Practice as an Approach to Improve Healthcare Delivery for Indigenous Peoples: A Systematic Critical Synthesis and Exploration of the Cultural Safety Education Literature. *International Journal of Environmental Research and Public Health, 19*(11), 6691. https://doi.org/10.3390/ijerph19116691

130. British Columbia Ministry of Children and Family Development. (2017). *Healing families, helping systems: A trauma-informed practice guide for working with children, youth and families*. https://www2.gov.bc.ca/assets/gov/health/child-teen-mental-health/trauma-informed_practice_guide.pdf

131. Center for Health Care Strategies. (2025). *Trauma-Informed Care Implementation Resource Centre*. https://www.traumainformedcare.chcs.org/what-is-trauma/

132. Bombay, A., Matheson, K., & Anisman, H. (2009). Intergenerational trauma: Convergence of multiple processes among First Nations peoples in Canada. *International Journal of Indigenous Health, 5*(3), 6–47.

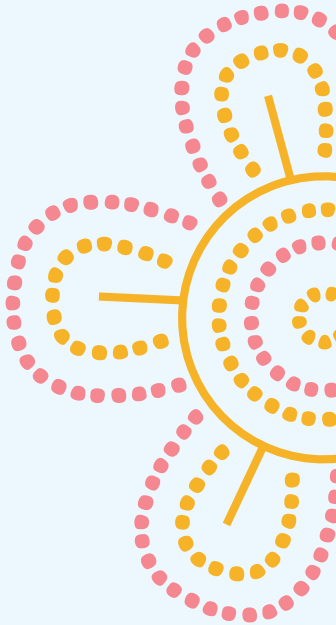
133. Canadian Federation of Nurse Unions. (2025). *Workplace violence*. https://nursesunions.ca/campaigns/violence/

134. First Nations Health Authority. (2014). Traditional wellness strategic framework. https://www.fnha.ca/WellnessSite/WellnessDocuments/FNHA_TraditionalWellnessStrategicFramework.pdf

135. Naess, A. (2005). The basics of deep ecology. *The Trumpeter, 21*(1), 61–66.

136. Cajete, G. (1994). *Look to the mountain: An ecology of Indigenous education*. Kivaki Press.

137. Redvers, N., Aubrey, P., Celidwen, Y., & Hill, K. (2023). Indigenous peoples: Traditional knowledges, climate change, and health. *PLOS Global Public Health, 3*(10), e0002474. https://doi.org/10.1371/journal.pgph.0002474



138. Brian Sinclair Working Group. (2017, September). *Out of sight: A summary of the events leading up to Brian Sinclair's death and the inquest that examined it and the interim recommendations of the Brian Sinclair Working Group*. https://professionals.wrha.mb.ca/old/professionals/files/OutOfSight.pdf

139. Sanchez, N. (2019, October 23). *Decolonization is for everyone* [Video]. TEDxSFU. https://www.orangepath.ca/resources/decolonization-is-for-everyone

140. Kehoe, H., Lovett, R., Marriott, R., Dimer, L., Maddox, R., & Phillips, G. (2022). Development of a decolonising framework for Aboriginal and Torres Strait Islander health policy analysis in Australia. *The International Indigenous Policy Journal, 13*(3). https://doi.org/10.18584/iipj.2022.13.3.11269

141. Park, J. (2021, October 20). *Mortality among First Nations people, 2006 to 2016*. Statistics Canada. https://doi.org/10.25318/82-003-x202101000001-eng

142. Government of Canada. (2025). *Indigenous Services Canada: Jordan's Principle*. https://www.sac-isc.gc.ca/eng/1568396042341/1568396159824

143. Rosario, A. A., Gau, A., Munsterman, E., & Ancheta, A. J. (2024). Decolonizing nursing for health equity: A scoping review. *Nursing Outlook, 72*(5), 102230. https://doi.org/10.1016/j.outlook.2024.102230

144. National Inquiry into Missing and Murdered Indigenous Women and Girls. (2019). *Reclaiming power and place: The final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*. Government of Canada. https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1a-1.pdf

145. Assembly of First Nations. (2025). *Advancing First Nations control and jurisdiction over social development for the well-being of First Nations*. https://afn.ca/community-services/children-families/

146. First Nations Child and Family Caring Society. (2025). *Home page*. https://fncaringsociety.com/

147. Blackstock, C. (2008). Jordan's Principle: Canada's broken promise to First Nations children. *Paediatrics & Child Health, 13*(10), 849–850.

148. Government of Canada. (2019). The government of Canada's assessment of the Canadian Human Rights Tribunal's ruling on compensation. https://www.sac-isc.gc.ca/eng/1569866874043/1569866891789

149. First Nations Health Authority. (2025). *Jordan's Principle*. https://www.fnha.ca/what-we-do/maternal-child-and-family-health/jordans-principle

150. First Nations Child and Family Caring Society. (2025). *Touchstones of hope*. https://fncaringsociety.com/touchstones-hope

151. Blackstock, C., Cross, T., George, J., Brown, I., & Formsma, J. (2006). *Touchstones of hope for Indigenous children, youth, and families*. First Nations Child and Family Caring Society of Canada.

152. Council of the Atikamekw of Manawan & the Council de la Nation Atikamekw. (2020, November). *Atikamekw Nehirowisiw: Joyce's Principle*. https://principedejoyce.com/sn_uploads/principe/Joyce_s_Principle_brief___Eng.pdf

153. Government of British Columbia. (2024). *Distinctions-based approach*. https://www2.gov.bc.ca/gov/content/governments/indigenous-people/new-relationship/united-nations-declaration-on-the-rights-of-indigenous-peoples/distinctions-based-approach

154. Government of British Columbia. (2023, December). *Distinctions-based approach primer*. https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/distinctions_based_approach_primer.pdf

155. Smylie, J., & Firestone, M. (2015). Back to the basics: Identifying and addressing underlying challenges in achieving high quality and relevant health statistics for Indigenous populations in Canada. *Statistical Journal of the IAOS, 31*(1), 67–87.

156. Crowshoe, L. L., Sehgal, A., Montesanti, S., Barnabe, C., Kennedy, A., Murry, A., Roach, P., Green, M., Bablitz, C., Tailfeathers, E., & Henderson, R. (2021). The Indigenous primary health care and policy research network: Guiding innovation within primary health care with Indigenous peoples in Alberta. *Health Policy, 125*(6), 725–731.

157. Mashford-Pringle, A., Hiscock, C., Rice, E. J., & Scott, B. (2023). Weaving First Nations, Inuit, and Métis principles and values into health research processes. *Journal of Clinical Epidemiology*, *160*, 54–60.

158. Lavoie, J. G. (2018). Medicare and the care of First Nations, Métis and Inuit. *Health Economics, Policy and Law, 13*(3–4), 280–298.

