



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

Our Health, Our Voice

ADVOCATING FOR URBAN INDIGENOUS PEOPLE IN
DISTINCTIONS-BASED HEALTHCARE LEGISLATION

In Friendship.

National Association of Friendship Centres

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PREPARED BY

**The National Association
of Friendship Centres**



WITH RESEARCH SUPPORT AND
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Executive Summary

The Government of Canada has committed to co-developing distinctions-based Indigenous health legislation with First Nations, Inuit and Métis Nation partners.

The National Association of Friendship Centres was engaged to provide our input from a non-representative, inclusive and Indigenous civil society perspective. While we do not politically represent any specific distinctions-based group, we provide Indigenous led and implemented supports, including health supports to over a million people, inclusive of First Nations, Inuit and Métis, across our extensive network.

Despite the general assumption that there is better **availability** of adequate and appropriate health care for Indigenous peoples who live in urban settings, Indigenous people living in urban settings still face challenges of **access** to high-quality and culturally relevant and responsive health care. In our collective experience, urban Indigenous people find themselves “squeezed from both sides” due to consistent lack of adequate, affordable, and appropriate health care support provided by Provinces, while also experiencing a hesitancy on the part of federal entities to provide funds or services due to where Indigenous people live. In our view, the constant jurisdictional wrangling between Provinces and the Federal government creates gaps in health care services and puts up more barriers than are removed.

The National Association of Friendship Centres (NAFC) believes what is needed is a layered, intersectional, and multi-jurisdictional approach to healthcare for Indigenous people that considers both where and how Indigenous peoples live as one of many determinants of their diverse healthcare needs. Such an approach considers distinct needs of First Nations, Inuit, Métis, and also considers their residency, geographic location, sexual and gender identity, and age, amongst other considerations, but is not limited by them, and does not define healthcare access or quality on the basis of these identities.

Instead of addressing healthcare solely in terms of distinctions-based rights and interests, we submit that a more nuanced and layered approach would ensure better outcomes for all Indigenous peoples, regardless of residency. We propose that healthcare policy should be focused on the needs and realities of Indigenous people first and foremost, many of whom may not fit within the current policy and practice approaches.

Friendship Centres have provided lifesaving, culturally relevant, and community driven services, including health services, for over 50 years. We stand as a key stakeholder in both the development of and implementation of any health legislation that is developed. Regardless of what is passed, Friendship Centres will be called upon by community members to assist with understanding what their rights are, how to access culturally relevant supports, and how to navigate the consistently complicated health care systems.



The content of this report is compiled from multiple sources. We conducted a synthesis review of academic and policy literature concerning the legislative landscape of Indigenous healthcare in Canada and the systemic barriers faced by urban Indigenous people in accessing healthcare, together with insights drawn from roundtable dialogues with Friendship Centre members who shared their lived experiences of and expertise navigating (and helping others navigate) healthcare systems across the country. A legal analysis was also conducted and those detailed results are presented in a separate document. In 2021, the NAFC commissioned a systemic review of health service access with respect to urban Indigenous people and we have included that paper with our submissions, along with the legal review. We ask that both the legal review and the systemic review not be shared publicly without our permission and prior consent.

The *Regroupement des centres d'amitié autochtones du Québec* (RCAAQ) has also developed their own submission with respect to Friendship Centres and realities in Quebec. We are aware and supportive of RCAAQ's submissions in addition to the findings here.

This report is organized into four sections:

- 1) **Understanding the Urban Indigenous Context:** Urban Indigenous people are First Nations (both status and non-status), Inuit, and Métis who come together in dynamic rural and metropolitan communities, in towns and cities alike, for many reasons. These urban Indigenous communities are long-standing and multiple generations deep, the city is home. Community members in these urban communities do not always identify with or fall neatly within three distinctions.
- 2) **Canada's Indigenous Health Policy:** Federal policy regarding Indigenous health services historically has not been fully inclusive of urban Indigenous realities. The adoption of Jordan's Principle by federal government acknowledges that inequality due to residency is unacceptable and that jurisdiction should not impede access to quality health care for Indigenous children. Rulings of the Canadian Human Rights Tribunal, Federal Court, and Federal Court of Appeal related to the First Nations child welfare human rights complaint demonstrate that even when the government of Canada has been determined to be discriminating, they will seek to narrow interpretations and jurisdiction, often at the expense of equality.
- 3) **Filling the Gaps in Urban Indigenous Health Access:** The results from the literature synthesis are brought together with insights gathered from roundtable discussions held in November and December 2021. Urban Indigenous people are shown to face several challenges to accessing safe healthcare services, emerging from two main sources:
 - + **Federal Health Policy:** Roundtable participants considered federal and provincial government support for Indigenous health to be made more complicated based on their residency and geography. Urban Indigenous people could not receive the same level of coverage for non-insured medical expenses or access culturally appropriate health services through federally



offered services and similarly through provincially offered services. In addition, the complexity of federal and provincial jurisdictions for health services makes health services extremely complex to navigate for both people and the people offering the services that are intended to help them.

- + **Systemic Racism:** Racism is experienced by many Indigenous peoples in mainstream healthcare spaces and often manifests as stereotyping, lower quality or delayed care, or dismissal of Indigenous cultural practices and traditional healing. A consequence of these experiences is a deep mistrust of healthcare spaces that leads many Indigenous peoples to avoid seeking or engaging with the care and services they need.

In each of these areas, Friendship Centres have identified these challenges and, in many cases, developed strategies to support urban Indigenous people on a status-inclusive basis in accessing the health services they need regardless of their identity as First Nations, Inuit, or Métis. The roundtable participants described some of these strategies to inform ideas for policy-makers and other organizations working with urban Indigenous communities.

4) **Key Considerations:** In order to move forward in an inclusive, layered and intersectional way with respect to Indigenous health legislation and any relevant accompanying regulations and policies, we put forward the following:

- + Engaging Friendship Centres, urban Indigenous health service providers, and other urban Indigenous organizations upfront as full service delivery partners will reduce gaps in healthcare policy and prevent the need for “work around” solutions.
- + Being direct and intently including relevant stakeholders, such as Friendship Centres, when developing inclusive and intersectional healthcare policies that consider and are responsive to the diverse needs of Indigenous individuals and their communities, regardless of residency.

The majority of Indigenous peoples live in urban communities, including rural and remote towns and cities, yet federal Indigenous healthcare approaches does not reflect this reality. For the Government of Canada to follow through on its commitment to eliminate the healthcare gap between Indigenous and non-Indigenous people, any healthcare legislation developed must fully support Indigenous health priorities, is status-inclusive and supports Indigenous peoples, regardless of residency and rooted in the multiple realities of Indigenous people.

Approach

In developing this document for consideration in the development of Indigenous health legislation, the National Association of Friendship Centres (NAFC) completed:

- 1) **Research Synthesis:** Completed an examination of available academic and policy literature addressing the topic of healthcare access, affordability, and appropriateness for urban Indigenous people
- 2) **Engagement Sessions:** Facilitated virtual round table discussions to collect insights from the lived experiences of those working “on the ground” to support access to health services for urban Indigenous People.

To conduct the Research Synthesis and design the Engagement Sessions, NAFC contracted Coeuraj, a transformation practice that provides strategic research and facilitates multi-interest collaboration to tackle systemic challenges.

The NAFC held two virtual events with participants from Friendship Centres across Canada. These virtual sessions composed of roundtable dialogues that explored urban Indigenous peoples experiences with accessing health services. Insights from these discussions are presented, together with supporting contexts from the Research Synthesis, in Section 3 of this report. However, a high-level overview is presented in the table below.

Summary of Engagement Sessions

SESSION #1

WHEN: November 10th, 2021

WHO: Friendship Centre directors, staff, frontline workers, and community members from across Canada

DISCUSSION PROMPTS

Vision

- + What would transformative change in health services for urban Indigenous communities look like to you?
- + How can the spirit of *Joyce's Principle* inform the Government of Canada's distinctions-based Indigenous health legislation?

Tactics

- + What resources are needed to better support high-quality, accessible, and culturally relevant health care services?
- + What can the Government of Canada do to help foster positive change for urban Indigenous peoples' health?

KEY THEMES

Vision

- + Community-led services.
- + Culturally relevant care.
- + Comprehensive wraparound services.
- + Seamless service access between community and urban spaces.
- + Sustainable, predictable funding.

Tactics

- + Investments in education, recruitment, and retention for more Indigenous healthcare personnel.
- + Uniform holistic approaches available in community and in urban areas.
- + Capacity-building funding for communities.
- + Addressing jurisdictional gaps.

