THE ROLE OF THE NURSE EDUCATOR IN CANADA

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The Role of the Nurse Educator in Canada

Published by: Canadian Association Of Schools Of Nursing

Designed by: Devin Crockett, EviKreative.com

Library and Archives Canada Cataloguing in Publication

Title: The role of the nurse educator in Canada / Dr. Karin Page-Cutrara and Dr. Patricia Bradley, editors.
Names: Page-Cutrara, Karin, 1967- editor. | Bradley, Patricia A., 1950- editor. | Canadian Association of Schools of Nursing, issuing body.
Description: Includes bibliographical references and index.
Identifiers: Canadiana (print) 20200236954 | Canadiana (ebook) 2020023711X | ISBN 9781989648032 (softcover) | ISBN 9781989648049 (PDF)
Subjects: LCSH: Nursing—Study and teaching—Canada. | LCSH: Nurse educators—Canada.
Classification: LCC RT81.C2 R65 2020 | DDC 610.73071/071—dc23

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CANADIAN ASSOCIATION
OF SCHOOLS OF NURSING

EDITORS:

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CHAPTER 14

14

Truth and Reconciliation: A Path for Reform in Nursing Education

Bernice Downey

Education is what got us into this mess—the use of education at least in terms of residential schools—but education is the key to reconciliation.

— Senator Murray Sinclair, CBC Interview, 2015

This chapter outlines the link between European settler colonization practices and the health inequalities among Indigenous peoples in Canada, and to propose nursing education reform that is responsive to the Truth and Reconciliation Commission of Canada's (TRC) Calls to Action (COAs). An overview on key elements of the TRC process with a focus on Calls to Action related to nursing education and policy reform is provided.

Chapter Learning Outcomes

After completing the chapter, the reader will be able to

- describe relationships between nurse policymakers, educators, and practitioners regarding the socio-historical context of Indigenous population health in Canada
- identify elements of nursing education reform that are responsive to the Truth and Reconciliation Commission of Canada's Calls to Action

Introduction

Universities across the country are engaged in a responsive process to the 2015 Truth and Reconciliation Commission of Canada's (TRC) Final Report: *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada.* The TRC's Calls to Action with respect to health urge the acknowledgement of the direct link between the current state of health among Indigenous people in Canada and previous Canadian government policies, including the residential school system. Efforts and strategies to establish measurable goals for identifying and closing the gaps in health outcomes between Indigenous people and their Canadian counterparts are required (2015, p. 164).

The TRC's (2015) report also identifies several areas of health education reform with a clear role for medical and nursing schools. For example, the TRC calls for an increase in the number of Indigenous health professionals and the provision of cultural competency training for all health care professionals (see Chapter Appendix 14A). Existing interprofessional health sciences programs will need to enhance the learning experience for Indigenous learners to increase the number of Indigenous health professionals. In addition, non-Indigenous health professionals, researchers, and educators must be educated to respond in a culturally safe way. Indigenous health curriculum should include the colonizing history and legacy of residential schools and the ways that Indigenous peoples in Canada have participated in self-determining efforts to redress colonizing influences. The Royal Commission on Aboriginal Peoples (RCAP) (Erasmus & Dussault, 1996), the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP, 2011), and more recently, the TRC Final Report all capture the self-determining narrative that can inform the awareness building that is essential. The TRC also called for a transformation of the relationship between the Crown and Aboriginal people, stating that the policy of assimilation was a complete failure and that Canada must look to the historical treaty relationship to establish a renewed relationship based on principles of mutual recognition, mutual respect, sharing, and mutual responsibility (p. 193).

Nursing policymakers and educators have long-recognized the need to further understand how to bridge the cultural divide in the provision of care for Indigenous populations. This awareness has grown out of the collaboration with Indigenous nurse leaders and organizations and health policy initiatives that have focused on Indigenous health over the years. These were often initiated by Indigenous nurses who recognized the structural and systemic change needed both to advance nursing education reform for Indigenous learners and, ultimately, to effect positive health outcomes for Indigenous people.

The overall goal of this chapter is to inform nursing policymakers and educators about the link between European settler colonization practices and the health inequalities among Indigenous peoples in Canada. Second, nursing education reform that is responsive to the TRC's Calls to Action (COAs) is proposed. A critical medical anthropology lens is used to frame the decolonizing approach required in the development of culturally safe nursing policy, education, clinical practice, and research with respect to Indigenous health and nursing education. The next section will provide an overview on key elements of the TRC process with a focus on COAs related to nursing education and policy reform.