159. Brockie, T., Haroz, E. E., Nelson, K. E., Cwik, M., Decker, E., Ricker, A., Littlepage, S., Mayhew, J., Wilson, D., Wetsit, L., & Barlow, A. (2021). Wakȟáŋyeža (Little Holy One) – An intergenerational intervention for Native American parents and children: A protocol for a randomized controlled trial with embedded single-case experimental design. *BMC Public Health, 21*, Article 12272. https://doi.org/10.1186/s12889-021-12272-9

160. Wilson, D. (2006). Foreword: The practice and politics of Indigenous health nursing. *Contemporary Nurse, 22*(2), x–xiii. https://doi.org/10.5172/conu.2006.22.2.x

161. Canadian Nurses Association. (2018). *Nursing declaration against anti-Indigenous racism in nursing and health care*. https://hl-prod-ca-oc-download.s3-ca-central-1.amazonaws.com/CNA/2f975e7e-4a40-45ca-863c-5ebf0a138d5e/UploadedImages/documents/Nursing_Declaration_Anti-Indigenous_Racism_November_8_2021_ENG_Copy.pdf

162. Goodwill, J. (1975). *Speaking together: Canada's Native women*. Secretary of State.

163. First Nations Health Authority. (2022). *Remembering Keegan*. https://www.fnha.ca/Documents/FNHA-Remembering-Keegan.pdf

164. Weber-Pillwax, C. (2021). It's in the blood: Theory and praxis of lifelong Indigenous education. *International Journal of Lifelong Education, 40*(4), 395–414. https://doi.org/10.1080/02601370.2021.1966528

165. Battiste, M. (2013). *Decolonizing education: Nourishing the learning spirit*. Purich Publishing Ltd.

166. Tuhiwai Smith, L. (2012). *Decolonizing methodologies: Research and Indigenous peoples* (2nd ed.). Zed Books.

167. Voronka, J. (2016). The politics of people with lived experience: Experiential authority and the risks of strategic essentialism. *Philosophy, Psychiatry, & Psychology, 23*(3), 189–201.

168. Ramsden, I. (1990). Cultural safety. *The New Zealand Nursing Journal, 83*(11), 18–19.

169. Wright Cardinal, S. (2017). *Beyond the sixties : Reclaiming Indigenous identity, reconnection to place, and reframing understandings of being Indigenous* (Doctoral dissertation, University of Victoria). https://dspace.library.uvic.ca/server/api/core/bitstreams/47a2769b-e8a9-40b0-b1be-59cb8b30be05/content

170. United Nations. (2007). *United Nations Declaration on the Rights of Indigenous Peoples: Article 5*. https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf

171. College of Registered Nurses of Saskatchewan. (2024). *Nurse practitioner practice standards (2024)*. https://www.crns.ca/np/nurse-practitioner-practice-standards-2024/

172. I-Chairs. (2024). *Indigenous health nursing ethical framework* [Unpublished manuscript].

173. Padley, M., Chakanyuka, C., Lavallée, S. J., & Bourque Bearskin, M. L. (in press). Lifelong learning beyond preceptorship through Indigenous ways of knowing, doing, and being. In M. Sedgwick & K. D. McCullough (Eds.), *Preceptorship in Canadian nursing education*. Canadian Association of Schools of Nursing.

174. Graham, H. (2024). CPR RACISM: A guide for health care providers to safely address racism in a health care setting. *International Journal of Indigenous Health, 19*(1).

175. Government of British Columbia. (2022). *Health Professions and Occupations Act (Bill 36)*. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/22043#part1

176. Office of the Superintendent of Health Profession and Occupation Oversight. (n.d.). *Home page*. https://superintendentofhealth.ca/#:~:text=Who%20We%20Are,to%20manage%20the%20Discipline%20Tribunal.

177. Provincial Health Services Authority. (2008). *San'yas Indigenous cultural safety program*. https://sanyas.ca/

178. British Columbia College of Nurses and Midwives. (2025, February 20). *Indigenous care concerns & complaints*. https://www.bccnm.ca/Public/complaints/Pages/Indigenous_reports.aspx

179. Indigenous Primary Health Care Council. (n.d.). Indigenous Health in Indigenous Hands with Culture as Treatment. https://iphcc.ca/

180. College of Physicians and Surgeons of Ontario. (2025). Equity, Diversity and Inclusion. https://www.cpso.on.ca/en/Physicians/Your-Practice/Equity-Diversity-and-Inclusion

181. Kamel, G. (2021). *Investigation report concerning the death of Joyce Echaquan 2020-00275: Law on the investigation of the causes and circumstances of death: For the protection of human life* [Coroner's report]. Bibliothèque et Archives nationales du Québec. https://numerique.banq.qc.ca/patrimoine/details/52327/4658465

182. Amador, M. (2023, September 14). Quebec following 'colonial practices' in writing new health law, say advocates. *APTN News*. https://www.aptnnews.ca/national-news/quebec-following-colonial-practices-in-writing-new-health-law-say-advocates/

183. Canadian Federation of Nurses Unions. (2021). *Wrap up resolutions*. https://nursesunions.ca/convention2025/wrap-up-2021-resolutions/

184. Turale, S., & Kunaviktikul, W. (2019). The contribution of nurses to health policy and advocacy requires leaders to provide training and mentorship. *International Nursing Review, 66*(3), 302–304.

185. BC Indigenous Health Nursing Research Chair Team. (2019). Advancing Indigenous Wellness; Innovating Wise Practices for Education, Standards, Partnerships and Research https://www.ihnr.ca/projects

186. Ontario Federation of Indigenous Friendship Centres. (n.d.). *Indigenous cultural competency training*. https://ofifc.org/training-learning/indigenous-cultural-competency-training-icct/

187. Ontario Federation of Indigenous Friendship Centres. (n.d.). https://ofifc.org/

188. First Nations Health and Social Secretariat of Manitoba. (2025). Indigenous Research Chairs in Nursing. https://www.fnhssm.com/ichair

189. First Nations Health and Social Secretariat of Manitoba. (2025). Anti-indigenous racism project. https://www.fnhssm.com/anti-indigenous-racism-project

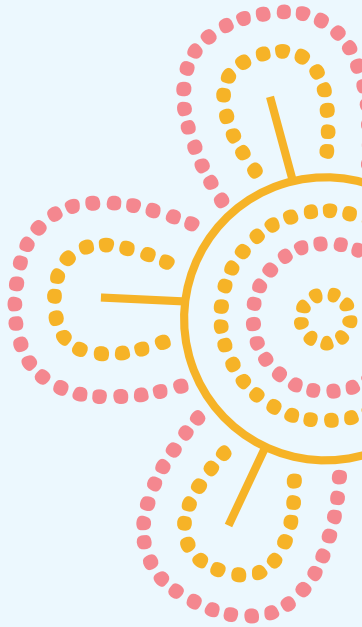
190. University of Manitoba, Rady Faculty of Health Sciences. (2025). *Equity, access and participation*. Equity, access and participation | Rady Faculty of Health Sciences | University of Manitoba

191. Government of Canada. (2021, August 3). *National Day for Truth and Reconciliation*. https://www.canada.ca/en/canadian-heritage/campaigns/national-day-truth-reconciliation.html

192. British Columbia Nurses' Union. (2022, May 12). *International Nurses Day – An apology to Indigenous peoples*. https://www.bcnu.org/news-and-events/news/2022/international-nurses-day