Summary of Engagement Sessions

SESSION #2

WHEN: December 1st, 2021

WHO: Friendship Centre
directors, staff, frontline workers,
and community members from
across Canada

DISCUSSION PROMPTS

Barriers

- + What are some of the difficulties that urban Indigenous people face accessing healthcare with current policies?

Opportunities

- + What workarounds have you found effective to help urban Indigenous people access the care they need?

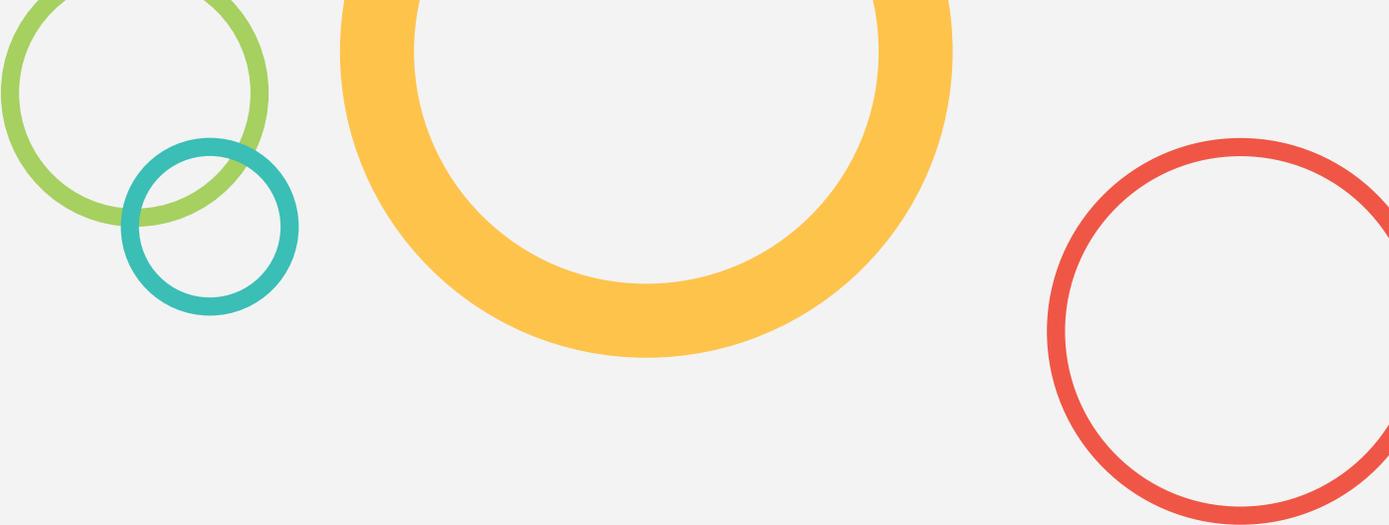
KEY THEMES

Barriers

- + Lack of health coverage and critical services due to distinctions-based approach to healthcare.
- + Uncertainty of where to access services or if they are safe.
- + Systemic racism.
- + Culturally misaligned care.
- + Barriers to care such as transport and language.

Opportunities

- + Friendship Centres as health providers and information hubs.
- + Friendship Centres integrate health services with education, prevention, etc.
- + Forging partnerships to provide wraparound services and aftercare.
- + Elders and health navigators to support the system.
- + Support in logistics such as transport and accommodations.



PART ONE

Understanding the Urban Indigenous Context

1 Understanding the Urban Indigenous Context

The NAFC will rely on and heavily reflect the work of the Urban Sub Working Group (USWG) of the Missing and Murdered Indigenous Women, Girls, and 2SLGBTQQIA+ (MMIWG2S) National Action Plan committee and the resulting *Urban Path to Reclaiming Power and Place, Regardless of Residency: Missing and Murdered Indigenous Women, Girls and 2SLGBTQQIA+ National Action Plan* (Urban Path) (Urban Sub-Working Group, 2021). The Urban Path is the most recent and comprehensive thinking around urban Indigenous experiences and realities. Throughout 2020-2021, the NAFC was an active member of the USWG of the MMIWG2S+ National Action Plan committee and the USWG, a collective of urban Indigenous organizational representatives, spent considerable amount of time discussing and articulating the urban experiences for Indigenous peoples and what a definition may look like.

While developed for the Urban Path, this work transcends numerous areas and should be considered and adopted in the development of this health legislation.

1.1 COMPLEXITY OF URBAN INDIGENOUS

The NAFC adopts and promotes that Indigenous people belong in urban centres. All lands in Canada, including urban areas, are the traditional ancestral territories of First Nations, Inuit, or Métis, despite the efforts to displace our Peoples from them (Urban Sub-Working Group, 2021).

Urbanization of Indigenous peoples should never be equated with assimilation. In fact, urban Indigenous communities often thrive with multiple, co-existing cultures, languages, and practices.

The MMIWG2S+ USWG articulated the complexity of even being able to come up with a definition of “urban Indigenous”:

Urban centres can be incredibly diverse. One may identify with the following categories: **First Nations, Inuit or Métis (distinctions-based), which aligns with the Canadian Constitution Act 1982. Each of these groups are incredibly unique, with their own needs and solutions, and there can also be a great deal of diversity within each of the distinctions-based groups. The Constitution also uses the term Aboriginal (which includes **First Nations, Inuit and Métis peoples) and the term *Indigenous can be used interchangeably with Aboriginal.

However, some may feel that they do not fit neatly within the distinctions-based categories and may more readily identify with the term *Indigenous. This term can also be used when referring to International legal concepts or experiences (such as common experiences with colonialism). We note that the term *Indigenous is also inclusive of people who have complex identities and may not fit the distinctions based approach for one or more reasons. For example, if they were taken

away or forced out of their community, adopted, have mixed heritage as a result of intermarriage, have been subject to rights denial or based on additional factors such as gender and sexual identities, gender expression, sexual orientation, residency, geography, ability, and age.

We also note that Individuals may be comfortable using different terms to describe themselves depending on the situation, who they are talking to, or where they happen to be (in their home community, elsewhere in Canada or outside of the country). For example, some would never use the term **First Nation to describe themselves, but may describe themselves by using their traditional languages, and/ or by describing family or other kin relationships, specific community, treaty area, clan, or grouping of peoples such as a Confederacy.

We recognize that some **First Nations, Inuit and Métis people are not comfortable being identified as *Indigenous and may feel that this blanket term (or a pan-*Indigenous approach) results in their exclusion (in the same way that some may feel excluded from the distinctions-based approach). For example, for **Inuit, it is important to use this term because it is from their language and there is ownership in that. It is our intention to recognize and celebrate all forms of our diverse identities – whether **First Nations, Inuit or Métis as well as those who may not neatly fit into these categories.

The above excerpt from the report demonstrates a collective challenge in how Indigenous peoples identify ourselves and also how we describe and identify ourselves to others, both within other Indigenous communities or to non-Indigenous people.

1.2 DEFINING URBAN INDIGENOUS

The MMIWG USWG developed a helpful definition, that we will adopt herein:

Urban Indigenous: First Nation, Inuit and Métis people living in small, medium and large communities, including rural, isolated and remote communities, which are: off-reserve; outside of their home community, community of origin or settlement; or outside of Inuit Nunangat (Inuit homelands).

This definition contemplates interconnected elements which are considered and reflected in this articulated definition:

- + **Demographic evolution.** Despite major data gaps and concerns, the information that we have demonstrates that Indigenous people living in urban and rural areas is vast and growing. Many Indigenous people, regardless of their affiliation and connection with their respective Nations, have lived in urban areas by choice or circumstance for multiple generations.
- + **Voluntary and Involuntary migration.** Multiple push and pull factors lead Indigenous people to be located in urban and rural areas. Pull factors includes things like employment, education, family considerations and opportunities. Push factors includes things like lack of health care and primary/secondary education options, housing availability, forced removal due to the child welfare or justice systems, violence, homophobia/transphobia, or lack of other specialized and required services.
- + **Recognition.** Many people have had community connections taken away from them due to government policy and legislation, experience lack of recognition by their community or identity due to federal government policy or legislation. For example, the harmful legacies and ongoing issues with the *Indian Act*, including residential schools, 60s scoop, ongoing millennial scoop, etc.
- + **Complex identities.** Pan Indigenous approaches must be resisted. While a distinctions-based approach will assist to understand the unique realities of First Nations, Inuit and Métis, Indigenous peoples living in urban areas, women, girls, 2SLGTBQQIA+, people with disabilities, and the elderly will also require unique health care considerations that may transcend their experiences across their respective distinction, but still require that their human rights and rights as Indigenous peoples be upheld and advanced.
- + **Geographic inclusion.** Indigenous peoples are everywhere. Perhaps there was a time when there was a designated place and location that they “should” or “ought to” be. Our concept of advancing Indigenous rights must be inclusive of Indigenous peoples wherever they reside, including metropolitan, urban, rural, isolated and remote communities, which have their own unique challenges and needs.

