# Submission to the Standing Committee on Health

*Marilee A. Nowgesic, Executive Director*
*Canadian Indigenous Nurses Association*

**May 23, 2018**

**180 Wellington, Room 420**
**Ottawa, Ontario**

**CANADIAN INDIGENOUS NURSES ASSOCIATION**
50 Driveway, Ottawa, Ontario K2P 1E2
T: (613) 724-4677●Toll Free: 1-866-724-3049●F:(613) 724-4718 ● Website: www.indigenousnurses.ca

## The Canadian Indigenous Nurses Association (CINA)

The Canadian Indigenous Nurses Association (CINA) is the longest-standing Indigenous health organization for over 43 years in Canada. CINA is governed by a board of directors whose mission is to improve the health of Indigenous peoples (First Nations, Inuit and Métis) by supporting and being the national voice of nurses and promoting the development and professional practice of Indigenous health nursing.

At the current time, there are an estimated 9,700 Indigenous nurses in Canada[1]. Many more are required and will be needed to adequately respond to emerging health needs and critical environments affecting the wellness of Indigenous peoples. Indigenous nurses play a vital role in providing culturally competent care in order to address the unique needs of their Indigenous patients.

In 2016, CINA, formerly called the Aboriginal Nurses Association of Canada (ANAC), signed a partnership accord with the Canadian Nurses Association (CAN) that reinforces the commitment of both associations to collaborating on advancing Indigenous health and Indigenous nursing needs, and to address the gaps between the health of Indigenous and non-Indigenous Canadians.

In addition to providing advocacy and support to members CINA also undertakes research and policy development. CINA welcomes the opportunity to be a participant of the Standing Committee of Health as one of the association's key areas of advocacy and policy work.

## Background

The Canadian Indigenous Nurses Association (CINA) is pleased to provide the Standing Committee on Health with recommendations to address the multiple layers and health complications by strengthening public health and developing health promotion campaigns that resonate with Indigenous populations. More specifically, and within an Indigenous Nursing lens, the design, development and implementation of strategies to prevent and to reduce the prevalence and incidence of diabetes in Canada.

[1] http://indigenousnurses.ca/sites/default/files/inline-files/Nursing_AborigNursing_sheet_2018_3.pdf

**CANADIAN INDIGENOUS NURSES ASSOCIATION**
50 Driveway, Ottawa, Ontario K2P 1E2
T: (613) 724-4677●Toll Free: 1-866-724-3049●F:(613) 724-4718 ● Website: www.indigenousnurses.ca

Indigenous Nurses across Canada, are the primary healthcare providers, and in most cases the first point-of-contact for many community members.

The Indigenous population is the fastest-growing population in Canada, and over the last 25 years, the urban Indigenous population has been growing to a steady rate [2]. Indigenous peoples present a higher-risk at developing diabetes and related complications[3]. Moreover, Indigenous individuals are diagnosed at a younger age than non-Indigenous individuals, and Indigenous females have a higher risk at developing gestational diabetes than non-Indigenous females [4].

In order to understand the origin of the health disparities in the Indigenous population, it is imperative that we consider colonialism as a social determinant of health. The complex interaction of access to appropriate and equitable care related to socioeconomic status, geography, infrastructures, language and cultural barriers, jurisdictional issues demonstrate the multifactorial causes of types 2 diabetes in Indigenous population. A study on "Health care experiences of Indigenous people living with type 2 diabetes in Canada[2]" provides insight on the reality of some Indigenous individuals (Table 1).

Table 1. Factors in reported experiences of diabetes care, adapted from Jacklin et al. (2018)

| FACTORS | EXAMPLES |
|---|---|
| 1. **Colonial legacy:** experiences in the health care system are influenced by their historical relationship with the government. | • Residential schools<br>• Tuberculosis, public health and power relations<br>• Mistrust and avoidance |
| 2. **The perpetuation of inequities:** experiences in the health care system are influenced by contemporary interactions with systems that perpetuate historical relations. | • Denied care<br>• Inferior care<br>• Policies unsupportive of culture |
| 3. **Structural barriers to care:** experiences are influenced by systems of care that prevent patient-centred care approached that could repair or build relationships. | • First Nations health policies<br>• Challenges to accessing care<br>o Geographic isolation<br>o Physician shortage |