193. Canadian Nurses Association. (2017). *Code of ethics for registered nurses*. https://www.cna-aiic.ca/en/nursing/regulated-nursing-in-canada/nursing-ethics

194. Canadian Association of Schools of Nursing. (2023). *Promoting anti-racism in nursing*. https://www.casn.ca/wp-content/uploads/2023/05/CASN-Promoting-Anti-Racism-in-Nursing-Education-in-Canada_FINAL.pdf



195. Canadian Association of Schools of Nursing. (2024, April). *Addressing the truth and reconciliation calls to action in nursing education: Workshop series*. https://www.casn.ca/2024/04/addressing-the-truth-and-reconciliation-calls-to-action-in-nursing-education-workshop-series/

196. Canadian Association of Schools of Nursing. (2023). https://www.casn.ca/2023/05/casn-announces-the-release-of-the-promoting-anti-racism-in-nursing-report/

197. Canadian Nursing Students' Association. (2021). *Indigenous Caucus*. https://www.cnsa.ca/indigenous-caucus

198. Health Standards Organization. (2025). *Advancing cultural safety and humility through standards and accreditation*. https://healthstandards.org/advancing-cultural-safety/

199. Health PEI. (2024). *Summary of Indigenous health resources and trainings*. https://src.healthpei.ca/sites/src.healthpei.ca/files/DHW/Summary_of_Indigenous_Health_Resources_and_Trainings.pdf

200. Government of Prince Edward Island. (2023). *Anti-racism action plan* 2023–2028. https://www.princeedwardisland.ca/sites/default/files/publications/anti_racism_action_plan_digital.pdf

201. Newfoundland & Labrador Centre for Applied Health Research. (2024). *Indigenous health*. Memorial University. https://www.mun.ca/nlcahr/research-and-knowledge-exchange/indigenous-health/

202. Government of Newfoundland and Labrador. (2021, July 7). *Ministerial Committee on Anti-Racism sets path for action*. https://www.gov.nl.ca/releases/2021/ipgs/0707n06/

203. Newfoundland and Labrador Human Rights Commission. (n.d.). *Community justice connect*. https://thinkhumanrights.ca/community-justice-connect/

204. Aboriginal Peoples Television Network (APTN) (2021, January 15). Alberta to end birth alerts. https://www.aptnnews.ca/national-news/provinces-continue-birth-alerts/

205. Aboriginal Healing Foundation. (2023). *Funded projects in Alberta*. https://www.ahf.ca/funded-projects/alberta

206. Government of Yukon. (2022). *Putting people first-2022 annual report*. https://yukon.ca/sites/default/files/hss/hss_puttingpeoplefirst_web_0_0.pdf

207. Government of the Northwest Territories. (n.d.). *Cultural safety in the NWT Health and Social Services System*. https://www.hss.gov.nt.ca/en/services/cultural-safety

208. Government of Canada. (2024). *Working together to improve health care for Canadians – Bilateral agreement with the Northwest Territories*. Working together to improve health care in Canada: Overview - Canada.ca

209. Government of the Northwest Territories. (2022). *Response to Motion 54-19(2): Improving health care in small communities* (Tabled Document 683-19(2)). https://www.ntlegislativeassembly.ca/sites/default/files/legacy/td_683-192.pdf

210. Nunavut Department of Education. (2007). *Inuit Qaujimajatuqangit education framework*. https://www.gov.nu.ca/sites/default/files/publications/2024-01/Inuit%20Qaujimajatuqangit%20ENG.pdf

211. Nunatsiaq News. (2024, March 5). *Nunavut-bound doctors now getting cultural training*. https://nunatsiaq.com/stories/article/nunavut-bound-doctors-now-getting-cultural-training/

212. Healey Akearok, G., Tabish, T. & Cherba, M. Cultural orientation and safety app for new and short-term health care providers in Nunavut. *Canadian Journal of Public Health* 111, 694–700 (2020). https://doi.org/10.17269/s41997-020-00311-8

213. The Canadian Press. (2023, September 12). College of Physicians calls on Quebec to recognize systemic racism in health system. *Global News*. https://globalnews.ca/news/9955501/college-of-physicians-bill-32-cultural-safety-systemic-racism-indigenous-health/

214. Fédération interprofessionnelle de la santé du Québec. (2021, October 1.). Recognizing systemic racism in our institutions: The beginning. https://affilies.fiqsante.qc.ca/en/2021/10/01/reconnaitre-le-racisme-systemique-au-sein-de-nos-institutions-lamorce-dune-veritable-reconciliation/

215. Fédération interprofessionnelle de la santé du Québec. (2022b, October 3). Élection d'un gouvernement de la CAQ: La FIQ en appelle à un gouvernement à l'écoute des professionnelles en soins. https://www.fiqsante.qc.ca/

216. Government of Canada, Indigenous Services Canada. (2024). Government of Canada actions to address anti-Indigenous racism in health systems. https://www.sac-isc.gc.ca/eng/1611863352025/1611863375715

217. Public Health Agency of Canada. (2023). Indigenous Cultural Competency Learning Road Map. Minister of Health. https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/aboriginal-health/indigenous-cultural-competency-learning-road-map/indigenous-cultural-competency-learning-road-map-en.pdf

218. Indigenous Research Chair in Nursing – New Brunswick. (2019–2023). *Funded by the Canadian Institutes of Health Research*. https://cognit.ca/en/project/216059#:~:text=The%20Chair%20will%20work%20to%20catalyse%20the,in%20order%20to%20strengthen%20Indigenous%20health%20nursing

219. Government of Nova Scotia. (2022). *Dismantling racism and hate act*. https://beta.novascotia.ca/documents/dismantling-racism-and-hate-act-annual-report

220. Greenwood, M., Atkinson, D., & Sutherland, J. (2022). Supporting health equity for First Nations, Inuit and Métis peoples. Canada Communicable Disease Report, 48(4), 119–123. https://www.nccih.ca/Publications/lists/Publications/HealthEquityFNIM/ccdrv48i04a01-eng.pdf

221. First Nations Health Authority, Province of British Columbia. (2025). *Mandate*. https://www.fnha.ca/about/fnha-overview/mandate#:~:text=%E2%80%8BThe%20FNHA%20works%20with,by%20BC%20First%20Nations%20leadership.&text=The%20Health%20Plans%20envision%20a,Inuit%20Health%20Branch%20Pacific%20Region

222. Government of Canada. (2023). *Visions for distinctions-based Indigenous health legislation: Executive summary*. https://www.sac-isc.gc.ca/eng/1667579335081/1667579367781

223. Tajikeimɨk Mi'kmaq Health and Wellness. (2025). *About us*. https://mhwns.ca/about-us/

224. Tajikeimɨk, IWK Health Centre, & Dalhousie University. (2022). First Nations, Mi'kmaq-led research leads to cultural safety curriculum for clinicians. news-release_cultural-safety-curriculum_Dec2022.pdf

225. IWK Health. (2022, December 5). First Nations, Mi'kmaq-led research leads to cultural safety curriculum for clinicians [Media release]. news-release_cultural-safety-curriculum_Dec2022.pdf

