

Indigenous Health Equity as a Priority in British Columbia's Public Health System:  
A Pilot Case Study

by

Alexandra Kent

Bachelor of Arts, University of Victoria, 2014

Graduate Certificate in Learning and Teaching in Higher Education, University of Victoria, 2016

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Requirements for the Degree of

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**Supervisory Committee**

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## Abstract

For her MPH thesis research, Alex Kent conducted secondary analysis of data from the Equity Lens in Public Health (ELPH) research program to explore whether and how Indigenous health equity is prioritized within one regional health authority [HA100] in British Columbia's public health system. Her thesis addresses the question: How has Indigenous health equity been identified and prioritized within HA100 as reflected in core documents and plans as well as interviews with key decision makers in the health authority? Using the Xpexy' Relational Environments Framework, a theoretical framework designed by Drs. Charlotte Loppie and Jeannine Carriere, Alex identifies and discusses the physical and theoretical settings where Indigenous health equity is and is not manifested in the public health system. Her findings highlight a number of examples of how HA100 has implemented successful strategies aimed at enhancing Indigenous health equity as well as several areas for improvement across the relational environments. Alex concludes that improving Indigenous health equity through human, non-human and symbolic interactions in institution, system and community settings appears to be a current priority for HA100; whereas reconciling historical relationships and creating equitable social, cultural and political conditions that promote optimal health and wellbeing for Indigenous peoples is positioned as a long-term and indirect goal.

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## Dedication

My thesis would not be possible without the support and contributions of:

- ❖ My thesis supervisors, Dr. Charlotte Loppie and Dr. Bernie Pauly, who are my mentors and role models;
- ❖ The Equity Lens in Public Health (ELPH) team, especially the principal investigators, who conceived the original study;
- ❖ The Canadian Institutes of Health Research (CIHR), the Centre for Indigenous Research and Community-Led Engagement (CIRCLE), ELPH and the School of Public Health and Social Policy (PHSP), who generously funded my research and my education;
- ❖ PHSP faculty, who have shared their wisdom and accommodated my thesis route; and finally,
- ❖ My partner, my family and my loved ones for their love and encouragement along the journey.

## Introduction

My thesis research builds off of my work with Equity Lens in Public Health (ELPH) research program, which studies the application of an equity lens in public health programs in British Columbia's (BC) health authorities. ELPH has identified several areas where inequities are present in BC, where the public health system has the ability— and the moral imperative— to act; these include but are not limited to mental health promotion, prevention of mental illness, prevention of harms of substance use, and Indigenous peoples' health. For my thesis, I conducted secondary analysis of ELPH data to look specifically at health equity priorities and strategies that are relevant to Indigenous peoples including First Nations, Inuit and Métis peoples in Canada. Using a theoretical framework designed by Drs. Charlotte Loppie and Jeannine Carriere (Kent, Loppie, Carriere, MacDonald, Pauly, 2017), I conceptualized and mapped the physical and relational settings where health equity is manifested in the public health system to explore whether and how health authorities and key decision makers prioritize Indigenous health equity. In order to fully capture the critical importance of contextual influences at the regional level, my thesis focuses on one health authority as a case study, which complements the case study design implemented by ELPH. To uphold ethics, the health authority used for this case study will not be identified, so it is referred to as HA100 in place of any identifiers throughout my thesis.

Before presenting my thesis research, I will start by locating myself and the ELPH research team in relation to my research question and objectives. Next, I will provide context for my research through a background section on Indigenous health equity and BC's public health system, followed by an overview of the Indigenous health policy framework in Canada and an assessment of the existing literature on the topic. These sections will set the stage for me to introduce my thesis research by presenting my research paradigm, methodology, methods, and

ethics. I will then proceed with an in-depth discussion of my findings from stakeholder engagement and data analysis, which will lead into the discussion chapter and conclusion.

### Locating Myself

I locate myself in this research as a fifth-generation Canadian settler of British and Dutch ancestry. Though I do not care to label myself as such, I am positioned in society as a white, Western-educated, English-speaking, able-bodied, middle-class, heterosexual woman. I acknowledge that by embodying this intersectional identity, I am privileged as a member of several dominant groups. Furthermore, as a settler living on the unceded territories of Songhees, Esquimalt and W̱SÁNEĆ peoples, I am implicated in Canada's history of colonialism as a beneficiary of the dispossession and subjugation of Indigenous peoples. I am approaching this research with humility and the understanding that I do not represent Indigenous peoples or their knowledge, worldviews or cultural lenses. I hope to contribute to the decolonization agenda as a non-Indigenous ally through critical engagement with public health research. I have had the privilege of working as a Research Fellow and Research Assistant with Equity Lens in Public Health (ELPH) research program and the Centre for Indigenous Research and Community-Led Engagement (CIRCLE), previously Centre for Aboriginal Health Research (CAHR), that partnered to add an Indigenous focus and Indigenous knowledge to the ELPH project. Working with both ELPH and CIRCLE has given me a unique perspective that integrates Western academia with Indigenous ways of knowing, in keeping with the Two-Eyed Seeing approach (Iwama, Marshall, Marshall, & Bartlette, 2009). It is from this position and with critical awareness of my location that I approach my thesis research.

### **Equity Lens in Public Health (ELPH) Research Program**

In addition to locating myself, I also locate my thesis research within the context of a larger initiative. As I am conducting secondary analysis, the ELPH research program influenced, in part, the topic and methodology described in this proposal. ELPH is a five-year program of research funded by CIHR in 2011 that grew out of the Core Public Health Functions Research Initiative (CPHFRI), which was initiated in 2005. Both CPHFRI and ELPH are specific to BC's public health system and operate in close partnership with BC's five regional health authorities, the Ministry of Health, and the Provincial Health Services Authority (PHSA), among other partners. These partnerships were solidified prior to ELPH's inception in 2011, before FNHA was formally introduced to BC's public health system and at a time when Indigenous departments had less presence within health authorities. ELPH research leads met with FNHA representatives once it was established to invite them to be a partner. Yet, the research was already in process at the time, so ELPH leads respected FNHA's decision not to partner and agreed to share updates and findings throughout the research process.

The ELPH project is dedicated to the development and application of an equity lens in public health and the implications for reducing health inequities (Pauly, MacDonald, Hancock, Martin, & Perkin, 2013). The overall purpose of ELPH is to:

... study, explore, and foster learning about the use of an equity lens during a period of complex system change in public health. An equity lens is a way of approaching public health policy that recognizes that someone's social circumstances influence their health, and that public health systems should work to lessen the negative effects of social position on health (University of Victoria, 2016).

The ELPH program of research has a particular focus on mental health promotion, prevention of mental illness and prevention of harms resulting from substance use, including harm reduction. It is organized into four distinct but interrelated studies: Study 1 “Assessing Health Equity Priorities and Strategies;” Study 2 “Intersectoral Collaboration for Health Inequities Reduction;” Study 3 “Assessing the Theoretical Relevance and Practical Utility of Health Equity Tools;” and Study 4 “Power and Ethics in Public Health” (University of Victoria, 2016).

My thesis is situated as a case study within ELPH Study 1: Health Equity Priorities and Strategies, the intent of which is to conduct individual case studies among BC’s five regional health authorities to determine: current activity on health equity and inequity reduction; whether and how health equity issues have been prioritized; the contextual influences on priorities and health equity plans/strategies; as well as how and what explains these changes over the course of the study. Each health authority is treated as an individual case to capture contextual influences at the regional level and facilitate comparison across cases. The case study design also enables comparative analysis across time for assessment of changes in the uptake and implementation of health equity as a priority.

For Study 1, the ELPH team collected baseline data in 2012/ 2013 and follow-up data in 2015/ 2016. Data included core documents that outline health authorities’ goals, visions, mandates and strategic directions, as well as interviews with senior executives and focus groups with frontline staff and managers from all regional health authorities, the Provincial Health Services Authority (PHSA), and the Ministry of Health. ELPH Study 1 employs situational analysis, which is an approach to research using post-modern grounded theorizing methodology to identify and describe social worlds and arenas of action to understand the human and non-human elements, interactions and context within a specified situation (Clarke, 2005). Consistent

with Clarke's methodology, ELPH used situational analysis to analyze the data and to facilitate analysis of multiple connections and relationships that can influence activities. Ordered, relational, social world, and positional maps are visual representations for understanding the phenomena of interest and the complexity inherent in a situation. As an outcome of the ELPH study, ELPH produced case reports for each regional health authority and an overall provincial level analysis that summarizes findings related to application and implementation of health equity across health authorities (Pauly, MacDonald, Hancock, Martin, & Perkin, 2013). This analysis is reported elsewhere.

In the original ELPH proposal, health inequities among Indigenous peoples, including First Nations, Inuit and Métis peoples, were highlighted as a concern in BC along with health inequities of other sub-populations. The ELPH team identified the need to pay special attention to health equity for Indigenous peoples in BC, which would require a more culturally relevant analytic framework. Consequently, the Principal Investigators approached Indigenous researchers, Dr. Charlotte Loppie [formerly Reading] and Dr. Jeannine Carriere, who developed the Xpey' Relational Environments framework, which serves as the basis of a parallel analysis that employs an Indigenous lens to explore the role of public health in Indigenous health equity (Kent, Loppie, Carriere, MacDonald, & Pauly, 2017). The ELPH team acknowledges the Haudenosaunee Gusweñta, or Two Row Wampum, as a model for conceptualizing the relationship between ELPH's use of situational analysis methodology and the Xpey' Relational Environments approach.

The Gusweñta, or Two Row Wampum, is a beaded belt that was exchanged as a symbol of diplomacy between Haudenosaunee (Iroquois) Nations and various settler groups throughout history, including representatives of the British Crown at the Treaty of Niagara in 1764

(Borrows, 1997; Parmenter, 2013). The belt depicts a First Nations canoe and a European ship traveling side by side down a river, neither of them trying to steer the other's vessel or intersect the other's path, symbolizing mutual respect and non-interference (Borrows, 1997). Like the *Gusweñta*, the analyses represent parallel processes that share an overarching purpose and common data set. The research recognizes Indigenous and Western approaches as distinctly yet equally significant, and draws together the strengths of both to allow for a 'wider, deeper, and more generative 'field of view' than either of these perspectives might [provide] in permanent isolation' (Iwama, Marshall, Marshall & Bartlette, 2009). Furthermore, the ELPH team has been cautious not to merge the two knowledge systems into one or try to force Indigenous knowledge into a Western paradigm. Using the *Gusweñta* as a model for conceptualizing the relationship between ELPH's situational analysis and the Xpey' Relational Environments analysis helps me position my thesis in relation to the broader ELPH program of research, and offers guiding principles for conducting research in a good way.

### **Research Question**

The focus for my thesis is on the Xpey' Relational Environments analysis that is dedicated to analyzing the public health system's priorities and strategies directly relevant to Indigenous health equity. The specific research question that I sought to answer is: How has Indigenous health equity been identified and prioritized within HA100 as reflected in core documents and plans as well as interviews with key decision makers in the health authority? To answer this question, I have used the Xpey' Relational Environments framework to conduct secondary analysis of a subset of ELPH's data. In consultation with my supervisors, I selected HA100 as a case study and focused on core documents and plans as well as interview transcripts with senior executives from Phase 1 of data collection.

## Background

Although knowledge and awareness are expanding in the areas of health equity and public health systems, relatively little research has bridged the two or further linked them to Indigenous health. In 2010, the Canadian Coalition for Global Health Research partnered with the Centre for Aboriginal Health Research [which is now CIRCLE] on a project titled, “Linking Equity Methods Research and Global Indigenous Health Research.” The project included an environmental scan, tools inventory, and workshop to develop a work plan for forwarding an agenda for collaboration between the two fields of research (Canadian Coalition for Global Health Research & Centre for Aboriginal Health Research, 2010 and Centre for Aboriginal Health Research, 2010). The investigators concluded that, “While advancements in equity methods research have been made in the past decade... more work was needed on research evidence focused on the health of Indigenous populations” (Canadian Coalition for Global Health Research & Centre for Aboriginal Health Research, 2010, p. 2). The following section will briefly outline some of the pertinent background information to set the context for my thesis.

### Definitions

**Health equity.** The standard definition of health inequity used in research circles is “differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust” (Whitehead, 1990, p. 5). On the other hand, the presence of equity can be detected when the most disadvantaged in society have access to the highest attainable standard of health, as measured by the health status of the most advantaged (Sparks, 2010).

**Indigenous peoples.** There is no universally recognized formal definition of ‘Indigenous’ peoples, as each community, nation and collectivity has the right to define and identify itself. Indigenous peoples, communities and nations can be generally understood as those which have

“a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, [and] consider themselves distinct from other sectors of the societies now prevailing on those territories, or parts of them” (Jose R. Martinez Cobo, as cited in CAHR, 2010).

The term ‘Aboriginal’ will be used if and when it appears in a quote or a name. For instance, HA100 uses the term ‘Aboriginal’ rather than Indigenous; this choice of terminology was explained to me by an informant from HA100’s Aboriginal Health Program, as follows:

And I should say just in terms of language, I know increasingly the term “Indigenous” is being used... And we actually took this to our Aboriginal Health Council, you know, for some guidance and so on. And at this point, the Aboriginal Health Council, which is comprised of First Nations, Métis, and non-status people reps from Friendship Centers, the consensus was to continue to use “Aboriginal.” So who knows, that might change in time. But I try and kind of use that term out of respect of what we heard there.

(Participant 1051)

The term ‘Indian’ is also used when quoting historic documents or when referring to the Indian Act’s legal term “Indians.” The federal government distinguishes between registered (or status) and non-registered (or non-status) Indians, defining a registered Indian as a person registered under the terms of the Indian Act (Lavoie, Gervais, Toner, Bergeron, & Thomas, 2011b).

Based on the 2011 National Household Survey (NHS) and the 2012 Aboriginal People’s Survey (APS), Statistics Canada reports that 155,020 First Nations people, 69,470 Métis, and 1,570 Inuit are living in British Columbia, in addition to 3,745 people who report other Indigenous identities and 2,480 people identifying with more than one Indigenous identity. Indigenous peoples are one of the fastest growing populations in Canada: “From 2006 to 2011,

the First Nations population in British Columbia increased by 20%, while the Métis population rose by 17%, and the Inuit population nearly doubled” (Statistics Canada, 2016, para. 3).

### **Indigenous Health Equity**

In BC and elsewhere, Indigenous peoples experience a disproportionate burden of inequities, when compared to the health status of the general population. Many researchers have explored the health status of Indigenous populations in Canada and around the world, and further linked this issue to inequities within determinants of health that extend beyond personal behaviour and genetics to encompass broader socio-political factors that influence health in profound ways (Adelson, 2005; British Columbia Office of the Provincial Health Officer, 2007; Butler-Jones, 2008; Health Officer’s Council of British Columbia, 2008; Reading & Wien, 2009). There is a recent movement in Indigenous health research away from the pathologizing lens that sensationalizes disparities or ‘deficiencies’ experienced within Indigenous communities, and realigns the focus toward the role of structural injustices in shaping social conditions.

I do not intend to reproduce findings from other studies that highlight inequitable health status; rather, the purpose of this research is to examine the role or potential contribution of public health systems and structures in the perpetuation or interruption of these inequities. Health care systems, including the public health system, have a mandate to provide public services that have a primary purpose of promoting, restoring or maintaining the health of the population. Public health has two overarching moral aims: promoting the health of the population and reducing health inequities (Powers & Faden, 2006). The public health system has therefore been identified as an important site for action to promote Indigenous health equity as well as ameliorate health inequities among Indigenous peoples. However, as a colonial system, it also

has the potential to contribute to increased inequities, particularly in relation to presenting barriers to accessing health care for Indigenous clients and patients.

One of the key barriers to health care access and equitable health outcomes for Indigenous peoples is racism (Allan & Smylie, 2015; Browne, 2017; Cameron et al., 2014; Hayman, 2010; Hayman, White & Spurling, 2009; Loppie, Reading & de Leeuw, 2014). Racism is manifested in interpersonal, systemic and structural forms in the public health system. Loppie, Reading and de Leeuw's explanation of how racism contributes to inequitable access and health outcomes elucidates its significance as a determinant of health:

The consequence of racism within health care settings is first and foremost emotional and social harm to Aboriginal peoples. A more long-term and insidious outcome, however, is that Aboriginal people lose trust in a system that claims to care for them. Experiences of harm and lack of trust can translate into [delayed or] diminished utilization of services critical to Aboriginal peoples' health, including screening for infectious or chronic disease as well as access to essential medical treatment or pharmaceutical interventions (2014, p. 8).

The cumulative impacts of racism and malpractice in health care settings, Indian Hospitals and Residential Schools have contributed to individual, collective and intergenerational trauma for Indigenous peoples. Indigenous peoples' experiences of racism in the Canadian health care system are well documented in research and survey data, as demonstrated by Allan and Smylie's (2015) literature review and collection of narratives; beyond this data, the authors note that countless personal accounts of racism go undocumented. Racism is experienced by individuals and families through everyday interactions with service providers that are disrespectful, demeaning, diminishing or disempowering towards the cultural identities of Indigenous peoples

(Brown, 2009, as cited in Loppie, Reading & de Leeuw, 2014). Furthermore, racism in the health care system extends beyond interpersonal interactions at the individual level to include systemic and structural racism that is perpetrated against Indigenous peoples and other racialized groups collectively. For example, when “racist policies intersect with racist stereotypes” (Loppie, Reading & de Leeuw, 2014, p. 8), organizations and institutions shape the encounters between service users and health care providers by reinforcing racist attitudes and behaviours (Browne, 2017). Structural racism is often rooted in historical and political policies, and linked to structural and systemic barriers in the governance framework.

Structural and systemic barriers in the health system include fragmented governance, jurisdictional complexity, gaps in service coverage, and lack of government accountability. These issues have been noted and problematized in landmark reports, including the Final Report of the Truth and Reconciliation Commission of Canada (Truth and Reconciliation Commission of Canada, 2015), the Final Report of the Royal Commission on Aboriginal Peoples (Aboriginal Affairs and Northern Development Canada, 1996) and the Report of the Chief Public Health Officer (Butler-Jones, 2008). Canada’s system of Indigenous health governance has been characterized as a ‘bureaucratic maze’ (Adelson, 2005, p. 5) and ‘a complex patchwork of policies, legislation and relationships’ (Lavoie, Gervais, Toner, Bergeron, & Thomas, 2011b, p. 1). These issues can be traced back to the 1867 British North America (BNA) Act, which stipulates that “Indians and the lands reserved for Indians” are a federal jurisdiction (Section 91(24)) and health care, social services and education, are provincial jurisdictions (Kelly, 2011).

The jurisdictional boundaries outlined by the BNA Act may be clear in theory, but they have proven to be ambiguous and convoluted in practice. The divisions not only exist across tiers of government, but also translate to divisions across ancestry, place of residence and land claim

agreements. These jurisdictional divisions create ambiguity over the provision of health services to Indigenous peoples and produce overlapping responsibilities among governing authorities at the federal and provincial/ territorial levels. Over the years, Indigenous peoples have sought increased control over decisions relating to health policies, programs and services; however, it is unclear whether this has ameliorated or exacerbated jurisdictional complexity (Lavoie, Gervais, Toner, Bergeron, & Thomas, 2011b; First Nations Health Council, 2011; Hirsch, 2011; and Webster, 2009).

### **British Columbia's Public Health System**

The BC Core Public Health Functions Framework (Population Health and Wellness, Ministry of Health Services, 2005) and the subsequent Guiding Framework for Public Health (Ministry of Health, 2013) outline public health core functions, including preventing disease, illness and injury; protecting populations from health risks; and promoting healthy public policies, environments and behaviours (Ministry of Health, 2013). These core functions of public health are the responsibility of the health system at large, non-governmental and private organizations, and civil society; that is, public health functions are not solely carried out by the formal public health system and public health practitioners. In the ELPH program of research, the focus is on the formal public health system in which the aim of policy and practice is health promotion, disease and injury prevention, health protection, and surveillance and assessment, rather than treatment and cure as it is in the larger health care system (Kent, Loppie, Carriere, MacDonald Pauly, 2017).