- + **Portability of Rights.** The rights of Indigenous peoples exist. Indigenous peoples should have full enjoyment of rights regardless of where they are physically located in Canada. A rights-based approach to design and delivery of services should be seen as a practical way to address gaps in services and supports.
- + **Jurisdictional wrangling.** There is a long-standing phenomenon of jurisdictional wrangling in the urban context. Urban Indigenous people are often treated as an afterthought or add on when developing Indigenous policy and legislation. The Federal government needs to work with Provinces and Territories to ensure that jurisdictional disputes does not disrupt the realization of rights and proper supports for Indigenous peoples.

1.3 URBAN INDIGENOUS BY THE NUMBERS

Using 2016 census data and following the definition of “Urban Indigenous people” provided above, an estimated 1,285,165 Indigenous people were Métis (regardless of residency), First Nations people living off-reserve¹ and Inuit living outside of Inuit Nunangat in 2016. This represented almost 77% of the total Indigenous population within Canada.² According to available data sources the urban Indigenous population includes:

- + 66% of First Nations individuals in Canada comprising;
 - + 56% of the registered, and 98% of non-registered, First Nations populations in Canada.
- + 27% of the Inuit population in Canada;
- + 99% of the Métis population;
- + 98% of individuals who claim multiple Indigenous identities.

Based on the 2016 census, Statistics Canada (Statistics Canada, 2017b) estimated 867,415 Indigenous people resided in towns or cities with a population of over 30,000 people, which corresponds to approximately 51.8% of the total Indigenous population. This estimate still leaves around 35% of the urban Indigenous population who may reside in less populated, or more rural/remote regions.³

1 The term “off-reserve” is used to be consistent with the data and terms used in the Canadians census.

2 Author’s calculations based upon 2016 census data (Statistics Canada, 2017a)

3 Author’s calculations based upon 2016 census data (Statistics Canada, 2017c)

Urban Indigenous communities are culturally diverse and heterogeneous. Many Indigenous families have lived in urban spaces for generations and feel strong connections or even feel more connected to their urban communities while maintaining a spectrum of relationships (from strong to none) with their respective Nation or Nations. Urban Indigenous people sometimes hold multiple Indigenous ancestries and identities simultaneously, and share experiences across their identities.

1.4 THE URBAN INDIGENOUS EXPERIENCE OF RACISM

Effective policies to address racism, both in healthcare and its indirect effects on Indigenous health, *must* consider the contextual realities of where and how Indigenous people live.

Urban environments are spaces where Indigenous people are typically a cultural minority within the population. Given that systemic racism is present across mainstream Canadian society, Urban Indigenous people’s experience of racism is likely to be a “pervasive” feature of their lived experiences as noted by the Royal Commission on Aboriginal Peoples (RCAP) (RCAP, 1993).

“[Roundtable] Participants said racism and discrimination against Aboriginal people in urban centres is ‘pervasive’. They said Aboriginal people face racial discrimination every day, in every urban centre, on the streets, at work, and sometimes at home. They said Aboriginal people experience violent attacks of a racist nature daily across the country. They said racism is so prevalent that many Aboriginal people simply accept violent racism and racial discrimination as a “normal” fact of life.”

— *National Roundtable on Urban Aboriginal Issues (RCAP, 1993)*

In the 2010 Urban Aboriginal People Survey (UAPS) (Environics Institute, 2010) 71% of respondents believed non-Indigenous Canadians harbour generally negative impressions about Indigenous peoples. In addition, almost 90% of respondents believed that Indigenous people are often treated unfairly, with 70% reporting that they have been personally teased or insulted due to their Indigenous background. Respondents who reported negative experiences with non-Indigenous people also described feeling shame, lower self-confidence, and low self-esteem as a result.

In addition to being subjected to disgraceful incidents of direct racism in healthcare (Turpel-Lafond, 2020) Indigenous people often experience “casual” or “everyday” racism in many aspects of urban life such as; at universities (Canel-Çınarbaş & Yohani, 2019; Clark et al., 2014) in youth physical activity programs (Mason et al., 2018) or shopping (Benoit et al., 2019). Research has demonstrated a significant relationship between experiences of interpersonal racism and depression within urban Indigenous populations (Paradies & Cunningham, 2012) connected to feeling stressed, lack of control, and shame which contributed to the resulting effects on mental health.

1.5 URBAN INDIGENOUS DATA CHALLENGES

Fully understanding the various factors that affect the healthcare experiences of urban Indigenous people is made especially challenging by a lack of data regarding urban Indigenous populations. Accurate, consistent information is a requirement to developing suitable solutions to meet the needs of urban Indigenous people (Collier, B., 2020; Rotondi et al., 2017).

For example, Statistics Canada's Aboriginal Peoples Survey (APS) only considers First Nations living off-reserve⁴, Inuit, and Métis. First Nations who live on reserve receive surveys administered by the First Nations Information Governance Centre (ISC, 2011). Although these surveys may address similar variables, the difference in methodologies prevents a rigorous analysis of realities for urban Indigenous people and allows for comparison within urban settings of Indigenous people to non-Indigenous populations at local, regional/provincial and national levels.

The high mobility and migration (in and out of urban areas or in and outside of Inuit Nunangat) of Indigenous people, higher rates of poverty, and a distrust of researchers and governments after many years of exploitative studies and policies, presents additional concerns regarding the accuracy of census data. One study (Rotondi et al., 2017) by the "Our Health Counts" project, adopted a community-based, respondent-driven method to determine that the Indigenous population of Toronto may have been two to four times larger than census estimates.

Accurate data collection and analysis regarding the health needs and social determinants of health for urban Indigenous people is the key to developing effective policy. Provinces have not adequately collected disaggregated data with respect to Indigeneity. The Federal government collects data largely from on reserve only. The NAFC has started work on its comprehensive national database initiative, however, data collection and analysis resources are not consistently available for urban Indigenous entities, such as Friendship Centres.

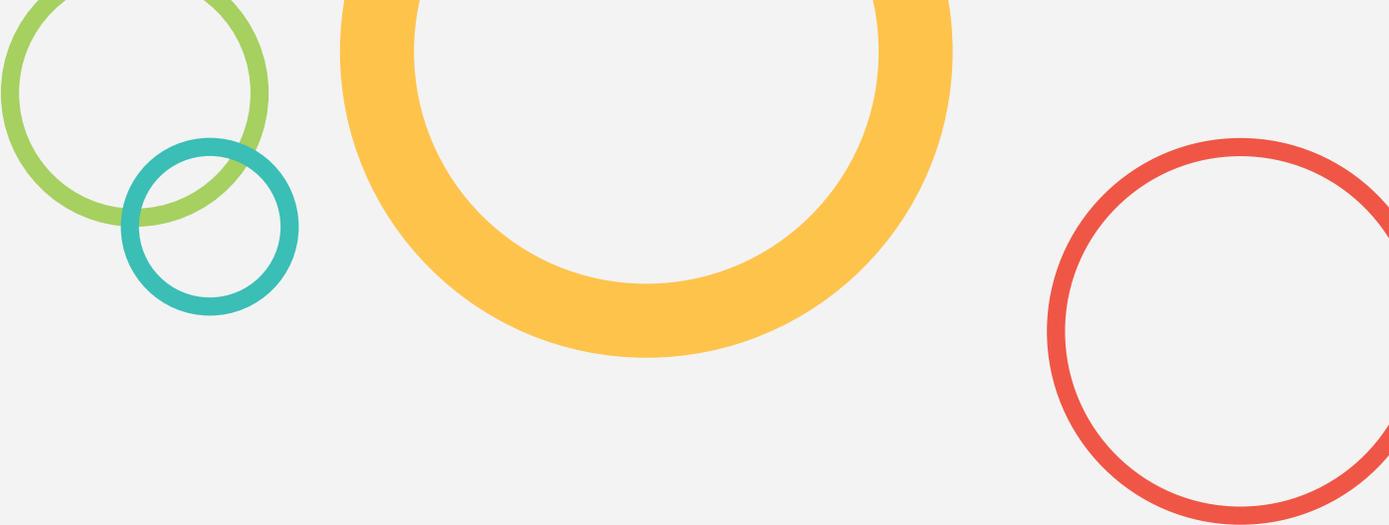
4 The term "off-reserve" is used to be consistent with Statistics Canada's terminology.

1.6 CONCLUSION

Our call for inclusivity and intersectionality should not be confused with a call for a “pan-Indigenous” approach, which assumes that a one-size fits all or that all Indigenous peoples should be lumped under one Indigenous umbrella approach to health care. Rather, we reiterate that in addition to considering approaches based on First Nations, Inuit and Métis distinctions, that intersecting identities also be taken into consideration. For example, ensuring that approaches taken will be inclusive of Indigenous peoples’ abilities, sexual and gender identities, and ages, regardless of where they reside.

