No. 293, June 2013

Health Professionals Working With First Nations, Inuit, and Métis Consensus Guideline

This consensus guideline has been prepared by the Aboriginal Health Initiative Committee and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

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Canadian Association of Midwives

Canadian Association of Perinatal and Women's Health Nurses

Indigenous Physicians Association of Canada

Inuit Tapiriit Kanatami

Métis National Council

Key Words: Aboriginal, First Nation, Inuit, Métis, Social Determinants of Health, indigenous health, women, maternal/child health, health inequity, culturally-safe care, cultural competence, health service, delivery, life-cycle, traditional practices, rural health, urban, sexual health, reproductive health

J Obstet Gynaecol Can 2013;35(6):550–553

Minwaashin Lodge

National Aboriginal Council of Midwives

National Aboriginal Health Organization

Native Women's Association of Canada

Native Youth Sexual Health Network

Pauktuutit Inuit Women of Canada

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Disclosure statements have been received from all contributors.

The literature searches and bibliographic support for this guideline were undertaken by Becky Skidmore, Medical Research Analyst, Society of Obstetricians and Gynaecologists of Canada.

Abstract

Objective: Our aim is to provide health care professionals in Canada with the knowledge and tools to provide culturally safe care to First Nations, Inuit, and Métis women and through them, to their families, in order to improve the health of First Nations, Inuit, and Métis.

Evidence: Published literature was retrieved through searches of PubMed, CINAHL, Sociological Abstracts, and The Cochrane Library in 2011 using appropriate controlled vocabulary (e.g.,cultural competency, health services, indigenous, transcultural nursing) and key words (e.g., indigenous health services, transcultural health care, cultural safety). Targeted searches on subtopics (e.g., ceremonial rites and sexual coming of age) were also performed. The PubMed search was restricted to the years 2005 and later because of the large number of records retrieved on this topic. Searches were updated on a regular basis and incorporated in the guideline to May 2012. Grey (unpublished) literature was identified through searching the websites of selected related agencies (e.g., Campbell Collaboration, Social Care Online, Institute for Healthcare Improvement).

Values: The quality of evidence in this document was rated using the criteria described in the Report of the Canadian Task force on Preventive Health Care (Table).

Sponsors: This consensus guideline was supported by the First Nations and Inuit Health Branch, Health Canada.

Summary Statements

1. Demographically, First Nations, Inuit, and Métis peoples are younger and more mobile than non-Aboriginal people. This requires extra effort on the part of health care professionals to establish an environment of trust and cultural safety in their workplaces as the opportunity to provide care may be brief. (III)
2. Canada ranks 6th in the world on the World Health Organization Human Development Index; however, the First Nations rank 68th. (II-3)
3. There have been centuries of formal agreements between European governments and First Nations. They were initially conducted in the spirit of friendship and cooperation, but later became centred on land ownership and resource extraction. Since they have been repeatedly dishonoured, there is an environment of mistrust in First Nations towards governments, their representatives, their policies, and anyone perceived to have authority. (III)
4. The Indian Act and its subsequent amendments were designed to control every aspect of a Status Indian's life and to promote assimilation. It was also a tool that the government used to access First Nations' land and resources. (III)
5. The intergenerational trauma experienced by First Nations, Inuit, and Métis is the product of colonialization. Residential schools, forced relocation, involuntary sterilization, forced adoption, religious conversion, and enfranchisement are a few examples of government policy towards First Nations, Inuit, and Métis that have created intergenerational post-traumatic stress and dysfunction. However, they continue to be a resilient people. (III)
6. Most Canadians are unaware that a large proportion of Canada's gross domestic product is funded by monies garnished from natural resources extracted from Aboriginal lands, while First Nations and Inuit communities rely on insufficient money transfers from the Federal government. (III)
7. Multinational companies extract resources from lands that are often on or adjacent to Aboriginal communities, or lands that are under land claims negotiations. The management of lands and resources by the provinces in some regions and by the territorial and federal governments in other regions has made it difficult for First Nations, Inuit, and Métis communities to communicate with multinational corporations, especially where land claim negotiations are ongoing or non-existent. Multinational corporations do not provide revenues to these communities. Most Aboriginal communities are impoverished without adequate public health infrastructure, and without economic capital to improve their condition. (III)
8. Jurisdictional issues today make it difficult to provide health care, take care of the land, and promote healthy communities. (III)
9. Eating traditional country foods helps to preserve cultural identity, but increasing environmental contaminants such as lead, arsenic, mercury, and persistent organic pollutants may compromise food safety. (II-3)
10. Given demographic shifts such as rapidly growing populations with large youth cohorts and the increasing urbanization of First Nations, Inuit, and Métis in Canada, it is an important reality that most clinicians will encounter First Nations, Inuit, and Métis in their practice. (II-3)
11. Traditionally, men and women in First Nations, Inuit, and Métis cultures enjoyed equal and complimentary roles. Colonialization generally led to First Nations and Inuit women being objectified, disrespected, and ignored. Through specific pieces of legislation, First Nations women in particular lost their voices and powers within their communities, including their role in promoting traditional health and education. (III)
12. The unemployment rate is much higher in Aboriginal communities than in those of non-Aboriginal Canadians. This is a major contributor to the gaps in socioeconomic status and access to equitable and quality health care. (II-3)
13. The language of health outcome measurement often perpetuates negative stereotypes towards First Nations, Inuit, and Métis because outcomes are reported out of the context of the social, political, and economic circumstances. (III)
14. Jurisdictional conflicts between federal, provincial, territorial, and band governments make it difficult to provide comprehensive public health and health services to First Nations. (III)
15. The harmony of First Nations, Inuit, and Métis societies was disrupted by European colonialization at the end of the 18th century, causing widespread effects on the sexual health of First Nations, Inuit, and Métis women and men. (III)