BC's formal public health system is made up of the Ministry of Health, the Provincial Health Services Authority (PHSA), five regional health authorities (Northern Health, Interior Health, Fraser Health, Vancouver Coastal Health, and Island Health), and the First Nations

Health Authority (Province of British Columbia, 2015). In 2001, the provincial government merged the previous 52 health authorities into five in an attempt to streamline a complicated and expensive health care system (Province of British Columbia, 2015). The regional health authorities are responsible for planning, managing, and delivering health programs and services within their geographic areas (Province of British Columbia, 2015). The Ministry of Health supports and funds the programs and services of all health authorities and provides guidance to ensure a standardized level of quality across geographic regions and populations (Province of British Columbia, 2015). The Provincial Health Services Authority also works with the other health authorities to plan and coordinate provincial programs and specialized health services throughout the province (Province of British Columbia, 2015). These governing authorities work together to provide comprehensive health services to all British Columbians.

HA100 is one of five regional health authorities responsible for planning, managing and delivering health programs and services within their respective geographic areas. HA100 has an Aboriginal Health Program that serves the needs of First Nations, Métis and Inuit populations in their region. The Aboriginal Health Program provides health services, including Aboriginal health clinics; Aboriginal liaison nurses; dietitians, diabetes nurse educators and nurse practitioners; the All Nations Healing Room, a culturally-safe space to perform traditional healing practices and ceremonies within an urban hospital; as well as funding initiatives for community-based projects ([HA100 Web site]). These services are offered to Indigenous patients and clients, supplementing HA100's regular health services, and also complementing the work being done by the First Nations Health Authority (FNHA)— in many cases, these programs or projects are developed in partnership with FNHA.

FNHA is a new health authority in BC that specifically represents and serves First Nations people. It is part of a unique health governance framework among BC First Nations, the Province of BC, and the Government of Canada that is a first of its kind in Canada. A tripartite framework facilitates the transfer of responsibilities for the planning, design, management and delivery of First Nations health programs and services in BC from Health Canada's First Nations and Inuit Health Branch to FNHA. The transfer officially took place on October 1<sup>st</sup>, 2013, but is the product of extensive consultations and negotiations that were formalized in a series of three health agreements: The Transformative Change Accord: First Nations Health Plan (2006), the Tripartite First Nations Health Plan (2007), and the BC Tripartite Framework Agreement on First Nation Health Governance (2011) (Government of Canada, 2011). These three agreements form a legally binding framework that outlines the First Nations health governance structure and mandate, the federal and provincial funding commitments, and the unified vision for an integrated health system (see the following section on the Indigenous Health Policy Framework).

Rather than adding to jurisdictional complexity through separate and parallel First Nations and non-First Nations health systems, the FNHA promotes stronger linkages between FNHA, Health Canada, BC Ministry of Health and BC health authorities (Government of Canada, 2011). Ultimately, the aim is to improve the quality, accessibility, effectiveness, and efficiency of health programs and services for First Nations by reducing complexity and promoting more integrated service delivery. The new framework also increases First Nations' control over health governance, which enhances the acceptability of these services through incorporation of culturally relevant models of wellness. FNHA has a 'community-driven, nation-based' mandate that represents the diversity of BC First Nations peoples and cultures (First Nations Health Council, 2011). However, FNHA's mandate applies exclusively to registered

First Nations peoples, and does not necessarily apply to other Indigenous groups (e.g., Métis, Inuit, non-status) in BC (Lavoie, Gervais, Toner, Bergeron, & Thomas, 2011b). It is anticipated that as time goes on, FNHA will play a greater role in influencing the planning and delivery of services to the wider Indigenous population in BC and potentially the non-Indigenous population as well (Government of Canada, 2011).

The First Nations health governance framework as well as the rest of BC's public health system are important context for the prioritization of Indigenous health equity in HA100. These systems are further embedded in and shaped by a complex multi-jurisdictional policy framework, which is outlined below.

## **Overview of the Indigenous Health Policy Framework**

Given legislation's important role in entrenching public health values and providing direction to leadership, there is potential to promote Indigenous health equity in the public health system by embedding it into policy at all levels of government. This section provides an overview of the historical context and contemporary policy framework that shapes Indigenous health equity in British Columbia. The Indigenous health policy framework also provides context for core public health functions in BC (Ministry of Health, 2013), with an overview of the jurisdictional responsibilities outlined in health legislation. I identified key federal, provincial, and interjurisdictional health legislation and policies that are either specific to, or of relevance to Indigenous peoples, which I then compiled and synthesized into summary tables (see Appendix A for summary tables). The summary tables highlight the policies' relevance to Indigenous health equity by drawing attention to their provisions surrounding health service provision, availability and accessibility; jurisdictional responsibilities and accountabilities; as well as mechanisms to enhance communities' capacity to deliver their own health services.

Lavoie, Gervais, Toner, Bergeron, and Thomas's Policy Synthesis Project (2011a) is an invaluable resource for the analysis of policies and their influence on Indigenous health equity. Their final report provides a comparative inventory of federal, provincial and territorial health policies and legislation between 1970 and 2008 that contain Indigenous health-specific provisions. Using this report as a starting point, I traced primary sources through parliamentary and legislative online libraries, in order to corroborate findings and fill gaps in information and identify any relevant policies that have been enacted since 2011, when the final report was published. For pragmatic reasons, I only included formal policies and legislation at the federal and provincial levels that are publicly available on the Internet. Though I recognize that

“Legislation and policies tell only part of the story...” (Lavoie, Gervais, Toner, Bergeron, & Thomas, 2011a, p. 12), it was not within the scope of this brief overview to include unwritten, unpublished, or informal agreements outside of the formal policy framework, nor could I cover individual self-government agreements and modern treaties, which re-affirm Indigenous Nations’ jurisdiction in health in some communities or regions.

### **Historical Context**

Indigenous health governance is situated within a complex political relationship among various parties, including but not limited to Indigenous Nations, the federal and provincial governments, and formerly the Crown. These relationships are formalized by various policies that establish the basic terms and conditions of the respective relationship. A review of the historical context sets the stage for the analysis of the division of power and the omission of Indigenous peoples and Indigenous health equity within health policies.

These political relationships started with the signing of original treaties between the Crown and some — but not all — First Nations in and around the nineteenth century. Health care was considered a treaty right, afforded to First Nations people living on-reserve, entrusting the Crown with the responsibility for delivering health services as part of its fiduciary duty to First Nations people (Lavoie, Gervais, Toner, Bergeron, & Thomas, 2011a). The Douglas treaties, also known as the Vancouver Island Treaties or the Fort Victoria Treaties, and Treaty 8 are the only historical treaties in BC. The Douglas Treaties were a series of 14 treaties signed in 1850 and 1854 among certain First Nations across Vancouver Island and representatives; whereas Treaty 8 is signed by several First Nations and Métis groups across parts of northern BC, northern Alberta and the northwest corner of Saskatchewan (Government of Canada, 1899). Unlike some of the other treaties signed across Canada, neither Treaty 8 nor the Douglas Treaties

contained any health-specific provisions; however, commitments to the provision of medicines in Treaty 8 territories are indicated in the Treaty Commissioner's notes (Lavoie, Gervais, Toner, Bergeron, & Thomas, 2011a).

The British North America (BNA) Act (1867), also known as the Constitution Act, is the foundation of the Canadian Constitution; it set forth the division of powers and defined jurisdictional boundaries for Canadian federalism. As mentioned above, it stipulates "Indian affairs", including "Indians and the lands reserved for Indians" as a federal jurisdiction (Section 91(24)) and health care, alongside social services and education, as a provincial jurisdiction (Government of Canada, 1867). These jurisdictional divisions are relevant to Indigenous health equity, as they create ambiguity over the provision of health care to First Nations, Métis and Inuit people that remains today (Kent, 2014).

The Indian Act (1876), which established the system of band council governments and continues to regulate their functioning, also fails to define clear jurisdictional responsibility for Indigenous health (Kent, 2014). Section 73 gives the Governor in Council the authority to make health-related regulations on reserves, but does not provide sufficient authority for a comprehensive public health and health services regulatory framework (Government of Canada, 1876). Section 81 of the Indian Act allows band councils to enact health-related by-laws; however, Section 4, has historically prevented their enactment by requiring that they be consistent with territorial and provincial health laws (Government of Canada, 1876).

The Canada Health Act (1984) reinforces the jurisdictional divisions defined by the BNA Act by stating that the provinces and territories are responsible for the delivery of health services. It is important to note that the Act does not contain Indigenous-specific provisions nor does it

address health service provision on-reserve (Lavoie, Gervais, Toner, Bergeron, & Thomas, 2011a).

### **Federal Policies**

The federal government plays an important role in providing leadership and policy direction that reflect national values. In addition to the foundational national policies that set the historical context, there are only two federal policies specific to Indigenous health in Canada: the Indian Health Policy (1979) and the Health Transfer Policy (1989). The Indian Health Policy (1979) recognizes First Nations' right to assume responsibility for administering any or all of their community health programs. It aligns with the principles of promoting Indigenous health equity through its three pillars:

- i) Improve the health status of Indian communities through community-driven mechanisms;
- ii) Strengthen relationships between Federal, Provincial, and local governments and Indian communities; and
- iii) Increase the capacity of Indian communities to take control of decisions affecting their health (Health Canada, 2014).

Like other historical policies, the term "Indian" excludes Métis, Inuit, non-status First Nations and First Nations living off-reserve, which creates ambiguity over the Act's range and application (Lavoie, Gervais, Toner, Bergeron, & Thomas, 2011a).

The Health Transfer Policy (1989) also facilitates decentralization of the planning and delivery of community-based health services that would otherwise be controlled by the federal government. Under this policy, communities can opt into agreements at their own pace, and can negotiate their level of control, flexibility and accountability (Government of British Columbia,

2005); yet the federal government still exercises control through financial transfers, reporting requirements, the use of third party management, and its ability to override all bylaws (Adelson, 2005). Once again, the Health Transfer Policy only applies to First Nations reserve communities, specifically those that are south of the 60th parallel; but in 1994, an integrated model was introduced for Northern communities originally deemed too small to successfully transfer control over health governance (Lavoie, Gervais, Toner, Bergeron, & Thomas, 2011b). While both of these federal policies contribute to enhancing health equity by transferring control of health services to Indigenous communities, they simultaneously entrench systemic inequities by limiting actual control and excluding certain Indigenous groups.

### **Provincial Policies**

Lavoie, Gervais, Toner, Bergeron, and Thomas's (2011a) findings highlight that Indigenous-specific legislation at the provincial and territorial levels is scarce. BC is no exception. In fact, their inventory of all health legislation across Canada reveals that not only does this province lack Indigenous-specific policies; it also lacks Indigenous-specific provisions within policies with a general health focus, with the exception of the Tobacco Control Act (see Appendix A for a summary table of all provincial health policies). The Tobacco Control Act (1996) has one specific provision that applies to the ceremonial use of tobacco. Section (3) Subsection (2), which stipulates that a person must not smoke tobacco or hold lighted tobacco in or around public spaces or other designated areas, "does not apply to the ceremonial use of tobacco in or on school property if the ceremonial use of tobacco is approved by the board and it is performed (a) in relation to a traditional aboriginal cultural activity, or (b) by a prescribed group for a prescribed purpose" (para. 21). This provision is important because it recognizes and respects Indigenous cultural practices; but the lack of explicit recognition of Indigenous peoples

and cultures in virtually all other provincial health policies symbolizes that Indigenous health equity is not recognized nor a priority for the provincial health system.

### **Interjurisdictional Policies**

While BC has not initiated any of its own policies on First Nations health governance, it has collaborated on interjurisdictional policies that are unprecedented in Canada.

Interjurisdictional policies serve to bridge jurisdictional gaps and enhance coordination for Indigenous health governance. These arrangements have also included Indigenous peoples and communities as partners in policymaking, thereby increasing the representation of Indigenous voices in identifying priorities, designing interventions, and delivering services to their communities. As noted above, there is a series of three health agreements that form a framework for BC's First Nations health governance: The Transformative Change Accord: First Nations Health Plan (2006), the Tripartite First Nations Health Plan (2007), and the BC Tripartite Framework Agreement on First Nation Health Governance (2011).

The Transformative Change Accord (2005) initiated the shift in First Nations policy in BC. It is a ten-year agreement that was signed by the Government of British Columbia, the Government of Canada, and the First Nations Leadership Council (FNLC). The Transformative Change Accord includes 29 action items, grouped under three broad objectives:

- i. Close the gaps between First Nations and other British Columbians in the areas of education, health, and housing;
- ii. Reconcile Aboriginal rights and title with those of the Crown; and
- iii. Establish a new relationship based on mutual respect and recognition (Government of British Columbia, 2005).

The Transformative Change Accord has a clear equity agenda, as it aims to “close the gap” in the areas of education, health and housing. It strategically brings together multiple tiers of jurisdiction to establish shared responsibility and to target systemic inequities at various levels.

The Tripartite First Nations Health Plan (2007) is another ten-year commitment that builds on the Transformative Change Accord. Again, this plan bridges jurisdictions by bringing together the Government of British Columbia, Health Canada, the Union of BC Indian Chiefs, the First Nations Summit, and the BC Assembly of First Nations as signatories. The Tripartite First Nations Health Plan added additional action items to the original 29, such as the creation of a new health governance structure specifically for BC First Nations. The new governance structure is comprised of four components: The First Nations Health Authority (FNHA); the First Nations Health Council (FNHC); the Tripartite Committee on First Nations Health; and the First Nations Health Directors Association (First Nations Leadership Council, Canada, & British Columbia, 2007).

The Tripartite Framework Agreement on First Nations Health Governance (2011) builds on the previous two plans and sets the policy framework in motion. The Government of British Columbia, the Government of Canada, and the FNLC signed the legally-binding framework agreement in October 2011, and on October 1<sup>st</sup>, 2013 Health Canada officially transferred its role in the design, management, and delivery of First Nations health programming in British Columbia to FNHA (Health Canada, 2013). The Tripartite Framework Agreement is an interjurisdictional collaboration that fills the gaps of other national and provincial policies by clearly outlining the roles and commitments of each party with respect to funding, supporting and/ or delivering health programs and services for First Nations peoples in BC. This new policy and governance framework is a first in Canada and represents a historic transformation towards a

more equitable health system. Nevertheless, it still falls short of promoting health equity for *all* Indigenous peoples by excluding Métis peoples, Inuit and non-status First Nations (Lavoie, Gervais, Toner, Bergeron, & Thomas, 2011b).

### **Implications for the Prioritization of Health Equity in BC's Public Health System**

This overview of the historical and contemporary policy framework demonstrates that there are only a handful of policies that are of relevance to Indigenous health equity at the national and provincial levels. Moreover, the policies that do exist do not clearly define jurisdictional responsibilities or coverage for certain Indigenous groups. The complications in the current health policy framework are reminiscent of the historical legislative vagueness, but are also a product of contemporary attempts to reconcile the historical relationship. In recent years, interjurisdictional policies have emerged to bridge jurisdictional gaps and to enhance representation of Indigenous peoples and cultures in the health system. While these models hold promise for transforming the policy framework and removing systemic barriers to health equity, they do not address the inequities faced by Métis peoples, Inuit or non-status First Nations. Because Indigenous health equity is not clearly stated as a priority in national or provincial legislation, health authorities and leaders within BC's public health system, including HA100, are tasked with taking a lead in embedding it within their own organizational plans and practices, while still aligning their activities with policy mandates.

## Overview of the Existing Literature

My research is grounded in a body of literature on Indigenous health equity. In order to assess the potential size, scope and nature of existing public health research and literature on the topic, I worked with my colleague Stan Bersenev to conduct a rapid scoping review for the period January, 1990 to December, 2015 [later updated for period January, 2016 to January 2017]. We applied a systematic search strategy guided by Levac, Colquhoun and O'Brien's (2010) recommendations to help answer the broad question, *what is known about Indigenous health equity?* We searched published literature (e.g. journal articles, books/ book chapters, research studies, government reports and literature reviews) in five databases, including Canadian Health Research Collection, CINAHL, MEDLINE, Social Sciences Index and Uvic Library Summons 2.0. We used the following search terms in all four of the databases: (Indigenous OR Aboriginal OR (First AND Nations) OR Native) AND (Health OR Wellness OR Wellbeing OR (Health AND Status) OR (Public AND Health) OR (Health AND Services)) AND (Equit\* OR Equal\* OR Access\* OR Disparit\* OR Equity Lens). Our search produced 42 sources— 33 once duplicates were accounted for, which we then organized into a summary table that classified key characteristics of the research (e.g. methodology, country, population) based on the descriptions in the articles' abstracts (see Appendix B for summary table). The summary table facilitated identification of research priorities in Indigenous health equity and revealed gaps in the research. Furthermore, it provided a foundation for a more in-depth analysis of the key concepts and themes in the body of articles.

### Themes in the Literature

The search results from the scoping review represent a diverse cross-section of research and literature relevant to Indigenous health equity. Some of the noteworthy themes that emerged

within the search results include: inequitable health outcomes, inequitable access to health services and inequities in the health system.

**Inequitable health outcomes.** One of the most prominent themes among the articles is an emphasis on measuring inequitable health outcomes among Indigenous populations. One of the most recent publications identified this as a “reductionist tendency to frame indigenous health as a problem of poor health indicators” (Hernandez, Ruano, Marchal, San Sebastian and Flores, 2017, abstract). These measurements are relative to the ‘general population’— but more often, the ‘non-Indigenous population’— of the country or region under study. This comparison is significant, as it establishes a standard to measure inequities as disparities or shortcomings, rather than measuring the presence of health equity from a strengths-based approach. Three abstracts explicitly reference the popular phrase “closing the gap” to reinforce the comparison of Indigenous and non-Indigenous populations (Otim, Kelaher, Anderson & Doran, 2014; Torri, 2012; and Turner et al., 2011).

Health outcomes are almost exclusively framed in terms of illness rather than wellness (e.g. psychological distress, mental ill health, mortality rates). Moreover, health outcomes tend to reflect medical conditions expressed at the individual level rather than social determinants of health at the population level. Only five of the articles acknowledge social determinants of health (e.g. poverty, education, colonial relations) in their abstracts, but did so as minor additions (Brierly, Suarez, Arora & Graham, 2014; Browne, 2017; Hayman, 2010; and Otim, Kelaher, Anderson and Doran, 2014).

**Inequitable access to health services and resources.** Another major theme that emerged throughout many of the articles is inequitable access to health services and resources for Indigenous peoples. Accessibility is a keyword in almost every article and is applied to a variety

of issues, such as: universal access to healthcare (Couzos & Davis, 2005; and Widdup et al., 2012); access to specialized services (Brown, Middleton, Fereday & Pincombe, 2016; Gerlach, Browne & Suto, 2016; Kelaher, Ferdinand & Taylor, 2012; and Turner et al., 2011); access to medicines (Couzos & Davis, 2005; and Kelaher et al., 2006); and access to safe drinking water (Patrick, 2011). Many of the studies highlight specific barriers to Indigenous peoples' access to health services and resources. Barriers range from socio-demographic factors, such as financial constraints or health literacy skills (Hayman, 2010; and Jones, Parker & Jamieson, 2014) to social and cultural factors, such as stigma, stereotyping, discrimination, and racism (Browne, 2017; Browne et al., 2016; Cameron et al., 2014; Hayman, 2010; and Hayman, White & Spurling, 2009).

These studies also balance the barriers with strategies for improving access for Indigenous peoples. The strategies cited focus less on socio-demographic factors and more on the social and cultural factors that can be addressed within the health system. This approach reflects the common perception that while the health system can play an important role in enhancing social equity and advocating for social justice, addressing socio-demographic factors (e.g. poverty) is often beyond the jurisdiction of the health system. Some of the organizational-level interventions to address cultural barriers include cultural safety training, holistic care services, relational approaches to care, inequity-responsive care, responsiveness to community needs, tailoring interventions to local contexts, providing support with and through cultural knowledge and shared cultural backgrounds (Brown, Middleton, Fereday & Pincombe, 2016; Browne et al., 2016; Gerlach, Browne & Suto, 2016; Hepworth et al., 2015).

