# Marcia Anderson-DeCoteau

[Speaker opens with greetings in Saulteaux Cree language]. We are here today on Treaty One territory which is a territory of my ancestors and of my descendants. My great, great, great grandpa was 41 in 1871 when treaty one was signed, he lived on the St Peter's reserve, and was represented at the treaty negotiations by Chief Henry Prince. I believe from our teachings that when Chief Prince was deliberating on the treaty, that he was thinking seven generations down the line. In my family, the seventh generation from the signing of Treaty One is the generation of my children. It's also the generation of children like Tina Fontaine and Jordan Anderson, both of whom experienced the tragic reality of the gaps in Indigenous health.

Tina Fontaine was a youth in CFS care when she was murdered, put in a garbage bag and dumped in the Red River. Jordan Anderson was a child from Norway House with complex medical needs who died in the hospital having never been to his home community, while the federal and provincial government fought over who would pay for his health care expenses if he left the hospital. These gaps are not the fulfilled hope of our ancestors, and we will not allow it to be another seven generations before we are as healthy as the people, we've agreed to share this land with.

Let me share just two statistics with you to highlight the general pattern of Indigenous health and health care gaps in Canada. Among First Nations people in Manitoba, the rate of diabetes is 203 per 1000. This is over four times greater than the rate of diabetes in the non-First Nations Population. The rate of amputation due to diabetes and outcome largely preventable through proper medical care is even greater. The rate amongst First Nations people is 3.39 per 1000 and 0.19 per 1000 for the non-First Nations Population. This means that a First Nations person living with diabetes is 18 times more likely than a non-First Nations person to have part of their leg cut off. How do we make sense of this?

The Truth and Reconciliation Commission of Canada calls on us to understand the gaps in Indigenous health as a result of previous government policies. From a population health perspective. The mechanisms by which these gaps are created are largely through the entrenchment of poverty, the chronic underfunding of education and child welfare, inadequate overcrowded housing, and other such social and economic policy choices. It would be fair to say, however, that the health care system has, to a large extent been complicit in the maintenance of these gaps, and at times an active contributor through multi-level racism.

Now for most people, when we think of racism, our immediate understanding is of personally mediated racism, we can easily see interpersonal racism in the words and actions of people who have come to believe that a certain group of people is inferior to another group of people. This bias can be conscious or unconscious, and even if unconscious can influence behavior and clinical decision making, as done and research largely documented in the US.

Recently, the College of Family Physicians of Canada released a report on the health and healthcare impacts of systemic racism on Indigenous peoples in Canada. They refer specifically to the case of Brian Sinclair, an indigenous man who was referred to the emergency room by a community physician. He waited 34 hours to receive care, vomiting on himself, and with other er visitors asking nurses and security guards to help him. When they finally checked on him, they found that he had been dead for several hours of an untreated but completely treatable bladder infection.

The next level of racism I want to discuss is institutional racism. Institutional racism is differential access to the good services and opportunities of society by race. There need not be an identifiable perpetrator, and it has generally evolved over time through historic actions, like the implementation of colonial policies.

Examples of institutional racism in health care can be found in the spring 2015 Auditor General's report on health care access in remote First Nations. There are many serious issues identified in the report, I'm only going to highlight one today.

Of the 45 nurses that they examined, only one had completed the five quote unquote mandatory training courses for nurses to practice in nursing stations. One of those courses is certification and advanced cardiac life support (ACLs) essentially keeping you alive or resuscitating you if you are critically ill or injured. Only 33% of those nurses are the only health care professionals in the only health care facility in these remote mostly flying communities, 33% had their ACLs training. Comparatively, 79% had completed the training on controlled substances or narcotics. Priorities, right? Let me ask you this, where else in Canada will we tolerate an inadequately prepared healthcare workforce at a time when we need it most?

As we continue to look at health care through this lens of multilevel racism, I next want to discuss epistemic racism. All of racism centers around the idea of one group of people being inherently superior to another group of people, and then using it using its power to maintain its societal position who might have advantaged access and control of power, money, and resources.

Epistemic racism focuses on the belief that the knowledge and ways of knowing of one people are superior to another. Now our healthcare system is based within a western Eurocentric value framework with specific rankings of knowledge, according to what type of western scientific inquiry produces the knowledge.