Key to evidence statements and grading of recommendations, using the ranking of the Canadian Task Force on Preventive Health Care

Quality of evidence assessment*	Classification of recommendations†
I: Evidence obtained from at least one properly randomized controlled trial	A. There is good evidence to recommend the clinical preventive action
II-1: Evidence from well-designed controlled trials without randomization	B. There is fair evidence to recommend the clinical preventive action
II-2: Evidence from well-designed cohort (prospective or retrospective) or case–control studies, preferably from more than one centre or research group	C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category	D. There is fair evidence to recommend against the clinical preventive action
	E. There is good evidence to recommend against the clinical preventive action
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees	L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

*The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

†Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.

Woolf SH, Battista RN, Angerson GM, Logan AG, Eel W. Canadian Task Force on Preventive Health Care. New grades for recommendations from the Canadian Task Force on Preventive Health Care. CMAJ 2003;169:207–8.

16. Research has shown that where cultural competency strategies have been implemented, health outcomes and patient satisfaction have improved. (II-3)
17. Subtle racism may occur without conscious intent, and is therefore best defined and identified by those who experience it. (III)

Recommendations

1. Health professionals should have an understanding of the terms by which First Nations, Inuit, and Métis identify themselves. (III-A)
2. Health professionals should have an understanding of the terms "cultural awareness," "cultural competence," "cultural safety," and "cultural humility." Health professionals should recognize that First Nations, Inuit, and Métis may have different perspectives about what culturally safe care is and should seek guidance on community-specific values. (III-A)
3. Health professionals should be aware of the limitations of statistics collected with respect to First Nations, Inuit, and Métis and should avoid making generalizations about mortality and morbidity risks when comparing First Nations, Inuit, and Métis with one another and with non-Aboriginal populations. (III-A)
4. Health professionals who wish to conduct research with First Nations, Inuit, and Métis must use recognized ethical frameworks that include the OCAP (ownership, control, access, and possession) principles, the Tri-Council Policy Statement, and community-specific guidelines. (II-2A)
5. Health professionals should recognize the intergenerational impact of residential schools as one of the root causes of health and social inequities among First Nations, Inuit, and Métis, with important implications for their experiences and practices surrounding pregnancy and parenting. (II-3A)
6. Health professionals should be aware that the discourse on health care policy and land claim negotiations often perpetuates negative stereotypes and often occurs without accurate reference to colonialization. (III-L)
7. Health professionals should be aware of ongoing debates regarding jurisdictional responsibilities that impede access to good quality, timely, and culturally safe health care for First Nations and Inuit, and of Jordan's Principle. Jordan's Principal calls on the government agency of first contact to ensure that children get necessary and timely care by paying for services immediately and seeking reimbursement from the appropriate agency later. (III-A)
8. Health professionals who provide care to First Nations and Inuit should be aware of the Non-Insured Health Benefits program, its eligibility and coverage requirements, and the exceptions and special permissions needed in some cases. Health professionals should recognize that they have a vital role in advocating for their First Nations and Inuit patients and assisting with obtaining these benefits. Health professionals should be aware that Métis do not have access to the Non-Insured Health Benefits and may face unique challenges accessing health care. (III-A)
9. All health professionals should acknowledge and respect the role that Aboriginal and Traditional midwives have in promoting the sexual and reproductive health of women and should be aware that this role is not limited to pregnancy and delivery, but often extends beyond the birth year. (II-2A)
10. Health professionals should inquire about their patients' use of traditional medicines and practices as part of routine health practices, including prenatal care. (III-A)
11. Health professionals should be aware that each First Nations, Inuit, and Métis community has its own traditions, values, and communication practices and should engage with the community in order to become familiar with these. (III-A)
12. Health professionals should be aware of Canadian *Criminal Code* laws governing sexual activities in minors, including those under the age of 12, those between 12 and 16 years old, and those with a much older partner. (III-A)
13. Given the prevalence of sexual abuse and exploitation, health professionals must address the possibility of sexual abuse or