**Inequities in the health system.** Another interesting finding from the literature is the role of the health system in creating, perpetuating or interrupting health inequities— or

alternatively, promoting, maintaining or hindering health equity. Several articles focus on structural and systemic barriers embedded in the organization of the health system , as well as the existing capacity within the health system to address Indigenous health equity. Structural and systemic barriers include availability of services, distance, long wait times, complexity of navigating the system, and lack of Indigenous staff (Boudville, Anjou & Taylor, 2013; Chamberlain et al., 2016; DiGiacomo et al., 2010; Gerlach, Browne & Suto, 2016 and Hayman, 2010). When it comes to capacity, on the one hand, authors critique mainstream services for not being culturally appropriate (Cameron et al., 2014; Chamberlain et al., 2016; Hayman, 2010 and Wardman, Clement & Quantz, 2005); but on the other hand, research demonstrates that Indigenous community health organizations lack capacity and resources to deliver a full range of health services (Arnold, 2014; Gerlach, Browne & Suto, 2016 and Otim, Kelaher, Anderson & Doran, 2014).

The articles also present strategies to combat some of these structural and systemic barriers, such as increased funding, presence of a liaison, Indigenous leadership and a coordinated system-wide approach (Boudville, Anjou & Taylor, 2013; Chamberlain et al., 2016; Hayman, White & Spurling, 2009; Hernandez, Ruano, Marchal, San Sebastian & Flores, 2017; Kelaher, Ferdinand & Taylor, 2012; and Turner et al., 2011). Additionally, some studies go beyond the organizational level to examine priority-setting and policy-making at the national or provincial/ state levels (Chamberlain et al., 2016; Gross, 2007; Torri, 2012; and Otim, Kelaher, Anderson & Doran, 2014). While the majority of the literature focuses on interventions within health organizations and health systems, the most recent studies captured in this scoping review critique this approach and advocate for a shift in focus to the broader context that influences structural and systemic barriers. Hernandez, Ruano, Marchal, San Sebastian and Flores argue

that “we need to move beyond... targeted service delivery tactics and move towards holistic, integrated approaches that address the causes of inequalities both inside and outside the health sector” (2017, abstract). Browne (2017) also emphasizes the need to understand the structural and historical forces that shape health professionals’ attitudes and clinical practice within the health system.

### **Gaps in the Literature**

While the scoping review produced some valuable findings, it also highlighted gaps in the existing literature on Indigenous health equity. For instance, certain groups are missing from the literature, including Métis, Inuit and urban Indigenous peoples, to name a few. Additionally, there is limited representation of intersectional identities, such as Indigenous women, Indigenous youth, Indigenous seniors and Indigenous homeless populations. The lack of emphasis on these sub-groups also brought to light the absence of comparisons within Indigenous groups, as inequities tend to be measured in comparison to the general [non-Indigenous] population. Health equity was rarely referenced explicitly in the titles or the abstracts of the articles; instead, it was implied by the key concepts and themes (e.g. disparities, accessibility, closing the gap). Although, it is noteworthy that when this scoping review was updated for 2016-2017, the most recent publications include more relevant search terms in the titles and main themes. Finally, there is a gap in research on Indigenous health equity in the area of public health systems and services in the literature reviewed.

### **Implications for My Thesis**

Having conducted the rapid scoping review, I am better able to strategically frame my thesis to fill a gap in Indigenous health equity research. The themes that emerged confirm that while there is a pre-existing body of research on the topic of Indigenous health equity, the

specific research questions, methods and scope of my thesis have not already been carried out.

Whereas most of the articles examine how Indigenous peoples access and use health services, the purpose of my thesis is to analyze the public health system's prioritization of Indigenous health equity and strategies for addressing inequities. I am focusing on the public health system in order to emphasize its role in creating and perpetuating health inequities as well as its responsibility to remedy the situation and promote equity.

My thesis is also unique in my application of Xpey' Relational Environments framework to conceptualize and map determinants of Indigenous health equity in the public health system. The framework is able to capture many of the issues cited in the literature (e.g. inequitable health outcomes, inequitable access to health services and inequities in the health system), and even detect themes that are missing in the existing literature. For instance, Chamberlain et al.'s (2016) recommendations include development of a tool with a clear "equity domain" to capture subtle historical and cultural dimensions, which Xpey' Relational Environments framework is ideally suited for. Moreover, it illustrates associations between various determinants of health equity, so as to highlight the interconnected nature of relational environments and draw attention to important causal links.

### Research paradigm

While upholding the teachings of the *Gusweñta* in the parallel methodologies, I have applied a decolonized research paradigm to my thesis research in order to foreground analytical dimensions congruent with Indigenous knowledge and worldviews. The philosophical underpinnings of decolonized research paradigms stem from ‘postcolonial’ theory, but also draw from critical social theory, feminist theory and post-structuralism. I choose not to use the term ‘post-colonialism’, as it suggests that we have *moved on* from our colonial history or as some explain, *transitioned* to ‘neocolonialism’, which I reject given the ongoing realities of political, economic and cultural oppression as well as intergenerational trauma for Indigenous peoples. Nevertheless, I embrace post-colonialism’s focus on the legacy of colonialism as the context for inequities (Brown, Smye & Varcoe, 2005). In examining the relevance of postcolonial paradigms to Indigenous health research, Brown, Smye and Varcoe assert that “Postcolonial theories provide a powerful analytical framework and vocabulary for understanding how health, healing, and human suffering are woven into the fabric of the socio-historical-political context” (2005, p. 19). This assessment of postcolonialism is compatible with my application of a decolonized research paradigm to critically analyze social, structural and systemic determinants of Indigenous health equity. Decolonized approaches build off of this understanding of the legacy of historical colonialism, and offer direction for deconstructing and dismantling the *ongoing* hegemonic power of Eurocentric thought and research practices.

## Methodology

My research design and methods are informed by the overarching principles and aims of applied qualitative health research. Applied qualitative health research is ideally suited for investigating the prioritization of Indigenous health equity because “it informs action and enhances decision making on practical issues... [and] can add immeasurably to our understanding of human, institutional, and systems behavior” (Tolley & Ebooks Corporation, 2016, p. 26). With this in mind, my goal is to generate findings that have utility and application in the public health system by helping policymakers and practitioners make decisions that will create conditions for health equity.

The field of qualitative health research is dominantly characterized by highly inductive approaches that build emergent theories from the ground up, such as Grounded Theory; however, there can be value in using theory-driven conceptual models as an organizing framework to guide the methodological focus (MacFarlane & O’Reilly-de Brun, 2012 and Tolley & Ebooks Corporation, 2016). Macfarlane and O’Reilly-de Brún (2011) explain that theory-driven conceptual frameworks can help elucidate complex concepts and relationships in the data that researchers may not otherwise identify through purely inductive processes. I used Xpey’ Relational Environments as a conceptual framework to orient my analysis and situate the emergent data in relation to pre-existing theoretical explanations. I have heeded Padgett’s advice to “weav[e] in theoretical ideas and concepts without permitting them to drive or constrain the study's emergent findings” (2012, p. 32). Xpey’ Relational Environments framework grounds my understanding of the complex interactions shaping Indigenous health equity; the framework therefore served as a starting point and a guide for my coding and analysis.

## Theoretical Framework

In 2014, Loppie and Carriere developed a theoretical framework to guide the analysis of Indigenous health equity within ELPH Study 1 (Kent, Loppie, Carriere, MacDonald, Pauly, 2017). The framework was later named Xpey' Relational Environments, after consultation with Shauna Underwood, an Indigenous Advisor at UVic, who helped the three of us select the word Xpey', which means western red cedar in Hul'q'umi'num', a dialect spoken by many First Nations on Vancouver Island. We were originally searching for a translation for 'tree' to describe the tree metaphor used for the analytic framework; however, as Underwood explained, there is no one word for tree in Hul'q'umi'num.' Therefore, we chose western red cedar for its cultural significance as a sacred medicine.

Xpey' Relational Environments is an adaptation of a tree metaphor previously used by Loppie to map out proximal, intermediate and distal determinants of Indigenous health (Reading and Wien, 2009). The tree metaphor employs intellectual biomimicry to provide a deeper analysis of abstract concepts through an understanding of the natural world (Woorama, 2007). Loppie artfully explains the tree metaphor as follows:

We typically think of trees as possessing three interconnected elements: the crown (leaves and branches) [or stem], the trunk, and the roots. Each part of the tree is dependent not only upon the other parts for sustenance and support, but also upon the environment that nourishes and sometimes damages them (Reading, 2015, p. 4).

Whereas the health of the unseen roots strongly influences the health of the tree, the condition of the crown is often an indicator of the tree's overall health. Xpey' Relational Environments applies this understanding to the physical and theoretical settings, or 'relational environments', in which health equity [or inequity] is manifested in public health systems and structures.

The theoretical framework conceptualizes relational environments as the three elements of a tree: stem, core and roots (see Figure 1). Like the crown of a tree, stem environments influence individual and community health in the most obvious and direct ways (Reading, 2015), encompassing interpersonal relationships such as those between service providers and clients or patients; the natural and built environment, including barriers to services and resources; and the symbolic positioning or representation of people's intersectional identities and cultures.

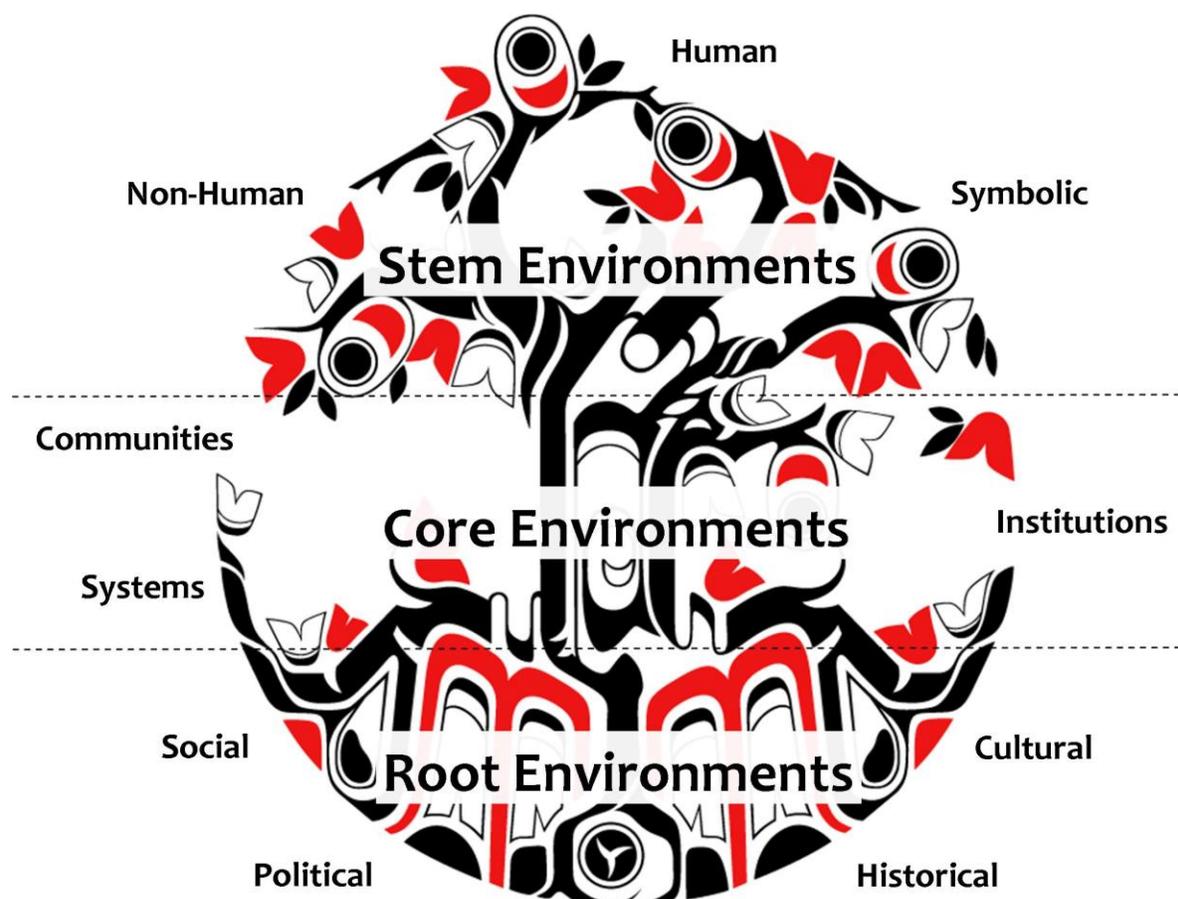
Like the trunk of a tree, core environments connect stem and root environments in ways that can facilitate or hinder health (Reading, 2015). These relational environments have a less direct impact on the health of individuals, but they strongly influence the relationships and settings within the stem environment. Core environments include: systems of authorities, policies and bureaucracies; leadership and management within relevant institutions and organizations; as well as the local systems and structures at the community level.

Finally, root environments are deeply embedded structures that represent the historical, political, social and cultural contexts from which all other relational environments evolve (Reading & Wien, 2009). Reading (2015) explains, "Just as maladies observed in the leaves are generally not the cause of unhealthy trees, inequities in human health frequently result from corruption or deficiencies in the unseen but critical root system" (p. 5). For Indigenous health equity, these roots take the form of colonial histories and intergenerational trauma, political relationships and arrangements, social and material inequities and cultural connection or loss.

Among these various relational environments at the stem, core, or root level, there are protective features that promote wellbeing and resilience as well as risk factors that can produce unfavorable circumstances or hinder health. This understanding of the ways in which relational environments are manifested in the public health system as well as the interconnections between

stem, core and root environments guided my coding and analysis, and helped to make meaning of the findings.

**Figure 1. Visual representation of Xpey' Relational Environments Framework<sup>1</sup>**



### Study Design

There are two key design features of my thesis research. First, it consists of secondary analysis of data already gathered by ELPH (see Data Collection). Padgett (2012) explains that considering the amount of time and costs that go into a qualitative study, secondary analyses are increasingly being embraced as a means of maximizing resources and extending the life of

<sup>1</sup> ELPH obtained permission from artist, kireihiryu, to use tree illustration.

research. I am in a unique position to carry out the secondary analysis because I am working closely with the original research team, but I am also collaborating with additional researchers (Loppie and Carriere) to integrate an Indigenous perspective. The second key design feature of my thesis is the application of a case study to capture contextual influences at the regional level, which complements ELPH's approach to treating each health authority as an individual case. I used HA100 as a pilot case study to test the application and relevance of Xpey' Relational Environments framework. The intended result is a report that presents Indigenous health equity as it is identified and prioritized by HA100's key decision makers as well as in the health authority's core documents and plans. Findings from the pilot case study have been corroborated with ELPH's situational analysis to strengthen conclusions and have been presented to stakeholders for validation (see stakeholder engagement section).

### **Data Collection**

Between 2011 and 2016, the ELPH team undertook a review of strategic plans, service plans, health equity plans, government reports and other relevant documents in each of the health authorities. Document collection occurred alongside in-depth interviews and focus groups with frontline staff, supervisors, managers and senior executives. Both sources of data were collected for baseline assessment in 2012/ 2013 and again for follow-up in 2015/2016. For my thesis, I conducted secondary analysis of the data collected from HA100 from Phase 1 (2012/2013). I narrowed the data set to interviews (N=4) and focus groups (N= 2) conducted with managers and senior executives. Collectively, the interviews and focus groups included 19 participants. Due to the sample size and potential to identify the health authority, participant demographics will not be disclosed for reasons of confidentiality. In addition to interview transcripts, I focused on

documents [or sections of documents] that either a) are specific to Indigenous peoples; or b) outline HA100's goals, vision, mandates and strategic directions; documents included:

- Five-Year Strategic Plan;
- Service Plan;
- Aboriginal Health Plan; and
- First Nations Health Council Partnership Accord.

Because data collection spanned two years for Phase 1, two annual service plans were included in the data set, for a total of five core documents.

The Indigenous-focused parallel analysis was introduced to ELPH Study 1 after the first phase of data collection; therefore, the original interview guide did not have any questions that explicitly inquire about Indigenous populations. In the summer of 2015, the ELPH team made important changes to the interview guide to prepare for follow-up interviews in Phase 2 of the study. Several questions and prompts were added to the interview guide that asked respondents to elaborate on their work in the area of Indigenous health and Indigenous health equity (see Appendix C for interview guide with updates highlighted). It is important to note that although the interview guide asked individuals to reflect on their work in the area of Indigenous health, almost all respondents were non-Indigenous public health practitioners working in the area of mental health promotion and the prevention of harms of substance use. ELPH made an effort to invite representatives from health authorities' Indigenous health departments for the second round of data collection, and were successful in recruiting two staff from HA100's Aboriginal Health Program. These additions helped increase the quantity of relevant data and enrich the quality of data; however, any comparison of baseline and follow-up data must proceed with caution and at the risk of exaggerating the relative significance of Indigenous health equity

across Phase 1 and Phase 2 data, due to the addition of prompts to the interview guide after Phase 1.

All ELPH interviews were recorded and transcribed verbatim. I imported cleaned and verified interview transcripts as Word documents into NVivo 10, a qualitative software package that facilitates storage, organization, management and analysis of qualitative data (QSR International, n.d.). I also imported documents in PDF format. Once compiled, I assigned attributes to each data source to allow sorting and analysis by various features (e.g., phase, health authority, characteristics of respondents/ document etc.).

### **Analysis Procedures**

Once all sources were imported into NVivo, I used the software to code the transcripts and documents. Initial codes were derived inductively to capture the depth and contextual detail of the content; although, I acknowledge that my use of Xpey' Relational Environments sensitized me to certain themes and therefore influenced coding. NVivo facilitated the development of "in vivo" code labels (Padgett, 2012) through use of word frequency queries to identify re-occurring terms and concepts in the sources. I then used Xpey' Relational Environments to categorize the data-driven codes into higher-level theory-driven themes and map them into stem, core and root environments. The process was highly iterative, moving backward and forward between the emergent codes and the predefined relational environments, without forcing the data into the pre-existing framework. I refined and manually sorted codes by placing them into categories based on thematic similarities until the best fit was achieved. By integrating the codes and categories into the theoretical framework, I developed a code hierarchy, constructed as "a pyramid-type chart displaying sub-codes at the bottom level, then codes, then code clusters or focused codes, and then categories or themes at the top" (Padgett, 2012, p. 183). Once established, this list of

codes guided coding of subsequent transcripts and documents, but served as a living document that evolved as new codes and themes emerged from the data.

While coding, I was cognizant of similarities and patterns across sources, but also made note of negative instances and irregularities. Similar to the popular research practice of Grounded Theory, I used constant comparative analysis, consisting of a systematic search for similarities and differences across interviews, incidents and contexts (Padgett, 2012). NVivo 10 software supplemented my analysis through use of word frequency queries to identify commonly occurring codes and their distribution in the sources. According to Miles and Huberman (1994), “counting themes via frequencies and percentages can help in identifying patterns or in verifying a hypothesis” (as cited in Padgett, 2012, p. 191). Cluster analysis diagrams were also used to visualize patterns and relationships in the coding. Xpey’ Relational Environments framework offered an organizing principle to conceptualize the layered meanings of the individual themes in relation to the theoretical categories; furthermore, it facilitated the identification of relationships between themes and across relational environments.

In addition to content analysis, I used discourse analysis to illuminate dominant values, attitudes and assumptions influencing prioritization of— or lack thereof— health equity and strategies for reducing health inequities. These discursive elements were often hidden or embedded within the text, so I drew upon my prior knowledge and critical analysis skills to uncover codes and themes. My intent was to make explicit how language itself, in concert with other processes of communication, reflects and reinforces power in social processes.

Throughout coding and analysis, I wrote memos to maintain a record of concept development and analytic decisions; I also kept a reflexive journal to record my reactions to the

data and examine my biases. As Padgett (2012) notes, qualitative research rarely follows a predictable course, so keeping track of progress and changes to the research is critical.