226. Tajikeimɨk. (2025). *Office of L'nu Nursing*. https://lnunursing.ca/; https://lnunursing.ca/about-lnu-nursing/

227. Indigenous Nurse Education Specialist. (n.d.). *L'nu Nursing Initiative*. https://mhwns.ca/job-postings/mikmaq-indigenous-nurse-education-specialist-2/#:~:text=The%20Mi%27kmaq%20Indigenous%20Nurse,the%20L%27nu%20Nursing%20Strategy

228. Tajikeimɨk & IWK Health. (n.d.). *tuaptmu'k W'loti: Using Mi'kmaw knowledge to create health & wellness*.

229. Nuji-Apoqnmuet Team. (n.d.). *Nuji-Apoqnmuet*. Tajikeimɨk. https://mhwns.ca/programs/nuji-apoqnmuet-team/

230. Msɨt Mijua'ji'jk. (n.d.). Tajikeimɨk. https://mhwns.ca/programs/tajikeim%C9%A8k-early-years/

231. Mi'kmaq Cancer Care. (n.d.). Tajikeimɨk. https://mhwns.ca/programs/mikmaq-cancer-care/

232. Mi'kmaq Indigenous Nurse Education Specialists (MINES). (n.d.). Tajikeimɨk. https://mhwns.ca/job-postings/mikmaq-indigenous-nurse-education-specialist-2/

233. Truth and Reconciliation Commission of Canada. (2015). *What we have learned: Principles of truth and reconciliation*. https://publications.gc.ca/collections/collection_2015/trc/IR4-6-2015-eng.pdf

234. Best, O. M. (2024). Talking back to the whiteness of nursing: Utilising cultural safety as a decolonising framework for nursing [Paper presentation]. In *26th International Nursing Philosophy Conference*, Sydney, Australia, September 27–29, 2023. John Wiley & Sons.

235. Mahboob, T. (2020, October 18). In her quest to become a nurse, Minnie Akparook faced relocation, residential school and racism. *CBC/Radio-Canada*. https://www.cbc.ca/radio/sunday/the-sunday-magazine-for-october-18-2020-1.5764900/in-her-quest-to-become-a-nurse-minnie-akparook-faced-relocation-residential-school-and-racism-1.5764913

236. Wilson-Raybould, J., & Danesh, R. (2024). *Reconciling history: A story of Canada*. Random House.

237. The Canadian Encyclopedia. (2023, November 28). First Nations in Canada. *The Canadian Encyclopedia*. https://www.thecanadianencyclopedia.ca/en/article/first-nations

238. Luo, C. X. (2024, February 24). *Missing children of Indian residential schools: On discovery of unmarked graves at former Indian residential school sites in Canada*. Academic Data Centre, Leddy Library. https://storymaps.arcgis.com/stories/cfe29bee35c54a70b9621349f19a3db2

239. Government of British Columbia. (2019). *Declaration on the Rights of Indigenous Peoples Act, SBC 2019, c. 44*. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/19044

240. Sinha, V., Sangster, M., Gerlach, A. J., Bennett, M., Lavoie, J. G., Lach, L., Balfour, M., & Folster, S. (2022). *The implementation of Jordan's Principle in Manitoba: Final report*. Assembly of Manitoba Chiefs. https://manitobachiefs.com/wp-content/uploads/22-01-28-The-Implementation-of-Jordans-Principle-in-Manitoba-Final-Report.pdf

Glossary

2SLGBTQQIA+
Acronym for Two-Spirit, lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual and other sexual- and gender-diverse people. *(See reference 1)*

Biomedical model of care
A Western-oriented health care model primarily focused on disease diagnosis and treatment through scientific and physiological methods, often limiting consideration of socio-cultural, emotional and spiritual factors. *(See reference 2)*

Colonial ideologies
Belief systems that rationalize and sustain colonization by promoting notions of racial or cultural superiority – justifying land dispossession and perpetuating systemic inequalities.
(See reference 3)

Colonial structures
Enduring institutional frameworks, policies and legal arrangements established during the colonial period that continue to shape contemporary social, political and economic relations. They are embedded in systems such as education, law and land management, often perpetuating power imbalances and cultural hierarchies that disadvantage Indigenous Peoples.
(See references 4 and 5)

Colonial systems
The interlocking institutions (e.g., governance, education, health care, justice) imposed through colonization that continue to marginalize Indigenous Peoples by centering non-Indigenous perspectives, laws and values. *(See reference 6)*

Colonialism
A process of acquiring and maintaining colonies, in which a wealthier power exploits and controls another society. It involves dispossession, dependence and oppression – forces experienced daily by Indigenous Peoples.
(See references 7 and 8)

The Crown
In the Canadian context, "the Crown" refers to the formal authority of the British monarchy and its representative governments, which entered into treaties and agreements with Indigenous Peoples and continue to bear legal and fiduciary obligations.
(See reference 9)

Cultural humility
A lifelong process of self-reflection and self-critique foundational to achieving cultural safety. It involves examining one's own assumptions, beliefs and privileges to foster relationships based on mutual trust, respect, open dialogue and shared decision-making.
(See references 10 and 11)

Cultural safety
An environment – as defined by the recipient of care – where individuals feel respected in their identity and free from racism and discrimination. This requires health care providers to address power imbalances, practice cultural humility and adopt anti-racist approaches.
(See reference 12)

Decolonization

The process of dismantling colonial ideologies – such as those surrounding land ownership, racial superiority and white privilege – and challenging Western dominance over knowledge systems and governance. *(See reference 4)*

Distinctions-based approach (DBA)

An approach that ensures work with First Nations, Métis and Inuit acknowledges and respects the unique rights, interests, priorities and concerns of each distinct group, including their individual cultures, histories, laws and governance. *(See reference 13)*

Ecosystem health

The sustainability and resilience of interconnected natural systems – land, water, air, plants, animals and humans – on which well-being depends. Many Indigenous perspectives emphasize the spiritual and relational dimensions of these systems, underscoring reciprocity with nature. *(See reference 14)*

Elders

Respected members of Indigenous communities recognized for their wisdom, life experience, cultural knowledge and leadership. They often serve as caretakers of ceremony, language and oral traditions, guiding community members (especially youth) in cultural practices. *(See reference 15)*

Enfranchisement

A legal process for terminating a person's Indian status, historically used as a tool in Canadian federal assimilation policies regarding Indigenous Peoples. *(See reference 16)*

First Nations

Refers to the original peoples and nations located in modern-day Canada (excluding the Arctic). Not all who identify as First Nations are deemed "Indians" under Indian Status; those without status remain constitutionally recognized as First Nations. *(See reference 17)*

Genocide

Although legally defined by the United Nations Convention on the Prevention and Punishment of the Crime of Genocide (1948) as acts intended to destroy, in whole or in part, a group, many scholars argue this definition should be broadened. In the context of Indigenous Peoples in Canada, genocide encompasses not only physical extermination but also the systematic destruction of cultural heritage, language and identity – through mechanisms such as residential schools, forced assimilation and land dispossession. *(See references 18 and 19)*