An easy way to look at this is to look at clinical practice guidelines, most of which describe the strength of the recommendation according to the type of evidence that produced it. So, class one recommendations are the result of multiple, large randomized controlled trials. These are the gold standard of evidence. Class two recommendations are the result of a single randomized controlled trial, or non-randomized clinical trials. Class three recommendations are based on the consensus of experts, case studies or case reports. Or if it's the current standard of care without any evidence. There is no place or grade for indigenous knowledge.

Now, I'm a General Internist and I do mainly cardiology, and my clinical practice. And I rely on these forms of evidence and these guidelines to guide my treatment of ischemic heart disease. But they didn't help me when the First Nations woman was having difficulty reconciling the medical treatment of her heart disease with her residential school experiences. They didn't help me when the First Nations man disclosed that the chest pain, he had was linked with the panic attacks he's had since his sexual abuse as a child. They don't help indigenous peoples when the healthcare system doesn't meet their needs, either because they can't get into the system, or when they do, they are treated as less than fully human, by a system built on a concept of health and healing that was privileged over their own.

I read a quote the other day by Marie Batiste and what it said was this, "education can either maintain domination or it can liberate. It can sustain colonization in Neo colonial ways, or it can decolonize every school is either a site of reproduction or a site of change." And I want to share a story today of how healthcare can be different and can be a site of change, of liberation, and of decolonization. Because I believe that quote is just as true of health care as it is of education.

So, Manito Ikwe Kagiikwe started as the mothering project and as a program that operates out of Mount Carmel clinic to support women who use substances and are pregnant or early parenting. My role with the program is to lead the evaluation team. And briefly here's how I got involved.

I was presenting at a conference a couple years ago in Winnipeg on maternal child health. The nurse lead for the program, Margaret Bryan's was also presenting this was early in program development, and she discussed the intention for the program to be culture based. A leading American maternal child health specialist, stood up and praised this approach, particularly because it would include an evaluation component, and thus would evaluate this indigenous knowledge to see if it was in fact valuable and valid to the health of Indigenous women, children and families.

I took my turn at the microphone to respectfully challenge his comment. It was respectful. What I said was that requiring one set of knowledge to be validated by another knowledge system presumes that second knowledge system to be superior and to have the power to proclaim it valid or not. This is what some have referred to as cognitive imperialism, and what I have referred to today as epistemic racism. According to United Nations Declaration on the Rights of Indigenous Peoples, it is indigenous communities, families and individuals who have the right to define what knowledge Western or traditional or both is relevant to their health and healing. So I got asked to do the evaluation.

The Anishinaabe name of the program, which was received through ceremony is Manito Ikwe Kagiikwe (spirit woman teachings) When this was taught to us as meaning that women carry all of the teachings within them that they need, and the role of the program is to walk with them gently and remind them that they know.

Women have traditional roles as caregivers, and knowledge keepers, and it is of critical importance to reclaim those roles. Our evaluation at this phase was mainly qualitative and focused on the stories that women told us about the program, we looked for ways that the meaning of the name and the seven sacred teachings were present. Listen to these words, which capture the essence of the name. "When you have a space, and a place and a time, and none of those issues that people label you with, where you get to go and none of those things are what confine you, or limit your ability or your heart or your spirit, then you have a real chance to grow into, to come into growing who you are, and who you want to become."

The first teaching is wisdom, Nibwaakaawin**.** To these women, Wisdom means knowledge that is based on lived experience by people who are willing to learn from the choices that they have made. It is knowledge that is shared in a way that treats everyone is equals. And that helps people to uncover their own knowledge. And that women told us about how they support one another through crises. They offer advice, and they make decisions for the program, all based on the experiences that they've had.

The second teaching is humility,Dabaadendiziwin. Humility is being yourself without thinking you are better or worse than anyone else. It is being able to make mistakes and be accountable to them. It is sharing what you have without needing credit or recognition when someone else succeeds. Humility is a critical aspect of what makes this program a safe space for these women who are often highly stigmatized in healthcare and society in general and are often labeled as hard to reach. One woman said, I see a lot of the struggles, like all of these women, they have their own stories, but I see a little bit of myself in them. And that's what keeps me going. We all have our stories, we all struggle, but we're all similar in little ways.