## Ethics

One of the advantages of conducting secondary analysis is that gaining research ethics approval is usually much easier because interacting with human subjects is not involved (Padgett, 2012, p. 192). In accordance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2), a second ethics application was not necessary because my research does not deviate from ELPH's approved ethics application, which is still active (UVic, 2013). My secondary analysis does not involve modification to ELPH's recruitment, participants, data collection, consent, or risk; furthermore, I did not undertake any supplementary research outside of the study. To verify that my secondary analysis was covered under the ELPH ethics application, a principal investigator from ELPH contacted the research ethics office to add my name to the ethical approval (UVic, 2013).

In addition to UVic's Human Research Ethics Board review, the ELPH team secured ethics approval from each of the regional health authorities, outlining precautionary steps for informed consent, protection of confidentiality and privacy. Because ELPH was conceived in 2011, before FNHA was formally established, FNHA was not approached until after the research was designed and funding was confirmed, which hindered the process of ethical and respectful engagement; therefore, FNHA was not part of the ethics approval process. ELPH respected their decision not to partner in the research. Nonetheless, as the study unfolded, team members remained conscious of and regularly acknowledged the important role FNHA plays in influencing the prioritization and implementation of health equity in BC's public health system.

As a Research Assistant on the ELPH project, I have signed a "Promise of Confidentiality and Security of Data" as part of their Data Management Protocol (see Appendix D). This document guided my ethical conduct for accessing, using, storing, sharing and

destroying data for the purposes of my secondary analysis. To uphold ethics, the health authority used for this case study will not be identified, so it is referred to as HA100 in place of any identifiers throughout my thesis. Additionally, because the core documents and plans in this data set are publicly available, years and page numbers will not be included in the references to reduce the likelihood of the health authority being traced.

As a non-Indigenous researcher working in the field of Indigenous health research, I am not only committed to conducting my thesis research in an ethical manner, but also a respectful and culturally safe manner. My approach to orienting this research in relation to the ELPH program of research aligns with the teachings of the *Gusweñta*, including respect for Indigenous self-determination and non-interference, as outlined above. My approach to engaging with the research as a non-Indigenous researcher is further guided by the notion of ethical space, a term coined by Roger Poole (1972) and further developed by Willie Ermine (2000). Ethical space describes an abstract space of interaction and dialogue between Indigenous and Western spheres of culture and knowledge relative to research issues. It creates a “neutral zone” for critical conversations when engaging with power imbalances and working across cultural, class, age, gender and ethnic differences (Ermine, Interagency Advisory Panel on Research Ethics and Indigenous Peoples' Health Research Centre, 2004). I conceptualize this space as the area between the two rows or parallel paths depicted by the *Gusweñta*, whereby I am able to engage in critical examination of equity, ethics and respectful relationships in the public health system and in my own research practices. This perspective keeps me grounded in an awareness of my socio-cultural location and the subjectivity of my interpretations, as well as an understanding of my responsibilities as a non-Indigenous researcher to conduct research in an ethical, respectful and culturally safe way.

## Stakeholder Engagement

To ensure the validity, adequacy and cultural relevance of the Xpey' Relational Environments framework and the study, preliminary findings were presented to key stakeholders in February 2016. After securing a CIHR Planning and Dissemination Grant, we facilitated a one-day gathering of representatives from the Indigenous health departments of each of the organizations in BC's public health system. Invitations were sent to Indigenous health leads from the five regional health authorities, the First Nations Health Authority, the Provincial Health Services Authority, the Ministry of Health, BC Association of Friendship Centers and Métis Nation BC. Almost all organizations had one or more representatives present at the meeting, with the exception of BC Association of Friendship Centers.

During the meeting, we introduced the ELPH study and the Xpey' Relational Environments framework to the stakeholders and presented some preliminary findings from the analysis. Participants were asked to provide comments, questions and recommendations. Several important reflections and key recommendations came out of the discussion. Participants affirmed that the Xpey' Relational Environments framework is a culturally appropriate and relevant tool for exploring Indigenous health equity. They also agreed that Indigenous health equity is a critical issue in BC's public health system and that it should be a research priority. However, some participants expressed concerns about how Indigenous health equity had been prioritized within the ELPH study, which in many ways reflects how it is prioritized within the public health system (see findings section).

Participants at the stakeholder engagement meeting recognized that the ELPH study was not originally conceived as an Indigenous health equity project and pointed out the limitations of applying an Indigenous focus through secondary analysis rather than situating the research in an

Indigenous approach from the onset. A couple participants mentioned that efforts to engage Indigenous representatives seemed like an afterthought in planning and in recruitment for data collection. Consequently, they felt the data presented do not reflect the work being done by Indigenous organizations (e.g. FNHA) or Indigenous departments within health authorities, which creates a significant gap in the representation of Indigenous health equity work in BC's public health system. Stakeholders also noted that there was a lack of engagement of Indigenous participants in the ELPH interviews, so the views presented reflect those of non-Indigenous participants; furthermore, gaps and deficiencies in the data may be underestimated. The feedback generated during the stakeholder engagement meeting is invaluable to this research and was taken into consideration throughout subsequent planning for the ELPH project. The stakeholder engagement meeting helped me approach my thesis with a critical awareness of the limitations of the study design and an understanding that any findings must be interpreted with caution.

## Findings

The findings are presented within the Xpey' Relational Environments framework to showcase the layered meanings of the individual themes in relation to the stem, core and root environments and in relationship with other themes across relational environments. Although Xpey' Relational Environments facilitated identification of numerous physical and theoretical settings in which health equity and/ or health inequity are manifested in HA100's public health systems and structures, I have highlighted the most salient themes from my analysis based on their coding frequency, significance to Indigenous health equity and in part, my personal research interests. Among the relational environments, I have analyzed both successful strategies that promote Indigenous health equity as well as barriers within the health authority that create or perpetuate inequities. The data include intentions to act, which are often outlined as goals or aspirations in their planning documents, as well as examples of current initiatives, which are often discussed in reports on progress or in interviews or focus groups with senior executives.

### Stem Environments

**Non-human stem environments.** Similar to the literature presented in my scoping review, a predominant theme in the data is equitable access to health services and resources for Indigenous peoples as a priority within the health authority and among the senior executives. In its Five-Year Strategic Plan, HA100 defines access as, "A patient's ability to obtain health care when and where it is needed."<sup>2</sup> HA100's Service Plan states that "[HA100's] goal is for a population that is uniformly healthy with equitable access to services;" furthermore, one of three strategic goals identified in the Aboriginal Health Plan is to improve access to services so

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<sup>2</sup> As noted in Ethics, references will not include standard APA citations in order to preserve the anonymity of the health authority.

“Aboriginal people [have] access to the same level of service as the broader population served by [HA100]”— or “...at a minimum comparable to those available to communities living in similar geographic locations” (FNHC Partnership Accord). ‘Accessibility’ is one of the most frequently coded nodes (see Appendix E for table of frequently coded nodes) and is most often used by participants as a keyword to define and explain health equity (Focus Group 104, Interview 105, and Interview 107). When developing the coding hierarchy, I categorized accessibility into multiple nodes in various layers of Xpey’ Relational Environments framework in order to make distinctions between several relevant references coded. Accessibility nodes included: understandings and definitions of accessibility under symbolic stem environments, barriers or facilitators to accessibility in non-human stem environments, and accessibility as a mission or value under institution’s core environments.

In non-human stem environments, prioritizing equitable access for Indigenous peoples was discussed in the context of identifying and removing barriers to accessing services and resources as well as putting measures in place to facilitate better access and better meet Indigenous peoples’ health needs. HA100 focuses on many of the same structural and systemic barriers as those identified in the literature, including factors such as where health care facilities are located and how many of them exist, how easy it is to apply for services, the availability of transportation and hours of operation. In particular, HA100 faces the challenge of addressing barriers to accessibility of primary care, physicians, nurses, dental care and other allied health care in rural, remote and isolated Indigenous communities (Aboriginal Health Plan).

HA100 aspires to improve accessibility by enhancing the quality, accessibility, delivery, effectiveness, efficiency, and cultural appropriateness of health care programs and services for Indigenous peoples, which is affirmed as a commitment in the FNHC Partnership Accord. Some

of the strategies they have put in place to operationalize these goals include nurses going off-site; providing services at community-venues or Friendship Centres; working with communities to address transportation issues; improving Telehealth services; building a network of remote, community, regional and tertiary hospitals; as well as transferring resources to Indigenous communities and partners to deliver health services through contractual arrangements. In addition to facilitating availability of services, HA100 recognizes the need to provide Indigenous clients and patients with the information and support they need to navigate what can be a confusing and complex health system (Aboriginal Health Plan). To raise awareness and support health literacy, HA100 seeks to provide easy access to health information in ways that are useful for Indigenous communities. HA100 does this by distributing information on all available services (provincial, regional, local, First Nations or other providers) through HA100's website, electronic and paper newsletters, brochures, community meetings and events, news releases and other means of dissemination. They also provide Aboriginal Liaison Nurses (see Human Stem Environments) and a toll-free phone line to help Indigenous clients and patients navigate inter-jurisdictional systems and services.

HA100 has made access to services and resources a priority in working towards Indigenous health equity; yet the data also suggest that, "Progress in this area has been somewhat limited" (Aboriginal Health Plan). One participant notes:

But in terms of equity of access: I don't think that there's been that sort of level of analysis of in terms of building of the facilities and staffing and programing in the facilities; and say, 'Ok well who, what are the barriers there for certain groups in the community to get the services they really need? And let's build this facility, lets' build program to address those.' I don't think that's actually happened. (Focus Group104)

Beyond the challenges in establishing new programs and facilities, it is also noted that the health authority faces challenges in regards to their inability to track Indigenous peoples' usage of existing services and resources, due to a lack of an "Aboriginal identifier." The Aboriginal Health Plan states, "... we cannot tell accurately whether access to services is increasing; and without an Aboriginal identifier it is more difficult to link Aboriginal people with needed health services." HA100 is developing tools to respond to this challenge (Aboriginal Health Plan), which will help assess the impact of the strategies they have implemented to improve accessibility and enhance the experiences of Indigenous clients and patients, as discussed above.

**Human stem environments.** Efforts to improve physical accessibility within non-human stem environments are useless if there are barriers within human stem environments that discourage Indigenous peoples from accessing available services. As described in the background section, Indigenous peoples are choosing to not access health services due to distrust, stemming from intergenerational experiences of racism and culturally unsafe practice in health care settings, Indian Hospitals and Residential Schools. HA100 asserts a commitment to building and restoring healthy relationships between Indigenous clients and service providers, in acknowledgement of the fact that "... better relationships between Aboriginal clients and their care providers lead to better health outcomes" (Aboriginal Health Plan). One way the health authority strives to build relationships is through Aboriginal Liaison Nurses, who provide a broad range of services that help create a culturally safe and responsive experience for Indigenous clients and their families. Aboriginal Liaison Nurses serve the dual function of improving accessibility by linking clients and patients to health providers and resources, and assisting them in navigating the health care system.

Several times throughout the Aboriginal Health Plan, it is noted that HA100 needs more capacity in the form of better links between Aboriginal Liaison Nurses and other staff, more hospitals with Aboriginal Liaison Nurses, and extended access to Aboriginal Liaison Nurses on weekends and evenings to meet growing needs. HA100's Aboriginal Health Program conducted a review, which found that:

... while [HA100's] Aboriginal Liaison Nurse positions are unable to meet all of the growing number of requests for their services, they are: seen as invaluable by the Aboriginal community; contributing to the well-documented need to increase the number of Aboriginal health care professionals within [HA100]; front-line ambassadors for [HA100's] objective to improve services for Aboriginal people; and positive role models and resources for their [HA100] colleagues with a focus on promoting collaboration, integration, and cultural safety (Aboriginal health Plan).

These findings highlight the value of Aboriginal Liaison Nurses in building relationships with both Indigenous clients and HA100 service providers, and ultimately enhancing Indigenous health equity. Moreover, the findings reinforce the critical need to invest in capacity building, which could take the form of hiring more Aboriginal Liaison Nurses and/ or training non-Indigenous service providers to equip them with the knowledge and skills to build healthy relationships with Indigenous clients and patients.

Principles and values of relationship building with Indigenous peoples and communities are also being integrated into public health programming in HA100. A few examples were highlighted in the data that showcase how HA100 staff are making Indigenous health equity a priority by investing in relationship building with Indigenous patients and clients. In particular, senior executives emphasized peri-natal programming, which has undergone a "massive shift" in

terms of time and resources focused on Indigenous women (Interview 107). One participant explains:

[For the general population] We send out their package and then ‘Call us if you need us...’ So there may be short term pieces for the others, especially around breast feeding and early we might do a, a home visit. And Aboriginal women, we are also giving sort of what we call ‘*our biggest offer*’ [emphasis in original]... If they’re Aboriginal, we call and offer a....a one on one connection, whether that be in the home or the coffee shop, wherever that might be... somehow make a connection (Interview 105).

The participant adds, “... So we’ve got a whole guideline as to how that goes” (Interview 105), indicating that eligibility criteria is not determined at the discretion of the nurse, but rather, there is an organizational policy in place that clearly outlines relationship building with Indigenous clients as a priority. Similarly, extra effort is made to form relationships with Indigenous clients, particularly “[First Nations] street level folks and the drug using folks,” in mental health and substance use programs (Interview 111), as well as focusing on First Nations peoples on-reserve for diabetes prevention education (Aboriginal Health Plan).

The above examples suggest that progress is being made towards building healthy relationships between Indigenous clients and service providers; however, the data also reveal critical limitations hindering relationship development. First, it takes considerable time to build relationships and once forged, they must be sustained; some staff see this as a challenge with already pressing work-loads (Aboriginal Health Plan). What is more, “there is still a lack of understanding on the part of some [HA100] staff that their mandate is to provide services to all residents, including people who reside on First Nations reserves” (Aboriginal Health Plan). Relationship building cannot be the sole responsibility of Aboriginal Liaison Nurses; it needs to



The term “high needs” is used extensively within HA100’s Five-Year Strategic Plan, which lists “Improved health of high needs populations” as one of the health authority’s strategic priorities. HA100’s definition of high needs populations is as follows:

Specific groups of people whose need for health care services is greater than that of the population in general, for example: children and youth, people living in rural and remote areas, Aboriginal people, homeless/hard to serve, the chronically ill, persons with disabilities, the frail elderly, and adults or seniors with mental illnesses and/or addictions (Five-Year Strategic Plan).

The commitment to focus efforts on Indigenous peoples as a “high needs population” is embedded in HA100’s core documents and strategic priorities, which in turn, influences how senior executives and other staff understand and talk about Indigenous health equity as a priority. Interview transcripts revealed that senior executives perceive the need to serve Indigenous peoples in relation to addressing the “excessive burden of illness and disease” Indigenous peoples carry (Interview 103). These discourses are consistent with literature on the topic of Indigenous health equity, which focuses on disparities or deficits. This rhetoric can be problematic, as it frames Indigenous identity as a risk factor and fails to examine social, structural and systemic issues that create and reinforce inequities. One of the participants interviewed critically reflects upon and challenges the dominant discourses:

Well I think one of the things that I want to put out there, and I’ve been ssss... grappling with a little bit is, um rather than talking about high needs, targeted, vulnerable— to me they are our priority populations and I feel a bit more comfortable, I mean I know it’s just a word but to me it feels like the priority is this, you know, particular sub-population... So, it’s something that I’ve been thinking about (Interview 102).

This alternative discourse is also used within the Aboriginal Health Plan, which refers to Indigenous peoples as a “priority population,” rather than “high needs.” These labels not only affect how Indigenous peoples are represented within core documents and plans, but also how Indigenous peoples are perceived and/ or stigmatized by service providers when accessing health services. “High needs” focuses on the individual seeking care, whereas “priority population” focuses on how the system should care for them.

Understanding of, acceptance of and respect for Indigenous worldviews, knowledges and healing practices within the public health system is also shaped, in part, by how they are represented in the health authority’s strategic directions and leadership. There is an absence of representation of Indigenous ways of knowing and doing in HA100, which is noted by a survey respondent in the Aboriginal Health Plan: “We all learn Western methods; what about traditional?” Although there are very few relevant references to select from, the data include two examples of how Indigenous knowledges and healing practices are currently given space within the health authority. First, two hospitals have opened Indigenous spiritual care rooms for Indigenous patients and their families to use for ceremonies and healing practices. Second, the Aboriginal Health Plan opens with a story from an Elder, which is included below:

We had strong spirituality and spiritual healers... we lived a long time... some people lived to be 105 years old.

We used songs, like the song about eagles. The eagle gave us our souls, and that gave us our songs. You’re not supposed to change the song; use it the way it was given to you.

Our families worked together on healing. But you have to believe in it. We believed in our Creator, but then we lost this because of new religions that were brought in.

We had no doctors. We used medicines from the woods, which was the garden for our

medicine that can still cure our people, so they can be cured at home.

The voices of the youngest and the oldest need to be respected, so call them out to your meetings ... We Elders don't have certificates, but we need to be recognized because of our knowledge of the language and our ability to teach it.

You need to respect these values and beliefs.

Including this story in the Aboriginal Health Plan is a symbol of respect for Indigenous voices and knowledge systems; furthermore, there is a call to action embedded within it to recognize and respect Indigenous medicines, worldviews and ways of knowing. This call to action is echoed throughout the Aboriginal Health Plan and the FNHC Partnership Accord, both of which state commitments to increase representation of Indigenous knowledge and ways of knowing. Specific recommendations noted by these core documents include: respect clients' cultural differences, values, preferences, and needs; include participation in traditional spiritual ceremonies as a measure of community health; have HA100 staff members learn more about communities' ways of living and cultural protocols; and incorporate Indigenous models of wellness and healing practices into the delivery of services, where appropriate. Building on this last recommendation, the FNHC Partnership Accord contains a specific directive to "Protect, incorporate and promote First Nations knowledge, beliefs, values, practices, medicines and models of health and healing into all health programs and services that serve BC First Nations."

An additional call to action that warrants further analysis is HA100's plan to develop an "Aboriginal lens" for use in program and policy planning. When the Aboriginal Health Plan was released, the goal was to have the Aboriginal lens in use by 2012/ 2013, which is when ELPH interviews were conducted. Two participants allude to use of an Aboriginal lens in public health programs (Interview 103 and Interview 105); however, the context in which it is discussed

suggests limited application and limited understanding. One participant comments that staff will apply different lenses (e.g. Aboriginal, rural, socio-economic) because they are consistently asked to do so, but that it is not formalized within the health authority (Interview 103). Another participant discusses new resources and assessment tools that were still being “rolled out,” which incorporate an Aboriginal lens, or as the participant describes:

“looking to an aboriginal....approach, which is not so much the tick-y-box approach that we have used a little bit in the past, but more looking at, from a women’s point of view, ‘What are your hopes and dreams for this? What is it I can help you with?’ using the motivational interviewing approach, which is new to some” (INTV105).

This quote is unclear with regards to the meaning and application of an Aboriginal lens, and raises several questions: *How is an Aboriginal Lens defined in HA100? Who is using an Aboriginal lens within HA100? Do they know how to use it? Are there any assurances that they will apply it to practice – or do so in a culturally safe manner? Finally, Should they be using an Aboriginal Lens— or labelling it as such?*

### **Core Environments**

**Institutions’ core environment.** The strategies and barriers discussed in non-human, human and symbolic stem environments are often reflective of how Indigenous health equity is prioritized within core environments, particularly at the institutional level. One of the principle ways in which Indigenous health equity is taken up as a priority within HA100 is by formalizing it as an organizational goal. The ELPH interview guide asked participants to reflect on whether health equity, broadly defined, is a priority within the health authority as well as within public health programs. One senior executive responded that health equity needs to be embraced as a priority throughout the whole health authority and individuals need to recognize and address

inequities within their respective programs, but noted that health equity is not presently an institution-wide goal and “it tends to be drifting away from that now” (Focus Group 104).

Although the interview guide did not include specific questions about Indigenous health equity in Phase 1 (see Appendix C for interview guide with subsequent revisions), some participants did refer to Indigenous health as an organizational priority without prompting. When asked about the health authority’s goals, one participant stated, “I mean certainly one of the ones that I think is very much in the forefront is for Aboriginal health, and organizationally there’s been quite a focus about...about trying to ensure health equity with that” (Interview 107).