Truth and Reconciliation Commission of Canada

The TRC was established in 2008 as part of the Indian Residential Schools Settlement Agreement. The mandate of the TRC was to reveal the truth about the history and legacy of Indian residential school systems and to guide and inspire a process of truth, healing, and reconciliation within Aboriginal families and between Aboriginal and non-Aboriginal communities, churches, governments, and Canadians generally (TRC, 2015, p. 23).

The work of the TRC was informed by both the RCAP and UNDRIP. The RCAP's final report urged Canadians to begin a "bold new path" towards changing the foundations of Canada's relationship with Aboriginal peoples. While the RCAP process may have contributed to an increased awareness about Indigenous people in Canada, over 20 years later, a majority of its recommendations had never been implemented and were essentially ignored by government (TRC, 2015, p. 186). However, RCAP's report recommendations were revisited by the TRC, and this important work, which Indigenous people across Canada contributed to, informed the TRC's process and the COAs. Thus, it is important to note that in many instances, the TRC's final report reaffirms the RCAP recommendations. In addition, the overall poor uptake of RCAP's recommendations contributed to the TRC's decision to format its report with the more directive "calls to action" instead of "recommendations."

The UNDRIP, an important international Indigenous-led process, also informed the work of the TRC. This work represented 25 years of collaboration with the world's Indigenous people from member states, and it was adopted by the UN Permanent Forum on Indigenous Peoples in 2007 (TRC, 2015, p. 187). The TRC described UNDRIP as "a milestone in a global campaign to recognize and respect the rights of Indigenous peoples" (p. 102), noting that historical abuses of Indigenous peoples and the taking of Indigenous lands and resources around the world has drawn the attention of the UN for many years. UNDRIP called on member states to adopt and adhere to UNDRIP as "minimum standards for the survival, dignity and well-being of the Indigenous peoples of the world" (p. 28). The TRC aligned its view of UNDRIP with that of S. James Anaya, a UN special rapporteur on the rights of Indigenous people, who observed:

> **It is perhaps best to understand the Declaration and the right of self- determination as instruments of reconciliation. Properly understood, self-determination is an animating force for efforts toward reconciliation—or, perhaps, more accurately, conciliation—with peoples that have suffered oppression at the hands of others. Self-determination requires confronting and reversing the legacies of empire, discrimination, and cultural suffocation. It does not do so to condone vengefulness or spite for past evils, or to foster divisiveness but rather to build a social and political order based on relations of mutual understanding and respect. That is what the right of self-determination of Indigenous peoples, and all other peoples, is about (TRC, 2015, pp. 187–188).**

Today, the Declaration is described as "the most comprehensive international instrument on the rights of Indigenous peoples." It is promoted as a universal framework for reconciliation as noted above, and "it elaborates on existing human rights standards and fundamental freedoms as they apply to the specific situation of Indigenous peoples" (TRC, 2015, p. 190).

The TRC has been described as "a Commission like no other" (p. v). While numerous reports had documented the presence of residential schools, this was the first time that survivor voices were formally heard. The TRC was charged with hearing from Aboriginal people who had been taken from their families as children and for much of their childhood were placed in residential schools. More than 6000 witnesses, most of whom survived the experience of living in the schools as students, reported physical and sexual abuse. Many children were fed a substandard diet and given a substandard education. Discipline was harsh and reported as unregulated. High numbers of children died in these schools (2015, p. 43), this in a country that describes as priding itself as a "bastion of democracy, peace and kindness throughout the world" (TRC, 2015, p. v).

The TRC's efforts to educate the public was an important part of its mandate. Events were held in all parts of the country over its six years of operation. Its final report, *Final Report of the Truth and Reconciliation Commission of Canada: Honouring the Truth, Reconciling for the Future*, states that 155 000 people visited the national events and over 9000 residential school survivors registered to attend them. The TRC also held 238 days of local hearings in 77 communities across the country. Town halls on reconciliation were held at various events in an effort to encourage people to join the conversation about healing and reconciliation. The TRC captured the attention of the country, and indeed its national events webcasts were viewed over 93 000 times in 62 countries (TRC, 2015, p. 31).

