

Developing a Policy to Address Anti-Indigenous Racism in Health Care

by

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Abstract

Indigenous peoples face negative health outcomes in comparison to the rest of the Canadian population, which is a result of race-based colonial policies and legislation, such as the *Indian Act*, that continue to effect Indigenous peoples' health. This capstone project draws on Anti-Racism Theory and Tribal Critical Race theory as they highlight Indigenous perspectives of history, colonization, as well as the systemic nature of anti-Indigenous racism. In examining policies, policy statements, and declarations of commitment, a critical analysis is provided of policy discourses currently in place within health authorities. Through six semi-structured interviews with health authority officials, this research locates a set of policy alternatives designed to address the oppression and harm faced by Indigenous peoples within health care systems in British Columbia. In taking an Indigenous health policy perspective, this policy analysis project lists recommendations towards implementing various initiatives in working towards a policy to address anti-Indigenous racism.

Keywords: anti-Indigenous racism; health policy; Indigenous health; Indigenous cultural safety; Indigenous pedagogy

Dedication

I would like to dedicate this capstone project to my family: Katrina, Clint, my mom, Darlene (Woos/Gylogyet), and my dad, Lyle. My backbone and my identity as a Wet'suwet'en woman are tied to my upbringing and being raised on our territory. Without my family I would not know who I am and how to present myself as a mixed-race Wet'suwet'en woman. You were there for me when I did not believe in myself and when I struggled through the challenges of being an Indigenous woman in a colonial institution. Sne kal yëgh to my funny and tough-as-nails family.

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List of Acronyms

BC	British Columbia
CAPAR	Canada's Action Plan Against Racism
CAPWHN	Canadian Association of Perinatal and Women's Health Nurses
CRT	Critical race theory
FNHA	First Nations Health Authority
ICS	Indigenous cultural safety
PHSA	Provincial Health Services Authority
TRC	Truth and Reconciliation Commission of Canada
TribalCrit	Tribal critical race theory
UNDRIP	United Nations Declaration on the Rights of Indigenous People
VCH	Vancouver Coastal Health

Executive Summary

Indigenous peoples experience inequalities in health care when compared to the rest of the Canadian population, which is a direct result of race-based colonial policies and discrimination and racism within health care institutions. Systemic racism can be seen in racially biased attitudes and practices of health care providers and administrators, Eurocentric practices of medicine, racial harassment, or refusal of health care services adversely affect Indigenous patients. This project explores current practices that can assist in reducing harm faced by Indigenous peoples or to address anti-Indigenous racism within health authorities in BC. Policy options or strategies are identified that may assist health authorities in increasing levels of Indigenous Cultural Safety (ICS) and to identify anti-racism approaches to reducing harm against Indigenous peoples.

This research is guided by the work of critical race theorists, which highlights Indigenous perspectives of history that provide a better understanding of the effects of colonization and bring a necessary focus toward the systemic nature of anti-Indigenous racism. A critical analysis of racism calls for the need to go beyond the idea that racism happens on an individual level and that it has deep roots in the structure of Canadian society. Tribal Critical Race Theory contends that colonization is endemic to society and that racism plays a pivotal role in colonization and within social, political, and legal structures. The researcher utilized her own Wet'suwet'en ways of knowing and being, calling for the need to advocate for Indigenous self-determination in health policy. Also, the research was guided by Kirkness and Barnhardt's 4Rs – respect, relevance, reciprocity, and responsibility – in relation to working with Indigenous peoples.

An environmental scan of publicly available literature and existing policies from within health authorities, education institutions, and other health organizations revealed that existing policies address interpersonal disputes and instances of harm and discrimination, rather than systemic racism and, specifically, anti-Indigenous racism. Drawing on existing literature and six qualitative interviews, this project articulates five key criteria that assist in evaluating the policy strategies: (a) protection of Indigenous peoples; (b) policy effectiveness; (c) inclusion of Indigenous pedagogies; (d) cost of inaction; and (d) administrative feasibility.

Four strategies or policy options were identified after conducting the literature review, environmental scan and qualitative interviews. The first policy option includes the collection of racial equity data in the health authorities, which includes a self-identification of racial identity to gain an understanding of the representation of Indigenous staff and patients within the health authority. The second policy option is to develop and implement an Indigenous recruitment, retention and support strategy, which entails the introduction of support mechanisms for current and new Indigenous staff and establishing a strategy to hire additional Indigenous staff. The third policy option is the

mandatory Indigenous cultural safety (ICS) training and ongoing professional development strategy. This option targets the entire health authority workforce and encourages the development of a best practices model and toolkit that may be shared and included within research models. The fourth policy option is to develop a strategy to address anti-Indigenous racism, which includes six key implements that make up a system-wide approach to addressing the harm that Indigenous peoples face in health authorities.

Based on the process of analyzing the policy options against the evaluative criteria, it was determined that each of the options must be implemented in order to address the key policy objective. To meaningfully address anti-Indigenous racism within health authorities, it is recommended that the first, second and fourth policy options must be implemented in the short run, which will be followed by the implementation of the third policy option in the long run. The collection of racial equity data will allow a baseline of data to be collected around the representation of Indigenous peoples. The Indigenous recruitment, retention and support strategy allows the onboarding of Indigenous staff and the implementation of support initiatives to assist in retaining Indigenous staff. The strategy to address anti-Indigenous racism will provide direction and goals that will hold the entire health authority accountable so there will be movement in reducing harm to Indigenous peoples. The mandatory ICS training and ongoing professional development strategy is important, yet with the implementation of the first, second and fourth policy options there may be findings that will assist in developing this policy option to be more successful. Thus, the third policy option will be implemented in the long run.

It must be highlighted that addressing anti-Indigenous racism within the health authorities is an evolving and ongoing process. There must be leadership throughout the entire organization towards addressing anti-Indigenous racism and directors should all be held accountable to change attitudes and behaviours toward Indigenous peoples. Involving Indigenous peoples within health care decision making and within all levels of health planning and development, from conception to completion, is integral to reduce inequities in Indigenous health.

Anti-Indigenous racism is engrained within the structures of our health care systems and it is important to acknowledge the limitations that individual policies may have in reducing the harm that Indigenous peoples face. It is expected that the recommended policy package will help to reduce anti-Indigenous racism and reduce health inequities between Indigenous and non-Indigenous peoples, yet fundamental change is needed in our social structures in Canada. Indigenous self-determination is a necessary component in promoting the closing of health gaps amongst Indigenous peoples.

Chapter 1: Introduction

If we all pretend that racism does not exist, that we do not know what it is or how to change it—it never has to go away. (hooks, 1998, p. 4)

Indigenous peoples face negative health outcomes in comparison to the rest of the Canadian population, which is a result of race-based colonial policies, such as the *Indian Act* (1985), which encompassed the residential school system that continues to effect Indigenous peoples' health today (Juutilainen, Miller, Heikkilä, & Rautio, 2014). These assimilative and racist policies separated families and removed Indigenous children from their communities, cultures, and livelihoods as Indigenous peoples (Truth and Reconciliation Commission of Canada [TRC], 2015). The residential school system created a legally sanctioned intergenerational trauma and fragmented Indigenous societies, undermining the well-being of Indigenous peoples, families, and communities for generations (TRC, 2015). Indigenous peoples continue to experience the impacts of the legacy of colonization, which is evidenced by the fact that Indigenous people's encounters with health care are frequently negative (Hole et al., 2015). Furthermore, structural violence is produced in health institutions, which reproduces Indigenous experiences of institutional trauma (Hole et al., 2015).

In British Columbia (BC), Indigenous health statistics have improved, yet there are still significant gaps between the Indigenous the non-Indigenous population (First Nations Health Authority, 2015). Statistics Canada (2018) reported that across the country only half of the off-reserve First Nations population reported very good or excellent health. In British Columbia, First Nations report higher rates of chronic conditions such as diabetes, various forms of cancer, asthma, and arthritis (First Nations Health Authority, 2018). First Nations people in BC have lower rates of connection to physician services and are utilizing emergency rooms at higher rates than other groups for primary care services, which demonstrate a need for improving primary care access to reduce emergency room admissions (First Nations Health Authority, 2018, pp. 4, 10). The First Nations Health Authority (2018) considers it problematic that First Nations people in BC are not regularly accessing primary health care services to treat various diseases and other treatable health conditions.

In 2015, representatives for the Ministry of Health, the regional health authorities, the Provincial Health Services Authority (PHSA) and the First Nations Health Authority (FNHA) signed *Declaration of Commitment to Cultural Safety and Humility for First Nations and Aboriginal People in BC* (FNHA, 2015), to improve health services and health outcomes for Indigenous peoples. This document concerns Métis, Inuit, and First Nations people living on and off reserve. In addition, several agreements, declarations and policy initiatives have been advanced to address the socio-economic disparities that Indigenous peoples face. For instance, the *Transformative Change Accord* (Government of British Columbia, Government of Canada, & Leadership Council Representing the

First Nations of British Columbia, 2005), the TRC's (2015) final report, the BC *Provincial Mandate Letters* (BC Office of the Premier, 2017a), and the Premier's commitment (BC Office of the Premier, 2017b) to adopt the United Nations Declaration on the Rights of Indigenous People (UNDRIP; United Nations, 2007).

Systemic racism can be seen in racially biased attitudes and practices of health care providers and administrators, Eurocentric practices of medicine, racial harassment, or refusal of health care services adversely affect Indigenous patients (Henry et al., 2010; Ward, Branch, & Fridkin, 2016). In addressing anti-Indigenous racism within health care systems, various Indigenous scholars argued that Indigenous frameworks and methods of research can put the voices of Indigenous peoples in the forefront of policy analysis and decision making (Clark, 2013; Smith, 1999). Indigenous voices are not often emphasized or are not heard within policy processes (Gomes, Leon, & Brown, 2013; Kenny, 2014). Thus, this study emphasizes Indigenous pedagogy within health research and in assessing policy options for the implementation of an anti-racism policy, with specific emphasis on oppression faced by Indigenous peoples within health care systems.

1.1. Rationale for Anti-Racism Approach and Tribal Critical Race Theory

Canada's historical legacy of social oppression toward Indigenous peoples propels racial inequalities. While Indigenous peoples experience racism at multiple levels (individual, institutional, and systemic racism), this project emphasizes current impacts of institutional and systemic racism within health institutions (Henry, Tator, Mattis, & Rees, 2010). Systemic racism is supported and enacted by institutions and other deep-rooted structures and attitudes, which Cheema (2007) stated are "sustained by the continuing political, social, and economic marginalization of Aboriginal peoples" (p. 20). Indigenous pedagogy and ways of understanding this colonial history can be explained within the context of tribal critical race theory (TribalCrit) (Brayboy, 2005) and anti-race theory (Bishop, 2015; Henry & Tator, 2000; Schick & St. Denis, 2005; Wilmot, 2005). TribalCrit and anti-race theory inform the policy analysis and assist in building a rationale for recommendations to address anti-Indigenous racism in health care. Anti-race theorists critically analyze structures that seek to work against initiatives, actions, narratives and policies that are considered to discriminate against Indigenous peoples based on race (Henry et al., 2010).

Racism is a key structural determinant of health for Indigenous peoples, which is often experienced because the current health structures and institutions privilege white settlers in Canada (Anderson & McGibbon, 2017). The TRC (2015) reported that historical experiences of abuse and harm within institutions such as residential schools and Indian hospitals continue to be experienced as social, political, economic, and health inequities. Racist stereotyping and discrimination decrease access to care and

quality of care for Indigenous peoples, yet this continues to be largely invisible to settler Canadians. It remains that “link between racism and health is a matter of life and death” (Ramaswamy & Kelly, 2015, p. 285). The inquest into the death of Brian Sinclair exemplifies this statement, wherein Mr. Sinclair was ignored in a hospital in Winnipeg, Manitoba, for 34 hours and died of complications from a treatable bladder infection (Brian Sinclair Working Group, 2017). The status quo is the legacy of harm and institutional violence that Indigenous peoples encounter in health care institutions every day, and Indigenous and non-Indigenous whistleblowers and truth tellers are making the call to address anti-Indigenous racism (Brian Sinclair Working Group, 2017; Harding, 2019; Ward et al., 2016; TRC, 2015).

1.1.1. Racism and Health Inequity

The Government of Canada (2018) has described the social and economic determinants of health as a “broad range of personal, social, economic and environmental factors that determine individual and population health” (para. 8), but did not explicitly recognize racism as a social determinant of health. Allan and Smylie (2015) argued the government must acknowledge “the foundational and ongoing realities of racism and colonialism ... which are obscured by the official framing of the Canadian nation as a harmonious multicultural mosaic” (p. 3). Furthermore, Allan and Smylie asserted that critical next steps must be taken for society to realize true movement toward addressing systemic racism:

- Generate meaningful data in order to understand and address the role of racism in the health disparities experienced by Indigenous peoples in Canada (Paradies et al., 2008).
- Develop or adapt effective interventions to address attitudinal, interpersonal and systemic racism towards Indigenous peoples.
- Pursue bold and brave evaluations of existing anti-racism strategies and interventions. (p. 3)

Although the Government of Canada (2018) has referred to health inequity as “unfair or unjust and modifiable” (“Health Inequities,” para. 3), there is a need to focus on the experiences of Indigenous peoples in health care systems as a direct result of racism within health institutions (Hole et al., 2015). Pressure from Indigenous activists, scholars, leaders, and community members has generated momentum for necessary shifts within health care systems, which has generally focused on the need for culturally safe care (Hole et al., 2015).