Friendship Centres have been providing Urban Indigenous people with essential services and cultural programming for decades. Furthermore, they have been able to achieve this by utilizing a community-driven approach. They serve the Indigenous people within their communities, regardless of their “recognized Indigenous identity” or their registered status. Friendship Centres work this way because their lived experience has shown that distinctions-based approaches are too exclusionary to meet the diverse needs of urban Indigenous populations. The experience is also aligned with recommendation 4.7.9 of RCAP that “[s]ervices to Aboriginal people in urban areas generally be delivered without regard to legal or treaty status.”(RCAP, 1996)

Although First Nation, Métis and Inuit people have different needs and cultures, in an urban context they face many similar challenges. Any effective support for Indigenous healthcare must reflect this shared context and be based on the policy principle that Indigenous people deserve access to quality and culturally-appropriate care wherever they reside, in addition to their distinct rights.



PART TWO

Canada's Indigenous Health Policy Historically Excludes Urban

2 Canada’s Indigenous Health Policy Historically Excludes Urban

“As an Indigenous person, I know that the [health] system is not broken but planned. The system was designed to not respect Indigenous values”

— December roundtable participant

2.1 INTRODUCTION

The purpose of this section is to demonstrate how existing federal legislation regarding healthcare excludes many Indigenous groups, including urban Indigenous people, from receiving equitable healthcare. Jurisdictional wrangling continues to be an ongoing issue for urban Indigenous people.

What should be a point of jurisdictional overlap between governments instead becomes a gap in essential services that many Indigenous peoples fall through. This is particularly true of non-status First Nations, Métis, Inuit, and urban Indigenous people who need additional support to navigate whether they are eligible for federal support for their healthcare needs, if so, how to access, and if not, whether they are available through provincial services.

2.2 JORDAN’S PRINCIPLE AND ISSUES OF JURISDICTIONAL WRANGLING IN INDIGENOUS SERVICE DELIVERY

The death of Jordan River Anderson (Lavallee, 2005; ISC, 2020b) is a tragic reminder that jurisdictional wrangling has a real effect on the lives of Indigenous people.

Jordan River Anderson was a First Nations child born with a rare neuromuscular disorder requiring hospitalization (Lavallee, 2005; Sinha et al., 2021). Jordan and his family resided on-reserve in their home community of Norway House Cree Nation. In order to receive the proper medical care, Jordan’s parents needed to place him into the provincial child welfare system. After two years, Winnipeg doctors recommended Jordan be discharged to a specialized facility near his home community. Both his family and his physicians agreed this would be in Jordan’s best interest. Unfortunately, the Government of Canada and the Government of Manitoba disagreed on who was responsible for the cost of Jordan’s home care. In 2005, Jordan died in the hospital as a result of his illness as the government officials were still negotiating (Lavallee, 2005; Sinha et al., 2021).

Jordan’s story demonstrates the consequences of a healthcare system founded on laws not designed with the realities of Indigenous peoples at the center. The division of powers derived from the *Constitution Act* has manifested insufficient policy, and a constant deflection of responsibility between and sometimes amongst governments.

Following public outcry, Jordan’s Principle was developed by First Nations organizations and advocacy groups and was originally intended to ensure all First Nations children receive equitable access to essential services (First Nations Child and Family Caring Society of Canada, 2014; ISC, 2017). Parliament’s introduction of Jordan’s Principle in 2007 as a directive to federal agencies that no First Nations child should be denied prescribed care over jurisdictional disputes.

Over the past 14 years, criticism of the Government of Canada’s interpretation and implementation of Jordan’s Principle has been substantial. In 2016, the Canadian Human Rights Tribunal ruled the Government of Canada failed in its implementation of Jordan’s Principle (*First Nations Child and Family Caring Society of Canada et al v. Attorney General of Canada (for the Minister of Indian and Northern Affairs Canada)*, 2016). This ruling has been followed by several non-compliance orders and other rulings against the Federal Government regarding Jordan’s Principle.

The Government of Canada’s narrow interpretation of the principle and the eligibility of Indigenous patients has been heavily criticized. Jordan’s Principle specifies its application to “all First Nations children.” However, in 2007 the Federal Government’s implementation focused on cases involving jurisdictional disputes over the care of First Nations children living on reserve, with multiple disabilities, and requiring services from multiple providers—circumstances almost exactly comparable to Jordan’s (Sinha et al., 2021). Recent jurisprudence has worked to broaden the Federal Government’s interpretation and demonstrate funding denial on the grounds of Indigenous geography, nature of illness, registered status, or service needs is incompatible with the principle of providing equitable access to “all.”

Jordan’s Principle also makes no mention of Métis or Inuit children, despite the MMIWG Call for Justice 17.22 specifically demands their inclusion in the policy (MMIWG, 2019). Even after the rulings of the Human Rights Tribunal, ISC’s current standards of eligibility for requests under Jordan’s Principle still requires that: the child or their parents are registered or are eligible under the Indian Act, have been recognized by their nation for the purposes of Jordan’s principle, or, are resident on-reserve (ISC, 2020a)⁵. Despite Jordan’s Principle applying to “all First Nations children” federal policies still clearly consider healthcare access through the lens of status and residence.

5 The term reserve is used for consistency with Indigenous Services Canada’s eligibility criteria for Jordan’s principle.

2.3 THE FEDERAL GOVERNMENT'S ROLE IN INDIGENOUS HEALTH

Canada's policies regarding healthcare for First Nations, Inuit, and Métis people are found in three specific acts of legislation: the *1867 Constitution Act*; the *Indian Act* and its many amendments; and the *1985 Canada Health Act*.

In delineating the division of powers between provincial and federal governments, the *Constitution Act* defined "Indians, and Lands reserved for the Indians" fell within federal jurisdiction (*Constitution Act, 1867*). The *Indian Act* would go on to define "Indian" as "a person who pursuant to this Act is registered as an Indian or is entitled to be registered as an Indian" (*Indian Act, 1876*). In 1939, the Supreme Court of Canada extended the definition of "Indian" to include Inuit.

The *Canada Health Act* (CHA) is the legislation that forms the foundation of Canada's public healthcare system (*Canada Health Act, 1985*). Through the CHA, the Government of Canada leverages its spending power to establish a set of standards for the provision of essential healthcare services across the country.

The CHA does not mention First Nations, Inuit, or Métis people. The CHA only specifies that provinces must deliver any medically-required health services to the *residents* of that province (*Canada Health Act, 1985*).

These three laws already begin to generate jurisdictional conflict. Indigenous peoples are residents of a province and the transfer of funds to provincial governments, for healthcare under the CHA, is based on population, which includes Indigenous peoples. However, the *Constitution Act* defines "Indians" as a federal responsibility, and the Government of Canada has historically maintained a very strict interpretation of its responsibilities to Indigenous peoples based on a literal reading of this legislation which ultimately limits federal responsibility at a human cost.

2.4 FEDERAL FUNDING FOR URBAN INDIGENOUS HEALTH

The First Nations and Inuit Health Branch (FNIHB) is the primary agency responsible for funding and managing health services for First Nations living on reserve and Inuit people living in Inuit Nunangat. FNIHB programs operate within three main areas: primary care, health infrastructure support, and supplementary health benefits (Behrend et al., 2021).

The primary care and health infrastructure support programs are only available to registered First Nations living on reserve and Inuit living in Inuit Nunangat (Halseth & Murdock, 2020). In 2019, over 50% of funding for these programs went to First Nations or Inuit governments or representative organizations directly (Behrend et al., 2021). The majority of the activities within these two streams provide long-term “ongoing” or “core” funding to their recipients. Long-term, stable funding being directed towards discrete First Nations and Inuit governments, or affiliated organizations, allows those communities to provide programming that meets their specific health, wellness, and cultural needs.

In contrast, urban Indigenous people are expected to make use of provincial services, which are not required to abide by such culturally-relevant considerations. Indigenous organizations, such as Friendship Centres, address an urgent need by providing appropriate and Indigenous-led health navigation and services regardless of Indigenous identity or registered status. Although many of these organizations do receive some funding from federal or provincial governments, it is generally attached to specific projects or calls for proposals and is rarely long-term or stable (Urban Aboriginal Task Force, 2007; Urban Aboriginal Knowledge Network, 2012; Collier. B., 2020).