The history of residential schools is situated in the broader history of the global European colonization of Indigenous peoples and their lands (TRC, 2015, p. 133). European settlers, beginning in the sixteenth century, gained control of Indigenous peoples' lands throughout the world. Settler activities resulted in "expansionary wars, the negotiation and breaking of treaties, attempts at cultural assimilation and the exploitation and marginalization of the original inhabitants of colonized lands" (TRC, 2015, p. 44). Colonizing practices were grounded in the religious beliefs of the Roman Catholic Church, which conceived of itself as guardian of a universal world order. Imperialists in the New World argued that colonizers were bringing civilization to "savage" people who could never civilize themselves. A critically important element of this civilization mission, which holds relevance in contemporary times, was the belief in European racial and cultural superiority. This view was replaced in the nineteenth century by a racism cloaked in the language of science and argued that peoples of the world had differing abilities, that genetically, there were limits on the ability of less-developed peoples to improve. In some cases, it was believed that contact with superior races could only lead to extinction of the inferior peoples (TRC, 2015, p. 47). This ideology shaped global policies towards Indigenous peoples, and in most countries, it continues to prevail.

Christian missionaries also played a central role in the European colonization effort. Their goal was to "convert the heathen" and their efforts towards achieving this goal provided the moral justification for the colonization of other peoples' land. Their approach is also described as making the greatest changes in the culture and psychology of the colonized. They worked to "undermine relationships to the land, language, religion, family relations, educational practices, morality and social custom" (TRC, 2015, p. 48).

Residential schooling was only one part of the colonization of Indigenous people. Government policies that supported their assimilative agenda served to suppress Indigenous culture and languages, disrupt Indigenous governments, destroy Indigenous economies, and confine Indigenous people to marginal and often unproductive land bases. These government policies were meant to eliminate Indigenous peoples as distinct political and cultural entities and have been formally acknowledged as a policy of cultural genocide (TRC, 2015, p. 133).

The TRC identified 94 COAs and emphasized them as essential in efforts towards redressing the legacy of residential schools and advancing reconciliation in Canada (TRC, 2015, p. 181). The COAs focus covers a broad range of issues across multiple sectors. With respect to health, the TRC makes the important link between the current state of Indigenous people's health in Canada and previous Canadian government policies that include the residential school system. Frohlick, Ross, and Richmond (2006; as cited in Marchildon, 2013, p. 17) note that multiple indicators demonstrate that the health status of Indigenous people in Canada is well below that of their non-Indigenous counterparts. Indigenous people continue to suffer from substantively higher rates of infectious diseases, injury, and suicide (Waldram et al., 2006, p. 73). Further, while the United Nations Development Programme's Human Development Index (HDI) (2009, p. 23) showed a slight narrowing of the gap in Canada, it continues to be significant. Indigenous peoples rank 32nd on the HDI versus non-Indigenous Canadians who rank 8th.

Statistics Canada affirmed that life expectancy for First Nations, Métis, and Inuit people in 2017 was substantially and consistently shorter than for other Canadians. For example, for First Nations, life expectancy was 72.5 years for males and 77.7 for females, which is 8.9 years and 9.6 years shorter, respectively, than reported for non-Indigenous males and females. For Métis, life expectancy was 76.9 years for males and 82.3 years for females, 4.5 and 5.0 years shorter, respectively, and for Inuit, it was 70.0 years for males and 76.1 years for females, which is 11.4 and 11.2 years shorter than for the non-Indigenous population (Tjepkema et al., 2019, p. 5).

Recent trends in the social determinants of health literature have raised awareness of the sociocultural context of Indigenous health inequality and have implications for nursing care and health promotion. The presence of significant health disparity between Indigenous people and their Canadian counterparts is well established. Contemporary socioeconomic conditions reflect this significant level of disparity. With respect to housing, 39 percent of Inuit in Nunavut lived in crowded homes versus 4 percent of the non-Aboriginal population (Arriagada, 2016). Food security is another example of a social determinant factor, with more than one-half (52 percent) of Inuit (ages 25 years or older) in Inuit Nunangat having experienced food insecurity in the previous 12 months (Arriagada, 2017). Arriagada (2017) reports that according to the Canadian Community Health Survey in the 2012 Aboriginal Peoples survey, among First Nations, 20 percent (ages 15 years or older) living off-reserve experienced food insecurity as compared with 8 percent of the non-Aboriginal population. Urban Métis reported a higher risk for food insecurity, as well as for obesity (Bhawra et al., 2015).

The TRC (2015) calls for the development of strategies that establish measurable goals to identify and close the gaps in health outcomes between First Nations, Inuit, and Métis people and non-Indigenous Canadians.