1.2. Indigenous Health and Indigenous Pedagogy

This research takes an Indigenous perspective of public health, which is built upon Indigenous experiences within the health care system. Indigenous and non-Indigenous scholars have called for evaluations of health policies and procedures (Churchill et al., 2017; Lawrence & Dua, 2005; Ward et al., 2016), which illuminate the

realities of anti-Indigenous racism. There is an increased awareness of the need for Indigenous pedagogy to be integrated into the health research as well as the need for more Indigenous peoples working within health care systems to address anti-Indigenous racism in partnership with settlers. The literature drawn on in this project spans scholarship in the fields of public health, Indigenous studies, public policy, and education, as Indigenous and non-Indigenous scholars are working to reduce and better understand systemic racism across multiple levels, including racism within organizational policies and practices and at the point of care.

1.2.1. Research Objective and Questions

This capstone research project examined the following question: How can health organizations respond to anti-Indigenous racism to reduce the harm that Indigenous peoples experience? The researcher also explored and analyzed health authority policies that address discrimination, workplace environment, and conduct. The research question is intended to respond to the interests of health authorities and organizations that aim to implement Indigenous cultural safety (ICS) practices and an anti-racism approach to addressing gaps in health outcomes for Indigenous peoples in BC.

The key objective is to address anti-Indigenous racism within health authorities in B.C. and to identify potential policy options and processes to increase levels of Indigenous cultural safety and to identify anti-racism approaches to reducing harm. The intended outcome is to develop recommendations that will build an inventory of determinants that can be used to assist health authorities in developing actionable plans to reduce harm experienced by Indigenous peoples in health care systems in BC.

Chapter 2: Background

2.1. The Cultural Safety Continuum and Approaching Systemic Racism

Health authorities have implemented various training approaches geared toward addressing anti-Indigenous racism within the health care facilities in BC. Many of these approaches focus on finding strategies to achieve cultural safety within health care services to better serve Indigenous peoples. Educational approaches to addressing anti-Indigenous racism differ largely because of the training delivery format and in the pedagogies that guide the training. The PHSA Indigenous Health department has defined racism as a social determinant of health and contends that anti-Indigenous racism must be confronted in order to disrupt the root causes of inequities that Indigenous peoples face in health institutions (Anderson & McGibbon, 2017). Many Indigenous approaches to health focus on the integration of traditional wellness practices, which are both vital and necessary to improving health outcomes for Indigenous peoples (FNHA, 2016b). Both an Indigenous cultural or traditional wellness approach and an anti-racism methodology have space within health authorities, though to address the “policy problem” the later approach must be investigated.

To better understand the pedagogy around anti-racism, the Indigenous Health department at PHSA contended that it is useful to envision culture and racism on a continuum (Anderson & McGibbon, 2017). Cultural awareness lies at the beginning of the continuum, which emphasizes cultural differences between groups of people. Cultural awareness is an important first step in working with people across cultures but does not address issues of inequity between groups (Anderson & McGibbon, 2017). In a similar vein, cultural sensitivity stresses cultural differences must be understood to better serve multiple cultural backgrounds, which coincide with the discourse surrounding multiculturalism in Canada (PHSA, 2018). However, Henry et al. (2010) stated that Canadians are ambivalent toward the recognition of other cultures, their experiences, and their unique identities. Indigenous scholars critiqued this approach, as it can further contribute to cultural stereotyping and a lack of understanding of the colonial context in Canada (Anderson & McGibbon, 2017; Lawrence & Dua, 2005).

Cultural competency, which is next on the continuum after cultural sensitivity, focuses on the knowledge, self-awareness, and skill development amongst service providers (PHSA, 2018). While this approach can have practical application, it can potentially be associated with the tip-sheet approach to cross-cultural work, wherein Indigenous cultures are inappropriately summarized on paper, though it may take a lifetime to understand the complexities of a single Indigenous nation (Anderson & McGibbon, 2017). Cultural humility is next on the continuum, which is defined as a form of cultural competency and focuses on the attitudes required to work with Indigenous peoples in practice settings, wherein one must acknowledge a role as a lifelong learner

(FNHA, n.d.-a). Cultural safety lies at the end of the continuum and this continuum helps people to understand spaces in the continuum in moving towards cultural safety and that it must be made a priority to problematize the structure of the system, not just people's individual behaviours and approaches to their work (Anderson & McGibbon, 2017).

Indigenous cultural safety (ICS) approaches within health care systems seek to actively work toward making health care services safer and more equitable for Indigenous peoples by addressing racism and discrimination (Ward et al., 2016). Ward et al. (2016) asserted cultural safety approaches to providing care focus on “the roots of health and health care inequities, such as colonization” (para. 8). Thus, this approach considers social and historical contexts that impact Indigenous peoples as well as the structural and interpersonal power imbalances that shape health and health care experiences (Anderson & McGibbon, 2017). Importantly, cultural safety can only be achieved when Indigenous peoples define the health care system as being safe and when they are not being discriminated against or stereotyped (Ward et al., 2016). The Health Council of Canada (2012) provided the following definition of cultural safety:

Cultural Safety

- is an outcome, defined and experienced by those who receive the service—they feel safe;
- is based on respectful engagement that can help patients find paths to well-being;
- is based on understanding the power differentials inherent in health service delivery, the institutional discrimination, and the need to fix these inequities through education and system change; and
- requires acknowledgement that we are all bearers of culture—there is self-reflection about one's own attitudes, beliefs, assumptions, and values. (p. 5)

Health care providers and administration can address anti-Indigenous racism within health care systems by developing and implementing cultural safety strategies throughout health authorities. Cultural safety strategies, which have been developed across Canada, often address the need for training and professional development. Churchill et al. (2017) noted a lack of peer-reviewed literature that evaluates cultural safety training programs and initiatives, which poses “significant challenges to compiling a comprehensive set of best practices for Indigenous-specific cultural safety training” (p. 15). This dearth of evaluative literature on cultural safety training results in a need for the development of high-level strategies that structure the development, implementation process, and evaluation of ICS training programming.

2.2. Tribal Critical Race Theory and Anti-Race Theory

The perspectives of various scholars shaped the policy problem and research questions that guided this research. Specifically, the framing of the policy problem, the identification of possible alternatives, the analysis of potential policy options, and the

development of recommendations to address anti-Indigenous racism in the Canadian policy context draw on TribalCrit (Brayboy, 2005) and anti-race theory (Bishop, 2015; Henry & Tator, 2000; Schick & St. Denis, 2005; Wilmot, 2005). The rationale for integrating the work of these scholars in a policy analysis is twofold. First, these works were utilized to highlight Indigenous perspectives of history that provide a better understanding of the effects of colonization. Second, these sources bring a necessary focus toward the systemic nature of anti-Indigenous racism and provide direction as to how individuals can respond to systemic racism.

2.2.1. Tribal Critical Race Theory

TribalCrit (Brayboy, 2005) emerged from critical race theory (CRT) as a framework that addresses Indigenous issues and “the specific needs of tribal peoples” (Brayboy, 2005, p. 428) more completely than other theoretical frameworks. Brayboy (2005) described TribalCrit as better suited to address relations between Indigenous nations and the United States federal government “to make sense of American Indians’ liminality as both racial and legal/political groups and individuals” (p. 425). Brayboy (2005) drew on his experiences as an American Indian, yet the process of colonization and the reality of Indigenous issues, both socially and politically, allow TribalCrit to be relevant within the Canadian context (Cardinal, 1969; Kitchen & Hodson, 2013). Importantly, Brayboy stated that TribalCrit is based out of “multiple, nuanced, and historically- and geographically-located epistemologies and ontologies found in Indigenous communities” (p. 427). TribalCrit is rooted in the commonalities between Indigenous experiences while concurrently recognizing the range and variation that exists within and between communities and individuals (Brayboy, 2005, p. 427).

Although Brayboy (2005) developed TribalCrit for applications within the education field, it is important for policy analysis, as it highlights how Western “thought, knowledge, and power structures dominate present-day society” (Brayboy, 2005, p. 430) through the dismissal of Indigenous knowledge and practices as being inconsequential or considered to be a relic in the modern world. Furthermore, TribalCrit effectively draws from CRT in stating that racism is endemic in society and that racism has become so deeply engrained in the public consciousness that it is generally invisible. Thus, TribalCrit employs many characteristics of CRT but makes distinctions to consider Indigenous perspectives and experiences.

Brayboy (2005) outlined nine main tenets of TribalCrit that set the framework for those working within this theory (see Figure 1). The nine tenets provide essential context and understanding to the complex relationship between Indigenous peoples and the United States federal government, which can be extended to the reality that Indigenous peoples face in Canada (Brayboy, 2005, p. 430). The first, second, and sixth tenets were important to this project. While proponents of CRT argue “racism is endemic to society” (Brayboy, 2005, p. 428), advocates of TribalCrit declare “colonization is endemic to society” (p. 429) and racism plays a pivotal role in colonization and within social,

political, and legal structures. TribalCrit explicitly recognizes that the policies of the United States toward American Indians are rooted in imperialism, white supremacy, and a desire for material gain (Brayboy, 2005, p. 432). Brayboy's sixth tenet focuses on Indigenous peoples' desire to obtain and forge self-determination. In Canada, this tenet translates as the need to advance First Nations jurisdiction or self-determination as a key component of good governance or successful nation-to-nation relationship between Indigenous governments and provincial and federal governments (Indigenous Corporate Training, 2018). This extends to self-determination within health care service implementation and delivery.

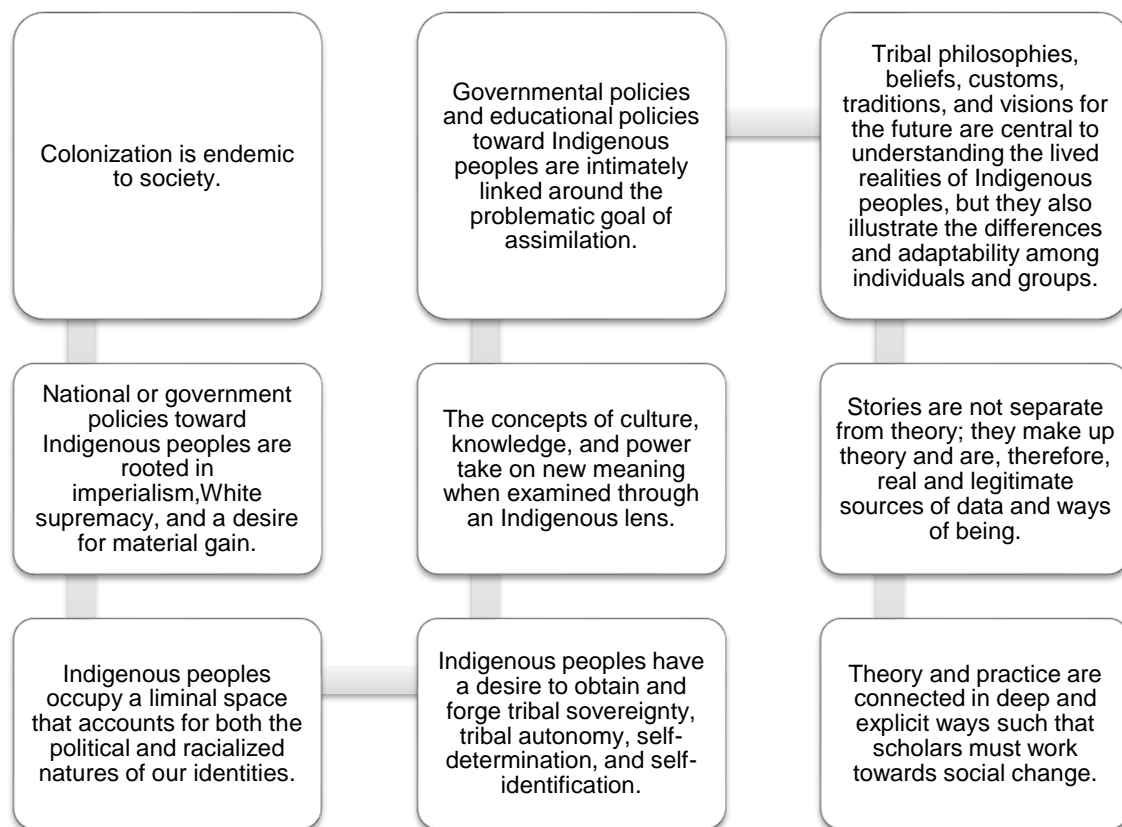


Figure 1. Brayboy's (2005) nine critical tenets within tribal critical race theory.

Brayboy's (2005) framework is essential in analyzing racism within the educational and health contexts, as much of the discussion is transferrable to Indigenous peoples' experiences within health care systems. Furthermore, it is important to focus on Indigenous-specific frameworks and modes of analysis because, as Brayboy noted CRT "does not address American Indians' liminality as both legal/political and racialized beings or the experience of colonization" (p. 428). However, the integration of TribalCrit within policy analysis would not be complete without an examination of the work of anti-race theorists since TribalCrit draws on this body of literature (Brayboy, 2005).

2.2.2. Anti-Race Theory

The works of Henry and Tator (2000), Bishop (2015), Schick and St. Denis (2005), Wilmot (2005), and Allan and Smylie (2015) provided a fulsome understanding of the discourses of racism or anti-race theory and the connection with the health of Indigenous peoples. This work serves as a tool for organizations to work against the societal beliefs, structures, initiatives, actions, narratives, and policies that are considered racist. Challenging racism includes acknowledging and responding to dynamics of social position, power, and privilege that exist within a historical and current context (Henry et al., 2010; Schick & St. Denis, 2005; Wilmot, 2005). Anti-racism education describes a type of critical instruction that supports learners as they practise self-reflection, acknowledge power and privilege, and learn tools and approaches for challenging individual and societal racism.