As discussed in symbolic stem environments, HA100’s Five-Year Strategic Plan, Service Plan and Aboriginal Health Plan list improving the health of Indigenous peoples as a “priority population” or “high needs population” as a strategic priority for the health authority. The term health equity is not explicitly referenced in these strategic priorities. However, the Aboriginal Health Plan does allude to equity when referring to a “longer-range goal” of “closing the gap in health outcomes between Aboriginal and non-Aboriginal people,” which reflects the popular discourses in the literature. Together, these references from the interview transcripts and core documents indicate that while improving Indigenous health is a current priority for HA100, creating equitable conditions for Indigenous health is more of a long-term goal.

In order to actualize its strategic priorities to improve Indigenous health and move towards Indigenous health equity, HA100 has several institution-wide initiatives that are specific to Indigenous peoples. As highlighted in many of the examples and references thus far, HA100 has a distinct Aboriginal Health Plan, which serves as a guide for staff by articulating the health authority’s goals and objectives for the services they are striving to provide and improve for Indigenous peoples in HA100’s service area. HA100 developed its first Aboriginal Health Plan

in 2006 and has since updated it twice. It is the responsibility of all HA100 programs and staff to be aware of the role they play in implementing the Aboriginal Health Plan (Aboriginal Health Plan). In addition to the Aboriginal Health Plan, HA100 has also signed a Partnership Accord with FNHC to formalize and strengthen the relationship between the two institutions; this relationship is discussed in more detail in political root environments. The Partnership Accord reaffirms both parties' joint commitment to "improve the well-being of all First Nations people living in the [HA100] region, regardless of Nationhood, status, and location."

Another institution-wide initiative that HA100 has instated is the Aboriginal Health Council, which provides input and advice to the rest of the health authority about how they can best address Indigenous health issues. The Aboriginal Health Council is comprised of First Nations service providers, Friendship Centres, and Métis Chartered communities and serves to represent the diverse cultures of Indigenous peoples and communities across HA100's geographic area (FNHC Partnership Accord). Indigenous peoples are also represented within the health authority by the Aboriginal Health Program, which offers advisory, collaborative and direct services provided by Aboriginal Liaison Nurses, cultural safety facilitators, physicians, nurse practitioners, nurse educators, nutritionists and dieticians. The success of this program is celebrated by one senior executive, who states, "... our efforts at having an Aboriginal department is a step toward trying to be in conversation with our First Nations communities" (Interview 111).

**Systems core environments.** Not only does HA100 develop and implement Indigenous health initiatives at the institutional level, it also partners with other health authorities and Indigenous organizations to develop capacity and address health equity at the systems level. One of the key collaborative initiatives that the health authority participates in is cultural safety

training, which has strong support from PHSA, FNHA and other partners in the public health system. HA100 states a commitment to delivering culturally-appropriate, culturally-responsive and culturally-safe services to Indigenous clients and patients (Aboriginal Health Plan). To do so, HA100 invests in capacity building and training to ensure that service providers have the knowledge and skills to respond effectively to Indigenous peoples' needs (Aboriginal Health Plan; Five-Year Strategic Plan; and Service Plan). At the time that data were collected, HA100 had "begun providing staff across the Health Authority with cultural safety training," with emphasis on training for new employees (Five-Year Strategic Plan), as part of a province-wide movement to enhance cultural safety in the health system.

In order to maximize the number of employees taking cultural safety training each year, HA100 provides two options: PHSA's online training and another approved form of training that is delivered in-person. In response to the Transformative Change Accord: First Nations Health Plan (2005), PHSA developed San'yas Indigenous Cultural Safety Training (ICS), which is offered to health service providers and other professionals in public services across the province (Provincial Health Services Authority, n.d.). This training contributes to the public health system's overall capacity to address Indigenous health equity, and is encouraged among staff in all the regional health authorities, including HA100. The Aboriginal Health Plan reports that at the time it was published, 426 HA100 staff members had completed the San'yas ICS training. The Aboriginal Health Plan also indicates that HA100 was collaborating with Indigenous partners to develop and deliver an in-person cultural safety training package to complement San'yas ICS online modules. This cultural safety training is intended to feature the First Nations cultures in the region and provide more local context (Aboriginal Health Plan).

There is a growing number of employees completing one or both of the cultural safety

training programs promoted by HA100. Still, culturally safety is a long-term commitment and financial investment. The Aboriginal Health Plan includes a quote from a First Nations survey respondent, who stresses, “You need to make cultural safety training mandatory if it is to really make a difference. When [HA100] is able to do this, the relationship will be better, but it has to be practiced (by [HA100] staff) and consistently experienced by First Nations patients.” To uphold Indigenous health equity as a priority, HA100 needs to commit to ongoing funding, implementation and evaluation of cultural safety training programs. HA100 is also working with universities’ nursing programs across the region to increase cultural safety in curricula for nursing education (Aboriginal Health Plan). These efforts are important steps toward reinforcing a cultural shift within the health authority and across the public health system at large.

**Communities core environments.** HA100 is working beyond the health authority and beyond the health system to engage with Indigenous communities in their service area. A commitment to collaborative relationships is affirmed in the FNHC Partnership Accord, which states:

[HA100] acknowledges the rights and responsibilities of... First Nations within its coverage area and enters into this relationship with the recognition that improving the health status of First Nations and other Aboriginal Peoples in the region requires a collaborative and defined mechanism for such a working relationship.

With this acknowledgement, HA100 commits to developing new relationships as well as sustaining and building upon existing relationships with First Nations communities and organizations that represent Indigenous peoples (e.g. Friendship Centres, Métis Chartered Communities) (Aboriginal Health Plan and Five-Year Strategic Plan). The aim is to “foster meaningful collaboration and partnership,” which will support the health authority’s efforts “to

become more accessible, receptive and responsive (in terms of appropriate actions) to community needs” (FNHC Partnership Accord). Relationship building at the community/institutional levels helps align local and regional priorities as well as community health plans, where applicable, with health authority directives. Furthermore, it facilitates a transition towards Indigenous peoples determining strategic priorities for their local health authority and being in a position to hold the health authority’s leadership accountable for delivery of services in their respective communities.

In addition to building relationships with Indigenous peoples to inform their own programs within the health authority, HA100 collaborates with Indigenous communities to create innovative arrangements for delivery of community-level health services, such as co-location of services, provision of programs in Indigenous venues (e.g. First Nations health centres and Friendship Centres), and transfers of responsibility to First Nations communities (Aboriginal Health Plan and Five-Year Strategic Plan). HA100 acknowledges that “Aboriginal people are more inclined to use services provided by and in their own communities, than they are to use [HA100’s] programs” (Aboriginal Health Plan). One initiative that HA100 was developing at the time that the Aboriginal Health Plan was released was an “Aboriginal funding stream” to transfer resources to Indigenous partners through a contractual arrangement so they can plan and deliver programs otherwise provided by the health authority (Aboriginal Health Plan). By shifting responsibility and resources to First Nations communities and Indigenous partners, the health authority does not have to make assumptions about what will work best for each community; instead, Indigenous peoples are empowered to make their own decisions and deliver services in a culturally-informed way. This practice is endorsed by the FNHC, which supports First Nations decision making and control by helping communities develop comprehensive health and

wellness plans that cover health services, but also child and family services, education, language, land management, water and air quality, and all areas that affect the social determinants of health (Aboriginal Health Plan). Though HA100 has made efforts to support capacity building in Indigenous communities through transfer of resources, the Aboriginal Health Plan notes that many communities continue to lack adequate resources. The FNHC Partnership Accord states that there is “a wide range of diverse nations who are at different stages of development, are different in size and accessibility, [and] have varying capacities to engage.” This limitation is consistent with the literature, which notes lack of capacity in Indigenous communities and local health organizations as a barrier to health equity.

HA100 also supports capacity development to address social determinants of health in community settings. Several references from both documents and interview transcripts celebrate the success of a particular community-driven, multi-stakeholder health network, which brought together a broad group of stakeholders to address transportation issues in a remote reserve community (Aboriginal Health Plan; Five-Year Strategic Plan and Focus Group 102). HA100 was a catalyst for the community development initiative by establishing the community health network in the area; but ultimately, the health authority was only one group at the table. The network includes partners such as First Nations, municipalities, school districts, the RCMP and the British Columbia Ambulance Services. Together, these groups were able to identify the lack of public transportation as a barrier to access to health services, and change the bus-route to go on-reserve. The Aboriginal Health Plan highlights this as an example of “service integration [that] is going well... [and] influenc[ing] systemic change for practices/ services for Aboriginal clients and families.” The success of this community development initiative is attributable to the combined efforts of several community partners and their shared commitment to inter-sectoral

collaboration.

Despite commitments made in key documents, systemic barriers persist within HA100 that hinder relationship building and collaboration with Indigenous communities. One senior executive brings the issue to light in the following quotes:

The organizational structure has completely crippled the ability to work collaboratively and innovatively in at the community level. All the while we're writing documents for the Ministry of Health, talking about all of our community collaboration and I almost can't edit those documents anymore... (Interview 111).

The same participant expands on this critique, explaining how the health authority has failed to uphold its commitment to working with Indigenous communities:

I think our efforts at having an Aboriginal department is a step toward trying to be in conversation with our First Nation's communities. I think there's a long way to go. I... can't remember the last time we had the table meet, I'm guessing it's - I sat on the table in [region] as well as [region], where they brought - where Aboriginal service providers were invited to come to the table to talk with us about how easy it was to use [HA100] services and how we might make our services more relevant and meaningful to First Nations communities and they happened monthly, initially, then they were quarterly, and I don't believe I've been to a meeting in probably a year. So, what message does that give? (Interview 111).

These insights from a senior executive reveal shortcomings that are not identified in the core documents and plans. Specifically, the health authority's commitments and strategic priorities, such as working in collaboration with Indigenous communities, are not always translated into action. This suggests that while Indigenous health equity may be stated as a priority in strategic

plans or in conversations among health authority leadership at the institutional level, it is not fully embedded into practice or experienced at the community level.

### **Root Environments**

**Political root environments.** Decision-making related to the prioritization of Indigenous health equity within the health authority is determined by the institution's internal governance structures as well as external influences through the health system's leadership, political authorities and the current political climate. When asked if political factors play a role in whether or not health equity is a priority, senior executives agreed that politics enter into every decision (Interview 103). In particular, the movement to have Indigenous health as a strategic priority was influenced by strong political direction. One participant reflected on the developments leading up to the shift in priority setting:

... the legacy is that ah in Canada we actually did have to address the issue of the wellbeing of Aboriginal peoples. And ah from the Kelowna Accord onwards umm Campbell and the government of the day did make some very important strategic directions and some policies *and* provided direction explicitly to groups like health authorities to incorporate in improvements for Aboriginal peoples (Interview 103).

These factors are important to consider in analyzing the prioritization of Indigenous health equity, as it demonstrates that decisions within health authorities and the public health system are situated within larger political, social, historical and cultural contexts, representing the root environments.

An important political dynamic that has changed the way in which Indigenous health equity is understood and prioritized within BC's public health system is the Tripartite Framework Agreement. As described in the summary of the policy framework, this legally-

binding Framework Agreement establishes the new First Nations health governance structure and outlines expectations for how the provincial health system will work with First Nations to address health priorities and needs (Government of Canada, 2011). With this new health governance structure in place, HA100 has entered into a relationship with: FNHA, which is responsible for planning and delivery of health programs for BC First Nations; FNHC, which provides political leadership and serves as the advocacy voice of BC First Nations on health related matters; First Nations Health Directors Association (FNHDA), which is an advisory body in research, policy and program planning; as well as the Tripartite Committee on First Nations Health, which helps align planning and service delivery among FNHA, BC's regional health authorities, BC Ministry of Health and Health Canada. HA100's roles and responsibilities in this relationship are outlined in the FNHC Partnership Accord, which formalizes their joint commitment to work together in implementing the Tripartite First Nations Health Plan (FNHC Partnership Accord).

HA100 is committed to working collaboratively with FNHC and other governing bodies in the health system to provide health care services for First Nations peoples, which involves coordinating program planning, health plans, service delivery and funding arrangements across institutions, systems and communities. The FNHC Partnership Accord affirms that:

The parties recognize that they are each accountable to make decisions for the programs and services for which they have responsibility and they are committing to collaborate with each other in the shared goal of improving health outcomes and towards creating a more integrated, culturally appropriate, safe, and effective health system for First Nations Peoples.

Because ELPH Phase 1 data collection was conducted prior to FNHA being formally established in October 2013, the data do not include examples of how HA100 is working with FNHA or FNHC. However, both the Aboriginal Health Plan and the FNHC Partnerships Accord suggest that the new First Nations health governance framework holds tremendous promise for facilitating a new relationship between Indigenous peoples and the health system. The Aboriginal Health Plan emphasizes that “the outcome of the [Tripartite Framework Agreement] is system transformation, not the entrenchment or reinforcement of how things have been done historically.” Ultimately, having institutions within the health system working collaboratively with First Nations health governing bodies with a united vision of Indigenous health equity contributes to a more coordinated health system that can address gaps in health services, improve inter-jurisdictional navigation and enhance access for Indigenous peoples.

**Social root environments.** The health fields, especially public health, are beginning to see a shift in understandings of factors that influence health and wellbeing to encompass social root environments, as demonstrated in the overview of existing literature. Unlike the majority of the literature captured in the scoping review, which frame Indigenous health equity in terms of health outcomes expressed at the individual level, the goals outlined in HA100’s strategic plans place a strong emphasis on social determinants of health that are expressed at the population level. They identify this in the Five-Year Strategic Plan, which states, “We recognize the vital role that broad determinants of health, such as housing, education, food and income, play on improving people’s health. Understanding the health determinants of a population is important in preventing illness, disability and injury.” HA100 endeavours to apply a population health approach, which focuses on applying strategies to reduce health inequities among sub-populations and improving the health of the entire population (Five-Year Strategic Plan). The

core documents and plans list a number of determinants of health that are on the health authority's radar, including factors such as: income, social status, education, employment, housing, transportation networks, social support, health services, gender and culture (Five-Year Strategic Plan and Service Plan).

It is worth noting that the two strategic plans for the health authority that are not specific to Indigenous peoples also do not include any Indigenous-specific determinants of health— with the exception of culture, which is important to Indigenous peoples but not exclusively Indigenous. Both the Aboriginal Health Plan and the FNHC Partnership Accord draw attention to the need for advocacy regarding broader determinants of health, based on recommendations from Indigenous partners and community members. It is explained that, “Many indicators of health have not typically included all the elements considered important by Aboriginal communities (e.g. use of language, traditional healing techniques). We wish to broaden the number of relevant indicators in the updated Aboriginal Health Plan” (Aboriginal Health Plan). FNHA and the Assembly of First Nations use wellness frameworks that include additional measures of community health, such as community control of health services, participation in traditional spiritual ceremonies, presence of certified First Nations health professionals, and involvement of both youth and Elders in community decision-making (Aboriginal Health Plan). Furthermore, survey respondents in the Aboriginal Health Plan add access to community gardens and community kitchens as indicators of community health that need to be considered. Based on the feedback from Indigenous partners and community members, the Aboriginal Health Plan recommends that HA100 supplement health data collection, health status monitoring, and reporting systems to include Indigenous-specific indicators of health and wellness.

By embracing Indigenous understandings of social determinants of health and facilitating discussions within the health authority, HA100 will be better able to monitor and assess relevant information that will assist in prioritizing community needs and designing relevant community-based programs (FNHC Partnership Accord and Focus Group 102). However, several references in the data echo a concern prevalent in the literature that taking action and addressing social determinants of health is beyond the jurisdiction of the health system. The Five-Year Strategic Plan acknowledges that the health authority cannot solve all health-related problems solely by providing health care services, and concedes, "... our ability to have a positive impact on the health and wellness of our residents depends on a vast array of factors, some of which we have little control over (such as housing, employment, and education)." This sentiment is shared by a senior executive, who explains the health authority's role as follows:

The determinants of health which are largely outside of our control, but which are by far the largest factor that affects health. So income, ethnicity, education etc., etc. And so, largely our role is advocacy there... that goes on by different players within the health authority to advocate for equity around those determinants (Focus Group 102).

Nevertheless, acknowledging social determinants of health and advocating for change is not enough to fulfill HA100's commitment to Indigenous health equity. As illustrated in community core environments, the health authority has been working with partners to address social determinants of health, such as access to transportation in First Nations communities, through innovative interventions at the community and systems levels. Institutions such as HA100 can contribute to addressing broader determinants of health equity, but it requires inter-sectoral and inter-jurisdictional collaboration with Indigenous partners and governing bodies.

**Social/ cultural/ historical root environments.** This final section combines social, cultural and historical roots environments because they are inextricably intertwined and cannot be analyzed in isolation. Moreover, the data generally reveal a collective absence of representation of these three relational environments in consideration of the prioritization of Indigenous health equity in HA100. This absence is particularly evident in the lack of references pertaining to colonialism, residential schools, Indian hospitals and racism, which all span across social, cultural and historical root environments. Out of thousands of coded references, a simple text search revealed that the frequency for each of these terms appearing in the data is as follows: colonialism (9), residential schools (9), Indian hospitals (1) and racism (1) (See Appendix E for coding frequency map). All but one of these references were captured from the Aboriginal Health Plan and represent personal testimonials shared by survey respondents, suggesting HA100 is not addressing these critical root environments in its other core documents or in conversations about Indigenous health equity.

The few references relevant to colonialism discuss the intergenerational effects of historic colonization, linking poor health outcomes to poverty, school attrition, and domestic violence, among other legacies of colonialism (Aboriginal Health Plan). However, the data fail to acknowledge contemporary forms of colonialism that persist in Canadian society and in the health system. One survey respondent quoted in the Aboriginal Health Plan asks, “Is there a place for [HA100] to come and talk about *today’s* [emphasis added] forms of colonization? It takes confidence to put yourself out there, including the tears.” This quote suggests HA100 is not currently facilitating these crucial discussions within the health authority for either service providers or service users. The misconception that colonialism is merely a chapter from history is coupled with a lack of awareness of and sensitivity towards the impacts of residential schools

and Indian hospitals, which is reflected upon by one HA100 staff member who completed cultural safety training:

“I knew some things about residential schools but I didn’t know about residential hospitals (aka “Indian hospitals”). There were so many statistics on what a big impact that had on First Nations communities...I went to school and college, and I thought I was informed, but goodness, I was surprised...It’s not about assigning blame and making people feel guilty, it’s about trying to make us aware so we can reduce and eliminate discrimination, so that, in the long term, this will contribute to improving health outcomes... [The training] makes me feel like I’m helping even a little bit just by encouraging others to increase their awareness (Aboriginal Health Plan).

This testimony reaffirms the value of cultural safety training in HA100 and in the public health system. Cultural safety training helps raise awareness of issues such as colonialism, residential schools, Indian hospitals and racism; it also helps staff become more comfortable talking about these difficult topics.

With only one explicit reference to the term ‘racism’ in the data— which was mentioned in an interviewer’s question (Focus Group 104), it would be easy to assume that like other social/ cultural/ historical root environments, there is a lack of awareness or understanding of the role of racism as a determinant of Indigenous health equity. However, closer analysis reveals denial of the presence of racism and discomfort with labeling attitudes and behaviours as such. This finding is captured by a telling exchange between an ELPH interviewer and one senior executive:

Interviewer: ... Like for example, could be related to racism, or you know gender. Is, am I following you correctly when you say “other things”?

Participant: Yeah, well I suppose it could be. You know, there could be some elements of discrimination, unintentional, if someone is showing up in the emergency department with some type of a syndrome, and depending on who they are and where they are coming from, they may be treated differently... I don't know that we have any evidence, solid evidence of that... (Focus Group 104).