Implementing the Calls to Action: A Critical Perspective

The release of the TRC's final report was for many Indigenous people a hopeful moment in the history of relations with the European settler society and their governments. The TRC's implementation approach of purposeful action was a shift from the RCAP's 400+ recommendations for systemic change in all sectors of Canadian society for removing multiple-level barriers and redressing the inequalities that are central to the Indigenous lived experience in Canada. In spite of failed past attempts to engage Canadian society in processes to redress the assimilative legacy of colonialist governments, including RCAP, the TRC and the uptake by national media seemed to offer another chance. This time, it appeared that the people of Canada were taking notice of the depth and scope of injustice perpetrated against Indigenous peoples by both governments and religious organizations. Manuel et al. (2017) describe this as "the gradual dawning of awareness among ordinary Canadians" (p. 56).

Many nurse educators in Canada are uninformed about both the historical context of the relationship between Indigenous peoples and the Canadian government and the TRC's work. This presents a major challenge towards knowing how to respond and implement the TRC's COAs. This lack of knowledge can be attributed to the gap in Canadian history curriculum at all levels of education. The TRC (2015) defines reconciliation as "an ongoing process of establishing and maintaining respectful relationships at all levels of Canadian society" (p. 145). The TRC noted that while getting to the truth was hard, getting to reconciliation will be even more challenging, calling for rejection of "paternalistic and racist foundations of the residential school's system" (p. vi) as a basis for an ongoing relationship. Further, reconciliation requires a new vision, one that is "based on a commitment to mutual respect" (p. vi) and an understanding of "the most harmful impacts of residential schools have been the loss of pride and self-respect of Aboriginal people and the lack of respect that non-Aboriginal people have been raised to have for their Aboriginal neighbours" (p. vi). Perhaps most importantly, the TRC situates reconciliation as a Canadian problem versus an Aboriginal problem. All aspects of Canadian society may need to be reconsidered, and this will take time.

Manuel et al. (2017) cautions that an important issue with respect to implementing the TRC COAs is that the "truth" must be acknowledged before moving too quickly to reconciliation. While many Canadians and nurse educators want to see reconciliation between Indigenous peoples and the mainstream settler society, there is a need to address the important issue of Aboriginal treaty and land rights. Manuel et al. argue that without this, there can be no reconciliation (p. 56). Newcomb (2018) discusses the notion of colonization and the process of domination. He makes the case that the reconciliation stage has overtaken the concept of truth.

Thus, the 2014 United Nations' *Outcome Document* is described as a document "that guides the implementation of UNDRIP and calls on governments to obtain the free, prior and informed consent of Indigenous peoples before adopting and implementing legislative or administrative measures that may affect them" (TRC, 2015, p. 188). In 2016, the federal government pledged to adopt UNDRIP as the framework for reconciliation. Since these important changes to government direction, courts have been testing the legislative waters to determine how UNDRIP principles can be used to interpret Canadian laws in a way that supports Indigenous rights. However, the text and principles of UNDRIP must be incorporated into legislation before they are fully binding.

The next section will explore the relevance of the TRC's COAs with respect to nursing education and practice. The first part will provide commentary on the historical context of Indigenous education reform in general. While not an exhaustive list, identification of some key nursing-specific factors related to the role of nursing educators and the development of leadership in Indigenous health education follows. The needs of nurse learners, both Indigenous and non-Indigenous, are highlighted.

Nursing Education: Developing a Post-colonial Response to the Calls to Action

In Ojibwe thinking, to speak the truth is to actually speak from the heart.

— Elder Jim Dumont, Truth and Reconciliation Commission of Canada, 2015

As postsecondary nursing educators and administrators consider the path forward in responding to the TRC's COAs in health and education, it is prudent to note that the notion of decolonizing postsecondary education is not a new concept. Indigenous education reform has been a focus of various government-funded inquiries and policy initiatives since the 1950s and 1960s, when Indigenous rights–based organizations and First Nations leaders were organizing politically and articulating their visions for the future. The National Indian Brotherhood identified "Indian control of Indian education" as a goal in the early 1970s. Unfettered access, with the formalization of postsecondary assistance programs, was the focus. Recognition of Aboriginal rights was emerging through legal acknowledgements, such as the Calder decision, which paved the way for policy reform, including education (Stonechild, 2006, p. 46). RCAP also affirmed the goal of Aboriginal self-determination and linked the primacy of higher education for Indigenous people to its achievement (Stonechild, 2006, p. 101). Needs regarding education were identified, which included increased support for Aboriginal-controlled higher education institutions; autonomy to design programs that would best meet their needs; availability of culturally relevant and holistic approaches to education, with a balance of spiritual, physical, emotional, and intellectual components; contact with Elders; and meaningful integration with community (Stonechild, 2006, p. 103).