Proponents of anti-racism seek to understand the oppression and the experiences of racialized and oppressed groups of people (Henry & Tator, 2000; Schick & St. Denis, 2005). Henry and Tator (2000) demonstrated that racism is enacted at individual, institutional, and systemic levels. Individual or existential racism is “rooted in [an] individual’s belief system and has been defined as the attitude, belief, or opinion that one’s own racial group has superior values, customs and norms, and conversely that other racial groups possess inferior traits and attributes” (Henry & Tator, 2000, p. 28). This form of racism is often characterized by prejudiced attitudes that are realized in both conscious and unconscious actions. Institutional racism is visible within the policies, practices, procedures, values and norms that operate within institutions and organizations (e.g., health leadership boards).

Systemic racism refers more generally to the laws, rules, and norms woven into the social system that results in the unequal distribution of economic, political, and social resources and rewards among various groups (Henry et al., 2010). This form of racism means “the denial of access, participation and equity ... [to Indigenous peoples] for services such as education, employment and housing” (Henry & Tator, 2000, p. 29). Institutional and systemic racism may not be visible or happen subconsciously, yet they “have the consequence of promoting, sustaining or entertaining differential advantage or privilege for white people” (Henry & Tator, 2000, pp. 29–30). Bishop (2015) contended that racism and oppression are more than simply the reality of individual people brought on by individualistic acts such as the calling of racial slurs or exclusion because they are a structural reality (pp. 120–121). A critical analysis of racism in Canada necessitates moving beyond the idea that racism happens on an individual level and that it has deep roots in the structure of Canadian society.

Indigenous systems of governance are denied in the structural formation of policy and practice in Canada’s institutional, legal, and political make up (Lawrence & Dua, 2005). Institutions, including health structures, are currently unable to respond to the varying needs of Indigenous peoples as they fail to respect the diversity of Indigenous

groups by referencing Indigenous peoples and knowledge under a homogenous, “pan-Indian” identity (Battiste, 2013; Henry & Tator, 2000). Indigenous peoples are denied the ability to identify with their unique cultural backgrounds, while the privilege of whiteness is exercised amongst settlers in Canada. As Schick and St. Denis (2005) noted, structural privileges are often masked by national narratives of “cultural difference” (p. 296), “tolerance” (p. 307), and “multiculturalism” (p. 307). Schick and St. Denis (2005) further stated that access to “white skin privilege ... greatly improves one's chances of avoiding systemic discrimination and overcoming disadvantage” (p. 269). Thus, anti-racist work must involve settlers and allow them to critically reflect and discuss race and confront whiteness as a key proponent of racism (Schick & St. Denis, 2005).

In Canada, much of the general population resists discussion of white privilege and race, which prevents movement beyond what is the “norm” wherein Indigenous peoples are viewed as abnormal (Schick & St. Denis, 2005). The privilege afforded to whiteness or having white skin does not only relate to skin colour, particularly when referring to oppression and racialization, as these issues relate to colonial systems that were put in place to “kill the Indian in the child” and altogether erase Indigenous peoples (Harper, as cited in TRC, 2015, pp. 131–132). Canadian societal structures ensure that white Canadians are well represented in both policy and decision-making processes as well as in the physical sense in relation to Indigenous peoples (Fridkin, 2015). Indigenous peoples are reminded daily that racism is rooted in Canadian society as well as within laws, health and educational institutions, and all levels of government. Anti-racism approaches and practices provide an avenue to confront, challenge, and develop movement towards changing the Canadian status quo.

Integrating Indigenous perspectives into health care includes the redefining of relationships between Indigenous peoples and governments to foster meaningful involvement of Indigenous peoples (Cheema, 2007; Fridkin, 2015). Involving Indigenous peoples within health care decision making and within all levels of health planning and development, from conception to completion, is integral to reduce inequities in Indigenous health (Cheema, 2007; Fridkin, 2015). Lawrence and Dua (2005) argued that Indigenous perspectives and the process of ongoing colonization are central to the construction anti-racism knowledge.

2.3. Ethics: Working with Indigenous Peoples in Research

In engaging in a policy analysis that focuses on the needs of Indigenous peoples in BC, there are ethical considerations that must be included, discussed, and followed. Policy processes often exclude Indigenous peoples, despite repeated attempts within health organizations and institutions to promote meaningful involvement of Indigenous peoples in engagement and decision-making processes (Fridkin, 2015; Kenny, 2004). There is a need to move beyond the status quo and to consider the nature of systemic racism toward Indigenous peoples as well as best practices in anti-racism training,

frameworks, and processes. The researcher is an Indigenous woman of Wet'suwet'en heritage, and carefully considered how to proceed with the inquiry in a good way (Ball & Janyst, 2008). The researcher aspired to conduct herself in a way that upheld her own Wet'suwet'en ways of knowing and being, which calls for the need to advocate for Indigenous self-determination in health policy.

Importantly, this research was guided by Kirkness and Barnhardt's (2001) work, which outlined the 4Rs – respect, relevance, reciprocity, and responsibility – in relation to working with Indigenous peoples. The researcher considered these as key guidelines, as they serve as an educational tool to non-Indigenous researchers. Respect calls for the need to respect the protocols of the lands on which the research took place, which in this case was the homelands of the Musqueam, Squamish, and Tsleil-Waututh First Nations in what is now known as Vancouver, BC. Reciprocity in the research process calls for the Indigenous research participants to be able to “be who they are” (Pidgeon, 2018, p. 11), and, in this case, reciprocity was extended to the researcher as well, as she wanted to ensure that this process included her own Wet'suwet'en ways of creating relationships with other people. Responsibility of the researcher focused on the researcher's “roles and responsibilities that are inherent in the storyteller as she/he listens and learns from those who participate in the research as rightsholders” (Pidgeon, 2018, p. 13). Finally, relevance related to the meaning and value that this policy analysis has generated for Indigenous peoples (Pidgeon, 2018). The objective of addressing anti-Indigenous racism is meaningful to the researcher as a Wet'suwet'en woman, and the researcher aims to continue to learn and strive to assist in the effort to generate change.

Chapter 3: Environmental Scan: Policy Discourses

The environmental scan included a review of publicly available literature, program assessments, and training materials related to existing policies that address anti-Indigenous racism in Canada. The development of an anti-racism policy necessitated a scan of what is already available, not only provincially or within BC, but what is occurring federally and within educational institutions. The environmental scan sheds light on what has been done in the past and what can be done better in the future.

3.1.1. Federal Anti-Racism Policy

In 2005, the Government of Canada released *Canada's Action Plan Against Racism* (CAPAR), which was written with the intent of highlighting the promotion of “equality, multiculturalism and diversity...both in the workplace and in the community” (p. iii). The main efforts to address racism are to assist victims and groups vulnerable to racism, develop approaches to promote diversity, strengthen the role of civil society, improve regional and international cooperation, and educate children and youth on diversity and anti-racism. The subsequent evaluation of CAPAR (Citizenship and Immigration Canada, 2010) reviewed funded initiatives and stated there was little cohesion and lack of governance structure within CAPAR initiatives and it was difficult to assess the results of CAPAR due to its horizontal nature and approach (Citizenship and Immigration Canada, 2010). The evaluation reported that initiatives addressing racism are more effective if they have a cohesive approach and an effective governance structure, as this allows multiple initiatives to work toward the same key goals and outcomes. A critical analysis of CAPAR illuminated the limitations for Indigenous peoples as anti-Indigenous racism was not specifically targeted (Citizenship and Immigration Canada, 2010). Although individual initiatives that were funded focused on Indigenous peoples, their horizontal nature, as Citizenship and Immigration Canada (2010) noted, did not promote structural widespread movement toward addressing anti-Indigenous racism.

3.1.2. Policy Discourses in British Columbia

The health authorities in BC have various policies wherein anti-racism is either alluded to or addressed indirectly within a policy. Many of the policies and related discourses hold important implications toward the development of an anti-racism policy. The following key policies or policy discourses were reviewed as they assist in addressing racism within health authorities: (a) multiculturalism, (b) bullying and harassment, (c) workplace environment policies, (d) discrimination, (e) cultural safety, and (f) conflict resolution. These discourses are described briefly in Table 1, along with the implications in addressing anti-Indigenous racism.

Table 1***Overview of Key Policy Discourses***

Policy	Overview
Discrimination	Discrimination is adverse treatment and denial of opportunities and equal rights to individuals and members of ethnic or racial groups due to prejudice (Human Rights Code, 1996; Interior Health Authority, 2018).
Indigenous Cultural Safety	Indigenous cultural safety addresses power imbalances within health care systems wherein there is a need for an environment free of racism and discrimination (PHSA, 2018).
Bullying and Harassment	Bullying and harassment are harmful behaviours seen as interpersonal disputes that are punishable within dispute resolution processes to foster respectful workplace environments (Island Health Authority, 2009).
Conflict Resolution	Wrongful or discriminatory workplace behaviours are subject to conflict resolution processes that are often employed in respectful workplace policies and codes of conduct, which focus on interpersonal conflicts.
Respectful Workplace Environment	Respectful workplace policies opt for a zero-tolerance position on discrimination and harassment and outline conflict resolution processes and/or guidelines to resolve individual workplace disputes (Interior Health Authority, 2018; Island Health Authority, 2009).
Multiculturalism	Policies on multiculturalism focus on the respectful treatment of all ethnic backgrounds, though do not focus on the experiences of Indigenous peoples (PHSA, 2018).

Note. PHSA = Provincial Health Services Authority

The policies that were reviewed used similar language in many respects, often emphasizing the need for a workplace that is free of “discrimination and harassment” (Interior Health Authority, 2018, p. 1) and often cited the BC Human Rights Code (1996). Further discussion includes an analysis of the policy discourses and Appendix A presents a breakdown of the policy goals, purpose or intent, and policy solutions. The policies identified in Table 1 show the key components of each policy stream. Indigenous health departments are leading the way toward implementing initiatives that aim to challenge the status quo within Indigenous health policy.

Appendix A lists the policies reviewed within the environmental scan for this inquiry. These policies were analyzed because they related closely or were considered to relate to discourses around harm that could be perpetuated by racism. The discourses include discrimination and harassment, oppression, and/or stereotyping in health and

education institutions. Most of the policies included in Appendix A are publicly available and can be found on health authority websites. At the time of writing, none of the health authorities in BC had an anti-racism policy. Thus, there was a need to look up anti-racism policies from other institutions, including education institutions. Many of these policies are related to individual conduct and focus on behaviour within the workplace.

3.2. Cultural Safety Initiatives

To better understand cultural safety and the initiatives that are being implemented in health authorities in BC, this section begins with a short introduction to the history of Indigenous cultural safety. In 1990, Māori nurse, Irihapeti Ramsden, from New Zealand introduced the concept of cultural safety; this went beyond cultural awareness and sensitivity and focused in on the realization of the legitimacy of difference and the power imbalances that are apparent between Indigenous and non-Indigenous peoples (Smye & Brown, 2002). Definitions of cultural safety differ slightly between health institutions, but they each focus on outcome-based priorities in health and require respectful engagement with Indigenous peoples that “recognizes and strives to address power imbalances inherent in the healthcare system” (First Nations Health Authority, 2016a, p. 10). Cultural safety policies intend for health care environments to feel safe for Indigenous peoples when receiving health care services, which means they can be free of racism and discrimination. (First Nations Health Authority, 2016).

The FNHA (2016a) released a policy statement addressing the need for cultural safety and humility in health care services, as did many other health authorities in BC. FNHA’s (2016a) cultural safety and humility position paper cites racism as being a determinant of health for Indigenous peoples.

Vancouver Coastal Health (VCH, 2015a, 2015b) released a *Cultural Safety Action Plan* along with a *Policy on Cultural Safety* (VCH, 2018). VCH Indigenous health aims to implement cultural competency within the health authority, which is focused on long-term integration and a continuous development process with ICS being the ultimate outcome. The plan includes staff education, acknowledgement of traditional territory, traditional healers and medicine, Aboriginal human resources, and facility development as key components (see Appendix A). VCH (n.d.) also released a guide called *Aboriginal Cultural Practices*, which includes a listing of policies that assist health care providers in understanding the importance and protocols within some Indigenous cultures.

The PHSA (n.d.-b) has developed online cultural safety and competency training called the *San’yas Indigenous Cultural Safety Training*. The San’yas ICS training curriculum is geared toward individuals working within health care services and has been taken up by each health authority in BC (PHSA, n.d.-b). The training curriculum includes core ICS training, Core ICS Health, Core ICS child welfare, and Core ICS mental health. Thousands of individuals have taken the San’yas training, which includes

government and health authority employees in BC, Manitoba, and Ontario (PHSA, n.d.-b).

3.3. PHSA Policies and Policy Initiatives

3.3.1. PHSA Indigenous Cultural Safety Strategy

The PHSA's (2018) *Indigenous Cultural Safety Strategy* is evidence-based and theoretically grounded in ICS. A key objective of the strategy is to create a culturally safe environment for Indigenous people by addressing anti-Indigenous racism, including discrimination and stereotyping, at interpersonal and organizational levels (PHSA, 2018). The strategy is focused on the direct care level, including clinical interactions, as well as on the organizational and institutional levels. At the organizational level, a focus is placed on leadership, strategy and policy, and quality and improvement, including planning, accountability, and reporting. At the direct care level, the focus is on equipping individual service providers and teams with the knowledge and skills to deliver culturally safe services.