Healers

Individuals (including Elders and Knowledge Holders, or community-designated practitioners) with specialized expertise in traditional medicines, ceremonies, spiritual guidance and holistic practices addressing physical, emotional, mental and spiritual well-being. *(See reference 20)*

Health equity

The pursuit of ensuring that individuals and communities have access to the resources needed for optimal health by addressing unique circumstances, removing systemic barriers and implementing culturally appropriate policies. *(See references 21 and 22)*

Hegemony

The dominance of one group's worldview, norms or ideology over others through cultural, social, political and economic means, often marginalizing alternative perspectives. *(See reference 23)*

Helpers

Community members who assist Healers, Elders or Knowledge Holders by preparing ceremonial spaces, gathering medicines, organizing events or providing logistical support to uphold cultural protocols. *(See reference 24)*

Indigenous governance

Traditional systems of decision-making, authority and community organization rooted in Indigenous laws, values and worldviews. These systems operate alongside colonial state structures and reflect the self-determined priorities of Indigenous Nations. *(See references 25 and 26)*

Indigenous Health Nursing

A specialty that integrates Indigenous Knowledge Systems, holistic healing practices and the cultural values of First Nations, Métis and Inuit Peoples, supported by the unique skills and lived experiences of Indigenous nurses and allied networks. *(See reference 27)*

Indigenous Knowledge systems

The complex body of knowledge, cultural practices and philosophies developed by Indigenous Peoples over generations, deeply connected to land, language, spirituality and community relationships. *(See reference 28)*

Indigenous Peoples

A term referring to peoples native to a region with long-standing ties to specific lands. In Canada, it is used as an umbrella term for First Nations (status and non-status), Métis and Inuit. *(See reference 29)*

Indigenous rights

The inherent collective rights of First Nations, Métis and Inuit Peoples – including rights to land, self-determination, language, culture, governance and spirituality – which are rooted in Indigenous laws and upheld by frameworks such as the Constitution and the United Nations Declaration on the Rights of Indigenous Peoples. *(See references 30 and 31)*

Indigenous-specific racism

Stereotyping, bias and prejudice uniquely directed at Indigenous Peoples in Canada, rooted in the history of settler colonialism and perpetuating systemic discrimination and inequities. *(See reference 32)*

Inuit

Meaning “the people” in Inuktitut, this term refers to the peoples of the Arctic regions – collectively known as Inuit Nunangat – which include Nunavut, Nunavik (northern Quebec), Nunatsiavut (Labrador) and the Inuvialuit Settlement Region. *(See reference 33)*

Knowledge Holders

Individuals entrusted by their communities to preserve and share cultural teachings, histories, ceremonies and traditional practices, serving as mentors and guides to ensure the continuity of Indigenous ways of knowing and being. *(See reference 34)*

Lived experiences

The personal knowledge and perceptions shaped by an individual’s unique identity and history. *(See reference 35)*

Māori

The Indigenous Peoples of Aotearoa (New Zealand), whose social structures traditionally revolve around whānau (family), hapū (sub-tribe) and iwi (tribe), and who maintain distinct cultural practices, language (Te Reo Māori) and protocols. *(See reference 36)*

Métis

Originating in the early 17th century from unions between European fur traders and First Nations women, the Métis are recognized as a distinct Indigenous group in Canada’s Constitution (1982). *(See reference 37)*

Off-reserve

Describes Indigenous Peoples living outside designated First Nations reserve boundaries (or outside traditional homelands for Inuit or Métis), often subject to different service and jurisdictional frameworks. *(See reference 38)*

On-reserve

Refers to individuals living on designated First Nations reserve land, where governance, funding and administrative structures differ from off-reserve contexts. *(See reference 39)*

Paternalistic

Practices in which dominant groups or institutions impose decisions and policies on Indigenous communities under the guise of acting in their best interests – assuming Indigenous Peoples lack the capacity for self-governance, thus reinforcing dependency and colonial power dynamics. *(See references 4 and 40)*

Potlatch

A ceremonial gathering among certain Northwest Coast First Nations, involving feasting, dancing and gift redistribution to reaffirm social status, kinship ties and cultural values. *(See reference 41)*

Prejudice

A negative way of thinking or an attitude toward a socially defined group or any individual perceived as a member of that group. *(See reference 32)*

Reconciliation

A continuous process of establishing and maintaining respectful relationships between Indigenous and non-Indigenous peoples to address the historical nd ongoing impacts of colonization – by acknowledging past harms and collaboratively working toward equity.
(See references 43 and 44)

Reflective practices

The ongoing self-examination of one's professional or personal actions, decisions and biases with the aim of improving awareness, competence and ethical engagement.
(See reference 45)

Reflexivity

A critical evaluation of how one's social position, cultural assumptions and personal biases influence work or interactions – moving beyond simple self-reflection by acknowledging power dynamics.
(See reference 46)

Reserve land

Land set aside under the *Indian Act* in Canada for the use and benefit of a First Nation, where legal title remains with the Crown despite certain First Nations rights.
(See reference 47)

Self-determination

The inherent right of Indigenous Peoples to freely determine their political, economic, social and cultural futures. It includes reclaiming authority over their lands, resources and governance structures, and designing policies that reflect their values and aspirations without external imposition.
(See references 6 and 31)

Social justice

A vision at the heart of health promotion that seeks to achieve health equity through the empowerment of individuals and communities by addressing systemic inequities and ensuring a fair distribution of resources.
(See references 48 and 49)

Sovereignty

For Indigenous Peoples, sovereignty signifies the inherent and long-standing right to self-govern, care for their lands and live according to their own laws and cultural knowledge – not merely the full control defined in Western contexts.
(See references 50 and 51)

Sun Dance

A sacred ceremony practiced by various Plains Indigenous Nations, involving communal gatherings for prayer, dancing, fasting and sometimes body-piercing or sacrifice, fostering spiritual renewal and social cohesion.
(See reference 52)

Systemic racism

The normalization of discriminatory and prejudicial practices within society and its institutions – enforced through policies and structures that perpetuate avoidable and unfair inequalities across racial groups.
(See reference 32)

Tokenism

The superficial or perfunctory inclusion of people from marginalized groups to project an image of diversity without genuinely engaging their voices or addressing systemic inequities. *(See reference 54)*

Traditional Indigenous healing practices

Holistic approaches to health and well-being grounded in Indigenous worldviews that may include ceremonies, herbal medicines, prayer, storytelling and community support to balance physical, mental, emotional and spiritual health. *(See reference 55)*

Trauma-informed

An approach that recognizes the prevalence and impact of trauma on individuals and communities, incorporating policies and practices that promote safety, trust, empowerment and the prevention of re-traumatization. *(See reference 56)*

Treaties

Agreements between Indigenous Peoples and government whereby Indigenous Peoples agree to share land in exchange for specific considerations and benefits. *(See reference 25)*

Truth and Reconciliation Commission's (TRC) Calls to Action

The 94 directives published in 2015 urging governments, institutions and all Canadians to address the legacy of residential schools and advance reconciliation with Indigenous Peoples. *(See references 43 and 44)*

Two-Spirit

An umbrella term used to describe Indigenous Peoples with diverse gender identities, expressions, roles or sexual orientations. Although relatively recent in usage, it reflects deep historical roots in Indigenous understandings of gender and sexuality and is integral to culturally safe practices. *(See references 59, 60, and 61)*

Glossary references

1. **Government of Canada.** 2SLGBTQI+ terminology. https://www.canada.ca/en/women-gender-equality/free-to-be-me/2slgbtqi-plus-glossary.html

2. **Engel, G. L.** (1977). "The need for a new medical model: A challenge for biomedicine." *Science*, 196(4286), 129–136.