However, implementation of change and of recommendations were met with challenges related to *fundamentally different and conflicting views on how reconciliation is defined and how it can be achieved*. The government's view includes a belief that Aboriginal people have to accept the validity and reality of the Crown sovereignty and parliamentary supremacy while Indigenous people see reconciliation as an opportunity to affirm their own sovereignty and return to their partnership ambitions from after the period of Confederation. The government also rejected the treaty right to education, a right that treaty nations negotiated in exchange for large areas of their traditional territory (Stonechild, 2006, p. 102). Efforts to advocate for reform in postsecondary education are still stymied by legislative frameworks that will not accommodate treaty rights to education. Funding for postsecondary education also remains restrictive and meets community needs only in a limited way (Stonechild, 2006, p. 104).

Education is a fundamental human and Aboriginal right, guaranteed in treaties, in international law, and in the Canadian Charter of Rights and Freedoms. A powerful statement in UNDRIP affirms Indigenous community rights with respect to education. It is the TRC's belief that fulfilling the promise of UNDRIP by acknowledging that the establishment and control of Indigenous educational systems and the provision of education in Indigenous languages, in a manner appropriate to their cultural methods of teaching and learning, is the key to overcoming the legacy of residential schools (TRC, 2015, p. 145).

Developing Indigenous Health Leadership in Nursing Education: We Don't Know What We Don't Know

In this post-TRC era, the unique sociopolitical context of Indigenous health must be situated. As such, the advocacy and support of a reconciliation agenda requires a strong understanding of reconciliation principles. The TRC (2015) defines reconciliation as "an ongoing process of establishing and maintaining respectful relationships at all levels of Canadian society" (p. 16). Schools of nursing need to understand who their partners are in the development of post-TRC initiatives. Engagement with partners needs to be aligned with Indigenous self-determining reconciliation principles (see Chapter Appendix 14B). These principles have been developed to assist those who are planning implementation of the COAs and can be used as a guide. This process requires nurse educators and faculty to know about the Indigenous peoples in their region both on- and off-reserve. They also need to know how European settler colonizing processes impacted their potential partners and be cognizant of how they are attempting to redress the impact, specifically with respect to regaining their health and well-being.

The establishment of an evidence base to support the implementation of Indigenous health education reform strategies is in early days, and it is fair to say that nurse educators are already challenged with accommodating learner needs and ensuring that curriculum is relevant to diverse population health contexts. Time constraints, large classes, lack of teaching assistant support, and shrinking education budgets all contribute to a sense of feeling overwhelmed, and perhaps to a subtle resistance to adding anything more to the curriculum.

As such, nurse educators and nursing education policy organizations are finding themselves with many questions in the wake of the TRC. For example:

- What factors and issues are relative to nursing education reform to support the implementation of the TRC's COAs?
- How do nurse educators need to prepare themselves to teach Indigenous health curriculum?
- What interprofessional factors should be considered for nursing school administrators? For example: how can nursing educators collaborate with other health profession educators?
- How can nurse educators support both Indigenous and non-Indigenous nurse learners?

The TRC envisioned that all Canadians would play a role in improving the health outcomes for Indigenous peoples, including all levels of government and many organizations, which need to work in partnership to implement solutions. Health leaders in Canada and the organizations they work for also will play a critical role (Richardson & Murphy, 2018, p. 5).

Nurse leaders in the role of both administrators and educators need to be prepared to contribute to this mandate. The following discussion is divided into five areas and factors for focusing reform: system, faculty, student, curricula, and partnership. This analysis is not all-inclusive but provides an overview of key factors and issues; some are longstanding (e.g., student admission issues), and some are newly emerging.

System-Level Reform Factors

Faculty and administrators within Canadian schools of nursing will need to undertake a school-wide reflexive process to both developing and implementing a reconciliation-based approach to Indigenous health education reform. For example, mission and value statements need to be reassessed to determine their compatibility with anti-racism/discrimination concepts and language. Similarly, individual attitudes stemming from integrated societal-level discriminatory stereotyping and prejudice towards Indigenous peoples need to be acknowledged and addressed. Strategic processes will need to be considered within the reality that there are many multicultural groups on campus and a general belief that all groups should receive the same attention.