The third teaching is respect, Minaadendamowin. Respect means that everyone's knowledge and value is recognized and treated as equal. It is treating others how you want to be treated. And really importantly, it's that no one is treated with discrimination or with judgment. One woman made me think about how rare it was for her to be treated with respect. When she said this, "I guess it just kind of makes it more like on an even basis. They're not looking down on everyone."

The fourth teaching is love, Zaagi’idiwin**.** To these women love is an unbreakable connection, undivided attention, leading first and foremost with kindness. It is sharing what you have. And it is showing appreciation and caring. When you share what you have, you don't expect anything back. I'm going to share two quotes from the evaluation, one from a staff member and one from a client. And I want you to make the link between how we hire people and what people experience. So, the staff person said this, "we hired for kindness. And we hired for actually we hired for kindness, we don't do kindness well, and health care or social services. And so, we worked really hard to find people who would just like shower people with love." I want you to take a moment and just think about your own healthcare experiences. And think about if you have ever felt showered with love. And I want you to keep that reflection. But I want you to also imagine that you are a racialized indigenous woman in Winnipeg. You have kids and care, and you need health care for your pregnancy while you're still using substances. Now, the healthcare experience you might have in this program is this. "We're like a little family. I love all of these staff workers. I love these girls; the clients are like a little family and I love it. We're all related in some way. Just even through the streets, whatever. We're all related in some way, and we all relate to the same things. "

The fifth teaching is bravery, Aakode’ewin. Bravery is revealing yourself without knowing what the outcome will be. It's setting goals and following through. It's being willing to try out new solutions. And in this context, it's getting your kids back in parenting. This is bravery. "I guess the other thing that was hard or that was difficult for me in the beginning, that I just recently learned to deal with, was this is my old stomping grounds. This is my old using area. So even when I was coming down here, even from downtown, I used to get really bad anxiety. I knew where I was going. I knew there was a safe place. I knew there was women I trusted, but bringing myself into the area, that was really difficult for me to do in the beginning."

The last two teachings are truth, Debwewin and honesty, Gwayakwaadiziwin. The quotes I share already highlight concepts of both, including staying true to your principles, doing what you say you're going to do. Sharing the hard truths, not with sugarcoating, but with kindness. I think the quotes have also already begun giving you a picture of how this healthcare experience is different from the usual health care experience. But I will share a few more to highlight some of the outcomes that women are experiencing.

One woman said "we have our own space, we have our own time, we're finding our own voices. And in that we're gathering strength." That is an incredibly valuable health outcome. Another woman said "I used to hate myself, I used to hate everyone around me. I used to hate my life. I don't feel like that anymore. I love the people around me now. I love myself. I'm proud of who I am. I'm not ashamed of myself anymore. I'm proud of who I am. And I wouldn't have got this far without these women."

You have likely heard in the media that one baby a day is apprehended from the hospitals in Winnipeg. All of the women who have kids in the program either have or have had kids in care, at least some of them now, are getting their kids back or going home from the hospital with their babies. One woman shared this, "I was ready to let him go. I was ready to let him go. But the women helped me with the social workers they helped guide me into like bringing my son home and stuff. I'm so thankful I stayed in the program. I can't imagine my life without my son."

Another woman shared "I never thought it would be this big. I mean, it's unreal. It's amazing. It's amazing. And it's right in front of my face every day because my daughter is right in front of my face every day. I don't want to say that I feel like I owe them everything. But they've given me everything I have." This program respected indigenous self-determination in a local context by giving decision making power and leadership to the indigenous woman who would be accessing the program. These indigenous women said that Indigenous knowledge of health and healing was essential to them. So, the program bases its operations in Indigenous cultures and teachings with the grounding of the seven sacred teachings as one example. That says this intersection coexistence of Western health care with indigenous knowledge has created outcomes that the women themselves judge as valuable. Strength, pride, voice, being cleaner reducing the harms of substance use, family, friends, and parenting relationships with their children for some. If we want to close Indigenous health gaps, part of the answer is reexamining the assumptions of Western healthcare, evidence-based medicine and the definition of "essential services" and ensuring that all indigenous people are able to access Western and traditional knowledges of health and healing as they define essential to them. [Speaker closes with thanks in Saulteaux Cree language]