3. **Said, E.** (1978). *Orientalism*. Pantheon Books.

4. **Tuck, E., & Yang, K. W.** (2012). "Decolonization is not a metaphor." *Decolonization: Indigeneity, Education & Society*, 1(1), 1–40.

5. **Wolfe, P.** (2006). "Settler colonialism and the elimination of the native." *Journal of Genocide Research*, 8(4), 387–409.

6. **Alfred, T., & Corntassel, J.** (2005). "Being Indigenous: Resurgences against contemporary colonialism." *Government and Opposition*, 40(4), 597–614.

7. **Hele, K.** (2023). Colonialism in Canada. In *The Canadian Encyclopedia*. https://www.thecanadianencyclopedia.ca/en/article/colonialism-in-canada

8. **McFarlane, P., & Schabus, N.** (2017). *Whose land is it anyway? A manual for decolonization.* Federation of PostSecondary Educators of BC. Retrieved from https://fpse.ca/sites/default/files/news_files/Decolonization%20Handbook.pdf

9. **Asch, M.** (2014). *On Being Here to Stay: Treaties and Aboriginal Rights in Canada.* University of Toronto Press.

10. **British Columbia College of Nurses and Midwives.** (2022). Practice Standards on Indigenous Cultural Safety, Cultural Humility, and AntiRacism.

11. **Three Years In.** (2020). A Report on the Achievements Since Signing the Declaration of Commitment to Cultural Safety and Humility. BC Health Regulators. https://bchealthregulators.ca/wp-content/uploads/2020/07/2020-Three-Years-In-Cultural-Safety-and-Humility-Report.pdf

12. **#itstartswithme.** First Nations Health Authority's Policy Statement on Cultural Safety and Humility. https://www.fnha.ca/documents/fnha-policy-statement-cultural-safety-and-humility.pdf

13. **Declaration on the Rights of Indigenous Peoples Act** (DistinctionsBased Approach). Government of British Columbia. (Sept. 2024). https://www2.gov.bc.ca/gov/content/governments/indigenous-people/new-relationship/united-nations-declaration-on-the-rights-of-indigenous-peoples/distinctions-based-approach

`14. **Berkes, F.** (2012). *Sacred Ecology* (3rd ed.). Routledge.

15. **Koptie, S.** (2009). "Irihapeti Ramsden: The public narrative on cultural safety." *First Peoples Child & Family Review*, 4(2), 30–43.

16. **McCardle, B.** (2021). Enfranchisement. In *The Canadian Encyclopedia*. https://www.thecanadianencyclopedia.ca/en/article/enfranchisement

17. **The Canadian Encyclopedia.** (2023). First Nations. In A. Gaudry (Ed.), *The Canadian Encyclopedia.* https://www.thecanadianencyclopedia.ca/en/article/first-nations

18. **United Nations.** (1948). *Convention on the Prevention and Punishment of the Crime of Genocide*. https://www.un.org/en/genocideprevention/documents/atrocity-crimes/Doc.1_Convention%20on%20the%20Prevention%20and%20Punishment%20of%20the%20Crime%20of%20Genocide.pdf

19. **Stannard, D. E.** (1993). *American Holocaust: The Conquest of the New World.* Oxford University Press.

20. **Kelm, M.-E.** (1998). *Colonizing Bodies: Aboriginal Health and Healing in British Columbia 1900–50.* UBC Press.

21. **Greenwood, M., Atkinson, D., & Sutherland, J.** (2022). Supporting health equity for First Nations, Inuit and Métis peoples. *Canada Communicable Disease Report*, 48(4), 119–123. https://doi.org/10.14745/ccdr.v48i04a01

22. **Chandanabhumma, P. P., & Narasimhan, S.** (2020). Towards health equity and social justice: An applied framework of decolonization in health promotion. *Health Promotion International*, 35(4), 831–840.

23. **Gramsci, A.** (1971). *Selections from the Prison Notebooks.* International Publishers.

24. **Bell, N.** (2018). "Minobimaadiziwin: Education for the good life." In *Handbook of Indigenous Education* (pp. 1–18). Springer.

25. **Indigenous and Northern Affairs Canada.** (2010). *A history of treatymaking in Canada.* https://www.rcaanc-cirnac.gc.ca/DAM/DAM-CIRNAC-RCAANC/DAM-TAG/STAGING/texte-text/ap_htmc_treatliv_1314921040169_eng.pdf

26. **Alfred, G. T.** (2009). "Colonialism and State Dependency." *Journal of Aboriginal Health*, 5, 42–60.

27. **BC Indigenous Health Nursing Research Chair Team.** (2019). Advancing Indigenous Wellness; Innovating Wise Practices for Education, Standards, Partnerships and Research https://www.ihnr.ca/projects

28. **Kovach, M.** (2009). *Indigenous Methodologies: Characteristics, Conversations, and Contexts.* University of Toronto Press.

29. **Parrott, Z.** (March 2007). Indigenous Peoples in Canada. In T*he Canadian Encyclopedia*. https://www.thecanadianencyclopedia.ca/en/article/aboriginal-people

30. **Keay, I., & Metcalf, C.** (2021). Recognizing Indigenous Rights in Canada: Property Rights and Natural Resource Values. *Canadian Public Policy*, 47(1), 18–55.

31. **United Nations.** (2007). *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).* https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf

32. **Government of British Columbia.** (2020). *In Plain Sight: Addressing Indigenous-specific racism and discrimination in BC health care.* Vancouver, BC: Ministry of Health. In-Plain-Sight-Full-Report-2020.pdf

33. **Freeman, M.A.** (2023). Inuit. In A. Gaudry (Ed.), *The Canadian Encyclopedia.* https://www.thecanadianencyclopedia.ca/en/article/inuit

34. **Hatcher, A., Bartlett, C., Marshall, M., & Marshall, A.** (2009). "TwoEyed Seeing in the classroom environment: Concepts, approaches, and challenges." *Canadian Journal of Science, Mathematics and Technology Education*, 9(3), 141–153.

35. **U.S. Department of Health and Human Services.** (2022). "What is Lived Experience?" by Grace Guerrero Ramirez et al. https://aspe.hhs.gov/sites/default/files/documents/d111ec032c54d2a01e5209a792f99629/What-is-lived-experience.pdf

36. **Durie, M. (**2004). "Maori specific approaches to health promotion." *Health Education & Behavior*, 31(6), 736–743.