In this quote, the participant avoids the term racism, using “discrimination” instead, and minimizes it as infrequent, unintentional and not supported by evidence. On the contrary, we know from the literature that racism is experienced by Indigenous peoples and other marginalized groups in the health system every day. Another senior executive in the same focus group confirms cases of mistreatment of Indigenous clients and patients in HA100:

We had enough evidence based on what we were, what we were aware of in terms of Aboriginal people, and that's where the Aboriginal Liaison worker came from, was based on the experiences of people in emergency departments. It was documented. And that's, that recommendation province-wide came from that feedback (Focus Group 104).

Still, the participant stumbles over word choice and avoids the use of the term racism. Similarly, in another interview, a participant talks about “disrespectful treatment” of Indigenous patients and Indigenous nurses in emergency departments (Interview 111). These few quotes from the data illustrate that HA100 participants were not comfortable with conversations about or use of the term racism. Moreover, with no references in the core documents and plans, it is evident there are no strategic priorities related to eliminating racism in the health authority, which undermines their commitment to reducing barriers to Indigenous health equity.

## Discussion

The findings of this study are largely consistent with the existing literature on the topic of Indigenous health equity and the themes that I identified in the scoping review, including inequitable health outcomes, inequitable access to health services and resources, and inequities in the health system. The emphasis on inequitable health outcomes is apparent in HA100's strategic priority of focusing on improving the health of "high needs populations," including Indigenous peoples (Five-Year Strategic Plan; Service Plan), to address the "excessive burden of illness and disease" (Interview 103). The ways in which HA100 positions Indigenous people in relation to inequitable health outcomes aligns with dominant discourses that measure inequities as disparities expressed at the individual level and fail to examine social, structural and systemic issues that create and reinforce inequities.

A major theme that emerged in both the data and the scoping review is an emphasis on access to health services and resources for Indigenous peoples, which is seen as a critical factor in improving health equity. HA100 focuses its strategic goals and interventions on many of the same structural and systemic barriers as those identified in the literature, including factors such as where health care facilities are located and how many of them there are, how easy it is to apply for services, the availability of transportation and hours of operation. Furthermore, the strategies HA100 has implemented with the aim of improving access for Indigenous peoples are supported by literature on best practices, including cultural safety training, capacity building, hiring Aboriginal Liaison Nurses, and collaborating with Indigenous partners for a more coordinated health system. While HA100 acknowledges that it has an important role to play in enhancing equity of access to health services and resources, it shares the common perception that

changing social equity by addressing social determinants of health is beyond the jurisdiction of the health system.

Although HA100 is conscious of the limited impact of health care services on social equity, the data demonstrate that social determinants of health (e.g. housing, living and working conditions, and education) are embedded in the health authority's core documents and conversations with senior executives, particularly in relation to Indigenous health equity. In this way, HA100 acknowledges the importance of social determinants of health to Indigenous peoples' health and wellbeing; whereas recognition of this inherent relationship is largely absent from the literature. However, there is room for improvement in the inclusion of Indigenous-specific indicators of health in both HA100 and the existing literature (Aboriginal Health Plan). This is especially evident in the analysis of racism as a determinant of Indigenous health equity. Participants avoided the term racism, minimized it as infrequent or unintentional, denied its presence in the health authority altogether and further claimed that it is not supported by evidence (Focus Group 104, Interview 111). Yet, we know from the literature that racism is experienced by Indigenous peoples in the health system on a frequent basis, and acts as a social and cultural barrier to health equity (Allan & Smylie, 2015; Browne, 2017; Cameron et al., 2014; Hayman, 2010; Hayman, White & Spurling, 2009; Loppie, Reading & de Leeuw, 2014).

### **Limitations**

There are a few noteworthy limitations of my study design. First, as a secondary analysis, I am 'riding the coattails' of the ELPH study, benefitting from relationships and partnerships that they have formed with various stakeholders and health authorities over the years. ELPH is a collaborative research project with public health leaders within BC health authorities that began in 2011 before FNHA was formally introduced to BC's public health system and at a time when

Indigenous departments had less presence within health authorities. ELPH research leads met with FNHA representatives once it was established to invite them to be a partner. The research was already well in process at the time, so ELPH respected their decision not to partner and agreed to share updates and findings throughout the research process. Thus, data collected in ELPH does not reflect important work being done by and with Indigenous peoples within BC's public health system, in part, due to lack of partnerships and timing of the project. This creates a significant gap in the representation of Indigenous peoples, communities and cultures in ELPH data, which in many ways, reflects the representations of Indigenous health equity within the public health system.

Second, the type of data collected by ELPH limit my scope and research questions. The original interview guide did not include any questions that explicitly inquire about Indigenous populations, and almost all respondents were non-Indigenous public health practitioners working in the area of mental health promotion and the prevention of harms of substance use. After the parallel analysis was introduced to the study, ELPH added additional questions to the interview guide and recruited participants from Indigenous health departments for Phase 2 data collection. Although I had access to the more recent data that include these additions, I chose to only include Phase 1 data for my thesis because comparison would not be possible given the revised interview guide. Moreover, only the findings from Phase 1 have been presented to and validated by the ELPH stakeholders. My decision to narrow the data set to core documents as well as interviews and focus groups with senior executives also limits the findings in terms of the over-representation of aspirational statements or intentions to act in comparison to reports on progress among current initiatives. With these limitations in mind, I recognize the data do not reflect a complete picture of the most current work in the area of Indigenous health equity. Some key

developments over the last few years that should be taken into consideration include expansion of HA100's Aboriginal Health Program, increased implementation of PHSA's San'Yas Cultural Safety Training across the health system, and notably, FNHA being formally established in October of 2013. These developments show progress in the prioritization of Indigenous health equity and have contributed to advancements in the quality, accessibility, effectiveness, and cultural appropriateness of health care programs and services for Indigenous peoples.

Finally, because I focused on one health authority as a pilot case study, the relevance, applicability and transferability of findings to other settings is limited. Although generalizability in the traditional sense is not the goal of case studies, my aim is to enhance transferability by demonstrating how the analysis can be expanded to other health authorities and other contexts. The pilot case study also served to highlight gaps in the research questions, the data, and the application of the analytic framework, which can inform future studies.

### **Further Research**

The initial work and subsequent feedback generated during the stakeholder engagement meeting is invaluable and provides important guidance for the application of the Xpey' Relational Environment Framework in future Indigenous health equity research endeavours. Specifically, the use of the Xpey' Relational Environments Framework as an analytic framework must be grounded within Indigenous research methodologies informed by cultural protocols and guided by Elders or Knowledge Holders. Furthermore, future applications of the framework— or adaptations of it— should include careful representation and consideration of the unique experiences of specific cultural groups (e.g. Métis peoples and Inuit). With further input into the framework from Indigenous Knowledge Holders and organizational leaders as well as the engagement of Indigenous-led research approaches, the Xpey' Relational Environments

framework could have utility in framing future research questions related to Indigenous equity in BC public health and elsewhere.

This application of Xpey' Relational Environments to a pilot case study within the ELPH program of research serves as an example of the analytic framework's utility for exploring and conceptualizing Indigenous health equity in BC's public health system. The framework captures the critical importance of determinants of Indigenous health equity in BC's formal public health system, but is also transferable to other studies and other contexts. One obvious application for future development is a focused analysis of FNHA's strategies to reduce inequities and enhance health equity for Indigenous peoples. Furthermore, Xpey' Relational Environments could also be used as an analytic framework to explore local health systems within an Indigenous community context, using community-based participatory action research.

### **Recommendations**

My recommendations for HA100 and the public health system span across the relational environments and reinforce the need for a multi-tiered, institution/ system-wide approach. My recommendations are not new, nor can I take credit for them. Rather, they draw from the wisdom and extensive consultation that went into the Final Report of the Royal Commission on Aboriginal Peoples (RCAP) (Aboriginal Affairs and Northern Development Canada, 1996) and the Final Report of the Truth and Reconciliation Commission of Canada (TRC) (Truth and Reconciliation Commission of Canada, 2015). Furthermore, my recommendations reflect basic principles of respectful relationships that Indigenous peoples have been advocating for centuries, such as the teachings offered to us by the Gusweñta: mutual respect, self-determination and non-interference.

**Recommendations for HA100.** Based on the findings from my analysis, HA100 needs to strive towards consistent recognition of Indigenous health equity as a strategic priority. Using the calls to action put forth by RCAP and the TRC, I have three recommendations for the health authority:

*1) Embed Indigenous health equity as an organizational priority in all strategic plans across all programs.* Indigenous health equity is implied as a strategic priority in HA100's core documents and plans and among senior executives; however, it is not explicitly stated as such. Under Health and Healing, Item 5, RCAP recommends "In developing policies to support Aboriginal health, all governments [and health authorities] should base them on the following principles: ... equity, that is, equitable access to the means of achieving health and rough equality of outcomes in health status" (1996, p. 19). Because the health authority has a mandate to serve all residents, including Indigenous peoples, all their plans and policies guiding service delivery are relevant to Indigenous peoples. HA100's current reliance on the Aboriginal Health Program and Aboriginal Health Plan as the primary source of knowledge and action on Indigenous health equity represents a siloed approach. Assigning the responsibility for Indigenous health to a distinct department within the health authority, as opposed to embedding it as a priority across all programs and strategic plans, reproduces the colonial practice of segregating and excluding Indigenous peoples from mainstream society. It also reflects the federal and provincial policy framework, which fails to outline Indigenous-specific provisions within the majority of health policies and legislation. Indigenous health equity is a large-scale commitment that requires 'all hands on deck'; therefore, *all* strategic plans, *all* programs, and *all* staff need to embrace the health authority's strategic priority of ensuring health equity for Indigenous peoples.

One of the ways in which HA100 can operationalize this goal to embed Indigenous health equity as an organizational priority is to include an explicit statement that expresses the health authority's commitment and responsibility to create conditions for Indigenous health equity in all strategic plans across all programs. HA100's Aboriginal Health Program and Aboriginal Health Council should be consulted on how this statement would be phrased and situated within the health authority. This statement would supplement and add clarity to the broad strategic priority of improving the health of "high needs populations," which includes Indigenous peoples among other marginalized groups. Furthermore, including this statement in all strategic plans, including the Aboriginal Health Plan, Service Plans, and Five-Year Strategic Plans, would provide consistency and a unified vision across the health authority. Articulating a clear strategic priority that provides direction for service delivery and management will facilitate greater awareness and uptake among all staff of their responsibility to contribute to HA100's commitment to improving Indigenous health equity.2) ***Respect Indigenous peoples and Indigenous knowledge systems.*** To properly recognize and respect Indigenous peoples as a priority population, HA100 needs to be consistent in how they position Indigenous peoples in relation to health equity and how they are treating Indigenous patients, clients and partners. HA100 currently goes back and forth between listing Indigenous peoples among other "high needs populations" and recognizing them as a "priority population" to work with to address inequities in the health system. TRC calls upon governments and governing bodies (e.g. health authorities) to "recognize, respect, and address the distinct health needs of [all] Aboriginal peoples" (TRC, 2015, p. 3). Furthermore, TRC's Call to Action #22 asserts:

We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of

Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients (TRC, 2015, p. 3).

Indigenous knowledge, ways of knowing and healing practices are missing from HA100's discussions about Indigenous health equity. These knowledge systems should be integrated within the health authority's plans and programs, where appropriate, as determined by Indigenous peoples and protocols.

As noted in the findings, the Aboriginal Health Plan and the FNHC Partnership Accord list several recommendations for HA100 to create space for Indigenous knowledge and knowledge systems; these include: respect clients' cultural differences, values, preferences, and needs; include participation in traditional spiritual ceremonies as a measure of community health; have HA100 staff members learn more about communities' ways of living and cultural protocols; and incorporate Indigenous models of wellness and healing practices into the delivery of services, where appropriate. In addition to these areas for action, I recommend that all HA100 core documents and plans open with an acknowledgement of the territories, cultures and languages representing Indigenous peoples in the health authority's service area. This acknowledgement would serve as a symbol of respect for Indigenous peoples and cultures as well as the lands that HA100 occupies. Moreover, to enhance representation of Indigenous cultures and Indigenous knowledge systems within the health authority, hiring Indigenous peoples should be a priority for recruitment in all positions across all departments, particularly in leadership positions among HA100 senior executives.

**3) Acknowledge Indigenous-specific determinants of health, including colonialism, residential schools, Indian hospitals, and racism.** In order to address barriers to Indigenous health equity, HA100 senior executives and all staff need to expand their understanding of the

sources of inequities to include Indigenous-specific determinants of health and their origins in colonialism. TRC's Call to Action #18 clearly states, "We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools..." (TRC, 2015, p. 2). HA100 currently focuses on disparities in health outcomes in such a way that frames Indigenous identity as a risk factor; this needs to shift towards acknowledgement of the social, structural and systemic determinants of health, coupled with recognition of the health authority's role in perpetuating or interrupting inequities.

One way in which HA100 can start to acknowledge and act on Indigenous-specific determinants of health is by including Indigenous wellness indicators in their strategic planning, monitoring and assessment of population health, as well as in their reporting systems. For instance, HA100 could utilize wellness frameworks developed by FNHA and the Assembly of First Nations, which include measures of community health, such as community control of health services, participation in traditional spiritual ceremonies, presence of certified First Nations health professionals, and involvement of both youth and Elders in community decision-making. Another simple change that HA100 could make in regards to this third recommendation is reframing their strategic direction of serving "high needs populations" to an explicit acknowledgement of the health authority's responsibility to provide services that meet the needs of Indigenous peoples, who experience unique determinants of health due to historical and ongoing colonialism and racism.

**Recommendations for the public health system.** In addition to my recommendations for HA100, I have three recommendations for the broader public health system, which also has a

responsibility to prioritize Indigenous health equity. These three recommendations are similarly rooted in RCAP and TRC's calls to action:

*1) Acknowledge and address systemic barriers to health equity.* Eliminating systemic barriers to health equity for Indigenous peoples requires multi-tiered, inter-jurisdictional efforts, as inequities are often entrenched in policies and political systems. I echo TRC's Call to Action #20, which calls upon all levels of government to work together "In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves..." (TRC, 2015, p. 3). BC's new First Nations health governance framework is a step towards a more coordinated and better integrated health care system for Indigenous peoples; however, there are still gaps for Métis peoples, Inuit, non-status First Nations peoples, and First Nations peoples not living on-reserve. These gaps need to be addressed by the health system, in collaboration with provincial and federal governments, in order to ensure health equity— not only between Indigenous peoples and the general population, but within and between Indigenous sub-groups.

Because many systemic barriers to Indigenous health equity lie outside what is typically understood as the health system's jurisdiction, the public health system should advocate for a redistribution of provincial and/ or federal funding. For instance, more funding and resources need to be allocated to community-driven services that are better positioned to address root environments, such as housing, transportation, intergenerational trauma, culturally-based healing practices, etc. This practice is endorsed by the FNHC, which supports First Nations decision-making and control by helping communities develop comprehensive health and wellness plans that cover health services, but also child and family services, education, language, land management, water and air quality, and all areas that affect the social determinants of health. The public health system can also support the redistribution of resources by transferring funds

through contractual arrangements for services otherwise provided by health authorities, which HA100 has started to do through its Aboriginal Funding Stream.

In addition to addressing jurisdictional barriers to health equity, the public health system has a responsibility to eliminate racism as a systemic barrier to health equity. One way in which the public health system can operationalize this goal is by establishing a reporting system and accountability framework to monitor and follow-up on racial discrimination reported by Indigenous patients/ clients. With a formal reporting system in place, public health professionals would no longer be able to deny the evidence of racism within their health authority, as demonstrated in the findings. The reporting system would need to be supplemented by ongoing training processes for staff, processes for holding perpetrators accountable, as well as protocols for issuing formal apologies and offering support for victims.

**2) *Mandate cultural safety training for all staff/ incoming staff.*** Although regional health authorities, such as HA100, are increasingly providing opportunities for staff to complete training programs, such as PHSA's San'yas Indigenous Cultural Safety Training or other curricula tailored to cultural or regional contexts, cultural safety training is not yet mandated across the public health system. TRC's Call to Action #23 calls upon all levels of government to "provide cultural competency training for all healthcare professionals" (TRC, 2015, p. 3). This requires a commitment among all health authorities within the public health system to ongoing funding, implementation and assessment of cultural safety training programs. All existing staff within health authorities should complete the training; furthermore, cultural safety should be built into the required training for all new staff that are hired.

To maximize effectiveness and efficiency of cultural safety training, the public health system should also work with universities to add cultural safety to university programs' curricula

for future health care professionals. This recommendation also comes from the TRC in its Call to Action #24: “We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues... This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism” (TRC, 2015, p. 3). Health authorities should partner with public health, nursing and other health-related academic programs to co-develop curricula and training materials for students that will graduate and enter into the public health field— and any health profession that provides services to Indigenous peoples. Embedding cultural safety into the education of future health professionals will contribute to the sustainability of cultural safety training and will potentially lead to a shift in the professional culture, whereby cultural safety skills and knowledge are standard across the public health system.

***3) Continue working with Indigenous partners and building meaningful relationships.***

Finally, and most importantly, it is essential that health authorities, governing bodies and political leadership within the health system continue working with Indigenous partners, organizations and communities. These relationships need to be respectful and uphold Indigenous peoples’ right to self-determination. The importance of this recommendation is emphasized in two of RCAP’s calls to action. First, under Health and Healing, Item 9, RCAP states that “Governments, both Aboriginal and non-Aboriginal, should support the development of regional Aboriginal agencies and councils to promote cooperation among communities and the strategic deployment of regional resources in the health field” (RCAP, 1996, p. 20). Health and Healing, Item 11 reinforces this recommendation with the following call to action:

... there is a need for cooperation and collaboration - the Commission believes that enlisting the support of the mainstream service system must be a significant element of its

strategy. Mainstream programs and service providers can contribute in two important ways: a) by supporting the development of Aboriginally controlled service systems; and b) by improving the effectiveness and appropriateness of their own services (RCAP, 1996, p. 21).

This final recommendation should be understood as a platform for moving forward with building healthy relationships with Indigenous peoples and the foundation for all other strategies to enhance Indigenous health equity in the public health system.

To implement these calls to action, the public health system should commit to investing time and resources into relationship building, consultation and collaborative initiatives with Indigenous communities. Collaborative relationships can take the form of co-location of services, provision of health programs in Indigenous venues, and transfers of responsibility to First Nations communities. The public health system should also explore opportunities to develop new relationships as well as sustain and build upon existing relationships with Métis Chartered Communities, Aboriginal Friendship Centres and Indigenous interest groups. A specific recommendation that could support relationship building between the public health system and Indigenous peoples in BC is to revisit the Tripartite First Nations Health Plan and FNHC Partnership Accords that were signed with regional health authorities, and to develop a report on progress towards commitments. These documents outline roles and responsibilities of collaborative relationships, and formalize joint commitments to work together in partnership to provide health care services to First Nations peoples; however, similar to the majority of the data in this case study, these commitments need to be substantiated with documented action.

## Conclusion

The aim of this research was to explore the public health system's prioritization of Indigenous health equity, using Xpey' Relational Environments Framework to analyze one regional health authority's priorities and strategies. I sought to answer the question: How has Indigenous health equity been identified and prioritized within HA100 as reflected in core documents and plans as well as interviews with key decision makers in the health authority? This pilot case study serves as an example of the analytic framework's utility for conceptualizing Indigenous health equity in BC's public health system. The framework captured many of the issues cited in the literature, including inequitable health outcomes, inequitable access to health services and inequities in the health system. It also filled gaps in the literature by bringing light to tensions around social, historical and cultural root environments. Moreover, analyzing data within this framework illustrated associations between various determinants of health equity, so as to highlight the interconnected nature of relational environments and draw attention to important causal links.

By organizing findings into stem, core and root relational environments, the prioritization of Indigenous health equity was embodied as human, non-human and symbolic processes that are embedded within institutions, systems and community settings, and further situated within larger political, social, historical and cultural contexts. The data highlight a number of relational environments in which HA100 has implemented successful strategies aimed at enhancing Indigenous health equity. Among stem environments, examples include delivering health services in Indigenous community settings, hiring Aboriginal Liaison Nurses, and making Indigenous health an organizational goal. For core environments, HA100's achievements include instating institution-wide Indigenous health programs and plans, providing opportunities for

cultural safety training, and building collaborative relationships with Indigenous communities. Within root environments, political leadership and directives have contributed to HA100's commitments to partnering with Indigenous health governing bodies. Progress is also being made towards acknowledging social determinants of health; however, there is room for improvement in how HA100 understands and embraces its role with regards to other root environments, particularly recognizing and acting on ongoing colonization and racism.