The PHSA (2018) *Indigenous Cultural Safety Strategy* is being developed in collaboration with the Indigenous Health department. This intervention-based strategy is organized into the following six action areas that encompass policy directions for PHSA: Administration and Governance; Human Resources, Training and People Development; Equitable Access and Service Delivery; Policy, Quality, Risk and Legal; Communication and Community Relations; and Planning, Monitoring, Evaluation and Research (PHSA, 2018). The strategy includes short- and long-term objectives that focus on movement along the cultural safety continuum and upon collaboration within health authorities to facilitate this progress.

3.3.2. Cultural Safety within BC Cancer

PHSA's BC Cancer Agency partnered with the BC Association of Friendship Centres, the FNHA and the Métis Nation British Columbia and the BC Association of Aboriginal Friendship Centres to produce *Improving Indigenous Cancer Journeys in BC: A Road Map* (FNHA, 2017). The priorities within the road map are identified as aligning within the TRC's (2015) calls to action that address health care services. This document addressed six priority areas in relation to cancer prevention, treatment, and survivorship with respect to the deliverance of culturally safe care (FNHA, 2017). The final action area of the main six focuses on supporting Indigenous cancer survivorship and end-of-life experiences while improving knowledge of Indigenous cancer experiences. This policy statement is an example of implementing ICS with multiple health authority partners.

3.3.3. Cultural Safety within BC Women's and Children's Hospitals

The BC Women's and BC Children's Hospitals (2018), along with their partners, released a *Patient Experience Roadmap*, which was developed to provide strategic direction in improving experiences for all stakeholders, including patients, their supporters and health care providers. The document defined cultural safety and humility and highlighted health care facilities as being spaces to encourage a climate for change (BC Children's and Women's Hospitals, 2018). This document is relevant to the development of an anti-racism policy, as it serves as an example within PHSA of the implementation of a cultural safety protocol and specifically calls on the need for partnerships between Indigenous peoples and communities and health care services and providers.

3.3.4. Fostering a Culture of Respect Policy

Currently PHSA addresses the need for a respectful workplace within the *Fostering a Culture of Respect* policy (PHSA, 2011b). The purpose of this policy is to confirm PHSA's commitment to generating a culture of respect across all programs and services while also promoting and maintaining an environment in which all individuals are treated with respect and dignity and are free from discrimination, harassment, or bullying. This PHSA (2011b) policy also cited the need for swift resolution of disrespectful conduct and outlined proper procedures for conflict resolution (also aligns with PHSA's code of conduct policy). This policy can assist in providing direction within an anti-racism policy, as it outlines examples for conflict resolution processes (PHSA, 2011b). It is, however, focused on individual level racism, which, as previously noted, cannot address the institutional or systemic racism that Indigenous peoples experience.

3.3.5. Code of Ethics

PHSA's (2011a) *Code of Ethics* policy was developed to provide guidelines for acceptable behaviour within the health authority's programs and services. The guidelines state that this policy is not considered to be fully comprehensive due to the complexity of each individual situation and is not to be considered a substitute for the exercise of good judgement within the workplace (PHSA, 2011a). The policy is cited as an educational tool, designed to inspire individuals to act in a way that promotes good care, assist in developing community relationships, and fosters public confidence in the health and social services that PHSA and its employees provide. This can be considered a foundational policy, as it is aimed to outline acceptable behaviour and conduct within the workplace and can serve to align in some ways with an anti-racism policy.

3.3.6. Organizational Policies and Position Papers

Organizational policies and position papers show a specific focus on recommendations, guidelines, and processes and may provide guidance on certain gaps in Indigenous health and the needed partnering with Indigenous organizations. Various

policies are informed by commitments and declarations to ICS and some policies state the need for an environment that is free from racism and support fair and equal access for all who wish to participate in organizational events and or initiatives (Canadian Association of Perinatal and Women's Health Nurses [CAPWHN], 2017; University of British Columbia, 2014).

CAPWHN (2017) released a position statement on cultural safety and humility, stating that nursing practices must be improved within both Indigenous- and non-Indigenous-based services to safeguard against neo-colonial practices in nursing. The CAPWHN document asserted the need to build awareness of ICS and to foster relationships and meaningful collaborative partnerships with Indigenous communities to improve experiences within health care. Finally, CAPWHN acknowledged the inequities in power dynamics in health care systems and that there is a need for better health outcomes for Indigenous women and families. The Royal College of Physicians and Surgeons of Canada (2014) also released a statement of Indigenous health values and principles, which outlined recommendations for action in the implementation of culturally safe services.

3.4. Critical Analysis and Discussion of Policy Discourses

An environmental scan of health authority documentation revealed no specific examples of anti-racism policies. Thus, the York University's (n.d.) anti-racism policy is included in this environmental scan even though it does not include specific mention of anti-Indigenous racism. The implications of an omission of Indigenous experiences of racism are significant because Indigenous experiences are lost amongst the discourses that serve to benefit non-Indigenous populations. In a review of medical and health research focused on Indigenous peoples, Wilson and Young (2008) found that many research projects did not sufficiently address the demographic needs of Indigenous peoples, with a profound neglect of Métis and urban Indigenous peoples. Indigenous peoples have specific experiences and unique needs that must be addressed within models and frameworks that are inclusive of Indigenous voices and promote Indigenous involvement in decision-making processes.

There are many policies related to reconciliation, ICS, and cultural humility within health authorities (FNHA, n.d.-a; PHSA, 2018). Such position papers and statements often provide a brief discussion of the history of colonization in Canada, specifically focusing on residential schools and Indian hospitals. Historical overviews and the relationship to current populations of Indigenous peoples provide context to current health gaps. These documents also often include the organization's or health authority's commitment to address health outcome gaps and policy issues along with an intention to align services with the outlined principles of ICS.

Health authority policies outline acceptable employee and patient conduct and processes to resolve individual conflicts. However, cultural safety and humility policy

statements and commitment documents lack a rigorous explanation of anti-Indigenous racism and race as a social construct. The literature review reveals that racism must be addressed with respect to the historical context of colonization and oppression that is experienced by Indigenous peoples. Existing policies address interpersonal disputes and instances of harm and discrimination, rather than systemic racism and, specifically, anti-Indigenous racism. Also, current policies address health authority patients, health care service providers, and the community within the health authority, yet they do not address or critique cultural or racial stereotypes and the harm that cultural or racialized groups may receive due to such beliefs.

The environmental scan revealed few policies existing that directly relate to addressing racism within health authorities. Policies outlining code of conduct for respectful workplace environments lack a component of calling for an equitable environment free of racism and racial stereotyping. As there can be contention around what racism looks like within a workplace environment, it would be helpful for examples of unacceptable behaviour to be included in policies that address racism, which should be included in all policy processes. In addition, guidelines for reporting should be considered along with specific examples of unacceptable behaviour and coinciding conflict resolution processes specifically related to racial discrimination. The discourses located within the environmental scan are beneficial for embedding within an anti-racism policy (i.e., discrimination, code of conduct, respectful workplace environment, etc.), but health authorities may also benefit from the development of an anti-racism policy. Appendix A includes a table of the policy and statement papers that have informed this paper.

Chapter 4: Research Methodology

This project utilized qualitative analysis to identify policy options for health authorities and organizations in implementing a policy to address anti-Indigenous racism. Semi-structured interviews informed the development of the policy evaluation framework and policy alternatives or options that have the greatest opportunity to reduce harm experienced by Indigenous peoples within health care systems.

4.1. Semi-Structured Interviews

The research question was investigated using semi-structured interviews conducted with both Indigenous and non-Indigenous health authority officials and scholars who work within an anti-racism and ICS framework. During the period of January 4, 2019, and January 16, 2019, the researcher conducted six semi-structured with leaders in the PHSA, First Nations Health Authority, the City of Vancouver, and Vancouver Coastal Health. No criteria for exclusion were set and interviews were 45 to 90 minutes in length.

The interviews were conducted with an interview guide and were digitally recorded and transcribed, after which qualitative analysis was undertaken to identify themes emerging from the interviews. Audio files were transferred and stored in Simon Fraser University vault. The interview data were thematically analyzed using an inductive approach to code and group themes emerging from the process of analysis. The researcher then visually depicted the research data, analysis, and recommendations developed from the evaluating strategy within this policy analysis process within a graphic recording. The researcher chose this approach, as data can be made more impactful if they are presented in a visual way, especially to visual learners, and graphic recording involves capturing ideas and expressions—in words, images, and colour—as they have been researched. The researcher used an 8- by 4-foot piece of paper to draw out the research process and policy recommendations. The graphic recording is included in Appendix C.

4.2. Recruitment Methods

Interviewees were selected based on a referral process by key contacts within the health authorities as well as online research to identify potential participants. As part of the informed consent process, participants were provided with a consent form that stated the interview is completely voluntary and could be withdrawn from at any time. Minors and captive populations were not included in the interviews.

Chapter 5: Results of Thematic Analysis

The interview process was intended to identify and evaluate policies and strategies that contribute to the implementation of anti-racism interventions. The experiences and legitimate concerns that were shared by participants offer valuable insight into the current attitudes and approaches to addressing anti-Indigenous racism in health care institutions. The subsequent themes emerged from the interviews and point toward key strategies and pedagogies that are developing in health care systems. To ensure that participants remained anonymous, the codes Participant A through to Participant F are used in this report to cite excerpts and quotes from interviews.

One limitation of this study is that findings reflect the experiences of Indigenous and non-Indigenous professionals who are working in three different health authorities (First Nations Health Authority, PHSA, and Vancouver Coastal Health). The findings do not necessarily reflect each of the policies and strategies that are being implemented across the province.

5.1. Systemic Racism in the Health Care System

The participants who identified as Indigenous people working within a health authority ($n = 3$) discussed the impacts of colonization and of systemic racism. Each of the participants provided examples of harm that Indigenous peoples had experienced while trying to access care within the health care system. Participant F stated that key reports, such as Gunn and Hall's (n.d.) *Ignored to Death: Systemic Racism in the Canadian Healthcare System*, which documents the death of Brian Sinclair, should be known and considered by each individual working within health care system, no matter what department they work in. Participant A also highlighted the importance of the inquiry on the death of Brian Sinclair and the frustration around the lack of knowledge of systemic racism in the health care system:

[In Canada] we're still like, "Really does racism exist? ... Maybe it doesn't. Maybe we're just really well-intentioned people, and maybe it's something else!" But the fact that we have the Brian Sinclair inquiry and that people are still thinking maybe it's something else?! It's just ridiculous. I mean that's it in a nutshell.
(Participant A)

All the interview participants stated they believe that health care providers do not have an appropriate understanding of the racist stereotypes of Indigenous peoples in Canada, which are rooted in the process of colonization. Participants reported doctors and nurses frequently stereotype Indigenous patients, and as a result these patients receive substandard treatment and are physically and mentally harmed in health institutions each day across the Canada. There is a deep mistrust amongst Indigenous peoples that is geared toward health care professionals, even for those Indigenous interview

participants who work within health authorities. Participant F revealed health care providers may not have the best intentions toward Indigenous peoples:

I would acknowledge that there is a lot of ignorance here and people do not understand what the issues are for Indigenous patients, clients, staff. Some don't care, some see it as irrelevant. Right now, I don't think people are experiencing any kind of discomfort around the violence Indigenous people experience. We may have unintentional, but certainly intentional harm. We have a lot of bystanders and a lot of witnesses who are guilty by association and guilty by doing nothing. (Participant F)

Participant F expressed frustration at the many examples of mistreatment and discrimination against Indigenous peoples in health care systems while the issue remains largely ignored by politicians and policymakers across the country. There is a lack of understanding of anti-Indigenous racism and the context in which it exists in Canada. There is also the general belief that this deeply complex issue is not being addressed and that there is an apathetic attitude toward the harm that Indigenous people experience.

The participants noted the systemic nature of anti-Indigenous racism calls for the need to shift the focus or the blame from the individual to the system. Participant F discussed the problem with individualistic policies that focus on the harm that is perpetrated by individuals within health authorities:

I recognize immediately that there is pressure to examine each example of harm as a one off, as a bad apple, that this is just one person having a bad day or needs to have more support and ... I think that may or may not be true. I'm concerned that you can't have all these examples [of harm against Indigenous people] and not understand that this is a systemic issue, that fundamentally these experiences of harm are across all borders in health care. All the health authorities experience this, [and] all service areas do this. (Participant F)

Participants plainly stated that anti-Indigenous racism is a systemic issue and the status quo is ubiquitous and harmful to Indigenous staff and patients (Participant F). Those who are committed to creating change are sure to come up against resistance, which was alluded to by each of the interview participants. Participant A affirmed this in the following quote:

I was working for one of the first people to start looking at [anti-Indigenous racism] in her research, and she got a lot of flack for it, so when you say, "Okay, we're going to address it," you're going to get resistance right away. At every step of the process you're going to hit that resistance. Naming it, defining the scope of what you want to look at, looking at the kinds of behaviours and looking at the impacts. (Participant A)

Participant A expressed both frustration and wisdom in acknowledging the process in addressing anti-Indigenous racism at every stage of the process. The interview participants revealed great persistence and passion in the pursuit of addressing the harms that Indigenous peoples experience within the health care system in BC.

