Indigenous-centred approaches to harm reduction, HIV and hepatitis C

February 24, 2020
Agenda:

• Overview by Dr. Alexandra King (*University of Saskatchewan*)
• Programming reflections from:
  • Norma Rabbitskin (*Sturgeon Lake Health Center*)
  • Carrie-Lynn Lund (*Canadian Aboriginal AIDS Network*)
• Q&A and Discussion
Dr. Alexandra King is an Internal Medicine Specialist with a focus on HIV/AIDS and hepatitis C. Alexandra is a Nipissing First Nations woman. She is the first Cameco Chair in Indigenous Health and Wellness at the University of Saskatchewan, and the Co-Chair of International Group on Indigenous Health Measurement working group on Indigenous wellness.
Indigenous Approaches to Harm Reduction, HIV and hepatitis C: Part 1

CATIE Webinar
February 24, 2020

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Nipissing First Nation
Cameco Chair in Indigenous Health and Wellness
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Territorial acknowledgement

I respectfully acknowledge that I live, work and play on Treaty Six First Nations Territory and the Homeland of the Métis Nation.
OVERVIEW:

INDIGENOUS PEOPLE IN CANADA, SOME RELEVANT STATS
CONCEPTUAL FRAMEWORKS
RESOURCES
https://native-land.ca/
Pre-and post-confederation treaties

CROWN-ABORIGINAL TREATIES IN CANADA 1763–2005
Pre-confederation treaties

Guswenta or Kaswentha – Two Row Wampum

- Haudenosaunee representation of 1613 Treaty of Tawagonshi between the Dutch and themselves
- Made of white and purple trade beads
  - One purple row = a sailboat, representing the Europeans
  - Other purple row = a canoe, representing the Native Americans
- 3 rows of white beads:
  - 1st row = peace
  - 2nd row = friendship
  - 3rd row = forever
2016 Census

# self-identified as Indigenous (1,673,780)

% Indigenous (4.9%)

% Non-Indigenous
# Population Size, 2016 Census

<table>
<thead>
<tr>
<th>Aboriginal identity</th>
<th>Number</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total – Population by Aboriginal identity</td>
<td>34,460,065</td>
<td>100.0</td>
</tr>
<tr>
<td>Aboriginal identity</td>
<td>1,673,780</td>
<td>4.9</td>
</tr>
<tr>
<td>Single Aboriginal response</td>
<td>1,629,800</td>
<td>4.7</td>
</tr>
<tr>
<td>First Nations (North American Indian) single identity</td>
<td>977,235</td>
<td>2.8</td>
</tr>
<tr>
<td>First Nations single identity (Registered or Treaty Indian)</td>
<td>744,855</td>
<td>2.2</td>
</tr>
<tr>
<td>First Nations single identity (not a Registered or Treaty Indian)</td>
<td>232,380</td>
<td>0.7</td>
</tr>
<tr>
<td>Métis single identity</td>
<td>587,545</td>
<td>1.7</td>
</tr>
<tr>
<td>Inuk (Inuit) single identity</td>
<td>65,025</td>
<td>0.2</td>
</tr>
<tr>
<td>Multiple Aboriginal identities</td>
<td>21,305</td>
<td>0.1</td>
</tr>
<tr>
<td>Aboriginal identities not included elsewhere</td>
<td>22,670</td>
<td>0.1</td>
</tr>
<tr>
<td>Non-Aboriginal identity</td>
<td>32,786,280</td>
<td>95.1</td>
</tr>
</tbody>
</table>

Statistics Canada. Focus on Geography Series, 2016 Census – Canada.
Opioid crisis – BC

First Nations people 5 times more likely to overdose in B.C., data shows

Statistics on Indigenous overdose victims released for the first time on Thursday

CBC News - Posted: Aug 03, 2017 1:59 PM PT | Last Updated: August 3, 2017

Provincial Overdose Data
Hover over a line for more details.

Illegal Drug Overdoses Attended by BC Ambulance Service over Previous 12 Months

http://www.bccdc.ca/health-professionals/data-reports-illegal-drug-overdose-events

- **Regional (former) vs SK rate**
  - 14.1 people per 100,000 population
  - higher than provincial rate
  - lower than provincial rate or reported no new infections

- **Males were more likely** than females to be diagnosed with HIV.
  - 58% males
  - 42% females

- **HIV was most common** among those aged 30-49 in males and aged 20-29 in females.
  - 3 in 5 males diagnosed with HIV was aged 30-49
  - 7 in 10 females diagnosed with HIV were aged 20-39

- **About 8 in 10** of the newly diagnosed females were within the **childbearing age** (15-45 years).

- **Injection drug use (IDU)** remained the **most common primary risk factor** among newly diagnosed people.