37. **Gaudry, A.** (2023). Metis. In M. Welch & D. Gallant (Ed.), *The Canadian Encyclopedia.* https://www.thecanadianencyclopedia.ca/en/article/metis

38. **Environics Institute.** (2010). *Urban Aboriginal Peoples Study.* Environics Institute.

39. **Government of Canada.** (1985). *Indian Act, R.S.C., 1985, c. I5*. https://laws-lois.justice.gc.ca/eng/acts/i-5/

40. **Coulthard, G. S**. (2014). *Red Skin, White Masks: Rejecting the Colonial Politics of Recognition.* University of Minnesota Press.

41 **Cole, D., & Chaikin, I.** (1990). *An Iron Hand Upon the People: The Law Against the Potlatch on the Northwest Coast.* Douglas & McIntyre.

42. *(Prejudice is addressed using Reference 32.)*

43. **Truth and Reconciliation Commission of Canada (TRC).** (2015). *What We Have Learned: Principles of Truth and Reconciliation*. TRC Calls to Action. https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf

44. **Truth and Reconciliation Commission of Canada (TRC).** (2015). *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the TRC of Canada*. https://irsi.ubc.ca/sites/default/files/inline-files/Executive_Summary_English_Web.pdf

45. **Schön, D. A.** (1983). *The Reflective Practitioner: How Professionals Think in Action.* Basic Books.

46. **Dawson, J., Laccos-Barrett, K., Hammond, C., & Rumbold, A.** (2022). Reflexive Practice as an Approach to Improve Healthcare Delivery for Indigenous Peoples: A Systematic Critical Synthesis and Exploration of the Cultural Safety Education Literature. *International Journal of Environmental Research and Public Health, 19*(11), 6691. https://doi.org/10.3390/ijerph19116691

47. **Government of Canada.** (1985). *Indian Act, R.S.C., 1985, c. I5.* https://laws-lois.justice.gc.ca/eng/acts/i-5/ *(Also cited for Reserve land)*

48. **Nutbeam, D.** (1998). Evaluating health promotion—progress, problems and solutions. *Health Promotion International*, 13(1), 27–44.

49. **Koh, H. K., Oppenheimer, S. C., MassinShort, S. B., Emmons, K. M., Geller, A. C., & Viswanath, K.** (2010). Translating research evidence into practice to reduce health disparities: A social determinants approach. *American Journal of Public Health,* 100(S1), S72–S80.

50. **Moreton Robinson, A.** (Ed.). (2020). *Sovereign subjects: Indigenous sovereignty matters* Routledge.

51. **Alfred, T.** (2005). *Wasase: Indigenous Pathways of Action and Freedom.* Broadview Press.

52. **Mails, T. E.** (1978). *Fools Crow.* University of Nebraska Press.

53. *(Systemic racism is addressed using Reference 32.)*

54. **Wingfield, A. H., & Wingfield, J. H.** (2014). "When visibility hurts and helps: How tokenism affects faculty of color." *Cultural Diversity and Ethnic Minority Psychology*, 20(4), 483–487.

55. **DeGagné, M.** (2007). "Toward an Aboriginal paradigm of healing: Addressing the legacy of residential schools." *Australasian Psychiatry*, 15(sup1), S49–S53.

56. **SAMHSA (Substance Abuse and Mental Health Services Administration).** (2014). *TraumaInformed Care in Behavioral Health Services (Treatment Improvement Protocol Series 57).*

57. *(Treaties are addressed by reusing Reference 25.)*

58. *(TRC Calls to Action are covered by References 43 and 44.)*

59. **Carrier, L., Dame, J., & Lane, J.** (2020). "Two-Spirit identity and Indigenous conceptualization of gender and sexuality: Implications for nursing practice." *Creative Nursing*, 26(2), 96–100.

60. **Pruden, H., Ira, M., & Salway, T.** "Two (Spirit)-Eyed Seeing: Honouring gender and sexual diversity for those Indigenous to Turtle Island." In *Routledge Handbook of Sexuality, Gender, Health and Rights* (pp. 71–80). Routledge.

61. **Government of Canada.** 2SLGBTQI+ terminology. https://www.canada.ca/en/women-gender-equality/free-to-be-me/2slgbtqi-plus-glossary.html

Key resources

International and national frameworks

United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)

UNDRIP Full Text (PDF)
This declaration is the most comprehensive international instrument on the rights of Indigenous Peoples. It provides a universal framework of minimum standards for their survival, dignity and well-being, elaborating on existing human rights as they apply to Indigenous contexts.

Truth and Reconciliation Commission of Canada TRC

TRC Overview
TRC Calls to Action (PDF)
To redress the legacy of residential schools and advance reconciliation, the TRC released 94 Calls to Action across various sectors of Canadian society.

MMIWG – National Inquiry into Missing and Murdered Indigenous Women and Girls

MMIWG Website
Government Summary
The Final Report includes 231 Calls for Justice directed at governments, institutions and Canadians to address the root causes of violence against First Nations, Métis and Inuit women, girls, Two-Spirit and gender-diverse people.

National Action Plan (2021): Ending Violence Against Indigenous Women, Girls and 2SLGBTQQIA+ People

Read the National Action Plan
This plan aims to end systemic racism and violence against Indigenous women, girls and 2SLGBTQQIA+ people through transformative change and coordinated policy action.

Provincial reports and commitments

In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Health Care

Summary Report (PDF)
This report exposes widespread systemic racism in BC's health care system and its harmful impacts on Indigenous patients, including mistrust, harm and death.

Jordan's Principle

Brant, J., & Filice, M. (2020). In *The Canadian Encyclopedia*.
Article link
A child-first legal principle that ensures First Nations children receive the services they need without delay, disruption or denial due to jurisdictional disputes between governments.

BC Declaration of Commitment: Cultural Safety and Humility in the Regulation of Health Professionals

Ministry of Health and First Nations Health Authority (2015)
Read the Declaration (PDF)

Three Years In: A Report on Achievements Since Signing the Declaration (2020)
BC Health Regulators
Read the report (PDF)
This declaration marks an important step toward embedding cultural safety and humility within health services for First Nations and Aboriginal Peoples in British Columbia, recognizing them as essential components of quality and safety in health care regulation.

#ItStarsWithMe: FNHA Policy Statement on Cultural Safety and Humility

First Nations Health Authority (2016)
FNHA Policy Statement (PDF)
This policy statement outlines the First Nations Health Authority's commitment to advancing cultural safety and humility across all levels of the health system. It encourages health professionals to engage in self-reflection, recognize the impact of systemic racism, and take personal and collective responsibility for respectful and equitable care for First Nations people.

Legislation and rights

Declaration on the Rights of Indigenous Peoples Act **(2019, SBC, C.14)**

Unanimously passed by the BC Legislative Assembly in November 2019, this Act made British Columbia the first jurisdiction in Canada to adopt the United Nations Declaration on the Rights of Indigenous Peoples into law.
Read the Act

Other principles and standards

BCCNM Practice Standard: Indigenous Cultural Safety, Cultural Humility and Anti-Racism

British Columbia College of Nurses & Midwives (2022)
Practice Standard (PDF)
The purpose of this standard is to set clear expectations for how BCCNM registrants are to provide culturally safe and anti-racist care for Indigenous clients.