The COVID-19 pandemic provides a tangible example of the disparity in approach between Indigenous peoples who were living in urban and on reserve or in the North in the government’s funding priorities. In March 2020, the Government of Canada announced \$305 million to provide immediate support to First Nation, Métis, and Inuit communities during the crisis (ISC, 2020c). \$290 million was allocated directly to First Nations, Métis and Inuit groups, whereas \$15 million (5%) was allotted for urban Indigenous people who comprise 77%⁶ of the Indigenous population in Canada. Urban Indigenous organizations received proposal-based funding through multiple rounds over the course of months, whereas Indigenous governments received funds based on population, remoteness, and community. In general, the charitable and not for profit sector was left out of many federal government financial announcements. Instead, financial supports rolled out largely to businesses. Friendship Centres and other urban Indigenous organizations were feeling pressed to provide supports for the vulnerable populations that they served, but not initially being able

6 Author’s calculations based upon 2016 census data (Statistics Canada, 2017a)

to secure financial supports either through Indigenous or charitable/not for profit avenues either. Ultimately, Friendship Centres were able to receive funding to cover flexible COVID-19 response funding and funding to assist with vaccination efforts, but we largely attribute this to great efforts on the part of NAFC to advocate for both the need and utility of the funding.

Preparing an appropriate response to a call for proposals/requests requires significant time and effort from Urban Indigenous organizations. This diverts staff from their program delivery and advocacy work, which is a considerable cost for organizations that already work tirelessly to meet the needs of many with the few resources they have at their disposal (*Evidence - HESA (43-1) - No. 14 - House of Commons of Canada, 2020*).

“Current data shows that Indigenous people will continue to move to urban centres and the numbers will continue to increase in urban centres. Systems, programs, pandemic planning and public policy are still crafted from a perspective that does not appropriately reflect where Indigenous people live.”

— *Christopher Sheppard, President of NAFC*

Of the three program areas that the FNIHB operates, the Non-Insured Health Benefits (NIHB) program is the only one that provides funding and support for registered First Nations in urban contexts (Halseth & Murdock, 2020; Behrend et al., 2021). NIHB covers non-insurable medical expenses not covered under provincial health service plans. For many First Nations people, who may lack access to private or employer-based insurance plans, the NIHB provides vital support to their health needs.

However, this support is not distributed in a fair and equitable manner as there are many discrepancies that impact healthcare for urban Indigenous people. Many First Nations people who relocate to urban spaces find that certain NIHB-supported services that they were able to access on reserve are no longer covered in their new location (Senese & Wilson, 2013; Snyder et al., 2015; Nelson, 2019).

From the perspective of the federal Indigenous health policy, non-status First Nations and Métis individuals are considered non-Indigenous residents in Canada. Their primary healthcare needs are a provincial responsibility. Any supplementary expenses, not covered by provincial service plans, are to be paid for by private or employer-based insurance, or out of pocket. Given the higher rates of poverty among Indigenous communities, relative to non-Indigenous Canadians, many are unable to meet these costs.

“With the FNIHB, without a treaty card you are just another person accessing healthcare.”

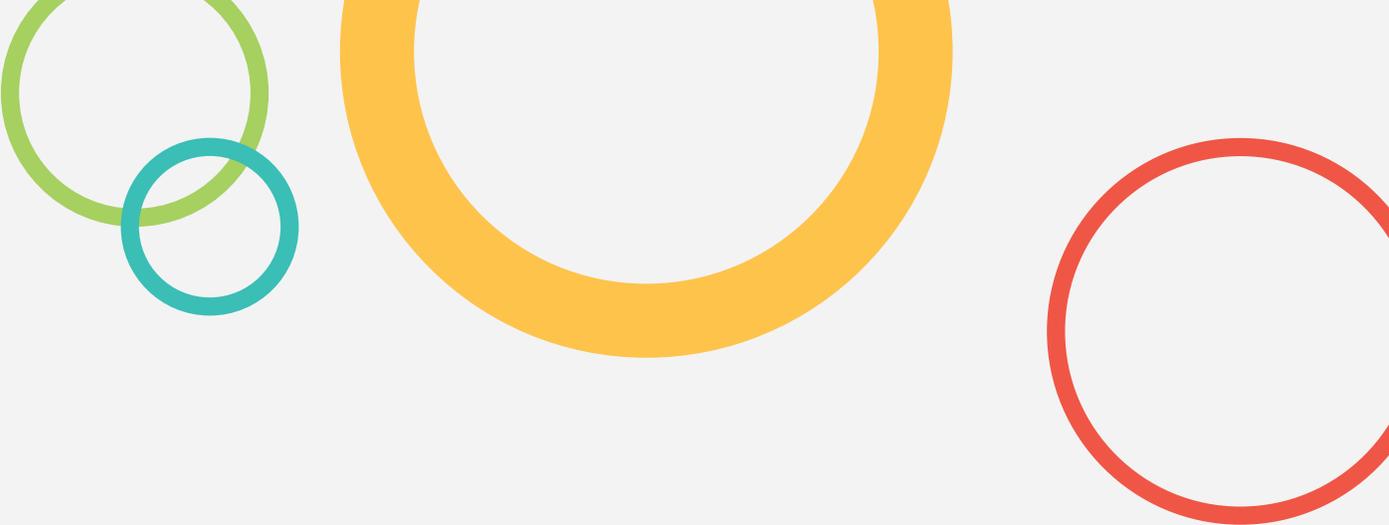
— *Participant in December engagement session*

2.5 CONCLUSION

The history of the government of Canada's involvement in Indigenous healthcare reveals a pattern of restrictive interpretations of responsibility the basis of identity and geography that has nearly solely been determined by the government of Canada without the input of Indigenous people themselves.

In our service experience, a purely distinctions-based approach to healthcare legislation will further widen or create more gaps in healthcare services for urban based First Nations, Inuit, and Métis. Due to the diversity of urban Indigenous populations, which include large numbers of non-status First Nations, urban Inuit and Métis people, as well as individuals with mixed Indigenous identities, these gaps and their consequences will disproportionately impact urban Indigenous people.

What is needed, and in our experience, what works are networks of connected health care systems that: emphasize health outcomes and accessibility for Indigenous individuals, inclusive of their layered identities; are founded on an understanding of intersectional needs; gives care to those who need it, where they need it, and; respects an individual's identity but does not position identity as a requirement for care.



PART THREE

Filling the Gaps in Urban Indigenous Health Access

3 Filling the Gaps in Urban Indigenous Health Access

3.1 INTRODUCTION

Our review of academic and policy literature confirmed our experience that urban Indigenous people face systemic challenges in accessing high-quality, culturally relevant healthcare services. Many of these obstacles were also described by participants in our roundtable discussions who provided additional insights from their lived experiences as urban Indigenous people as well as working with urban Indigenous people across Canada.

In our analysis, we combined the insights from the engagement sessions with corresponding data from our literature review. Two key themes emerged from our analysis that illustrate how the combined effects of **systemic racism** and service gaps stemming from **federal policy** limit the ability for urban Indigenous people to access suitable care.

This section describes this system in more detail combining insights from roundtable participants with supporting contexts gathered through our literature review.

3.2 POLICY AND SERVICE GAPS CREATE BARRIERS TO HEALTHCARE FOR URBAN INDIGENOUS PEOPLE

As noted in Section 2, the majority of the Government of Canada’s support for Indigenous healthcare has been limited to registered First Nations on reserve and Inuit living in the North, and many of these services are not available or accessible to people living in urban spaces through either their respective Nations or their Province of residence.

The impacts that this policy approach has on urban Indigenous access to healthcare services was emphatically stated by participants in both engagement sessions.

“The reality for off-reserve is we are the most discriminated and disadvantaged people - no access to services from our communities/bands and on top of that we face the systemic racism that is inherent in the public health system”

— November roundtable participant

3.2.1 HIGH COSTS OF HEALTH CARE SERVICES NEGATIVELY AFFECTS URBAN INDIGENOUS PEOPLE

In Canada, a person’s ability to access healthcare services and the quality of those services depends upon their ability to pay for the care needed and the policies that governments and service providers employ to make health services more affordable.

In Canada, public health insurance is the main policy mechanism to ensure that healthcare is affordable for the majority of residents. In general, these provincially-operated plans cover all medically necessary treatments. However, any supplementary expenses, not covered by provincial service plans, are to be paid for by private or employer-based insurance, or out of pocket.

The ability to pay for medical care, and associated expenses, is one reason why wealth metrics (such as income) are a social determinant of health. Indigenous people have experienced generations of economic and social exclusion through colonialism and racism. Therefore, there is an established wealth and employment gap (relative to non-Indigenous Canadians) which means that many Indigenous people can struggle to afford non-insured health expenses.