5.2. Transformation of Systems

The interview participants spoke about the need for the transformation of health care systems, which would involve an overhaul of the entire structure of the health authorities in BC. Although there has been development in ICS practices throughout each of the health authorities, Participant F stated that it has not been possible to change discriminatory attitudes or paradigms toward Indigenous peoples. A transformation of systems, Participant C stated, would include interventions that are built to address anti-Indigenous racism within health care systems, which are intended to reduce harm to Indigenous peoples. Participant F noted a system-wide approach within the health authority would include the integration of ICS initiatives throughout the entire organization. To manage both a project approach and a big system approach,, Participant C said that there is a need for invested people and a lot of time to resolve major gaps in health outcomes and to address anti-Indigenous racism:

We've had extremely fortunate luck to have the right people understanding the same problems at the right time in the system come together. Everybody agrees it is time to address these major gaps in health outcomes. And that means having to do the hard, hard work of taking a look at ourselves and realizing where we have been part of that problem in creating that gap. (Participant C)

Each participant discussed various approaches in addressing anti-Indigenous racism or to how Indigenous pedagogies can be built into the health care system to make safer spaces for Indigenous staff and patients. Participant C reported a lack of understanding for how Indigenous people access health care services and that is coupled with racist stereotypes around Indigenous peoples, which create an unsafe environment within health care systems. The participants debated the role of policy in addressing anti-Indigenous racism, yet they all relayed that they believed there was a need for policy to guide practices within the health authorities.

Two distinct approaches to transformational and systemic change that participants discussed include an anti-racism approach and a cultural revisionism process. Participants noted each health authority has a somewhat different approach based on the needs of their regions.

5.2.1. Cultural Revisionism Approach

Participant F called an approach already implemented by many health authorities in BC the revisionism approach. This approach includes ICS education and training for

health authority staff. Most interview participants ($n = 4$) highlighted the importance of embedding of cultural safety practices into health care systems. Participant F said that many health authorities are focused on this theory of practice, which includes bringing in Elders and knowledge keepers to educate health care providers about Indigenous practices surrounding health and wellness. Participant C noted that VCH's (2018) ICS policy mandates the health authority staff to conduct care in a culturally safe way. This policy enables Indigenous peoples to practise smudging within hospitals and mitigates the health authority's already existing smoke-free policy (Participant C). Indigenous health promotion, according to Participant B, calls for the recognition of the positive impact that cultural approaches to wellness provide.

5.2.2. Anti-Racism Approach

An anti-racism approach to generating transformational change in health care systems was considered by the interview participants as distinct from ICS initiatives. One participant described the focus on anti-Indigenous racism and addressing the harm that is experienced by Indigenous peoples within health care systems as a critical and strategic approach (Participant F). Participant D described addressing anti-Indigenous racism, specifically, as distinct to “diversity initiatives,” as it is “important to address forms of racism against Indigenous peoples as distinct” within the health authorities in BC. Participant F noted that an anti-racism approach is not considered “popular” because it is “the most difficult conversation that we can have as Canadians.” Discussing racism is difficult, although Participant C stated it is important to “disrupt the whiteness of an organization, or the white supremacy of an organization” in order to shift the culture of a workplace.

Despite noting differences in approaches to change, interview participants agreed that health authorities must undergo transformation to ensure that Indigenous peoples receive better treatment within health care systems. The participants noted it is possible to explore multiple approaches to addressing gaps in health outcomes and that prioritizing Indigenous voices is paramount to generating change. Despite the lack of “critical mass” (Participant F) around addressing anti-Indigenous racism, participants highlighted the need for more research into understanding any sorts of best practices.

5.3. Research and Evaluation

The interview participants had distinct views on how to address anti-Indigenous racism or gaps in health outcomes for Indigenous peoples, which is due to the lack of baseline data around Indigenous staff and patients within health authorities (Participant F). Participants also stated it is essential to this work to have leaders and decision makers who draw on evidence-based practices and consistently make decisions based on evidence presented to them. Participant F stated that making evidence-based decisions follows a critical perspective that is more likely to be effective and to move past the status quo. In working toward addressing anti-Indigenous racism, Participant F

discussed the need to work with departments and organizations that are ready to engage in this work:

We look at ... service areas that are, from the research perspective, untainted [have not had Indigenous cultural safety training]. That's a good opportunity to do baseline work and then apply some intervention and do some evaluations. We're looking at these service areas very critically. It's an exciting time from a research perspective. We're really looking at more of a sophisticated framework for change. (Participant F)

The need for a critical lens and strong research and evaluation practices is clear; also, the evaluation process must be conducted to measure outcomes of any interventions. In addition, Participant D asserted any anti-racism interventions should be validated by Indigenous peoples to ensure that these initiatives are deemed by the community to be effective in addressing racism. Participant F advised that any information collected be subjected to an ethical process that is developed by Indigenous peoples and is then followed throughout the research process. Importantly, Participant D shared that it is key that health organizations then consider and begin to address the development of an implementation strategy for system-wide policy solutions.

Participant F stated that the need for ongoing assessment or evaluation of any anti-racism interventions needs to be from an Indigenous perspective to evaluate levels of safety. The participant also noted, "We need to give this a great deal of weight, so it is taken seriously because we don't have good baseline data to be able to evaluate change within the system" (Participant F). This shows both the need for Indigenous peoples to state when the system feels safer as well as the need for ongoing evaluation. Much of what is not currently known about racism in the health care systems led the interview participants back to the notion that additional data need to be collected in order to better reveal the extent of the racism problem.

The interview participants were asked to comment on the implementation of a self-identification system for staff and patients within health authorities. Although participants offered mixed responses regarding the implementation of a system of self-identification, they unanimously stated that this could be a significant data collection method. A self-identification system has the potential to provide statistics on Indigenous staff within health organizations as well as Indigenous staff retention data.

Participant F asserted self-identification programs will change the landscape of evidence and help to create a baseline of evidence. This participant also stated that there will be data on service uptake amongst Indigenous patients, interventions being used to address anti-Indigenous racism, as well as recruitment and retention of Indigenous staff (Participant F). Self-identification programs are also essential because

they begin discussions about race and racism. As Participant C relayed, it is difficult to address racism without discussing the issue of race:

I think the self-ID conversation is so important ... because it's so hard for people to talk about race. To talk about racism, we have to talk about race. And it's not for the purpose of reifying race ... race is a social construction. ... It's about acknowledging the real impacts that race has been constructed has on people.... We can't talk about anti-Indigenous racism if we're not gonna talk about Indigenous people or indigeneity. There's also a bit of a catch-22 there, because who would ... out themselves as Indigenous in the context where it's just gonna come back and create more negative experiences because of the racism in the environment?

Self-identifying as Indigenous has many implications, and Participant C discussed the major concern, which is that Indigenous peoples may experience harm in the health care system because they have been labelled and identified. Participant D stated that self-identification can perpetuate lateral violence amongst Indigenous peoples, which relates to conversations around indigeneity and blood quantum. Given these concerns, the majority of interview participants advised that it should not be mandatory to self-identify, in order to mitigate those risks ($n = 5$). However, Participant C stated that all people must be given option to self-identify their race so that the program does not single out Indigenous people and instead enables everyone to “trouble our own ideas about race.”

5.4. Power and Inequality

Throughout the interviews, the interview participants noted that addressing anti-Indigenous racism in health care can and must be done using various interventions. Although this work has been ongoing for many years, participants reported only recent noticeable traction of the work with the current mandate of the BC Ministry of Health. As Participant E noted, the current mandate focuses on the implementation of the TRC's (2015) calls to action in health care as well as the implementation of the UNDRIP (United Nations, 2007). Participant E further discussed how work within creating ICS training has been made more efficient by the current mandate of the Ministry of Health:

I can't trace causality, but since the new government came in and that new mandate letter was released ... it's easier to get my work done and for me to influence the system to be more culturally safe. There have been more people acknowledging the traditional territory.... There has been incredible uptake of cultural safety training. We can barely keep up with demand. We trained over 1000 people in basic introductory cultural safety training ... It was almost double what we did in 2017, and that was a huge jump as well.

Participant E has noted that provincial mandate letters have a great deal of influence on the current ability of the health authorities to provide specific ICS training. Participant D

also discussed commitments to reconciliation in BC and nationally and said that work within the health care system must align with commitments to reconciliation and the promotion of reconciliation. The provincial mandate for reconciliation has influenced a great deal of discussion around the treatment of Indigenous peoples within Canadian institutions, including health care systems (BC NDP, 2017).

In addition to discussions around the power of provincial and federal governments, the interview participants spoke of the relationships and partnerships between health authorities in BC. Health authority partnerships, both formal and personal, were considered in a positive light, as health authorities have signed a memorandum of understanding regarding the *Declaration of Commitment* around ICS (FNHA, 2015). Participants noted that this was due to the advocacy and lobbying to service providers, organizations, and governments on the part of Indigenous peoples.

The power structures that exist throughout the health care systems in BC were discussed as being a major barrier to advancing ICS initiatives and anti-racism initiatives. Participant F relayed frustration in this discussion as Indigenous peoples are often held accountable for the change that is needed to happen within the health authorities:

We see this as part of the burden that's put on our shoulders as Indigenous scholars, leaders, administrators. When it's not taken up by people who are asking for that accountability. They're not holding themselves accountable, but they're holding us accountable.

Participant F has described a frustration that was evidenced by other participants as well, in which Indigenous health departments are held accountable for their work and are asked how ICS interventions are creating change, while the entire organization should be held accountable to change attitudes and behaviours toward Indigenous peoples. The integration of anti-racism interventions and ICS interventions will be most effective with the burden being placed on the entire organization.

5.5. Human Resources

Health human resource was an important topic within participant interviews as the inclusion of Indigenous staff within the health authorities was identified as an important step in working toward increasing investment into ICS. Participant D advised recruitment and retention plans and strategies be implemented faster as qualified Indigenous people are urgently needed to work within health care systems. The integration and inclusion of Indigenous peoples in health care organizations is necessary for a number of reasons, which Participant B alluded to:

The real value that Indigenous people bring to that is the cultural piece and the feelings of safety and the cultural competency and humility and the cultural safety

that they bring ... it's to build familiarity relationships and to build an understanding with non-Indigenous health care providers. If it's not always an Indigenous health care provider, can there be an Aboriginal Patient Navigator present? It can reinforce what is considered unacceptable [behaviour].
(Participant B)

Participants noted an increase in Indigenous employees generates a presence in health care systems, which they indicated make health care organizations a more culturally safe environment. Participant C also said that recruiting staff within the organization who are dedicated to change can help to bring about systems change. Participant C noted, although recruiting Indigenous people into an unsafe environment within the health authorities is problematic, the inclusion of Indigenous peoples is necessary in order to bring about a more equitable environment.

Within health authorities it is difficult to access reliable staff retention data, as some positions are temporary and there is an overall high rate of turnover within health authorities (Participant E). Participant E stated that a hiring policy is more effective than a strategy for implementing Indigenous staff recruitment and retention, as it mandates the need to diversify staff hiring processes. Participants also unanimously stated that Indigenous recruitment and retention strategies help to implement immediate actions to attract more Indigenous staff. The trade-offs regarding race-based hiring practices can include discrimination against those who are hired as a result of these strategies or policies. Participant C discussed some of these issues and how they may be mitigated:

There [are] issues with affirmative action policies for equity, and a lot of negative repercussions on people who are hired because, "Oh, you're only hired since you're Indigenous," but if you have a shortlist and say, "Okay, half of the people on our shortlist need to be people of colour or Indigenous," that has a huge impact on creating a more equitable workforce. That ... [ensures] that people are hired based on their own merit. It's just that you made sure to diversify your pool of candidates.

Hiring policies that include benchmarks in a shortlist of candidates can assist in avoiding negative repercussions for those who may be hired in a race-specific position. Participant E cautioned that hiring policies can be difficult to amend because it may be necessary to get a human rights exemption, as organizations cannot discriminate based on race. Participant D stated that it can be an effective practice to also pose questions during interviews that focus on identity (self-identification) as well as the candidate's views on race and racism. Regardless of the chosen approach, Participant D stated the increased presence of Indigenous peoples within organizations can "disrupt whiteness and white supremacy." The need to diversify staff within the health authorities was a unanimous idea participants raised throughout the interviews.

5.6. Education, Training, and Policy Development

Education and training focusing on ICS was a focal point throughout the interviews, which centred on training and education for Indigenous peoples as well as for health authority employees and health practitioners. The interview participants discussed working toward building capacity for Indigenous peoples through education. Participant E stated that post-secondary institutions must focus on becoming more culturally safe to support Indigenous students to become successful in their studies, which will better enable them to move in to health care positions:

The resources should be focused on post-secondary institutions because there are just not enough qualified Indigenous people for the number of jobs that we need to fill. I think that the education institutions and systems need more to be more culturally safe to support Indigenous students to complete these programs.

Most interview participants ($n = 5$) agreed that there is a need to focus resources within education to ensure that Indigenous peoples receive health career training. Participants cited universities and colleges as spaces where anti-Indigenous racism exists and can detract Indigenous students from entering health-related careers.