While there are a number of examples of how HA100 has made positive steps towards prioritizing and implementing Indigenous health equity within its programs and services, analysis revealed several areas for improvement across the relational environments. In the stem environments, for instance, HA100's organizational culture perpetuates a dominant discourse that positions Indigenous peoples as a "high needs population," and there is limited representation of Indigenous knowledge systems and healing practices within the health authority. In core environments, there are systemic barriers that hinder relationship building and collaboration with Indigenous communities, such as HA100's organizational structure and the way in which Indigenous-specific programming is siloed within the health authority. Finally, root environments present the most pressing need for improvement, particularly in relation to recognition and acknowledgement of Indigenous-specific determinants of health, such as colonialism, residential schools, Indian hospitals and racism. These areas can be improved through multi-tiered, institution/ system-wide approaches that span the relational environments.

I want to reinforce that the recommendations I have put forward in this thesis are not my own. The RCAP (1996) and TRC (2015) calls to action are directly and undeniably relevant to the incessant issues we continue to face in addressing social, systemic and structural barriers to Indigenous health equity. All 440 RCAP recommendations and 94 TRC calls to action warrant

immediate action, yet few of these have been implemented. Based on the findings from this research, I propose that several of these calls to action can be addressed within HA100 and BC's public health system. Within HA100, this can be achieved through: 1) embedding Indigenous health equity as a priority in all strategic plans across all programs; 2) demonstrating respect for Indigenous peoples and Indigenous knowledge systems; and 3) considering Indigenous-specific determinants of health, including colonialism, residential schools, Indian hospitals, and racism. Action is also required across the public health system to complement and strengthen the health authority's efforts; my recommendations include: 1) acknowledging and addressing systemic barriers to Indigenous health equity; 2) mandating cultural safety training for all staff/ incoming staff; and 3) continuing working with Indigenous partners and building relationships. Again, these recommendations for wise practices have been clearly outlined elsewhere and the evidence demanding action is abundant. It is time we take action, both individually and collectively.

In conclusion, improving Indigenous health equity through human, non-human and symbolic interactions in institutional, system and community settings is a current priority for HA100; whereas reconciling historical relationships and creating equitable social, cultural and political conditions that promote optimal health and wellbeing for Indigenous peoples is more of a long-term and indirect goal for HA100. One senior executive commented on the slow progress towards Indigenous health equity:

...it took 25 years before we started to doing anything about the inequity for Aboriginal peoples... I actually am optimistic that it will become an integral part of what we do because we're making it happen, and the conversation is far broader now than it ever has been (Interview 103).

This quote captures both the struggles and the hope with regards to the prioritization of

Indigenous health equity, as reflected in both HA100 and BC's wider public health system. My hope is that this research will contribute to the conversation that is now taking place and add to the momentum that has been gaining in order to make the vision of health equity for Indigenous peoples more tangible.

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### Appendix A: Summary Table of Indigenous Health Policies in Canada (Organized by Jurisdiction)

Adapted from Lavoie, Gervais, Toner, Bergeron, and Thomas (2011a)

Name of the Policy	Year Ratified	Relevance to Indigenous Health Equity
<b>Historical Context</b>		
<b>Douglas Treaties</b> <i>Also known as the Vancouver Island Treaties or the Fort Victoria Treaties</i>	1850, 1854	<ul style="list-style-type: none"> <li>◆ The Douglas Treaties were a series of 14 treaties signed between certain First Nations across Vancouver Island and representatives of Her Majesty Queen Victoria.</li> <li>◆ Unlike some of the other treaties signed across Canada, the Douglas Treaties did not contain any health-specific provision (Lavoie, Gervais, Toner, Bergeron, &amp; Thomas, 2011a).</li> </ul>
<b>British North America (BNA) Act</b>	1867	<ul style="list-style-type: none"> <li>◆ The BNA Act is the foundation of the Canadian Constitution. It set forth the division of powers and defined jurisdictional boundaries for Canadian federalism.</li> <li>◆ It stipulates “Indian affairs”, including “Indians and the lands reserved for Indians” as a federal jurisdiction (Section 91(24)) and health care, alongside social services and education, as a provincial jurisdiction (Kelly, 2011).</li> <li>◆ The Act creates ambiguity over the provision of health care to Indigenous peoples that remains today (Kent, 2014).</li> </ul>
<b>Indian Act</b>	1876	<ul style="list-style-type: none"> <li>◆ The Indian Act established the system of band council governments, and continues to regulate their functioning.</li> <li>◆ The Indian Act fails to define clear jurisdictional responsibility for Indigenous health governance (Kent, 2014).</li> <li>◆ Section 73 gives the Governor in Council the authority to make health-related regulations on reserves, but does not provide sufficient authority for a comprehensive public health and health services regulatory framework (Lavoie, Gervais, Toner, Bergeron, &amp; Thomas, 2011a).</li> <li>◆ Section 81 allows bands to enact health related by-laws. However, section 4, has historically prevented their enactment by requiring that they be consistent with territorial and provincial health laws (Lavoie, Gervais, Toner, Bergeron, &amp; Thomas, 2011a).</li> </ul>

<b>Treaty No. 8</b>	1899	<ul style="list-style-type: none"> <li>◆ Treaty No. 8 covers an area of 840,000 square kilometers, which encompasses the northern half of Alberta, the northwest corner of Saskatchewan, and parts of northern BC (Lavoie, Gervais, Toner, Bergeron, &amp; Thomas, 2011a).</li> <li>◆ Treaty No. 8 recognizes the co-existence of First Nations and Métis peoples.</li> <li>◆ Like the Douglas, Treaty No. 8 contains no health-specific provisions within the text of the treaty. However, the Treaty Commissioner’s notes include clear commitments to the provision of medicines (Lavoie, Gervais, Toner, Bergeron, &amp; Thomas, 2011a).</li> </ul>
<b>Canada Health Act</b>	1984	<ul style="list-style-type: none"> <li>◆ The Canada Health Act reinforces the jurisdictional divisions defined by the BNA Act, by stating that the provinces and territories are responsible for the delivery of health services.</li> <li>◆ The Act does not contain Indigenous-specific provisions or address health service provision on-reserve (Lavoie, Gervais, Toner, Bergeron, &amp; Thomas, 2011a).</li> </ul>
<b>Federal Policies</b>		
<b>Indian Health Policy</b>	1979	<ul style="list-style-type: none"> <li>◆ The Indian Health Policy has three pillars:               <ol style="list-style-type: none"> <li>1. Improve the health status of Indian communities through community-driven mechanisms;</li> <li>2. Strengthen relationships between Federal, Provincial, and local governments and Indian communities; and</li> <li>3. Increase the capacity of Indian communities to take control of decisions affecting their health.</li> </ol> </li> <li>◆ The Policy recognized First Nations’ right to assume responsibility for administering any or all of their community health programs.</li> <li>◆ The term “Indian” excludes Métis, Inuit, non-status First Nations and First Nations living off-reserve, thus creating ambiguity over the Act’s range and application (Lavoie, Gervais, Toner, Bergeron, &amp; Thomas, 2011a).</li> </ul>
<b>Health Transfer Policy</b>	1989	<ul style="list-style-type: none"> <li>◆ The Health Transfer Policy facilitates the decentralization of the planning and delivery of community-based health services that would otherwise be controlled by the federal government.</li> <li>◆ Communities can opt into agreements at their own pace, and can negotiate their level of control, flexibility and accountability (Government of British Columbia, 2005).</li> </ul>

		<ul style="list-style-type: none"> <li>◆ The Health Transfer Policy only applies to First Nations reserve communities south of the 60th parallel; but in 1994, an integrated model was introduced for Northern communities originally deemed too small to successfully transfer control over health governance (Lavoie, Gervais, Toner, Bergeron, &amp; Thomas, 2011b).</li> <li>◆ Even though the Health Transfer Policy broadens opportunities for First Nations' control over health governance, the federal government still exercises control through financial transfers, reporting requirements, the use of third party management, and its ability to override all bylaws (Adelson, 2005).</li> </ul>
<b>Provincial Policies</b>		
<b>Health Act</b>	1996	There are no Indigenous-specific provisions
<b>Health Authorities Act</b>	1996	There are no Indigenous-specific provisions
<b>Health Care (Consent) and Care Facility (Admission) Act</b>	1996	There are no Indigenous-specific provisions
<b>Health Emergency Act</b>	1996	There are no Indigenous-specific provisions
<b>Health Professions Act</b>	1996	There are no Indigenous-specific provisions
<b>Health Research Foundation Act [Repealed]</b>	1996	There are no Indigenous-specific provisions
<b>Health Special Account Act</b>	1996	There are no Indigenous-specific provisions
<b>Hearing Aid Act</b>	1996	There are no Indigenous-specific provisions
<b>Hospital Act</b>	1996	There are no Indigenous-specific provisions
<b>Hospital (Auxiliary) Act [Repealed]</b>	1996	There are no Indigenous-specific provisions
<b>Hospital District Act</b>	1996	There are no Indigenous-specific provisions
<b>Hospital District Finance Act [Repealed]</b>	1996	There are no Indigenous-specific provisions
<b>Hospital Insurance Act</b>	1996	There are no Indigenous-specific provisions

<b>Medical and Health Care Services Special Account Act [Repealed]</b>	1996	There are no Indigenous-specific provisions
<b>Medical Practitioners Act</b>	1996	There are no Indigenous-specific provisions
<b>Medicare Protection Act</b>	1996	There are no Indigenous-specific provisions
<b>Mental Health Act</b>	1996	There are no Indigenous-specific provisions
<b>Ministry of Health Act</b>	1996	There are no Indigenous-specific provisions
<b>Health and Social Services Delivery Improvement Act</b>	2002	There are no Indigenous-specific provisions
<b>Health Sector Partnerships Agreement Act</b>	2003	There are no Indigenous-specific provisions
<b>Tobacco Control Act</b>	1996	Section (3) Subsection (2) does not apply to the ceremonial use of tobacco in or on school property if the ceremonial use of tobacco is approved by the board and it is performed (a) in relation to a traditional aboriginal cultural activity, or (b) by a prescribed group for a prescribed purpose
<b>Interjurisdictional Policies</b>		
<b>Transformative Change Accord (TCA)</b>	2005	<ul style="list-style-type: none"> <li>◆ Signed by the Government of British Columbia, the Government of Canada, and the First Nations Leadership Council (FNLC)</li> <li>◆ The TCA is a 10-year commitment that includes 29 action items, grouped under three broad objectives: <ol style="list-style-type: none"> <li>1. Close the gaps between First Nations and other British Columbians in the areas of education, health, and housing;</li> <li>2. Reconcile Aboriginal rights and title with those of the Crown;</li> <li>3. Establish a new relationship based on mutual respect and recognition (Government of British Columbia, 2005).</li> </ol> </li> <li>◆ It is aimed primarily at First Nations, and does not include other Indigenous groups in BC (Lavoie, Gervais, Toner, Bergeron, &amp; Thomas, 2011a).</li> <li>◆ The TCA marks a major shift in Indigenous health policy in BC.</li> </ul>
<b>Tripartite First Nations Health Plan (TFNHP)</b>	2007	<ul style="list-style-type: none"> <li>◆ Signed by the Government of British Columbia, Health Canada, the Union of BC Indian Chiefs, the First Nations Summit, and the BC Assembly of First Nations.</li> </ul>

		<ul style="list-style-type: none"> <li>◆ The TFNHP is a 10-year commitment that builds on the TCA, adding new action items, such as the creation of a new health governance structure specifically for BC First Nations.</li> <li>◆ The new governance structure is comprised of four components: <ol style="list-style-type: none"> <li>1. First Nations Health Authority (FNHA);</li> <li>2. First Nations Health Council;</li> <li>3. Tripartite Committee on First Nations Health;</li> <li>4. First Nations Health Directors Association (FNLC et al., 2007).</li> </ol> </li> </ul>
<p><b>Tripartite Framework Agreement on First Nations Health Governance</b></p>		<ul style="list-style-type: none"> <li>◆ The Tripartite Framework Agreement builds on the previous two plans, and sets the policy framework in motion.</li> <li>◆ The Government of British Columbia, the Government of Canada, and the First Nations Leadership Council signed the legally-binding framework agreement that outlines: <ul style="list-style-type: none"> <li>○ How First Nations will work with the health system to better meet First Nations health priorities and needs;</li> <li>○ The funding commitments for the transfer of federal First Nations health programs and services; and</li> <li>○ The new health governance structure for First Nations health services (Government of Canada, 2011).</li> </ul> </li> <li>◆ On October 1<sup>st</sup>, 2013, Health Canada officially transferred its role in the design, management, and delivery of First Nations health programming in British Columbia to First Nations Health Authority (Health Canada, 2013).</li> <li>◆ The Tripartite Framework Agreement is a first in Canada and represents a historic transformation of health policy.</li> </ul>

**Appendix B: Summary Table of Rapid Scoping Review Search Results (Organized by Database)**

Citation	Population	Country	Key Concepts	Methods	Key Findings
<b>MEDLINE (21 results)</b>					
Arnold (2014) <sup>3</sup>	Native American Women	United States	Access, proper equipment	Systematic Review	Hyde Amendment restrictions infringe on the reproductive rights of Native American women
Boudville, Anjou and Taylor (2013)	Indigenous Australians; adults (19-44 years)	Australia	Accessibility of health services; barriers to access and solutions to increase access; cataract surgery; Australian health system	Qualitative study; interviews and focus groups; 530 participants, including a cross-section of healthcare professionals as well as Aboriginal clients; 21 site locations	Health system barriers at primary care, specialist care and hospital levels; Barriers include: long waiting times, cost of surgery, complexity of the steps involved in treatment, lack of surgical capacity and low awareness of regional eye health needs; Strategies to overcome these barriers involve a system-wide approach
Brierley, Suarez, Arora and Graham (2014)	Indigenous peoples in remote Amazonian Peru	Peru (Peruvian Amazon, north-eastern Peru)	Healthcare accessibility; health status; health education; health beliefs and perceptions	Interviews with 179 adult inhabitants of 10 remote settlements attending health clinics	Common issues include: poverty, household overcrowding, poor sanitation; and low levels of health education

<sup>3</sup> Also appears in Social Sciences Index and CINAHL.

Cameron et al. (2014) <sup>4</sup>	Aboriginal People	Canada	Structural injustices, barriers, stigma, stereotyping, discrimination	Qualitative; Indigenous, interpretive and participatory research methodologies employed in partnership with Aboriginals	Structural injustices act as barriers to access, such as addressing the stigma, stereotyping and discrimination experienced by Aboriginal people
Couzos and Davis (2005) <sup>5</sup>	Aboriginal and Torres Strait Islander People	Australia & New Zealand	Targeted programs that are relevant to cultural needs for Aboriginal and Torres Strait People	This article reports on the findings of a study examining the uptake of the Asthma 3+ Visit Plan initiative among Aboriginal community controlled health services	Significant barriers prevent Aboriginal people's access to Asthma 3+ Visit Plan; Aboriginal and Torres Strait Islander patient access to both spacer devices and asthma medication is often poor; A targeted asthma information strategy is needed
DiGiacom et al. (2010) <sup>6</sup>	Aboriginal Australians	Australia	Inadequate information systems and communication strategies	Qualitative (Interviewing healthcare professionals to inform on barriers relating to cardiac rehabilitation programs)	Inadequate information systems and communications strategies contribute to low Aboriginal participations rates in CR

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<sup>4</sup> Also appears in CINAHL.

<sup>5</sup> Also appears in CINAHL.

<sup>6</sup> Also appears in CINAHL.

Gao et al. (2008)	Status Aboriginal people with chronic kidney disease	Canada (Alberta)	Healthcare accessibility; health services; chronic kidney disease; ethnic disparities	Compared health outcomes among Aboriginal and non-Aboriginal patients with chronic kidney disease in Canada	Findings suggest potential inequities in care among status Aboriginal people with chronic kidney disease, such as increased hospital admittance and visits to a nephrologist
Hayman (2010)	Aboriginal and Torres Strait people ; urban and regional populations	Australia	Accessibility of health services; cultural appropriateness; health care organization	Analyzed 413 Adult Health Checks; evaluated health status; identified chronic disease risk factors	Access to a quality improvement program improves health outcomes for patients in Aboriginal and Torres Strait Islander health settings
Hayman, White and Spurling (2009)	Aboriginal and Torres Strait people; urban and regional populations	Australia (Inala, south-western Brisbane, Queensland)	Accessibility of health services; mainstream general practice; health outcomes; health care organization and administration	Focus group with an Indigenous community; telephone interviews	Deficits such as: lack of Indigenous staff, staff perceived as unfriendly, inflexibility regarding time and lack of Indigenous artwork; Strategies for improving access include: Indigenous leadership, increased funding and engaging with community programs

Hepworth et al. (2015)	Urban Aboriginals and Torres Strait Islanders	Australia (Southern Queensland)	Accessibility of mental health care; primary health care services; structural and functional access barriers; cultural safety; psychological and mental health; health inequities	Mixed-methods research design; open-ended interviews with psychologist, social worker and clients; focus groups with additional healthcare professionals; quantitative data used to review service utilization and access	Increased access by Aboriginals and Torres Strait Islanders to mental health care was related to three main themes: responsiveness to community needs, trusting relationships and shared cultural background; Strategies for decreasing barriers to access include: holistic health care services, cultural safety and close proximity to where people lived
Johnston and Coory (2005)	Indigenous mothers and babies	Australia	Perinatal mortality; birthweight and gestational age; prevention; accessibility of primary health care and hospital care	Population-based, descriptive study; compared perinatal mortality rates among Indigenous and non-Indigenous babies; stratified by birth-weight and gestational age	Indigenous babies are twice as likely to die as their non-Indigenous counterparts; main causes are: they are born too early and too small; strategies to reduce the number of deaths include primary health care initiatives

Jones, Parker and Jamieson (2014) <sup>7</sup>	South Australian Indigenous Population	Australia	Access, Socioeconomic, Health literacy	Quantitative (nested logistics regression; multivariable modeling; risk indicators; odds ratios; confidence intervals)	Vulnerable population, risk indicators contributing to poor self-rated oral health included socio-demographic, dental care access and oral health literacy-related factors
Kelاهر, Ferdinand and Taylor (2012)	Indigenous Australians	Australia	Accessibility of eye health services; cataract surgery; socio-economic indices; community education	Community- level study that used data from multiple sources including Medicare Australia, inpatient and outpatient data and the National Indigenous Eye Health Survey	Rates of cataract surgery among communities with high Indigenous populations fell below rates in areas with low Indigenous populations; addressing disparities in access to eye health services requires a coordinated approach and community education
Kelاهر et al. (2006) <sup>8</sup>	Aboriginal and Torres Strait Islander People	Australia	Targeted population, targeted programs, improved access to medicine	Mixed Methods; data collection: public submissions; interviews with government and other stakeholders; pharmacist survey; medicine utilization and expenditure data	SPBSAs have been very successful and demonstrates an effective model for the development of Indigenous health policy

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<sup>7</sup> Also appears in CINAHL.

<sup>8</sup> Also appears in CINAHL.

Otim, Kelaher and Doran (2014)	Indigenous Australians	Australia (Victoria)	Indigenous-specific health care services; priority setting; economic evaluation	Paper survey instrument; face-to-face survey approach; Indigenous and non-Indigenous decision-makers; mixed methods analysis (descriptive statistics and content analysis)	Key criteria for priority setting in Indigenous health care include: the size of the health burden; sustainability and acceptability of interventions; historical trends/patterns; and efficiency Economic evaluation can be a useful tool for a systematic approach to using available data/evidence in priority setting
Patrick (2011)	First Nations	Canada (BC)	Access to safe drinking water; source water protection; water quality standards	N/A	The author proposes that that “greater attention to source water protection has potential for both to improve drinking water quality as well as to re-connect health and place for First Nations in Canada”
Tieman et al. (2014)	Aboriginals and Torres Strait Islanders	Australia	LIt.search (PubMed search filter), Aboriginal and Torres Strait Islander health literature <sup>9</sup>	Scoping study of the characteristics of published Aboriginal and Torres Strait Islander literature, followed by systematic identification and testing of search terms	Demonstrated complexity in the use of search terms and publication characteristics; developed LIt.search, a search filter, to facilitate the use of evidence in practice and policy-making

<sup>9</sup> This source was excluded due to its lack of relevance to health equity. However, it was useful and helped inform my scoping study.