- The proportion of newly diagnosed people reporting IDU had increased from 2014 to 2018.
HCV Burden

3.4 Key populations at risk of HCV infection

Table 3 summarizes the estimated prevalence among key populations at risk for HCV, based on data collected from both routine and enhanced surveillance systems. These estimates are based on different years of data collection and do not distinguish current from past or resolved HCV infections. In addition, the prevalence estimates reported by M-Track, E-SYS and I-Track are not nationally representative of the target populations sampled, since data collection only occurred across a small number of sites across Canada. Appendix 1 provides more detail on the surveillance systems used for the data presented below. Risk factors associated with HCV infection will be the focus of Chapters 5.0 to 7.0 in this report.

TABLE 3. Estimated prevalence of HCV infection in the Canadian general population and sub-groups

<table>
<thead>
<tr>
<th>Population/risk group</th>
<th>Canadian population</th>
<th>People who inject drugs</th>
<th>Inmates</th>
<th>Men who have sex with men</th>
<th>Street Youth</th>
<th>Aboriginal population</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCV prevalence</td>
<td>0.8%</td>
<td>60%</td>
<td>28%</td>
<td>5%</td>
<td>5%</td>
<td>3%</td>
</tr>
</tbody>
</table>

FIGURE 8. Reported rates of acute HCV infection by year and ethnic group, EHSSS, 2004-2009

Over-represented in Populations at Risk for HCV

- Non-Indigenous people in Canada


### Table: Population at Risk for HCV

<table>
<thead>
<tr>
<th>Population</th>
<th>Indigenous Identity</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>I-Track</td>
<td>36.2%</td>
<td>2010-2012</td>
</tr>
<tr>
<td>E-SYS</td>
<td>33.3%</td>
<td>1999-2003</td>
</tr>
<tr>
<td>Federal Inmates</td>
<td>25.0%</td>
<td>2014-2015</td>
</tr>
</tbody>
</table>

Truth and Reconciliation Commission

94 Calls to Action:

• Child welfare
• Education
• Language and culture
• Health (18-24)
• Justice
• Reconciliation (43-94)

** Tightly coupled with the United Nations Declaration on the Rights of Indigenous Peoples and the ILO Convention C169 – Indigenous and Tribal Peoples Convention
Canada’s Truth & Reconciliation Commission
Call to Action #18

“We call upon the …governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people…”
Direct Causal Links: Colonialism & Health Inequity

Reconciliatory Objectives

1. Expose colonialism (“government policies”, C2A-18) as a **direct risk factor** for health inequity

2. Operationalize colonialism as a health indicator that can be targeted within cascades of care (i.e., front-line work)

Indigenous health determinants: Metaphoric analysis

Material & Living Conditions
Income, education, employment, physical environments, food security/sovereignty, childhood development

Social Structure
Health system, education system, labor market, child welfare, justice system, government, gender

Indigenous Wellness Resources
Culture, self-determination, Indigeneity, spirituality, community, languages, land

Colonialism
Indian Act, residential schools, 60s Scoop, racism
Layering of stress factors and resilient factors

- Indigeneity
- Racism/colonialism
- Identity
- Residential schools/60s scoop/foster care
- Resilience
- SES/poor housing
- HIV/HCV/drug use/sex trade/criminal justice system/homelessness
- Food insecurity/malnutrition
HCV burden among Indigenous Females: Colonialism & Intersectionality

- Patriarchy
- Racism
- Sexism

Poverty
Violence

Females overrepresented!

- Indigenous people
- Non-Indigenous people
Ethical Space

Western Worldview

Ethical Space

Indigenous Worldview

Two-eyed Seeing: *Etuaptmumk*

The perspective of “Two-eyed Seeing”, as put forward by Mi’kmaq Elder Albert Marshall

- To see from one eye with the strengths of Indigenous ways of knowing
- And to see from the other eye with the strengths of Western ways of knowing

...and to use both of these eyes together.
Cultural responsiveness framework

**Principle:** To improve Indigenous health status and eliminate Indigenous health inequities that exist in Saskatchewan

**Strategic directions:**
- Restore community-based health and wellness systems
- Establish a *middle ground* for engagement between mainstream and Indigenous systems and worldviews
- Transform mainstream service delivery to become culturally responsive

**Trauma-informed, strengths-based, community-specific and spiritually grounded**
# Harm reduction – definitions over time

<table>
<thead>
<tr>
<th>Western</th>
<th>Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop</td>
<td>• Native ethic of non-interference: A high degree of respect for every human being's independence leads the Indian to view giving instructions, coercing, or even persuading another person to do something as undesirable behaviour (Dr. Clare Brant)</td>
</tr>
<tr>
<td>• Practical strategies and ideas focused on reducing the harmful consequences associated with drug use and other risky health behaviours</td>
<td>• Decolonize</td>
</tr>
<tr>
<td>• Range of public health policies designed to lessen the negative social and/or physical consequences associated with various human behaviours, both legal and illegal</td>
<td>• Love (Sempulyan, Sandy-Leo Laframboise)</td>
</tr>
</tbody>
</table>
Indigenous approaches ...