Some schools are moving forward both independently and in collaboration with their university or postsecondary partners to begin a post-TRC implementation process that may be inclusive of assessment of curricula and acknowledgement of key COAs related to health and other related activities. This is in keeping with many other Indigenous health stakeholders, including governments, health agencies, health professional organizations, and hospitals. These activities are important first steps, but there is a need for a more transformative collective system-level and organization-level change process to address and improve the health of Indigenous people in Canada (Richardson & Murphy, 2018, p. 1).

Universities Canada in 2017 released a survey that provided an update of reconciliation initiatives underway at 96 Canadian universities. Findings showed that over two-thirds were working to include Indigenous representation within their governance or leadership structures to ensure Indigenous voices are included in decision making in a meaningful way. Many universities and health institutions have undertaken commemorative or symbolic gestures to acknowledge Indigenous peoples, Indian Residential schools, or reconciliation. The development of strategic education pathways for Indigenous health education also requires an understanding of the issues and factors at play within diverse nursing school environments. This assessment should be inclusive of both macrolevel and microlevel measurement criteria. For example:

- How do current nursing school mission or vision statements align with existing Indigenous health priorities and objectives? Are they in alignment with TRC reconciliation principles?
- Are the targeted Indigenous health reform priorities inclusive of goals that aim for improved health status for Indigenous populations and enhancement of Indigenous learner experience within the school?
- Is there a school-wide commitment to addressing Indigenous health inequity?
- Have Indigenous community representatives been invited to participate in strategic planning efforts?
- Is there a commitment to hire Indigenous faculty?
- Have nursing education leaders engaged in their own cultural safety training, and are they promoting the uptake of the TRC's COAs?
- Are existing admission policies creating barriers for Indigenous applicants?
- Have local Indigenous people, Elders, or Traditional healers been engaged in the development of Indigenous health curriculum?
- Is the Indigenous curriculum inclusive of Indigenous knowledge and Traditional healing concepts?
- Is curriculum inclusive of equity and inclusion concepts, such as anti-racism theory?
- How prepared are faculty to deliver Indigenous health curriculum in a culturally safe way?
- How are critical incidents related to racism in the classroom handled by both the faculty and the school administration?
- How are Indigenous students supported overall and when challenging radicalized situations arise?
- Has the school designated space for Indigenous student support services?

Non-Indigenous nursing policy and educational experts often rely on collaboration with Indigenous leaders or educators and communities to inform their work. These processes often place a burden on those who are already experiencing challenges and stress related to limited capacity and resources to implement their own priorities. Collaborative initiatives with community representatives is needed to develop a network of available Elders or Knowledge Holders who are able to participate. A remuneration protocol should also be developed so that participants receive their stipends in a timely way. In an effort to support an emerging leading practice, Elders or Knowledge Holders should be offered part or full-time appointments.

Faculty-Related Reform Factors

Mainstream dominant nursing education and policy leadership has resulted in an educational curriculum lacking in an Indigenous context and minimal numbers of Indigenous faculty to teach it in a culturally relevant manner. Schools of nursing across the country are engaging in initiatives to enhance or develop Indigenous health curriculum; however, non-Indigenous faculty may be feeling inadequately prepared to effectively develop and deliver Indigenous health curriculum. They may have had a challenging experience related to teaching students about Indigenous health and are both nervous and uncertain about how to "properly" talk about Indigenous issues. How curriculum is developed, who teaches Indigenous health courses, and how courses are taught are important emerging considerations. For example, Stansfield and Browne (2013) recommend that nurse educators "critically examine their own worldviews and taken-for-granted dominance of particular perspectives" towards the inclusion of other knowledge paradigms, such as Indigenous knowledge, that may "also be reflective of core epistemologies central to nursing curriculum" (p. 146). Reed and Shearer (2009) note that while the nursing profession is typically inclusive of diverse epistemological perspectives, the curriculum content and teaching approaches remain grounded in Western Eurocentric epistemological assumptions. They propose that Indigenous knowledge systems offer rich perspectives and may enhance the relational aspect of nursing practice, teaching, and research.

The notion of who teaches Indigenous health curriculum is also emerging as an important issue. There is also often little time or resources to consider educators' needs in facilitating a learning environment for nurse learners that will prepare them to be responsive to diverse populations. This situation is compounded by the limited education that a generation of educators received regarding Indigenous people's lived experience in this country. The TRC calls for nursing schools to increase the number of Indigenous nurse graduates. The reality of this endeavour is that the numbers are still relatively low, and those who are available to be recruited as educators are quickly recruited. One problem is that often a lone Indigenous faculty member is designated as the individual who "is handling" the Indigenous health agenda. This situation lends itself to professional burnout. Power et al. (2013) report that according to Thackrah and Thompson (2013), the delivery of Indigenous health content by a non-Indigenous academic failed to address issues of racism in the class (p. 95).