[2] http://www.aadnc-aandc.gc.ca/eng/1100100014298/1100100014302
[3] Jacklin (2018)
[4] https://www.canada.ca/en/public-health/services/chronic-diseases/reports-publications/diabetes/diabetes-canada-facts-figures-a-public-health-perspective/report-highlights.html#chp1

| | |
|---|---|
| | ○ Appointment allocation<br>○ Healthcare worker turnover/lack of continuity of care |
| 4. **The role of health care relationships in mitigating harm:** relationship with providers affects how interactions are interpreted by Indigenous patients and whether or not advice is followed. | • Presumed authority of providers leading to relationship breakdown<br>• Good therapeutic relationships grounded in relationship-centred approach |

To respond to the needs of First Nations and Inuit peoples with diabetes, Indigenous Services Canada (ISC) (formerly Health Canada) created the Aboriginal Diabetes Initiative (ADI) in 1999. The initiative aims to reduce the incidence of type 2 diabetes among Indigenous peoples in more than 600 communities, by supporting activities related to health promotion and primary prevention. Moreover, ADI oversees the service delivery by trained community diabetes workers and health service providers [5]. Budget 2010 committed on funding $110 million over two years for the initiative. Currently, the federal government commits to investing $50 million per year to support the third phase of the ADI (2010-2015). In 2015, the federal government committed to funding 46.8 million annually for the initiative.

The Federal government has made a commitment to deliver better health care outcomes for First Nations, Inuit and Métis communities. The 2018 budget committed $1.5 billion dollars over 5 years to invest in better outcomes for indigenous health. Yet those most likely to benefit from this funding are urban Canadians who also have access to trained homecare professionals and medical specialists. Unfortunately, Budget 2018's investments still leave rural, northern and remote or isolated Indigenous communities and in particular indigenous communities without access to the immediate care they need.

Despite the initiatives in place, health care delivery specific to diabetes still face some barriers, such as: the geographic locations of communities (u/r/r/i), the lack of healthcare workers and the social determinants of health (e.g., housing, water, infrastructure and access to nutritious food), the lack of culturally appropriate diabetes programs and services that are developed in

[5] https://www.canada.ca/en/indigenous-services-canada/services/first-nations-inuit-health/reports-publications/diseases-health-conditions/aboriginal-diabetes-initiative-program-framework-2010-2015-health-canada-2011.html#a1.0

collaboration with Indigenous communities and the lack of a regular surveillance data on Indigenous health [6] [7].

This situation is further complicated by the rising costs of prescription medications. In a recent report released by the Canadian Federation of Nurses Unions (CFNU): *Body Count: The Human Cost of financial barriers to prescription medications*, 57% of Canadians with diabetes reported failing to adhere to their prescribed therapies due to affordability issues related to medications, devices and supplies [8] [9]. This is a phenomenon otherwise known as cost-related non-adherence (CRNA)[10].

In preparation for the elaboration of strategies on diabetes, CINA has not had the opportunity to design, develop or implement participation in consultations at the community level. In part, this gap respects the Indigenous leadership, and their ability to communicate with their regional counterparts, technicians, community members and also to review the impacts on our rights as Indigenous people. In the meantime, CINA continues to work with their partners at the Canadian Nurses Association, and other external stakeholders to review the impacts of legalization and regulation as it pertains to the scope of work of our Indigenous Nurses. We continue to work along with our national Indigenous leadership such as the Assembly of First Nations – Chiefs Committee on Health, the Métis National Council, and others such as the First Nations Health Managers Association and the Canadian Association of Schools of Nursing. Each of these partners has made a commitment to advance Indigenous nursing through policy development, curriculum changes, and accreditation of programs for continued professional learning.

In our pre-budget submission, we echoed the Truth and Reconciliation Commission's (TRC) Calls to Action[11] to address some on-going health inequities, including addressing access to healing centres, home care, and developing indigenous health professionals. In order to keep our Indigenous family healthy, concrete actions are necessary to address the TRC Calls to Actions, more specifically the number 19 related to chronic diseases:

> We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and

[6] Diabetes : canada at the tipping point
[7] 2015 report on diabetes – driving change
[8] Diabetes Canada. (2011). *The Burden of Out-of-Pocket Costs for Canadians with Diabetes.* Toronto
[9] Diabetes Canada. (2011). *Diabetes: Canada at the Tipping Point – Charting a New Path.* Toronto
[10] Kennedy J, Morgan SG. (2006). *A Cross-national study of prescription non-compliance due to cost: data from joint Canada – United States Health Survey.* Clinical Therapeutics 2006; 28(8): 1217-1224
[11] *Truth and Reconciliation Commission of Canada: calls to action*: Truth and Reconciliation Commission of Canada; 2015

close the gaps in health outcomes Calls to Action between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

# Proposed Indigenous Diabetes Strategies

## Community

### Future generations - Technology

CINA commits in supporting Indigenous youth and to create a sustainable environment for the next seven generations. The generation X and Y are now susceptible to be diagnosed with diabetes. These generations are incredibly sophisticated technology wise, and there is potential to adapt the technology to provide better health outcomes for our youth. Smart phone applications for self-care are now available and are relevant in addressing Indigenous youth's needs. However, some First Nations communities still have limited connectivity to the internet. Thus, compared to the non-Indigenous populations, this is a barrier to effective self-care and diabetes management.