Stories of Indigenous-specific racism

These real and tragic cases reveal the systemic harms Indigenous Peoples have experienced in the Canadian health care system. They continue to inform public awareness, professional responsibility and policy change.

Joyce Echaquan

A 37-year-old Atikamekw mother who died in hospital after experiencing racist abuse from health care staff.
The Guardian – Joyce Echaquan's death an 'undeniable' example of systemic racism

Brian Sinclair

A 45-year-old Indigenous man who died after being ignored for 34 hours in a Winnipeg ER waiting room.
NCBI case report

Keegan Combes

A young First Nations man whose death prompted reflection on the health system's ongoing failures to protect and care for Indigenous youth.
BCCNM Reflection

Watch

Visioning the Future: Determinants of Health (1h 28m)

National Collaborating Centre for Indigenous Health

Watch the webinar

Explores how colonialism and structural inequities influence the health and well-being of First Nations, Métis and Inuit Peoples.

Scenes from the Nanaimo Indian Hospital (2024, March 5)

Holdom, B. – BC Studies

Read the article

A reflective review exploring the history and haunting legacy of the Nanaimo Indian Hospital. The following short films complement this piece:

Education and Applied Theatre (6 min)

Uses theatrical methods to teach about Indian hospitals and their legacy.

Mental Health (7 min)

Examines the psychological impact of colonial health institutions.

Reawakening Language (11 min)

Highlights language revitalization as a pathway to healing.

Researching and Revealing Indian Hospitals in Canada (15 min)

Maureen Lux

Watch the webinar

A brief but powerful introduction to Indian Hospitals and the institutionalization of medical racism against Indigenous Peoples.

Create the Witness Blanket: A Virtual Learning Resource

Carey Newman, Hayalthkin'geme

Explore the exhibit

A powerful digital experience that tells the story of residential school survivors and emphasizes the importance of witnessing and truth-telling.

Indian Hospitals History – Alberta Health Services

Watch video

An overview of the history and legacy of Indian Hospitals in Canada and their impact on Indigenous health.

Manitoba Indigenous TB history project (7:32 min)

Watch video

Traces the experiences of Indigenous Peoples during the TB epidemic and the trauma associated with TB sanatoriums.

TEDx Talk: Cultural Safety Education (16:51 min)

Len Pierre

Watch TEDx Talk
An Indigenous educator explains the foundational role of cultural safety in reconciliation, health care and education.

Facebook Live: Confronting Anti-Indigenous Racism in Nursing and Health Care (1h 5m)

Canadian Federation of Nurses Unions (CFNU)
Watch the Facebook Live

A national livestreamed discussion featuring Indigenous nurses and health care leaders addressing racism, cultural safety and systemic change.

Listen

Voices from the Field: NCCIH podcast – Visioning the Future

A discussion on Indigenous population and public health, featuring First Nations, Métis and Inuit perspectives on the determinants of health.
Episode: Visioning the Future

Read

Johnson, H., Smith, D., & Beck, L. (2022). Systems innovation through First Nations self-determination. In M. Greenwood, S. de Leeuw, R. Stout, R. Larstone, & J. Sutherland (Eds.), Introduction to determinants of First Nations, Inuit and Métis Peoples' health in Canada (pp. 251–263). *Canadian Scholars*.
Access chapter information

Loppie, C., & Wien, F. (2022). *Understanding Indigenous health inequalities through a social determinants model.* National Collaborating Centre for Indigenous Health.
Read the PDF

Lavoie, J. G., Kornelsen, D., Boyer, Y., & Wylie, L. (2016). Lost in maps: Regionalization and Indigenous health services. *Healthcare Papers, 16*(1), 63–73.
DOI: 10.12927/hcpap.2016.24773

Webb, D. (2022). *Indigenous health in federal, provincial, and territorial health policies and systems.* National Collaborating Centre for Indigenous Health.
Read the report

Critical learning and educational tools

4 Seasons of Reconciliation Education

Visit website
An award-winning multimedia course developed in partnership with Indigenous educators, Elders and communities. Widely adopted in workplaces and schools across Canada, it introduces foundational knowledge of reconciliation, residential schools and Indigenous rights. Highly recommended for health care professionals to reflect on their roles in reconciliation and cultural safety.

Who Is a Settler, According to Indigenous and Black Scholars

Ashleigh-Rae Thomas
Read the article
This article explores the term settler and invites critical reflection on settler colonialism, privilege and responsibility. It draws on insights from Indigenous and Black scholars and offers a valuable lens for nurses considering their social location, allyship and commitments to anti-racist care.

Land acknowledgement activity: beyond the script

Understanding land acknowledgements requires more than reciting words. It involves ongoing learning, critical self-location and a commitment to relational accountability with the Indigenous Peoples whose lands we live, learn and work on. This activity invites you to engage deeply with the meaning and implications of land acknowledgements in your public health or nursing practice.

Mcleod, A. (2021).
'Land Acknowledgments' Are Just Moral Exhibitionism
A provocative critique that challenges the performative use of land acknowledgements and urges readers to consider deeper relational responsibilities.

âpihtawikosisân (2016).
Beyond Territorial Acknowledgments
A foundational article that explores how to engage respectfully and meaningfully with place, land and Indigenous sovereignty beyond symbolic gestures.

Native Land Digital
Native Land Map
Use this interactive tool to identify the Indigenous Nations, territories and treaties associated with where you currently live, study or work.

Reflexive exercise: revisiting the past and connecting to contemporary life

We invite you to consider the historical roots of systemic racism in health care and examine how nursing has been both complicit in and responsible for disrupting colonial structures. These activities are designed to encourage self-awareness, critical analysis and a deeper commitment to culturally safe practice.

Read and reflect

Symenuk, P., Thompson, G., Kosteniuk, B., & Grypma, S. (2020).
In search of the truth: Uncovering nursing's involvement in colonial harms and assimilative policies five years post Truth and Reconciliation Commission.
Witness: The Canadian Journal of Critical Nursing Discourse, 2(1), 84–96.
A critical examination of nursing's historical and ongoing relationship to colonial systems, and a call for ethical, relational and reparative practices in education and care.

Indigenous determinants of health exercise

Using key terms such as ***Indigenous health***, ***colonization***, ***intergenerational trauma*** and ***access to health care***, complete an online search or literature review. As you explore the historical and jurisdictional factors that impact the health of Indigenous Peoples, reflect on the following.

- What determinants of health appear to be having the greatest impact on the health and wellness of Indigenous Peoples?
- How might these findings influence your approach to care, your responsibilities as a nurse or your advocacy for systemic change?

Despite the lingering effects of racism fatigue, our Peoples are strong and hold distinct traditional systems of care rooted in the land. Roots that make the baskets that hold our stories, carry our salmon, berries and medicines to sustain our ancestral well-being and our right to health.

(Colleen Seymour, Tk'emlu'ps te Secwe'pemc member, 2022)

CFNU

CANADIAN FEDERATION OF NURSES UNIONS

nursesunions.ca