	First Nations (on-reserve ⁷)	First Nations (off-reserve)	Metis	Inuit ⁸	Non-Indigenous
Median Total Income (\$)	16,907	25,134	31,916	27,665	34,604
Employment rate	36.3%	52.0%	60.3%	52.5%	60.5%

Table 1.1: 2016 census data showing socio-economic factors often recognized as determinants of health (Statistics Canada, 2017c, 2018)

7 The term off-reserve is used here to be consistent with vocabulary used in the Canadian census

8 Values shown for individuals outside of Inuit Nunangat who singly identify as Inuit.

To address the issue of affordability in light of this socio-economic inequity, the federal government provides the Non-Insured Health Benefits NIHB program to cover medical expenses that are not insured under provincial health plans. However, this support is only available for status First Nations and eligible Inuit individuals. Métis and non-status First Nations are not supported by this program. Additionally, many health expenses that are funded by NIHB on reserve or in the North are no longer covered for urban First Nations (Senese & Wilson, 2013; Snyder et al., 2015; Nelson, 2019).

From the perspective of the federal Indigenous health policy, non-status First Nations and Métis individuals are considered equivalent to non-Indigenous residents in Canada i.e. their primary healthcare needs are a provincial responsibility.

“With the FNIHB, without a treaty card you are just another person accessing healthcare”
— *Participant in December engagement session.*

Participants noted the differences in available support for medical expenses between Indigenous people available in communities that are not available for urban Indigenous people.

“Canada funds Band Councils to provide a suite of enriched services including: maternal health, infant health, preschool health, school health, senior health, mental health; vaccination; birth planning; health education and nutrition; alcoholism, smoking and drug addiction prevention; infectious disease control and other general clinic services, including the control of cardiovascular disease, hypertension and diabetes; and nursing care and personal home care.”
— *December roundtable participant*

3.2.2 AVAILABILITY OF A HEALTH SERVICE DOES NOT ALWAYS TRANSLATE TO ACCESSIBILITY

For those who can meet the financial costs of health services, many urban Indigenous people experience challenges due to a lack of *appropriate or accessible* healthcare facilities, staff, and support.

Remarks from participants of both engagement sessions referred to services that may have been technically available to urban Indigenous people but, in reality, were inaccessible due to a number of factors such as: insufficient staff numbers, clinics that were not available 24/7, or services that were not addressed in a comprehensive wraparound manner. Specific examples of areas where participants felt services for urban Indigenous people were lacking included:

- + Mental health
- + Diabetes care
- + Elder care
- + Maternity support (e.g. Indigenous doulas)
- + Child care support
- + Difficulty in providing safe supports for two-spirit people (especially in rural or remote areas)

We have consistently stated that the availability of healthcare services does not always mean the ability for Indigenous people to access those services. Lack of affordable and realistic transportation options within urban settings is a very real barrier for urban Indigenous people. For example, if a person sees a medical professional who recommends testing at a special facility, sometimes the facility may be 1-2 hours on public transit or have no access via public transit requiring private transportation. If that person has a job that will not allow time off to go, the person has small children, or a disability, it may mean that they may opt to not get that test if it means that the ability to get to the facility is too difficult. The NIHB program provides some support for transportation expenses for status First Nations living on reserve, sometimes to travel great distances at great cost, but for a person to be able to even travel within the city in which they live is not available. Transportation support is not available for urban Indigenous people (Health Canada, 2017) including those living in rural areas who face significant transportation challenges.

“Transportation [needs to be] available to go to hospitals - [people] off reserve use local transport systems or a taxi. If you are on reserve you have transport and access to a home to support your stay while your services are delivered (back and forth everyday). Not the same for off reserve members we do not have transportation support.”

— *December session participant.*

3.2.3 NAVIGATING HEALTH CARE SERVICES FOR URBAN INDIGENOUS PEOPLE IS COMPLEX

“Wellness includes understanding where to go and who can provide support through the system”

— *Participant in the December session*

The complexity of healthcare for First Nations, Inuit, and Métis people is a recognized challenge (J. Lavoie, 2011; J. G. Lavoie, 2018). Factors such as government jurisdictions, inconsistent health insurance plans, geography, and language barriers contribute to a labyrinth of policies, processes, and practices that must be navigated in order to access care.

Jordan’s Principle is an example of such complexity, which presents an additional barrier to accessing services. At present, Jordan’s Principle is so complicated that some Friendship Centres are able to employ “Jordan’s Principle workers” to assist families in navigating the messy jurisdictional landscape to access care for their children but this is not a staple at all Friendship Centres as the ability to employ Jordan’s Principle workers is dependent on available funding. (NAFC, 2020b)

Participants working with urban Indigenous people described the need for greater support in understanding the services available in their communities and further help in accessing these services. Fully supported Jordan’s Principle workers and health navigators in every Friendship Centre across the country would be a good start in providing support for urban Indigenous communities.

“There is uncertainty of where to go/who to call. Often there are gaps in communication.”

— *Participant in the December session*

3.2.4 RACISM LEADS TO UNACCEPTABLE AND INAPPROPRIATE CARE FOR URBAN INDIGENOUS PEOPLE

Indigenous people’s experiences of racism within healthcare spaces and the effects of intergenerational trauma combine to create a deep sense of fear and mistrust of the healthcare system within Indigenous communities. This can lead Indigenous people to deem that available services are “unacceptable” and avoid or delay seeking healthcare, even if they acknowledge their need for care, which may lead to delays in diagnosis or treatment.

The B.C. Government's extensive study of systemic racism in provincial healthcare (Turpel-Lafond, 2020) described three key patterns that emerged which are consistent with themes in other research and those in the roundtable discussions, which we describe below.

Stereotypes: Indigenous people are frequently exposed to negative stereotypes and attitudes regarding Indigenous people from staff in the healthcare system. Common biases included the perceptions that Indigenous people were:

- + Drinkers or alcoholics;
- + Addicts seeking drugs;
- + Incapable or unwilling to take responsibility for their health;
- + Bad parents; and/or
- + Overly-advantaged and received things "for free".

"When an Indigenous person walks into a hospital, they are not taken seriously. [Assumed to be] just looking for drugs."

— *Participant from December roundtable*

Inequitable care: First Nations, Inuit, and Métis people often describe incidents where they have received poor quality of care, which is often attributed to the fact that they are Indigenous. Examples of this discriminatory treatment include:

- + Inappropriate personal interactions;
- + Long wait times or denial of service;
- + Poor communication or dismissal of concerns;
- + Inferior medical treatment (e.g. medical mistakes or inappropriate pain management); and
- + Lack of respect for cultural needs and/or protocols.

"Such long wait times. Indigenous people are placed last because of the triage nurse"

— *Participant from December roundtable session*

Distrust and avoidance of the healthcare system: Another common theme in the experiences of Indigenous health seekers is distrust of mainstream health services as a response to experiences of racism. This can result in the following behaviours:

- + Feeling they need to “prove” themselves to medical staff;
- + Hiding their Indigeneity;
- + Leaving healthcare services despite advice; or
- + Avoiding healthcare all together.

Experiences of racism have a profound effect on urban Indigenous people’s ability to access healthcare in that it causes people to refuse to seek treatment from mainstream healthcare providers. This avoidance can make the medical condition worse and make any future treatment less effective, thus leading to more negative experiences in the system. For urban Indigenous people, in particular, this vicious cycle may be worsened by socio-environmental factors such as more frequent exposure to racism in their daily lives, as noted in Section 1.3.

Many participants in the engagement sessions spoke of the pervasiveness of racism in healthcare and it’s supplementary services. The roundtable participants spoke of the real need for culturally safe healthcare spaces accessible to urban Indigenous people. Some themes that emerged in the discussion of how to implement culturally safe spaces are noted below.

3.3 RECOMMENDATIONS FOR STRATEGIES AND SOLUTIONS TO ADDRESS POLICY GAPS

It is no surprise that Indigenous people's experiences are significantly influenced by non-medical factors and influence whether they will return or continue to use a health service in the future.

Based on the comments from participants in the engagement sessions and the research conducted in this report, we have identified gaps, but also some important strategies and solutions to consider that will address the lack of meaningful recognition of urban Indigenous communities in healthcare policy.

In 2021, the NAFC commissioned a study on research on urban Indigenous people and health care. This study revealed many facilitators of accessing health services for Indigenous people, which included:

- + Traditional healing is highly valued
- + Indigenous led and run health services improves connection and trust
- + Access to culture, opportunity to practice culture and to use culture as health treatment is highly valued by urban Indigenous people
- + Need for culturally safe care is important to facilitate access to health care for urban Indigenous people

Friendship Centres provide many essential services and programs to support urban Indigenous communities in their health and wellness needs, however they are often limited by a lack of recognition and stable and predictable funds to provide health care services and supportive services.