Also relating to education, the interview participants discussed the need for health authority staff and for all health care employees to take ICS training. Participant F stated that Indigenous health care professionals, including researchers and care providers, are leading this difficult work toward addressing anti-Indigenous racism. Participant D noted health authority staff in all positions, but specifically in positions of leadership, need to better understand the current policies and agreements signed with the health authorities regarding Indigenous peoples:

I would be creating a ... BC First Nations health governance 101 course that would be ... required by everybody [in the health authority]. A mandatory course in addition to the San'yas cultural competency, you know the cultural safety training that everybody is mandated to have to take. (Participant D)

Participant D stated, in addition to mandatory training focused on Indigenous health governance, trauma-informed practice must be understood and included in curriculum because it will assist in providing better services to those who have experienced trauma such as residential school trauma, sexual assault trauma, etc. Participant D also discussed the system-wide benefits of mandating this training:

When your doctors are training in cultural safety and humility and trauma-informed care, that makes them better providers for their entire population.... For the trauma-informed staff who are dealing with patients or clients who are residential school survivors, that kind of understanding, that kind of humility, is going to make that doctor better at handling other traumatized patients. ... The

wider benefits of what we're doing, in trying to promote the cultural safety and humility and trauma-informed care piece, will have the benefit of trickling throughout the system. (Participant D)

As Participant D stated, there are system-wide benefits to ICS training and trauma-informed training sessions, but there are different schools of thought in training approach. Participant A revealed a contradiction that exists in training approaches:

There are different schools of thought in the education process. People who feel that you should never feel uncomfortable. [Some] feel like uncomfortableness comes with the territory and [that] you can't change behaviour unless you've been very uncomfortable. There's a range of beliefs [and] there's so much work to do in that area. (Participant A)

Despite the range of beliefs that exist, the interview participants were strong proponents of training that focuses on ICS, trauma-informed approaches and addressing anti-Indigenous racism. Nevertheless, Participant E stated that ICS training should never become a punitive measure, meaning that training should be mandatory for all staff, not assigned because of racist actions or statements from individuals.

In order to mandate this training, there will need to be guidance from Indigenous peoples and increased inclusion of Indigenous peoples within the health authorities. This begs the question as to whether Indigenous peoples will be placed in positions that allow them to be a part of the policy process and important decision-making processes. Participant C discussed some pitfalls and ways of being more inclusive of Indigenous peoples within the policy process:

[Often] we won't let any Indigenous people actually be policymakers. We're gonna look to Indigenous people for the answer to the problem that settler people created. Then we'll just give you the money, so you can just solve it yourself. And then when we [decide], "Oh, you didn't really make a difference, or you didn't use your money the best way or whatever." ... Then say, "You, [Indigenous people], failed. I think it best that Indigenous and non-Indigenous people make decisions together and both being accountable to the process." Indigenous people need to be involved in every stage of policy development, especially at the very beginning, at the definition of the policy problem. (Participant C)

The balance of involving Indigenous peoples and settlers in this work toward addressing anti-Indigenous racism and allowing Indigenous peoples to be a part of the policy- and decision-making process is key, according to Participant C. Overall, the interview participants communicated that the process of addressing anti-Indigenous racism includes a component of education and training that should be mandated by policies that are, in turn, developed and led by Indigenous peoples.

Chapter 6: Policy Criteria and Guiding Priorities

The criteria focused on the needs of Indigenous peoples, both employees and patients or those accessing services or employment within the health authorities across BC. As Kenny (2004) stated, “It is important to create criteria and guidelines for doing research with Aboriginal people that are culturally relevant and appropriate in each Aboriginal context” (p. 10). The criteria were selected based on the literature review and analysis of current policies that exist within BC’s health authorities. The environmental scan revealed the need to address anti-Indigenous racism within health authorities and to go beyond interpersonal racism and focus on the need to address anti-Indigenous racism the institutional or systemic level. The policy criteria served as guiding priorities to show the strengths and challenges within each policy option and how each of the options may complement one another. Table 2 presents a breakdown of the criteria and further discussion includes how the criteria will help to assess the policy options and their relative importance and trade-offs amongst the criteria.

Table 2

Policy Criteria and Measures

Criteria		Measures
Protection (Key Objective) x 2		
Indigenous Experiences of Harm	The extent to which the incidence of Indigenous peoples experiencing harm within health authorities is reduced	High Medium Low
Policy Effectiveness		
Implementing anti-racism approach and ICS	The extent to which the policy is expected to increase understanding of colonization and violence Indigenous peoples experience within health authorities	High Medium Low
Inclusion of Indigenous Pedagogies		
Indigenous Pedagogies Lead Policy Processes	The extent to which Indigenous pedagogies and perspectives are included in the policies and strategies to reduce harm within health authorities	High Medium Low
Cost		
Health costs for Indigenous peoples	The expected costs incurred by Indigenous peoples if anti-Indigenous racism is not addressed (net costs include social, health, and economic costs)	High Medium Low
Administrative Feasibility		
Total logistical features required to implement the strategy	The level of coordination required between health authority agencies or departments, relative to other strategies	High Medium Low

6.1. Limitations of Policy Analysis Framework within Indigenous Pedagogical Approach

An Indigenous researcher intent on using Indigenous research methodologies while studying and learning within a Western institution faces various challenges. This policy analysis has been carefully undertaken with ethical considerations in mind, specifically utilizing Kirkness and Barnhardt's (2001) Four R's, which includes respect, relevance, reciprocity, and responsibility. The principles outlined by Kirkness and Barnhardt's work helped the researcher to engage in a dialogue to ensure that an Indigenous way of thinking guided this research. As a Wet'suwet'en woman, engaging in a policy analysis process that has fundamentally been developed and dominated by white settlers, conducting this research was a challenging ordeal. The researcher's belief systems stem from a Wet'suwet'en worldview that is intimately linked with the land and in building relationships with the people who live on that land. The researcher's relationship to the land includes caring for those who live upon it. The researcher's family, community, nation, and the future generations drove this research as Indigenous peoples' health and wellness is paramount to thriving, self-determining nations.

6.2. Protection

The protection of Indigenous peoples from experiencing harm within health care systems is a key objective of the policy. Protection is meant to evaluate the extent to which the policy options can provide Indigenous peoples with protection from harm, which includes various forms of discrimination and violence from within the health authority. Specifically, this policy criterion evaluates whether a strategy may have potential to establish elements of safety for Indigenous peoples. The unit of measurement is based on a score of high, medium, or low. A low score reflects that there is an estimated lower extent to which the strategy can offer increased protection to Indigenous employees and patients within the health authority. A medium score reflects that there are elements implemented that may increase protection and safety for Indigenous peoples. A high score reflects that the policy is projected to meaningfully increase the level of protection. This criterion assesses a strategy, relative to other strategies within this policy analysis. Answers to the following questions guided the evaluation.

- Does the strategy allow data gathering and evaluation mechanisms that will assist in reducing harm against Indigenous peoples within the health authorities (i.e., allow a baseline of evidence to be generated)?
- The extent to which anti-Indigenous racism is acknowledged, discussed, and addressed within decision-making initiatives and policies.
- The extent to which Indigenous pedagogies and approaches to change are embedded within the health authority's policies and practices.

6.3. Policy Effectiveness

Policy effectiveness is meant to evaluate the extent to which the policy options are expected to increase understanding of colonization and violence that Indigenous peoples experience within health authorities. The effectiveness of the policy will be measured by the ability of the policy to then create and potentially maintain an environment that supports Indigenous cultural safety, which is essential to the establishment of practices and procedures that benefit Indigenous peoples. A key element of this criterion is that an assigned score or rating is due to the potential that the policy option is effective in establishing elements of safety that may increase a perceived sense of cultural safety for Indigenous peoples. This criterion assesses a strategy or policy option, relative to other strategies, for its ability and likeliness to establish the following elements that are considered to make a policy effective:

- An increase in the longevity and uptake of programming for focusing on ICS.
- Can the strategy increase perceived levels of ICS for all Indigenous peoples within the health authorities?
- Does the strategy increase the awareness for non-Indigenous peoples of impacts of violence and stereotyping faced by Indigenous peoples that exists within health care systems?

The unit of measurement is based on a score of high, medium, or low. A low score reflects that there is an estimated lower extent to which the policy option can meet the tenants of this criterion, while a high score reflects that the strategy performs well relative to other strategies.

6.4. Indigenous Community Inclusion

The Indigenous community inclusion criterion assesses the extent to which each policy or strategy option is supported by those impacted by the policy. To measure community inclusion, the category is evaluated based on the extent to which the policy is aligned with the needs of Indigenous peoples to feel safe within the health authorities. This vision for safety within health authorities is supported when there is a significant presence of Indigenous peoples working within the system and who are promoting content, materials, and spaces that reflect the need to exist without experiencing harm or discrimination. It is, again, important to note that this criterion is assessing the potential of the policy option to include elements of safety that can increase a perceived sense of cultural safety for Indigenous peoples. This criterion assesses a strategy or policy option, relative to other strategies, for its ability and likeliness to establish the following elements that are supportive and inclusive of Indigenous perspectives. The following questions guide the evaluation of each strategy:

- The extent to which the strategy is inclusive of Indigenous pedagogy and voices, which are also supported by Indigenous research?

- Does the level of inclusion support onboarding of Indigenous peoples as employees, contractors, students, and advisors?
- Does the strategy entail a mechanism for evaluation by Indigenous peoples?

This category is measured by receiving a low score if the policy option or strategy is perceived to not be inclusive and supported by Indigenous peoples, a medium score if the policy option is perceived to be somewhat inclusive, and a high score if the option is inclusive and is perceived to be supported by Indigenous peoples.

6.5. Cost

The cost category assesses the expected costs incurred by Indigenous peoples if anti-Indigenous racism is not addressed. The net costs that may be incurred are specifically focused on the health outcomes of Indigenous peoples, but also consider social and economic costs to Indigenous peoples. As loss of life is a potential outcome of anti-Indigenous racism within health authorities, this criterion highlights the negative effects of inaction and assesses the urgency of each strategy. Implementing a policy to address anti-Indigenous racism must be assessed relative to other strategies that are currently in use amongst health authorities. A low score reflects that, though there will be health costs to Indigenous peoples if the strategy is not implemented, there is an estimated lower cost if the strategy is not implemented right away and there will be lower health repercussions towards Indigenous peoples. A high score reflects that the costs will be higher than that of another strategy that received a low score and Indigenous peoples will receive more health repercussions. It must be highlighted that a high score reflects that the policy option is urgent and requires implementation and costs are high to Indigenous peoples.

6.6. Administrative Feasibility

The administrative feasibility category is comprised of the level of coordination and planning required between health authority agencies. To evaluate the administrative feasibility for each policy option, the required involvement of multiple agencies is assessed as well as levels of leadership within the health authority such as the board of directors and executives. The ability of the policy option or strategy to be applied within multiple departments from human resources to finance and administration is also assessed. The interview participants and the literature review highlight the need for strategies to be engrained throughout the structure of the health authority, thus an increased level of participation from leadership and throughout all agencies is favourable. The level of feasibility is rated in comparison to other strategies and considers the logistical aspects required to implement the strategy. The unit of measurement is based on a score of high, medium, or low. A low score reflects that there is an estimated low perceived ability for the strategy to be integrated within multiple agencies and relative to other strategies. A high score reflects that the strategy has a higher perceived ability to be applied within multiple agencies compared to other strategies.

Chapter 7: Policy Options and Evaluations

The policy options that were developed we done so with great consideration for the ethical framework outlined in this document as well as the theoretical frameworks related to TribalCrit and anti-race theory (Brayboy, 2005). There are important implications for utilizing discourse related to anti-racism and Henry and Tator (2000) argued that policies and training models should focus on ways to develop “critical reflective skills and practices; respond to allegations of racism; empower communities; monitor anti-racism initiatives; and emphasize the role of the individual as well as the institutions” (p. 334). To generate change within health care institutions, there must be a focus on policy options that have been recommended by those already doing the work in BC.

7.1. Collection of Racial Equity Data

This policy option requires the implementation of a program for the collection of racial equity data, which collects information on the racial background of health authority staff and patients (i.e. self-identification program). The goal in this context will be to discover the representation of Indigenous staff and patients within the health authority. As outlined in the theme section (Chapter 4) of this policy analysis, the interview participants pinpointed a lack of data around Indigenous staff and patients within health authorities in BC. All staff within BC’s health authorities will be provided with the ability to self-identify, as it is not ethical to single out Indigenous peoples. A baseline of data will be collected and will allow health authorities to “determine if it needs to expand its current programming and services or to develop new strategies to attract more [Indigenous] peoples” (Indigenous Corporate Training, 2018, para. 4). This option calls for the development and implementation of a survey or a measurement tool that will enable health authority employees and patients to identify their race or their ethnic background or chosen identity. The survey will acknowledge that race is a socially constructed paradigm and there will be disclaimer that this information will be kept confidential and used for research purposes. There will be ongoing evaluation of this process to identify if this method of data collection is effective. Exit interviews should be prioritized with Indigenous employees and interview data should be pooled to reveal a cross-departmental understanding of patterns for exiting the organization and potential solutions.

7.1.1. Evaluation

This self-identification program for all staff and patients addresses fewer of the components of the protection criterion. However, given that this option addresses a large gap in understandings of Indigenous access to care, as well as extent of Indigenous employees within the health authorities, it has potential to provide protection through policy mechanisms in the future. There is a need for a baseline of information within the

health authorities to make evidence-based policy decisions around Indigenous health. Thus, this strategy receives a score of medium or low for this criterion.

With regard to the effectiveness of the policy, this option scored medium as it is focused on building a baseline of knowledge and data, with a focus on quantitative data. It has potential to show patterns of employment and rates of retention amongst Indigenous employees and in which departments they are retained longer or where they are not retained. Within the inclusion of Indigenous pedagogies criterion, the policy option scored medium or low, as the need to self-identify may not initially be accepted by Indigenous peoples due to any perceived concern about receiving anti-Indigenous racism as a result of indicating their race. This criterion, however, is aimed at exposing barriers or gaps that Indigenous peoples experience. The expected cost to implement the policy is considered medium in comparison to other policy options. The health costs for Indigenous peoples if this policy is not implemented are considered medium relative to the other policy options, so this criterion received a medium score. The administrative feasibility or the level of coordination will be required between all agencies within the health authority. Due to the development of the program, coordination will be demanding; however, it will require less coordination once implemented. Thus, administrative feasibility is scored high, as it can permeate throughout the entire health authority.