exploitation once a trusting relationship has been established. All gynaecologic and obstetric examinations must be approached sensitively, allowing the patient to determine when she feels comfortable enough to proceed. (III-A)

14. Health professionals should be aware of the increased prevalence of HIV/AIDS among First Nations, Inuit, and Métis and should offer HIV counselling and screening to women who are pregnant or of child-bearing age. Culturally safe approaches to HIV and other hematogenously transferred disease counselling, testing, diagnosis, and treatment should be supported and adopted. (III-A)
15. Health professionals should be aware of the high rates of cervical cancer and poorer outcomes once diagnosed for First Nations and Inuit patients. Health professionals should strive to limit the disparity between their Aboriginal and non-Aboriginal patients by promoting culturally safe screening options. (I-A)
16. Health professionals must ensure that First Nations, Inuit, and Métis women have access to services for all their reproductive health needs, including terminations, without prejudice. Health professionals should strive to ensure confidentiality, particularly in small and fly-in communities. (III-A)
17. Health professionals should recognize pregnancy as a unique opportunity to engage with and affirm the sexual and reproductive health rights, values, and beliefs of First Nations, Inuit, and Métis women. (III-L)
18. Health care providers should ask about, respect, and advocate for institutional protocols and policies supporting the wishes of individuals and families regarding disposal or preservation of tissues involved in conception, pregnancy, miscarriages, terminations, hysterectomy, and other procedures. (III-A)
19. Health professionals should recognize that mental illnesses such as mood disorders, anxiety, and addictions are a major public health issue for many First Nations, Inuit, and Métis. (II-3B) Use of mood-altering substances that lead to addiction is often a mechanism for coping with the pain of their intergenerational trauma. Health professionals should familiarize themselves with culturally safe harm reduction strategies that can be used to support First Nations, Inuit, and Métis women and their families struggling with substance dependence. (II-2A)
20. Health professionals should support and promote the return of birth to rural and remote communities for women at low risk of complications. The necessary involvement of community in decision-making around the distribution and allocation of resources for maternity care should be acknowledged and facilitated. (III-A)
21. Health professionals should be aware that there is a great lack of research, resources, and programming about mature women's health issues, including menopause, that is specific to First Nations, Inuit, and Métis. Health professionals should advocate for further research in this area. (III-A)
22. Health professionals should seek guidance about culturally specific communication practices and should tailor communications to the specific situations and histories of their patients. (III-A)
23. Health professionals may express to their patients that they wish to establish a respectful rapport through listening, acknowledging differences, and encouraging feedback. (III-L)
24. First Nations, Inuit, and Métis should receive care in their own language, where possible. Health care programs and institutions providing service to significant numbers of First Nations, Inuit, and Métis should have interpreters and First Nations, Inuit, and Métis health advocates on staff. (III-A)

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is available online at
http://www.sogc.org and **http://www.jogc.com**.