Virdun et al. (2013) propose that collaboration between Indigenous and non-Indigenous faculty is one way to create safe spaces for Indigenous and non-Indigenous academics. Further, an alliance between the two groups can assist in the development of a sensitively designed health care curricula and increase confidence among academic staff to enable Indigenous cultural competency for nursing students. They propose that Indigenous curricula could be threaded throughout a curriculum and raised in many teaching and learning situations rather than being siloed into particular subjects and taught by particular staff (pp. 95–97). Jackson, Power, Sherwood, and Geia (2013; as cited in Power et al., 2013) reported that an intensive workshop facilitated by Indigenous academics holds potential to transform perceptions about Indigenous people among a master's-level class.

As schools of nursing engage in a responsive effort to meet the TRC's COAs to ensure that all health care professionals are culturally competent, nurse educators must first educate themselves to adequately prepare students to provide culturally safe nursing care for First Nations, Inuit, and Métis peoples. The case is made by Allan and Smylie (2015, p. 10) regarding the need to bridge the gap between Indigenous patients and non-Indigenous health care providers to address the health inequities experienced by Indigenous populations. Many Indigenous people have reported disrespectful and discriminatory care by health care providers that stems from entrenched and unchallenged assumptions about Indigenous peoples based on colonial narratives. Harmful outcomes linked to these attitudes and behaviours include delay or denial of treatment resulting in substandard care, negligence, worsened health conditions, and even death (Churchill et al., 2017, p. 53).

Indigenous peoples' efforts to address their negative and discriminatory health care experiences in recent years have been focused on the concept of *cultural safety* that was developed by Maori nurse Irihapeti Ramsden (2002) in Aotearoa/New Zealand. Ramsden proposed the concept as a response to the mainstream health care system's failure to meet the needs of the Maori community. In Canada, the concept of cultural competency has been emphasized by mainstream health care professional associations; however, it is considered only one element of a continuum that begins with cultural awareness and cultural sensitivity, followed by competency, and ending with cultural safety (Churchill et al., 2017, p. 5).

The Canadian Indigenous Nurses Association (CINA, formerly the Aboriginal Nurses Association of Canada), the Canadian Association of Schools of Nursing (CASN), and the Canadian Nurses Association (CNA) describe the initial three elements of this continuum as a beginning place for students and faculty in which to develop an appreciation for the complexity of culture. Further, cultural safety offers opportunities to expose and manage unequal power relations. The concept of cultural safety is also action-oriented and aligned with the advocacy role of nurses and the nursing profession (Aboriginal Nurses Association of Canada [A.N.A.C.], 2009). It is an approach that considers the social and historical contexts and the structural and interpersonal power imbalances and how they shape health and health care experiences. Health care providers are encouraged to be self-reflective and self-aware regarding their positions of power and the impact of their role in relation to their patients (Churchill et al., 2017, p. 5). The link between cultural competency and cultural safety noted by Jacklin et al. (2017) is that the health care provider will develop the cultural competencies that are necessary to deliver culturally safe care. This is an approach that addresses the root causes of health disparities, such as structural racism and discrimination (Churchill et al., 2017, p. 5). Churchill et al. (2017) note that while the release of the TRC has led to a renewed interest in the notion of cultural competency and cultural safety, few cultural safety programs have been implemented in Canada. Further, the literature indicates that there is room for additional, more rigorous evaluation of existing cultural safety training programs. Their work identifies seven "wise practices" to guide further development of these programs. Notable for this chapter as noted in Churchill, is the broad consensus (Baba, 2013; Browne et. al, 2015; Durie, 2010; Guerra & Kurtz, 2016, as cited in Churchill et al., 2017) that programs will have limited long-term effect on health care provider impact, patient outcomes, organizational transformation, and health inequity if they are not developed and implemented with both organization-wide and system-level support (Churchill et al., 2017, p. 5).