7.2. Indigenous Recruitment, Retention, and Support

This policy option entails the implementation of a recruitment and retention strategy that focuses on Indigenous peoples. There are four essential components of this strategy: (a) culturally safe support mechanisms put in place for Indigenous staff; (b) establish an Indigenous Human Resource position in each agency or department; (c) implement an evaluation plan and timeline for an annual report to ensure that goals toward Indigenous recruitment and retention have been achieved as well as potential explanations and solutions that can be produced from the evaluation; (d) support Indigenous recruitment and retention for leadership and management levels (i.e., create bridging programs and opportunities for promotion to management positions). These essential components form a strategy that must be backed by the development of an Indigenous hiring policy as the interview participants noted that policies help to ensure that the strategies are fully implemented. Within this strategy, there is an opportunity for colleges and universities to better coordinate with Indigenous students to build research opportunities and to mutually build capacity and bridge Indigenous students into health authority positions. Greater establishment of Indigenous health policy within health authorities will assist in the movement to address anti-Indigenous racism and to incorporate ICS within all levels of the health authorities.

7.2.1. Evaluation

This policy option scores medium on the ability to reduce the incidence and experiences of harm within the health authorities. In comparison to other alternatives, this strategy provides the ability to increase perceived levels of cultural safety as it offers the ability to increase Indigenous presence in the health authority and provides a mechanism for evaluation. In terms of increasing awareness of anti-racism approaches to addressing harm this strategy scores low because, although it will increase the presence of Indigenous peoples, it may not decrease levels of harm. However, this policy option scores medium in being able to integrate Indigenous pedagogies within the health authority. There will be variation in this criterion based on the environment that Indigenous peoples face within the health authority.

The health costs associated with inaction if this strategy is not implemented are considered to be low relative to other strategies. Thus, this criterion is rated low because it is important to have Indigenous peoples represented in the health authority, yet it is less urgent than the other strategies. Regarding the administrative feasibility criterion, considerations for the ability of the policy option to be implemented within multiple agencies, this strategy scores medium to high, as it is focused on being implemented throughout the health authority. This strategy supports the success of other strategies (i.e., mandatory ICS training).

7.3. Mandatory Indigenous Cultural Safety (ICS) Training and Ongoing Professional Development

This policy option involves the implementation of health authority-wide training and education strategy for ICS as well as resources for ongoing professional development. This option requires continued partnerships between health authorities to ensure concerted effort toward ICS training and trauma-informed care. Partnerships will assist in sharing resources for training or partnering to assist in training efforts. The target audience is the non-Indigenous workforce within health authorities, which includes current and newly hired individuals. This strategy will include online training including the San'yas Core Health ICS training as well as direction to other resources such as the FNHA's (n.d.-b) online ICS and Humility Training Webinars. An opportunity to build a foundation of knowledge is presented with online training. In-person and ongoing training can assist in educating individuals and developing a deeper understanding of an anti-racism approach to reducing harm against Indigenous peoples and the colonial roots of health inequities. Furthermore, the development of a best practices model and toolkit it will be the development of that can be shared and included within research models. There must be a component in place to maintain ongoing education and communities of practice focused on ICS ongoing mechanisms to apply what they've learned.

7.3.1. Evaluation

Mandatory ICS training geared toward the health authority workforce scores medium regarding the protection criterion and having the ability to reduce harm experienced by Indigenous peoples. Although mandatory training generates discussion toward anti-Indigenous racism, there is a need for further training and foundational education within other educational institutions, which will allow greater discussion and addressing of the harms Indigenous peoples experience. The ability of the policy to effectively increase awareness of anti-Indigenous racism and its root causes is scored as medium because the policy option, as noted, will need further action in increasing understanding and awareness of the harms Indigenous people face. In being inclusive of Indigenous perspectives, this strategy scores high, as it includes a history of colonization and content created by Indigenous peoples. The health costs for Indigenous peoples if this policy is not implemented are considered high relative to the other policy options, so this criterion received a high score. Finally, this option scored medium within administrative feasibility, as it will be implemented within all health authority agencies, though there may be issues with compliance to training and will best be supported with a policy for regulation of training.

7.4. Develop a Strategy to Address Anti-Indigenous Racism

This policy option includes the development of a system-wide strategy within the health authority that directs the implementation of programming to address anti-Indigenous racism and to incorporate ICS into the health authority. This policy alternative calls for the development of a systematic approach that will be implemented in each agency or department within health care organizations. The development of this strategy will consider multiple avenues or strategies that include: (a) Indigenous recruitment and retention plan; (b) curriculum development and curriculum updates (i.e., Indigenous health governance curriculum development, ICS curriculum updates); (c) ICS training plan development; (d) ICS planning and evaluation frameworks; (e) policy development; (f) communication and engagement frameworks. These strategic implements are interconnected, and together they will generate movement toward systemically addressing anti-Indigenous racism within health authorities.

The PHSA's (2018) ICS strategy serves as a model to other health authorities in developing strategic or directional plans towards ICS. This policy alternative calls for regional health authorities in BC to develop their own directional strategies, which will assist health authorities in achieving goals and objectives and build motivation toward projects and plans to become more culturally safe. The development of the strategy includes researching and evaluating the appropriate measures within each health authority that must take place as well as focus on approval from a board of directors in order to be fully implemented and effectively strategized. The development of this plan is a decisive move toward addressing systemic racism within the health authorities as well as more equitable care for Indigenous peoples.

7.4.1. Evaluation

This strategy scores the highest in terms of its ability to reduce harm that Indigenous peoples experience within health care systems and, therefore, receives a high score on this criterion. This option is projected to increase understandings of colonization and violence Indigenous peoples experience within health authorities and amongst non-Indigenous peoples, so received a high score within the policy effectiveness criterion. Furthermore, this strategy has a higher projected ability to include Indigenous pedagogies and perspectives into policies, although the project must be administered by Indigenous peoples in order to fully be inclusive of Indigenous pedagogies. Thus, this strategy receives a medium score.

The health costs for Indigenous peoples if this policy is not implemented are considered high relative to the other policy options, so this criterion received a high score. This policy strategy has a higher ability to be implemented within multiple agencies within health authorities in comparison to other policy strategies, as the key objective of this strategy is to address anti-Indigenous racism on a systemic level. Therefore, this policy strategy receives a high score within the administrative feasibility criterion. This strategy incorporates the premise of the other policy options, yet is largely focused on the development of a system-changing device, which is a complex but necessary undertaking.

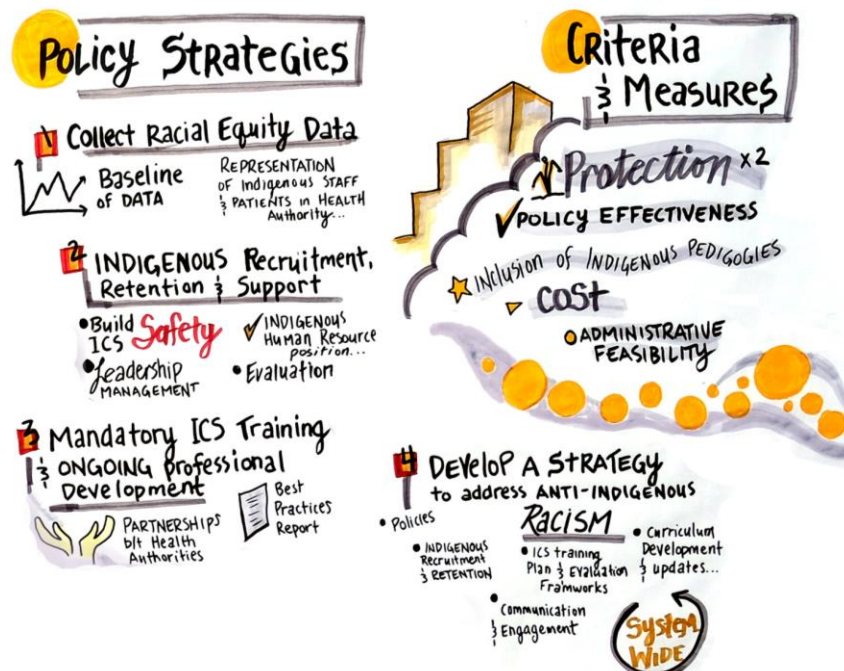


Figure 2. Policy options and criteria illustrated by M. Buchholz

Chapter 8: Recommendations

This capstone project focused on the problem of anti-Indigenous racism existing structurally within health care settings, which causes harm and violence to both Indigenous health care employees and patients. The BC Office of the Premier (2017b) has committed to implementing UNDRIP (United Nations, 2007) and the TRC's (2015) calls to action highlight the need for implementing ICS within health care systems. In British Columbia, ICS and anti-racism curriculum differ amongst health authorities as the pedagogies that guide the curriculum vary. Furthermore, it is integral to involve Indigenous peoples within health care decision making and within all levels of health planning and development, from conception to completion, to reduce inequities in Indigenous health. There must be leadership throughout the entire organization towards addressing anti-Indigenous racism and directors should all be held accountable to change attitudes and behaviours toward Indigenous peoples. Anti-racism and ICS interventions will be implemented effectively with the burden of change being placed on the entire organization.

The researcher analyzed four policy options to address anti-Indigenous racism in health care against five evaluative criteria. The policy options were considered in relation to one another and how the outcomes of each alternative would meet the key objective of this research. In analyzing each alternative against the evaluative criteria, it was found that the projected outcomes of individual strategies do not meet the key objective of achieving a decrease in the harm and discrimination that Indigenous peoples experience at an optimal level. The policy alternatives alone do not satisfy the key criteria. It is within an Indigenous holistic pedagogy, and in considering Kirkness and Barnhardt's (2001) 4 R's, wherein the notion of empowerment is at the heart of Indigenous participation in the health care system, and Indigenous peoples want better access to the system, to care, and to employment that is not discriminatory. Thus, it is essential that the policy strategies are considered as interconnected and that they complement one another based on their collective ability to address a systemic issue. For instance, the Indigenous recruitment, retention and support strategy will be strengthened if there will be data collected and analyzed from the collection of racial equity data. The collection of data will aid in providing a baseline of qualitative and quantitative data surrounding Indigenous employees and patients.

The collection of racial equity data will assist in the Indigenous recruitment, retention and support strategy evaluation as Indigenous employees can be surveyed for job leave or retention. Data gained from the racial equity data program can inform employment policies as well as service delivery policies. The final capstone is the development of a strategy to address anti-Indigenous racism, which is considered crucial in developing actionable items within the health authority that may also measure success and failures in moving towards addressing anti-Indigenous racism. In the short run it is feasible and desirable to implement the collection of racial equity data, and to

begin and develop the Indigenous recruitment, retention and support strategy and the strategy to address anti-Indigenous racism. In the long run, it is suggested to implement the mandatory ICS training and ongoing support strategy. It will be effective to build the baseline of data as well as build a strategy to support Indigenous staff before implementing the ICS training and ongoing support strategy. As some health authorities may be in development stage of these policy options longer than others, it is recommended that the development of a strategy to address anti-Indigenous racism begins as soon as possible. Appendix B shows the policy matrix scoring table, which assisted in the policy analysis process.

8.1. Suggestions for Future Research

Additional research is needed that examines the approaches to education or best practices around Indigenous Cultural Safety. Future research involving multiple fields including psychology and anthropology can assist in developing effective educational approaches to ICS and addressing anti-Indigenous racism. For instance, research focusing on attitudinal approaches to change and behavioural change approaches will assist in best practices or methodologies toward reducing anti-Indigenous racism. Furthermore, the interview participants discussed concerns around lateral violence and the impact that it has within Indigenous communities. Research and discussion around reducing lateral violence within workplaces will assist all employees within health authorities as the reduction of violence assists in promoting a healthy workplace environment. Finally, the development of a best practices document for ICS strategies will provide direction for future program development in BC. The objective of future research is to provide guidance to governments and health authorities in making evidence-based policy decisions to reduce the harm that Indigenous peoples face.

8.2. Conclusion and Reflections

As a Wet'suwet'en woman and a policy analyst, the researcher deemed it essential to incorporate Indigenous pedagogy into this research. The researcher advises this pedagogical approach be embraced as a component within the policy analysis process. Policy processes described by Bardach (2012), Dunn (2004), and Patton, Sawicki, and Carl (2013) presented practical approaches to analyzing public policy issues. By integrating the researcher's own Indigenous pedagogy, including incorporating an ethics component in research with Indigenous peoples, the process gained valuable components of cultural safety. This process helped the researcher to situate herself within the inquiry in a good way and to be reflexive throughout the policy analysis process. Kirkness and Barnhardt's (2001) model of the 4Rs helped the researcher to consider her own moral motivations in researching anti-Indigenous racism in health care. As an Indigenous woman, the researcher is pressured to adapt to Western institutional norms and processes, yet she contends that policy processes can assist in Indigenous self-determination if they can integrate Indigenous ways of knowing and being.