- Grounded in lived experience, ancestral wisdom
- Wholistic: individual (spiritual, emotional/social, mental, physical), family, community, nation, all life forces
- Inclusive: all genders, all ages, all walks ... leave no one behind
- Non-judgmental
- Make use of Western tools, where appropriate
INDIGENOUS HARM REDUCTION = REDUCING THE HARMS OF COLONIALISM

INDIGENOUS HARM REDUCTION RESOURCES: Overview of Key Findings and Recommendations

PROJECT LEADS:
Canadian Aboriginal AIDS Network (CAAN)
Interagency Coalition on AIDS and Development (ICAD)

FUNDER:
Public Health Agency of Canada

http://www.icad-cisd.com
OUR APPROACH (3):

PEERS:
• 41: Peers engaged in the information gathering process

PEER REPRESENTATION:
• 58%: Lived or living experience of injecting drug use
• 22%: Elders or Indigenous Knowledge Holders
• 34%: Health or social service providers
• 95%: Self-identified as Indigenous
• 24%: Two-spirit, trans-identified or LGBTQ
• Vast majority were First Nations
  *(This gap was identified and addressed by bringing in additional representation for the review of the final draft of the document)*

REVIEW PROCESS:
• Advisory Committee: 3 rounds of review
• Peer-Review: 2 rounds of review with all peers involved in the information gathering and additional community members

http://www.icad-cisd.com
OUTLINE OF POLICY BRIEF:

• Indigenous Harm Reduction (5)
• Challenges to Indigenous Harm Reduction (4)
• Recommendations for Indigenous Harm Reduction Policy and Practice (6)
• Promising Practices in Indigenous Harm Reduction (6)

“Indigenous harm reduction means reducing the harms of colonialism.”
- Rawiri Evans, Maori Educator

http://www.icad-cisd.com
CASE STUDIES:

1. **13 MOONS HARM REDUCTION INITIATIVE**
   - Indigenous youth (11-35 years old) in Winnipeg, Manitoba

2. **CULTURE SAVES LIVES**
   - First Nations populations in Vancouver, British Columbia

3. **MAMISARVIK HEALING CENTRE**
   - Inuit people in Ottawa, Ontario. One of a kind in Canada.

4. **STURGEON LAKE TRADITIONAL HEALTH PROGRAM**
   - Sturgeon Lake First Nation (on-reserve)

http://www.icad-cisd.com
CATIE Programming Dialogue

• 26 participants gathered in Edmonton in October 2018
• Worked with an advisory committee to root the meeting and discussion in Indigenous principles and practices
• Structured discussion to share examples of programs, identify key elements and discuss how reconciliation informs this
• Worked with Advisory Committee to summarize information and draft the report
• The report summarizes key themes and program examples, and will help inform work and future discussions

Available at www.catie.ca
Guiding principles

• Create space for Indigenous practices, languages and culture

• Promote self-determination in planning and delivering programs

• Engage people with lived experience in program planning and delivery

• Destigmatize programs and communities

• Create programs that are person-centred

• Respect for one’s personal journey

Available at www.catie.ca
2020 World Indigenous Peoples’ Conference on Viral Hepatitis

September 23-26, 2020
Sheraton Cavalier Hotel
Saskatoon, Canada

For more information about registration, abstract submission, scholarships, travel, accommodations and more, please visit:

www.wipcvh2020.org

Email: info@wipcvh2020.org Twitter: @wipcvh #wipcvh2020
Norma Rabbitskin is a fluent Cree speaker from Big River First Nation, Saskatchewan. She is the Senior Nurse with the Sturgeon Lake Health Center. Norma leads community-based programs that are grounded in traditional healing practices and language to help revitalize culture and build community wellness.
Carrielynn Lund is a Métis consultant who assists Aboriginal communities to identify and address health and social issues. She has done extensive work in the area of health research, particularly with Aboriginal youth and resilience and research ethics. She is currently working with the Canadian Aboriginal AIDS Network and is the DRUM & SASH project and CanHepC Coordinator.
Questions and discussion
Register for part two at CATIE.ca!

Tuesday, March 3 at 12pm EST
Reconciliatory partnerships with Indigenous communities for Harm Reduction, HIV and Hepatitis C programs