“It is required that Friendship Centres be recognized as Health Services Providers, same as Band Councils, with appropriate funding dollars tied to the services we are giving to our people in urban areas”

— *December session participant*

As this participant suggests, the most effective strategy to end policy biases that discriminate against urban Indigenous people is to recognize community-driven organizations, such as Friendship Centres, as legitimate service providers for urban Indigenous people. On-going funding for the delivery of services and programs to community-driven organizations will increase the availability and affordability of urban based culturally-appropriate care.

One participant discussed an example where integration with traditional Indigenous healing practices helped ease the burden on a limited number of health professionals and increased the availability of culturally appropriate care.

“Over 100 suicides in the region but only 1 mental healthcare worker in the community, working nine to five. One way we’ve worked around this is to have an Elders support group to offer their services.”

— *December session participant*

Friendship Centres are already filling the gap in transportation needs for Indigenous people. However, as with many of their programs, stable funding is a concern.

“COVID funding from a provincial level in Alberta - increase of funds has allowed a few centres to purchase vans, but if you need to drive someone 5 hrs for an appointment there are additional expenses. Need to ensure there is sustainable funding beyond just one year so they have long-term certainty.”

— *December session participant*

Of course, instead of bringing health seekers to the services, the services can be taken out to those in need using mobile clinics or by making use of telehealth appointments.

“Mobile screening clinics came out of partnerships with Alberta Health Services. Would have been the last people they’d expect to help with culturally appropriate services, but being able to use Friendship Centres as service hubs, with an Elder there and a sharing circle, has been a big help. Particularly applicable to cancer screening.”

— *December session participant*

“[Friendship Centre] staff will help people with travel for healthcare, particularly since the Greyhound bus system no longer functions. Especially the cancer types of travel, need more options as a patient for Telehealth so they don’t have to travel for a 5 minute visit after travelling for hours.”

— *December session participant*

Friendship Centres are often called upon to help their clients understand the healthcare service options that are available to them and support them with making and travelling to those appointments. However, in Quebec and Newfoundland and Labrador, these support services are expanded upon and given more formal recognition as healthcare **Navigators** (NAFC, 2021). Navigators support Indigenous health seekers by acting as guides, translators, supporters, and advocates on their behalf. The role is especially important for people who may live alone or distant from their relatives or community, or for First Nations and Inuit people from remote communities who travel to urban environments to access health services.

“[There is a] hospital in QC that does a project of integration they call it Navigator post. It requires a lot of work and we don’t have the resources we always have to ask and ask and beg. We [the Friendship Centre] have trained personnel but need money to pay people”

— November session participant

3.3.1 INDIGENOUS-LED HEALTH SPACES

“Indigenous people feel like an afterthought. We need to direct our own health.”

— November session participant

There were many comments directed at ensuring greater leadership over issues that concerned Indigenous health. The most common theme regarded the need for health services to be delivered in Indigenous spaces, instead of mainstream spaces such as hospitals which may be associated with experiences of personal and intergenerational trauma.

“The local youth group has a mental health worker who comes in once a week. [They] provide support for youth and availability - different from a person in a hospital”

—December session participant

3.3.2 INTEGRATION OF INDIGENOUS PEOPLE AND WORLDVIEWS IN HEALTHCARE

Where health services cannot be delivered in Indigenous spaces, participants suggested greater integration of Indigenous perspectives into service delivery. This included greater recruitment of Indigenous staff in hospitals, not only in medical roles but also providing roles for Indigenous health navigators and Elders.

A particular area of concern was the perception that mainstream health practitioners did not recognize the contribution that the presence of family and community members to the Indigenous healing process.

“We need patient and family centered care, connected/community/kin care; having them [family and community connections] involved in the healthcare process and support people through it.”

— *December session participant*

“The Acute care setting is where people pass away. Western perspectives don’t allow for smudging or families or groups to be with the person as they pass”

— *December session participant*

Although community needs for Indigenous healing services such as medicine bundles (which are not available in mainstream hospitals) were mentioned, most participants advocated for an integrated approach that combines Indigenous and biomedical knowledge.

“A consortium of medical professionals and knowledge holders. This can develop a culturally grounded healthcare apparatus for Indigenous people”

— *November session participant*

3.3.3 CULTURAL AWARENESS AND EDUCATION

Participants noted the importance of education in bringing significant change to the healthcare system. Some participants associated manifestations of racism with healthcare providers’ lack of knowledge or understanding of Indigenous customs, or an underestimation of the scale of cultural differences.

“[There is a] huge lack of understanding by the people working in healthcare that Indigenous culture is a separate culture, and is different for every area. They seem to believe that Indigenous people don’t have a different set of values and worldview. The health community needs to educate themselves that it’s a distinct set of cultures.”

— *December session participant*

Healthcare is not a simple transaction between provider and client, it is a series of experiences and relationships. Friendship Centres’ focus on wraparound services that cover the entire patient experience. They ensure safe access to supplementary services, such as transportation to and from healthcare spaces. Efforts in cultural and anti-racist training for healthcare staff is dampened if an Indigenous person experiences racism in a taxi or bus trip to the hospital. As such, support for extending the concept of “safe spaces” to supplementary services like transportation, is worth serious consideration.

“Ancillary services are experiencing systemic racism issues, such as taxi rides. It’s not just a medical issue, it’s the whole experience.”

— *Participant in the November session*

3.3.4 FRIENDSHIP CENTRE-LED EXISTING STRATEGIES AND APPROACHES HELP INCREASE ACCESS TO HEALTH CARE FOR INDIGENOUS PEOPLE IN URBAN SETTINGS

Regarding current strategies to promote safe spaces in healthcare, several people commented on the role of Friendship Centres as service providers delivering services within the centre or via mobile clinics.

“To address lack of culturally safe programs we are working with the province, along with other agents, to work with doctors to provide services through Friendship Centres (along with Elders) offering in-house services to compliment the Centre’s wraparound services”

— *December session participant*

An example of this integrated model is the Minowé Clinic operating through the Friendship Centre in Val-d’Or, Quebec (NAFC, 2021; Val-d’Or Native Friendship Centre, 2014). The clinic provides culturally appropriate services,, while integrating these services with the Friendship Centre’s other programs and support services. Participants also noted the importance of having such Friendship Centres recognized as healthcare service providers, with stable funding on par with band-operated clinics.

The SafeSpace Network program was built as an effective solution to allow urban Indigenous people to report incidents of racism and has been piloted in British Columbia in partnership with Friendship Centres in British Columbia (NAFC, 2021; *Safespace Networks – BCAAFC*, 2021). The program includes an app that allows people to anonymously report their experiences of racism to a system that sits outside of the government or health authority, which holds them accountable. This technology places the power to report discrimination directly into the hands of patients, which is especially important for non-status First Nations and Métis who lack the advocacy of a band government in seeking a just resolution. The NAFC is exploring the opportunity to expand this work nationally.

3.4 CONCLUSION

“FCs are workarounds unto themselves - especially if they have medical programs and services.”

— *December session participant*

Urban Indigenous communities will continue to grow. Any legislation developed with respect to Indigenous peoples must ensure that the realities of Indigenous people are centered in the development and implementation of such legislation. At the very least, legislation should not increase gaps in service and make access to culturally relevant and safe health care *more* difficult.

The role of Friendship Centres in supporting the physical, social, mental, and emotional health of urban First Nations, Inuit, and Métis cannot be overstated. Friendship Centres provide key health services, both direct care/treatment and support services, for people whose needs would otherwise go unmet. They fill an important service delivery gap that currently exists for urban Indigenous people.

Friendship Centres achieve this by leveraging the support of the communities that they serve and by innovative “workarounds” and strategies that make the best use of what funding they do have. However, as one participant pointed out; Friendship Centres are workarounds. Because, whether they acknowledge it or not, federal and provincial governments are relying on Friendship Centres to provide care to those who slip through the cracks in distinctions-based policy.