As the Indigenous youth is the fastest growing segment of the Canadian population and are susceptible to getting diagnosed at a faster rate than non-Indigenous youth. Therefore, it is crucial that the voice of Indigenous youth is placed on the forefront regarding their health and wellness.

***CINA recommends*** that additional considerations need to be developed that resonate with Indigenous youth and in particular, Indigenous environments.

***CINA also recommends*** that consultations with Indigenous youth regarding the prevention of diabetes has to be conducted to establish priorities.

COMMUNITY BASED/COMMUNITY PACED INITIATIVES

Community people need to design diabetes management programs that relate to their specific needs which includes, location, availability of retail stores such as pharmacy or grocery stores, ability to design food management that relates to economic resources. Community people need to be able to design promotional materials and information that responds to educational attainment and can be used as a "discussion piece with ability to translate to an indigenous dialect common to their area. The information needs to respond to variable age groups – not a one size fits all approach. Materials developed are assessed by and for the community to be able to understand diabetes management and also allows for modifications that reflect current trend. Let's talk in the language that is familiar to that age cohort. What is "sic" for youth, takes on some greater changes for adults or seniors.

***CINA recommends*** continuous work with established entities – which includes but is not limited to nationally, regionally and community focussed organizations – that address Indigenous diabetes.

FOOD SECURITY

Compared to non-Indigenous households, Indigenous households in Canada are more likely than households to experience the sociodemographic risk factors associated with food insecurity. Indigenous peoples are experiencing an extreme risk of poverty, single-motherhood, living in a rental accommodation and reliance on social assistance. Thus, Indigenous populations are at a much higher risk of food insecurity[12].

Food insecurity strongly affects the ability to manage health conditions, such as diabetes. In addition of tackling the socioeconomic factors that contributes to food insecurity, CINA supports the traditional, sustainable and ecological approached to the prevention of type 2 diabetes. CINA believes that efforts focussing on reclaiming and increasing the availability of local and traditional foods. Therefore, indigenous community members need to be engaged to preserve the traditional ways in promoting health and wellness.

***CINA recommends*** that we work with current programs that address food security for Indigenous population and identify alternative approached that resonate with Indigenous people.

[12] http://proof.utoronto.ca/resources/research-publications/aboriginal-peoples-and-food-insecurity/

## Healthcare Profession

TRAINING ON CULTURAL COMPETENCY AND CULTURAL SAFETY FOR HEALTH CARE PROVIDERS
CINA works with the Canadian Association of Schools of Nursing CASN) to focus on the inclusion of Indigenous nursing students across the country to be fully engagement to the development of a new curriculum relevant to our current national infrastructure. However, additional training is required to the actual health care professionals develop the cultural competency of the ones who are at risk of mitigating harm.

***CINA recommends*** that cultural competency and cultural safety training are provided to all health care professionals for them to adopt an anti-racism approach in their practice. In the light of the recent publication of the TRC, CINA is aware that the truth of the Canadian history is still not fully integrated in primary, secondary and postsecondary education. Thus, CINA believes is a priority in reducing the prevalence and incidence of chronic diseases, to address the health disparities and to effectively address the inequities related to social determinants of health.

REVISION OF CLINICAL PRACTICE GUIDELINES FOR ISC NURSES
CINA revised the content and is still working on the Indigenous Services Canada's Clinical Practice Guidelines to better meet the specific needs of Indigenous patients. These guidelines are crucial in orienting the practice of nurses working in First Nations and Inuit communities. Thus, in the light the recent findings of the TRC, it is imperative that the influence of hat the legacy of colonisation and the social determinants on diabetes needs to be integrated in the diabetes chapters of the Clinical Practice Guidelines. Without this content, nurses could mitigate harm, in blaming the patient for their condition.

***CINA recommends*** Indigenous Services Canada, in collaboration with CINA, revise the chapter on diabetes to better demonstrate the link between colonization and diabetes.

CANADIAN INDIGENOUS NURSES
ASSOCIATION