Torri (2012; 2011) <sup>10</sup>	Indigenous Population	Chile	Indigenous and western health systems; intercultural health practices	Qualitative	Effective and equitable intercultural health practices will not take place unless there will be an integral valorization of Indigenous cultures from a broader perspective
Turner, Xie, Arnold, Dunn and Taylor (2011)	Indigenous Australians; adults (40+ years)	Australia	Access to and utilization of eye health services; Aboriginal Medical Service; cultural appropriateness	A national, stratified, random cluster sample drawn from 30 communities across Australia; each community included roughly 300 Indigenous people	The availability of an optometrist working in an Aboriginal Medical Service and/ or a regional eye health coordinators was significantly associated with improved utilization of and access to Aboriginal Health Services
Wardman, Clement and Quantz (2005)	Rural Aboriginals; on-reserve and off-reserve	Canada (BC)	Access to and utilization of health services; rural community organizations	267 face-to-face interviews with Aboriginal persons in seven rural community organizations across the province	Most respondents indicated that services were available; common concerns include: the need to travel for services and the lack of access to more specialized services
Widdup et al. (2012) <sup>11</sup>	Aboriginal and non-Aboriginal families with infants	Australia	Access, improving targeted programs	Quantitative; case-control study; comparison of Aboriginal and non-Aboriginal infants	Highlights the challenges of ensuring equitable access to a universal post-natal home visiting program for Aboriginal families

<sup>10</sup> Also appears in Social Sciences Index.

<sup>11</sup> Also appears in CINAHL.

<b>CINAHL (8 results; 7 of the 8 are duplicates)</b>					
Gross (2007)	Indigenous Youth	Australia	Accessibility of health services; cultural relevance and appropriateness	Quantitative; data collected over a one-year period was cross referenced with service records	Use of an Indigenous Health Worker significantly contributes to the needs of Indigenous young people in youth detention by reducing barriers to access for the assessment of mental health problems and substance misuse
<b>Social Sciences Index (4 results; 2 of the 4 are duplicates)</b>					
Koopmans, Uiters, Devillé and Foets (2013)	Turkish, Moroccans, Surinamese and Antillean migrants <sup>12</sup>	Holland	Accessibility of mental health care; immigrants; targeted programs	N/A	Access to outpatient mental health care is equal for migrants compared to the native Dutch population and the degree to which differences in use reflect need, educational level, proficiency in Dutch and acculturation
Oliveira et al. (2006)	Native Hawaiians	United States, Hawaii	Culturally appropriate programs; Native Hawaiian cultural factors	Qualitative; review of program expansion, sustainability and treatment efficacy research	Psychology can support improved access and quality of rural health services through the development of integrated behavioral health programs within primary care settings

<sup>12</sup> This source was excluded on the basis of population relevance.

<b>Canadian Health Research Collection (3 results)</b>					
Ferguson and Office of the Auditor General (2015)	Remote First Nations Communities	Canada	Health Canada is doing a poor job assessing the needs of First Nations communities in remote areas. An overhaul of work operations is needed	Performance audit report – independent, objective and systematic assessment of how well government is managing its activities, responsibilities and resources	Health Canada (HC) is responsible for not ensuring mandatory nurse training and nursing station deficiency (lack of resources). HC did not account for FN community needs when allocating resources; did not compare access to health services with other FN communities; inter-jurisdictional challenges have been problem
O'Brien et al. (2015)	First Nations Children	Canada	Accessibility of dental services; inequity in services	Review of over 300 government documents; 25 interviews with professionals in health and child welfare	First Nations children face challenges to accessing dental services compared to other children; jurisdictional ambiguities and underfunding give rise to jurisdictional disputes
Rosenberg and McMaster University (2009)	Older Aboriginal People	Canada	Lack of research regarding older Aboriginal people	Quantitative; 2006 Census data, the Aboriginal Peoples Survey (APS) and the Canadian Community Health Survey (CCHS)	Data analyses and literature are limited because of the dominance of research and literature focused on younger Aboriginal Peoples

UVic Library Summons 2.0 (2016-2017 Additions) (6 results)					
Citation	Population	Country	Key Concepts	Methods	Key Findings
Brown, Middleton, Fereday and Pincombe (2016)	Aboriginal and Torres Strait islander women	Australia	Maternity health outcomes; culturally-appropriate care; Aboriginal women's experiences of midwifery	Interpretive Heideggerian phenomenological approach; semi-structured interviews with midwives; analysis informed by van Manen's approach	Aboriginal and Torres Strait islander women face health disparity in relation to their maternity health outcomes; culture and culturally appropriate care can contribute to positive health outcomes for Aboriginal women; midwives can support women with and through Aboriginal cultural knowledge
Browne (2017)	Aboriginal peoples who use illicit drugs and/or illicit alcohol living in Vancouver's inner city	Canada	Racism; discrimination; stigma; intersectionality; experiences accessing healthcare services; patient-provider encounters	Indigenous methodologies; community-led study design, data collection and analysis; peer-facilitated talking circles; intersectionality framework	Inequities among Aboriginal peoples are perpetuated by systemic racism and discrimination; stigmatizing racial stereotypes negatively influence health professionals' attitudes and clinical practice; the authors conclude that healthcare providers must understand the structural and historical factors that influence inequities in healthcare

Browne et al. (2016)	Urban Aboriginals in two inner cities in Canada	Canada	Cultural safety; discrimination; health equity; racism; structural violence; colonialism; trauma- and violence-informed care	Ethnographic design; mixed methods; participant observation; in-depth interviews with 114 patients and staff	The authors present four key dimensions of equity-oriented health services: inequity-responsive care, culturally-safe care, trauma- and violence-informed care, and contextually tailored care; the authors conclude that organizational-level interventions are needed to promote the provision of more equitable, responsive and respectful health services for Indigenous peoples; efforts must engage Indigenous leaders, agencies and communities as partners to operationalize and tailor key dimensions to local contexts
Chamberlain et al. (2016)	Australian Aboriginal families	Australia	Services supporting Aboriginal families; coordinating health services	Authors reflect on the utility of a care coordination framework for assessing service coordination; methods include stakeholder consultation, service mapping and in-depth interviews with service providers and an Aboriginal mother	Improving the health of Aboriginal people and improving coordination of services are national priorities in Australia; a fragmented range of services support Aboriginal families with complex and changing needs; few opportunities for developing relationships and several factors that undermined relationships

Gerlach, Browne and Suto (2016)	Indigenous children	Canada	Indigenous early child development; early childhood interventions; relational approaches	In depth, semi-structured interviews were used to obtain the perspectives of Indigenous caregivers and Elders, Aboriginal infant development workers, and administrative leaders; critical qualitative inquiry	inseparability between child health inequities and the impact of structural social factors on families' lives; relational approaches to care, including: fostering cultural connections, creating networks of belonging and support, responding to caregivers' self-identified priorities, and mitigating racism in healthcare encounters
Hernandez, Ruano, Marchal, San Sebastian and Flores (2017)	Indigenous peoples in Guatemala and across the world	Guatemala and global	Systems thinking; holistic, integrated approaches; transformational change; equity-oriented research; redressing power imbalances	Commentary by the Center for the Study of Equity and Governance in Health Systems (CEGSS by its initials in Spanish), based on their experiences conducting equity-oriented research with indigenous peoples in Guatemala	Disproportionate burden of poverty, disease, mortality and other inequities among Indigenous peoples; reductionist tendency to frame Indigenous health as a problem of poor health indicators to be solved through targeted service delivery tactics; need to move towards integrated system-wide approaches to transform the systems that generate and reproduce inequities in indigenous health

## Appendix C: Interview Guide with Updates Highlighted (developed by ELPH team)

### SENIOR EXECUTIVES, PROGRAM MANAGERS, AND FRONT LINE STAFF

#### PREAMBLE

We would like to thank you again for your continued involvement and support of the ELPH research project. As you may recall, the overall goal of this project is to understand how health equity is taken up in different levels of the health system, with a specific focus on mental health promotion and prevention of harms of substance use policies and programs. The interview questions may seem familiar and you may wonder why we are asking the same questions a second time. We are asking the same questions in ELPH Phase II as this allows us to assess changes over time with respect to health equity uptake in your work settings.

#### PUBLIC HEALTH WORK AND HEALTH EQUITY

1. Tell me about your work. (Ask specifically for work related to mental health promotion, prevention of harms of substance use including harm reduction)
2. Do you have a focus on health equity in your work?
  - If not, go to next question.
  - If yes, please elaborate:
    - What percentage (if any) of your work is devoted to health equity work?
    - How is health equity applied in your work?
    - Specifically how is health equity applied in the services you provide related to mental health promotion, harm reduction or prevention of harms of substance use? What specific populations? Could you give me some examples?
    - Can you tell me about your work in the area of Indigenous health and health equity?
    - Any other actions or strategies are you involved in around health equity?

#### HEALTHY MINDS HEALTHY PEOPLE

3. Are you familiar with the BC Ministry of Health's Ten-Year Plan to Address Mental Health and Substance Use in British Columbia, Healthy Minds, Healthy People (HMHP)?
  - How has this document influenced your work in terms of the prevention of harms of substance use and the promotion of mental health?
    - What about specific populations ?
  - Has HMHP specifically influenced integration or application of health equity in your work related to mental health promotion and prevention of harms of substance use?

#### MEANING OF HEALTH EQUITY

4. The term health equity means different things to different people. What does it mean to you?
5. Do people talk about health equity in your workplace?
  - If yes, what kind of language is used? (E.g. terms, populations, groups etc)
  - Where and when do these conversations take place?
  - How would you describe these discussions?

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#### PRIORITY SETTING AND HEALTH EQUITY:

6. What supports do you have or do you need to apply health equity in your work?
7. In your opinion, to what extent would you say health equity is a priority: for you? In your department? In your organization? **What about health equity as a priority for specific populations (e.g. LGBTQ, women, street-entrenched, immigrants etc)?**
8. What do you think influences whether or not health equity is priority in your department? And in your organization?
  - What are some of the challenges in making health equity a priority?
  - What helps make health equity a priority?

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#### HEALTH EQUITY GOALS AND STRATEGIES

9. Are you aware of any department goals related to health equity promotion or reduction of health inequities? What about organizational goals? If so, can you describe?
  - **Are there any equity goals related to indigenous health?**
10. Are you aware of any strategies your department has in relation to health equity? Your organization?
  - **For particular groups?**
11. What do you see as the future directions in the promotion of health equity and reduction of health inequities for you? Your department? The organization?
  - **For particular groups?**

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#### EVIDENCE AND EVALUATION

12. What does evidence mean to you and what sources of evidence do you use in your practice?
13. Do you have sources of evidence that you draw on in relation to health equity? If so, please describe.
14. Are you aware of any ways that your HA measures health inequities? What about for Aboriginal populations? If so, what do you know about this? Does it impact your work? If so,

please give an example.

15. What, if anything does your HA do in terms of monitoring progress in reducing health inequities? **For specific populations?**

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#### HEALTH EQUITY TOOLS

16. Can you tell me whether or not you or your department uses any kind of equity tool in your work?

- If so, what equity tools do you use?
- If so, tell me about the use of that tool.
  - Where is it used? When? How?
- Specifically, do you use any kind of equity tool in promotion of mental health?
  - Is it helpful/would it be helpful?
- What about in programs to prevent the harms of substance use?

17. Is there anything else that you would like to mention that I haven't asked you about?

## Appendix D: Data Management Protocol (developed by ELPH team, June 25, 2013)

Safeguarding information is extremely important for all research. According to the Tri Council Policy Statement for Ethical Conduct for Research Involving Humans (2010), this includes the full lifecycle of information including collection, use, dissemination, retention and disposal. This document will help you to maintain the expected standard for safeguarding research data.

### IDENTIFYING PARTICIPANTS IN DATA

Individuals will not be identified by name or position and individual data will not be accessible by the non-academic co-investigators, knowledge users or community partners.

When transcribing, names can be recorded on the working copy of the transcript, so we can sort out pseudonyms appropriately. The transcript will be cleaned, names replaced with pseudonyms prior to any printing or transfer into NVivo. Once a transcript is cleaned, any copies with identifiers will be destroyed.

### STORING DATA

All qualitative and quantitative data will be maintained on a University of Victoria shared drive that is accessed through a password protected computer. There will be no names or other possible identifiers used in the transcripts or other data that are stored or are in NVivo files. All hard copies printed out will be stored in a locked filing cabinet located in a locked office. All data will be stored at the Centre for Addictions Research of BC, University of Victoria. Only members of the UVic research team who are directly engaged with project management and data collection/analysis will have access to the keys and passwords.

The University of Victoria systems admin advises that: “Large network file shares are available for departments to store and share files. These high-performance file shares are backed up daily and accessible from anywhere on the UVic network. They offer departments an excellent way to store, share, and collaborate on files. This is also a more secure way of storing files since they are not susceptible to catastrophic hard drive failure or theft of a laptop or desktop or other device like a USB drive.

It is recommended that confidential data **not be stored** on locally on your computer, laptop, external drive or USB device.”

In the unusual circumstances that confidential data needs to be stored on a personal hard drive or transferred, please refer to the link below concerning PGP Whole Disk Encryption provided by April Feddema.

These links are for anyone who stores internal or confidential information on their local hard drive, laptop, or other device such as an external drive or USB flash drive.

#### PGP Whole Disk Encryption

This link reviews what PGP Whole Disk Encryption is, the cost, and how to access the software.

<http://www.uvic.ca/systems/services/informationsecurity/diskencryption/index.php>

And here is the link to University Policy No: IM7800, Information Security Policy. This also links to procedures for responding to incidents, addressing vulnerabilities, classification of information and procedures for responding to a loss or theft of a computer.

<http://www.uvic.ca/universitysecretary/assets/docs/policies/IM7800.pdf>

## TRANSPORTING DATA

Interviews that are audio recorded will be transferred to the appropriate shared drive immediately after data collection, and deleted from the recording device. Raw data will not be transported off site for any purpose. Individuals accessing the shared drive from a remote location must use a password protected computer.

Confidential data should not be stored on locally on your computer, laptop, external drive or USB device.

## ACCESSING DATA

Only members of the academic research team who are actively working on data analysis will have access to raw data. Only aggregate summaries of data will be provided to collaborators.

## SHARED DRIVES

Permissions for who can access each folder on the shared drive can be set by systems admin (NURS) or John (CARBC). Access to folders containing data should be restricted to researchers and staff on that project who need the data to do their work. Confidentiality agreements will be signed by RAs and transcriptions.

## REMOTE ACCESS FOR NURS SHARED DRIVE

University of Victoria advises: “For anyone who needs to connect to the shared drive from home, or while connected on the wireless network on campus, here is the link needed to install the VPN client.

<http://www.uvic.ca/systems/services/internettelephone/remotearchive/index.php>

Running the VPN will allow users to then map a network drive to [\\netdrive.uvic.ca\nurs](http://netdrive.uvic.ca/nurs) from their home computer in order to access files they have stored securely on the shared drive.

Here are the links showing how to connect to the netdrive from a Windows or Mac computer.”

Windows: <http://www.uvic.ca/systems/support/storagebackup/departmentalstorage/sfgwindows.php>

Mac: <http://www.uvic.ca/systems/support/storagebackup/departmentalstorage/sfgwindows.php>

(April Feddema, University Systems, 2012)

## REMOTE ACCESS FOR CARBC SHARED DRIVE

This drive is usually accessed remotely using remote desktop. This means if you want to get into the CARBC shared drive from off site, your computer has to dial in to a computer at CARBC that is on and in the “logged off” state. You need to install VPN, and ask John to change the settings on your CARBC ID so that you can use remote desktop. You also need the address of the computer you want to dial in to.

## **RECORDING CONSENT TO PROVIDE DATA**

Informed consent will vary by research method. Whenever possible, participants will be asked to read and sign a letter of consent. The procedure will be used for all focus groups and interviews. In the case of telephone interviews, participants will be emailed the letter of consent. Prior to the start of the interview, the participant interviewer will go over the consent with the participant and answer any questions. Verbal consent will be recorded at the start of the audio recording of the interview.

Participation in online data collection will be done electronically. There will be an online consent form as part of the data collection software. Participants will indicate their consent by checking a box. If they do not check the box, the program will not proceed to data collection.

Signed consent forms, or acknowledgement of obtaining consent will be kept in paper or electronic copies noting consent was obtained will be indicated on the interview contact spreadsheet. All paper copies indicating consent will be kept in a locked filing cabinet with interview transcripts or surveys. All electronic copies will be kept on password protected computers.

## **FOCUS GROUPS**

Given the group nature of focus groups, confidentiality cannot be guaranteed. Furthermore, these individuals are participating in the interviews and focus groups in relation to their position in the workplace so it is possible that others are aware of the composition of focus groups. Every effort will be taken to ensure confidentiality. For example, individuals will not be identified by name or position and individual data will not be accessible by non-academic co-investigators or research partners. Only aggregate summary data stripped of any identifying features will be provided to collaborators.

For focus groups, it is important to make sure that you know who is in the focus group, especially if it's over the phone, and get everyone to sign a consent form whether or not they say anything in the focus group.

## **DESTROYING DATA**

All data will be maintained according to study research ethics protocol. This is usually for five years unless indicated that it may be kept indefinitely for secondary research analysis purposes.

Hard copies will be shredded and all electronic copies will be deleted. Some ethics protocols allow for different purposes and lengths of time. These details will be on the consent form.

### **PROMISE OF CONFIDENTIALITY AND SECURITY OF DATA**

I have agreed to participate in this research as a Research Assistant.

I understand that the research data (audiotapes, transcripts, survey forms and consent forms) that I have access contain sensitive and confidential information. Therefore, I agree to the following:

1. I will not at any time discuss the data or results of this study in a manner that identifies persons or organizations.
2. I will not discuss the data or results of this study (outside the study team) until the results are ready to be disseminated.
3. I will keep any research data temporarily in my possession secure in a locked place.
4. I will erase all research data from my computer hard drive once I have finished using it.
5. I will return all research data to the Research Team (Bernie Pauly) when I am finished using it.

Signed: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Cc of this form received: \_\_\_\_\_

Appendix E: Table of Barriers and Facilitators to Indigenous Health Equity, Organized by Reference Frequency in the Data

Frequent  Less Frequent

Partnerships	Location	Stakeholder Engagement	Awareness	Cultural Safety		Positionality		Social Determinants of Health	
	Integrated Service Delivery	Local Networks	Relationship Building	Capacity Building	Leadership	Stigma		Community Control	
Community Based				Perceptions					
					Liaison	Respect	Self-Determination	Indigenous Healers	OCAP
Collaboration	Consultation and Feedback	Cultural Safety Training	Availability	Education			Choices	Colonialism	
				Food Security	Time		Poverty		
					1	2	3	4	

1) Cultural Connection    2) Cost    3) Discrimination    4) Health Literacy

Same Table with Colours Representing Stem, Core and Root Environments

Stem Environment		Core Environment			Root Environment				
Partnerships	Location	Stakeholder Engagement	Awareness	Cultural Safety		Positionality		Social Determinants of Health	
	Accessibility	Integrated Service Delivery	Local Networks	Relationship Building	Capacity Building	Leadership	Stigma		Community Control
Community Based					Perceptions	Employment	Trust	Housing	
		Collaboration	Consultation and Feedback	Cultural Safety Training		Respect	Self-Determination	Indigenous Healers	OCAP
Liaison	Availability				Education		Choices	Colonialism	
					Food Security	Time	Poverty	1	2

2) Cultural Connection

2) Cost

3) Discrimination

4) Health Literacy