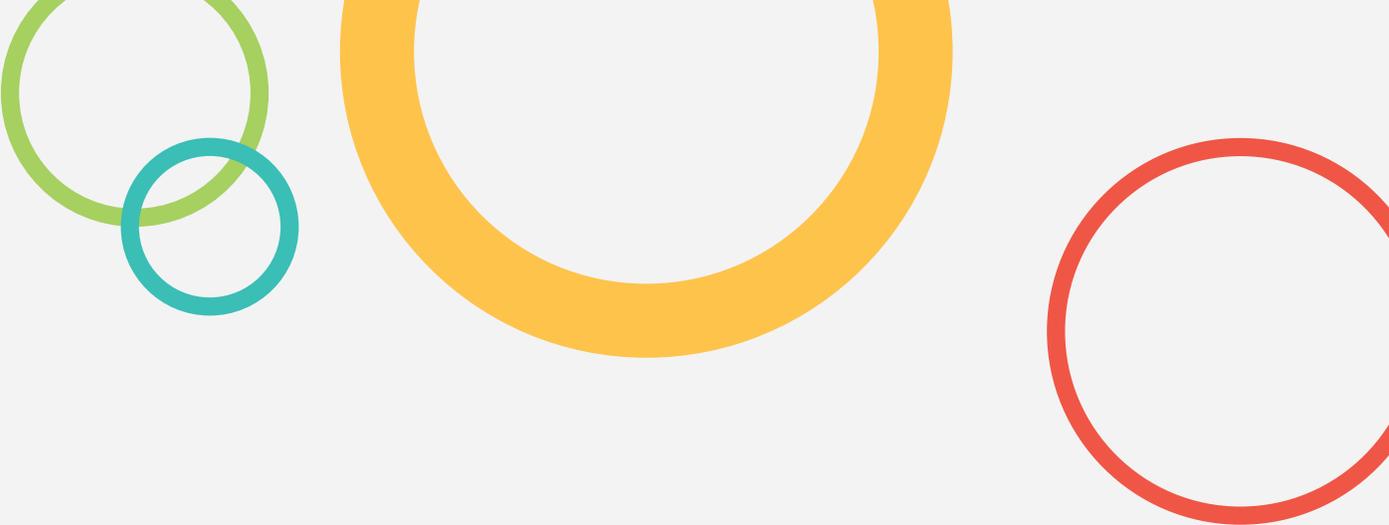
As the Government of Canada considers new legislation (ISC, 2021a) to address service gaps and racism in healthcare, there is an opportunity for a different tactic.

What if, instead of being a workaround, Friendship Centres were **acknowledged as full partners and leaders in healthcare delivery** in their communities?

We submit that engaging Friendship Centres, urban Indigenous health service providers, and other urban Indigenous organizations upfront as full-service delivery partners will reduce gaps in healthcare policy and prevent the need for “work around” solutions.

What if, instead of solely placing urban Indigenous people within a distinctions-based approach, governments **worked with the Friendship Centres to develop intersectional healthcare policies and services** that were focused on delivering better outcomes for Indigenous individuals and communities?

We submit that being direct and intently including relevant stakeholders, such as Friendship Centres, upfront when developing inclusive and intersectional healthcare policies that consider and are responsive to the diverse needs of Indigenous individuals and their communities, regardless of residency.



PART FOUR

Final Considerations

4 Final Considerations

“Intersectionality recognizes that a person’s experience will be different than another’s based on their particular interplay of race, ethnicity, Indigeneity, gender, class, sexuality, geography, age, and ability, as well as how these intersections encourage systems of oppression and, ultimately, target Indigenous women, girls, and 2SLGBTQQIA people”.

— *National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG, 2019)*

The Government of Canada has committed to a “distinction-based approach” to co-developing Indigenous health legislation. They also explicitly state that their approach is “guided by the Truth and Reconciliation Commission’s Calls to Action [TRC], the United Nations Declaration on the Rights of Indigenous peoples [UNDRIP], [and the] Calls for Justice in the final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls [MMIWG].”

However, TRC Call to Action 20 calls for governments to recognize the “distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples” (TRC, 2015).. In addition, Article 24.1 of UNDRIP calls upon states to ensure Indigenous individuals have equal access rights to the “enjoyment of the highest attainable standard of physical and mental health” (United Nations [General Assembly], 2007). The federal government’s past interpretation of the distinct rights afforded to First Nations, Inuit, and Métis makes access to some healthcare services dependent upon residence, which we believe impacts urban Indigenous people’s right of equal access to high standards of health. Future distinctions-based policies, that place an individual’s residence or affiliation with an Indigenous government above their healthcare needs, is contrary to the guiding principles represented by UNDRIP and the TRC and will exacerbate jurisdictional conditions that impact Indigenous health.

The MMIWG Inquiry advocated for an intersectional approach to developing policies that effects First Nations, Inuit, and Métis people in Canada (MMIWG, 2019). An intersectional approach requires an understanding of how the context and environment of where Indigenous people live is just as important as addressing the distinct circumstances and interests of First Nations, Inuit, and Métis people. This is especially true with regards to tackling racism. Racism is an unfortunately common experience for Indigenous people, and frequent and pervasive racism is a facet of everyday life for urban Indigenous people. The effects of racism on their health and their relationship to the healthcare system must be addressed in any attempt to decolonize the healthcare system.

The Government of Canada describes its co-development of distinction-based health legislation (ISC, 2021a) as an opportunity to:

- + establish overarching principles as the foundation of federal health services for Indigenous peoples;
- + support the transformation of health service delivery through collaboration with Indigenous organizations in the development, provision and improvement of services to increase Indigenous-led health service delivery; and
- + continue to advance the Government of Canada’s commitment to reconciliation and a renewed nation-to-nation, Inuit-Crown and government-to-government relationship with Indigenous peoples based on the recognition of rights, respect, cooperation and partnership.

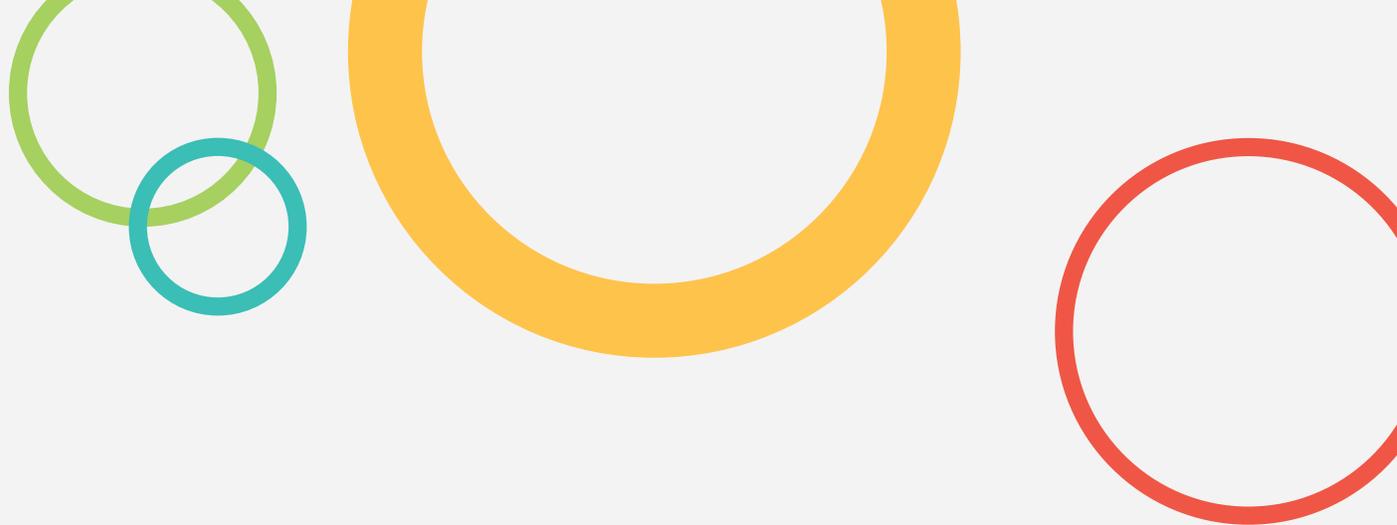
As over half of the Indigenous population in Canada live in urban areas, any effective principles for guiding federal health services must reflect this fact and consider the lived experiences of these people. From synthesizing the insights from those working to provide frontline services to urban Indigenous people, we propose that one example of an **overarching principle** to guide federal health services should be:

“Access to health services that are culturally relevant on a non-discrimination, status-inclusive basis whether, on reserve or off reserve and regardless of race, Indigenous identity or gender identity”

As an example of service delivery without discrimination on the basis of Indigenous identity is the National Association of Friendship Centres and their members who have over a half century and decades of experience providing services to Indigenous people. Their approach is intersectional by design and respects the needs and cultures of First Nations, Inuit, and Métis health seekers, without being limited by these distinctions.

Friendship Centres deliver holistic services to urban Indigenous people by developing strong, collaborative relationships within their communities and across the country. The NAFC are leaders in building partnerships with Indigenous, non-Indigenous, and governmental organizations.

Although urban areas of Canada have some of the best medical and allied health care services in the world, Indigenous people living in urban areas are experiencing barriers in accessing these services. Health legislation that affects the lives and rights of Indigenous peoples must include consideration of and include Indigenous people who live in urban settings.



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**National Association
of Friendship Centres**

**Association nationale
des centres d'amitié**

January 2022

275 MacLaren Street
Ottawa, Ontario K2P 0L9
(613) 563-4844

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