Furthermore, the interview process revealed that examining anti-Indigenous racism is triggering and difficult to discuss for all who work with or for Indigenous peoples in public health, both Indigenous and non-Indigenous. Kirkness and Barnhardt (2001) contended,

To respect the cultural integrity of First Nations ... communities, [institutions] must adopt a posture that goes beyond the usual generation and conveyance of literate knowledge, to include the institutional legitimation of Indigenous knowledge and skills, or as Goody (1982) has put it, to foster "a re-valuation of forms of knowledge that are not derived from books," [but] such a responsibility requires an institutional respect for Indigenous knowledge. (p. 102)

Indigenous knowledge may never receive the full respect that it deserves within Western institutions, yet there is a movement of resurgence amongst Indigenous scholars and communities for Indigenous peoples to continuously exercise their ability to be self-determining and to live with dignity and respect.

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Appendix A: Review of Policies and Literature Related to Anti-Racism

Name of Organization	Purpose/Goal/ Issue	Key concepts included (definitions)	Policy being proposed, solutions, position, key statements
Respectful Workplace Policies			
Fraser Health Authority	<ul style="list-style-type: none"> Establishes policy, practices, and procedures that promote a safe, inclusive environment for employees, physicians, volunteers, students, and others (Fraser Health, 2018) Employees are to be treated with dignity and respect, free from discrimination and harassment, and are supported in resolving disputes 	<ul style="list-style-type: none"> Definitions are included for the following terms, as well as what constitutes each act or behaviour with some examples listed: personal harassment, discrimination, discriminatory harassment, sexual harassment, and 'what is not harassment'. 	<ul style="list-style-type: none"> Fraser Health employees must be responsible for their own conduct and its impact on others; respectfully resolve personal differences; report policy violations to leadership; use proper policy processes to resolve conflict. Leaders create and maintain a respectful work environment; provide educational and discussion opportunities regarding this policy; engage in protocol to address transgressions.
Island Health Authority Title: Respectful Workplace Policy	<ul style="list-style-type: none"> Ensure all individuals are treated with dignity and respect, free from discrimination and harassment Provide an environment that respects and promotes human rights and personal dignity Transgressions lead to discipline, or termination 	<ul style="list-style-type: none"> Characteristics of a respectful workplace, personal harassment, bullying, discrimination, discriminatory harassment, sexual harassment 	<p>Implementation plan:</p> <ul style="list-style-type: none"> Education: human rights, harassment, bullying, appropriate behaviour, dispute resolution; A process for informal resolution of complaints; A process for reporting and investigating complaints, including discrimination and discriminatory harassment; Interventions to strengthen the relationships teamwork.

<p>First Nations Health Authority</p> <p>Title: Respectful Workplace Policy</p>	<ul style="list-style-type: none"> • This policy establishes principles and guidance for a safe, healthy working environment • FNHA staff and workplaces are respectful and individual's personal values, experiences, and preferences are recognized and considered 	<ul style="list-style-type: none"> • Bullying, cultural humility, cultural safety, discrimination, harassment, lateral kindness, lateral violence, manager/supervisor, sexual harassment, worker, workplace 	<ul style="list-style-type: none"> • Eliminate all forms of inappropriate conduct in the workplace, as they will not be tolerated in any form • Supports culturally safe, respectful working environment, which includes being free from sexism, racism and to be respected in their culture, values and preferences • Compliance: Violations of this policy may result in disciplinary action
<p>Vancouver Coastal Health</p> <p>Title: Respectful Workplace Policy and Human Rights Policy</p>	<ul style="list-style-type: none"> • Respectful workplace: where people work-together to meet organizational goals; it is foundational for a healthy culture that nurtures staff's physical and psychological well-being, engagement and performance 	<ul style="list-style-type: none"> • Bullying and harassment • List of inappropriate comments and conduct (i.e. discriminating or harassing behaviour that violates the Human Rights Code). 	<ul style="list-style-type: none"> • Human Resources Advisors are expected to lead the process of complaint review and VCH may investigate incidents • VCH associates are accountable for their own behavior and must conduct themselves respectfully • Witnesses responsibility: witnesses should intervene if appropriate and report to leaders
<p>PHSA</p> <p>Title: Resolution of Respectful workplace and Human Rights Issues</p>	<ul style="list-style-type: none"> • This policy aims to encourage timely resolution of disrespectful conduct through collaborative conversations. • Provide formal resolution processes where collaborative conversations do not resolve the behaviour 	<ul style="list-style-type: none"> • Disrespectful Conduct • Discrimination • Sexual Harassment 	<ul style="list-style-type: none"> • Process for resolving disrespectful conduct and discrimination in the workplace, which includes the three-step process (step 1: resolution; informal conversation, step 2: resolution; leader/designate involvement, step 3: resolution; formal).
Anti-Racism Policies			
<p>York University</p> <p>Title: Racism: Policy and Procedures</p>	<ul style="list-style-type: none"> • Racial and ethno-cultural diversity is a source of "excellence, enrichment and strength" and 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • The policy outlines commitments to and expectations of members and a complaint procedure to address violations;

	there is a commitment to human rights and to the principle that the community has a right to equitable treatment or intolerable actions prohibited by the Ontario Human Rights Code		<ul style="list-style-type: none"> Violators who infringe a right protected by the Ontario Human Rights Code are subject to complaint procedures, remedies and sanctions in the University's policies, codes, regulations and collective agreements.
<p>School of Social Work – University of BC</p> <p>Title: Anti-discrimination and anti-racism policy</p>	<ul style="list-style-type: none"> Committed to social justice and fostering anti-discriminatory and anti-racist practices. Promote an inclusive, respectful, and welcoming environment for students, faculty, staff and other community members. 	<ul style="list-style-type: none"> Discrimination, prohibited grounds of discrimination, mutual respect, equity, racism 	<ul style="list-style-type: none"> This is a public acknowledgement that UBC's School of Social Work will work to ensure that there is an environment free of racism and discrimination. After 3 years, the policy will be reviewed by the Director, School Council, Equity Committee and informed by student body, staff and faculty.
Cultural Safety and Humility / Cultural Competency			
<p>Canadian Association of Perinatal and Women's Health Nurses (CAPWHN)</p> <p>Title: The Canadian Association of Perinatal and Women's Health Nurses Position Statement on Cultural Safety & Humility</p>	<ul style="list-style-type: none"> Build awareness and understanding of cultural safety and construct relationships with Indigenous people Professionals engage in perinatal and women's health nursing to working towards cultural safety to safeguard against neo-colonial practices in nursing 	<ul style="list-style-type: none"> Cultural Safety: Indigenous peoples have a right to access health care (system) that is free of racism and discrimination Cultural Humility: Indigenous peoples are equal partners, deal with personal biases, develop meaningful relationships, acknowledge culture as integral 	<ul style="list-style-type: none"> Aiming for meaningful, collaborative partnerships; recognize fundamental inequities in power dynamics in health care systems and hope to move towards improved health and well-being for women and families. Moving beyond cultural awareness, to create an environment free of racism and discrimination where people can safely access health care services.
Declaration of Commitment, Cultural Safety and Humility in Health	<ul style="list-style-type: none"> In July, 2015, all BC Health Authority CEOs signed the declaration to demonstrate their 	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> Create a climate for change, engage and enable stakeholders, implement and sustain (embed cultural safety

Services Delivery for First Nations and Aboriginal People in BC	commitment to advancing cultural humility and cultural safety within health services		in all levels of the health system)
First Nations Health Authority Title: Policy Statement on Cultural Safety and Humility	<ul style="list-style-type: none"> Indigenous people have a right to access a health care system that is free of racism and discrimination. System-wide change is needed to implement cultural safety and humility. Provincial leadership must focus on concrete actions to achieve the vision of a culturally safe health system 	<ul style="list-style-type: none"> Definition provided of cultural safety and cultural humility within the context of meaningful partnerships 	<p>The following points are recognized as needing recognition and action:</p> <ul style="list-style-type: none"> Racial discrimination is fed by colonial ideals; There is a need to review and revise policies and structures to support cultural safety (i.e. promote cultural safety and humility training); Develop strategies to increase cultural safety and humility in health care organizations and incorporate them into organizational policies; Actions are needed at multiple levels throughout the health care system.
Vancouver Coastal Health Title: Toward Aboriginal Cultural Competency	<ul style="list-style-type: none"> Committed to providing quality care and reducing health inequities – cultural competency is a key strategy to achieve this goal. Cultural competency is a long-term and continuous development process with cultural safety being the outcome 	<ul style="list-style-type: none"> Cultural safety and cultural competency 	<ul style="list-style-type: none"> VCH CSA includes staff education plan Key actions: Acknowledgement of traditional territory; traditional healers and medicine – protocols and MOU with local First Nations Aboriginal Human Resources will aid in the recruitment and retention of Indigenous staff); Facility Development
FNHA Title: Improving Indigenous Cancer Journeys in	<ul style="list-style-type: none"> The Road Map is the result of a multi-year partnership between BC Cancer, First Nations Health Authority, Métis Nation British 	<p>Definitions:</p> <ul style="list-style-type: none"> Cultural Safety Cultural Humility Shared Decision-making Traditional Wellness 	<p>The strategy addresses all aspects of cancer, from prevention through to survivorship with a focus on delivering culturally safe cancer care.</p> <p>The Strategy Includes</p>

BC: A Road Map	Columbia and the BC Association of Aboriginal Friendship Centres.		<ul style="list-style-type: none"> Partnerships; Prevention; Screening; Cultural Safety; Survivorship; End-of-life; Knowledge Development
PHSA: Women's & Children's hospital Title: Patient Experience Roadmap	<ul style="list-style-type: none"> The purpose of this document is to provide a strategic direction that defines and supports initiatives to improve patient experience and to create a culture of authentic and safe partnerships with patients and their supporters. 	<ul style="list-style-type: none"> Climate for change; Cultural Safety; Cultural Humility; Reflective Practice; Trauma-Informed Practice (TIP); Self-Managed Care Patient Activation; Health Literacy; Patient Experience 	<ul style="list-style-type: none"> The Patient Experience Roadmap applies a broad lens and proposed consolidated direction for work being planned, implemented and evaluated that focuses on patient experiences at BC Children's Hospital and Women's Hospital and Health Centre.
Workplace Environment Policies			
Interior Health Title: Workplace Environment Procedural Guidelines	<ul style="list-style-type: none"> The health authority aims for a workplace free of discrimination and harassment and any conduct prohibited by the BC Human Rights Code. Commit to a professional working environment where employees, medical staff, contractors, volunteers and students are treated with respect 	<ul style="list-style-type: none"> Parties, complainants, respondents, witnesses Respectful Conduct: courtesy, civility, consideration and compassion, taking responsibility for individual behaviour Respectful vs. disrespectful behaviour. 	<ul style="list-style-type: none"> The procedural guidelines outlined include the processes that must be followed with complaints Management must ensure the policy is communicated to staff, maintain a zero-tolerance stance, take action when goals are not met. Bystanders should report their concerns and may otherwise violate the policy.
Code of Ethics			
PHSA Title: Code of Ethics	<ul style="list-style-type: none"> PHSA and its Agencies, Divisions, Services and affiliated research entities are "committed to carrying out their duties with integrity and honesty". 	<ul style="list-style-type: none"> None 	This policy promotes the PHSA's goal to: <ul style="list-style-type: none"> Provide an ethical environment that provides the opportunity to give feedback about care. Provide health and social services "impartially and objectively, free from

	<ul style="list-style-type: none"> Shows acceptable behaviour – the Code is not a substitute for good judgement. Inspire individuals to promote good care, and build relationships 		wrongful discrimination based on gender, gender identity, age, race, religion, ethnic origin, language, social status or sexual orientation”.
Fostering a Culture of Respect			
PHSA Title: Fostering a Culture of Respect	a) PHSA is committed to a culture of respect; b) Promote and maintain environment of respect and dignity that is free from discrimination, harassment and bullying; c) Ensure timely resolution of disrespectful conduct through clarifying conversations; d) Options, processes and resources for reporting & addressing disrespectful conduct, discrimination, harassment, bullying.	Definitions <ul style="list-style-type: none"> Bullying and Harassment Disrespectful Conduct Discrimination Psychologically safe workplaces 	<ul style="list-style-type: none"> Options for reporting disrespectful behaviour, discrimination, bullying and/or harassment; advice or guidance; reporting Clarifying conversation Formal fact-finding process Other resolution processes Witness and third-party complaints Violation of this policy Bad faith complaints Retaliation Confidentiality Record and disposition
Multiculturalism			
PHSA - BC Cancer Agency Title: Multiculturalism	<ul style="list-style-type: none"> All individuals within the Agency's community should experience equal, safe, appropriate and caring treatment and care as needed regardless of race, colour, ancestry, religion, or place of origin. 	None	<ul style="list-style-type: none"> Calls for the need to provide information, supports and services to all “cultural groups” and “minorities”; Provide training for Agency workforce to accommodate cultural differences; Staff must consider cultural factors in relations between health professionals and minority culture patients

Appendix B: Policy Analysis

Objectives	Policy Option 1: Collection of Racial Equity Data	Policy Option 2: Indigenous Recruitment, Retention and Support	Policy Option 3: Mandatory ICS Training & Ongoing Professional Development	Policy Option 4: Develop a Strategy to Address Anti-Indigenous Racism
Protection x2	Medium-Low 3	Medium 4	Medium 6	High 6
Effectiveness	Medium 2	Low 1	Medium 2	High 3
Indigenous Community Inclusion	Medium-Low 1.5	Medium 2	High 3	Medium 2
Cost	Medium 2	Low 1	High 3	High 3
Administrative Feasibility	High 3	Medium-High 2.5	Medium 2	High 3
Total:	12.5	10.5	16	17

Legend

High = Good (3)

Medium = Okay (2)

Low = Not Good (1)

DEVELOPING A POLICY To Address ANTI-INDIGENOUS RACISM IN HEALTH CARE