Student-Level Reform Factors

> The current education system has been designed to completely eradicate who I am and to kill that Indian Mi'kmaq spirit that's in me. But I do know I need knowledge and I need education. But the kind of education I need has to be reflective of who I am as a Mi'kmaq. And that knowledge that I get, that I will receive, I have a responsibility with that knowledge to pass it down so others will benefit from it… the kind of legacy that I want to leave my children in the future generations is one of which they will be able to excel, they will be able to compete without having to worry about is the education system going to further eradicate their selves.
>
> — Albert Marshall, a former student of the Shubenacadie residential school in Nova Scotia in his comments made to the TRC

The quotation that opens this section illustrates the long history of education-related discrimination that Indigenous learners have experienced in the mainstream Canadian education system. For Indigenous peoples, education is a lifelong learning process that includes both formal and informal opportunities for learning at all ages (National Collaborating Centre for Aboriginal Health [NCCAH], 2009). As nursing educators and policy makers attend to a TRC responsive effort, it is important to acknowledge the truth that Indigenous nursing students have experienced discrimination related to systemic barriers and colonizing education practice. The National Collaborating Centre for Aboriginal Health (NCCAH, 2009) notes that postsecondary educational attainment barriers include historical, social, geographic, demographic, cultural, and individual barriers. The legacy of Canadian assimilation policies are noted to have generated many challenging social problems and a general distrust and hostility towards education (R.A. Malatest & Associates Ltd., 2004, as cited in NCCAH, 2009).

Amelioration of barriers is an important element in nursing education reform. Admission-related issues, unprepared faculty who lack an understanding of colonial influence on education or the health of Indigenous peoples, experiences of racism within both peer groups and faculty engagement, and a lack of Indigenous health curriculum that includes Indigenous knowledge and Traditional healing are examples of barriers and issues faced by Indigenous nursing students. Power et al. (2013) discuss barriers and enablers to successful graduation. For example, the authors identified student characteristics such as Indigenous academic leadership, understanding of inequity from non-Indigenous academics, and sustainable relationships with family, community, university, and industry (p. 95).

A key focus traditionally in nursing education reform has been on the provision of academic and personal support to Indigenous students. However, Butler, Berry, and Exner-Pirot (2018) report that education planners should also consider the implementation of programs that include different services and approaches. Integrated programming that is equally appealing to both Indigenous and non-Indigenous students and that balances different ways of knowing are proposed. CINA, CASN, CNA, A.N.A.C., 2009, p. 1) advocate that all registered nurse graduates be prepared and competent to work with First Nations, Inuit, and Métis people.

Indigenous health policymakers acknowledge that an important approach to learning for Indigenous students, beyond mainstream skills such as literacy and numeracy, is "land, the knowledge and skills in and from place, language and culture" (Battiste, 2005, as cited in NCCAH, 2009). Further, Smylie and Cooper (2006, as cited in

NCCAH, 2009) note that the incorporation of these values into education is clearly linked to determinants of health and to people knowing who they are as a healthy person and family and community member.

Innovative approaches to nursing education that involve partnership with community are noted in the TRC to have been part of the dialogue between Indigenous people and government for many years. A professional learning approach for nurses is building partnership with community and grounding them in best practices related to everyday work. Further, there is an increased effectiveness when this learning includes engagement with peers, communities, and Elders. Bill and Gillis (2018, p. 29) note that supporting Indigenous students to learn closer to home can be achieved through the use of innovative tools such as remote presence technologies. Distributed learning is acknowledged as facilitating the integration of Traditional health teachings into mainstream curricula. Stansfield and Browne (2013) identify the challenge of broadening student's viewpoints from individualism to one of connectedness and community. They advocate the integration of Indigenous knowledge into nursing curriculum as a way to foster respectful relation connection.

Curriculum Development Factors

This section focuses on three main factors to consider as the work to address Indigenous health curriculum-related issues unfolds within schools of nursing: integration of Indigenous health curriculum, the need for strength-based and resiliency-focused curricula, and the inclusion of Indigenous knowledge.

Integration of Indigenous Health Curriculum

Integration of Indigenous health curriculum is necessary in preparing all nurses to work with Indigenous populations to improve their health status. The TRC (2015, p. 21) reported that educators advised the TRC of the inadequate role that postsecondary institutions played in training the teachers who taught in the schools. Further, they have pledged to change educational practices and curriculum to be more inclusive of Indigenous knowledge and history. More information is needed as to the level and focus of Indigenous health curricula within nursing schools overall. For example, is Indigenous health content being captured within an issue-focused approach such as chronic illness epidemiology or social determinants of health trends? Or does the school provide a standalone Indigenous health course? Schools of nursing will have to consider strategies to both increase the number of Indigenous faculty and facilitate the cultural safety training needs of non-Indigenous faculty as discussed above.

Development of Strength-Based Curricula

The focus of awareness regarding Indigenous health among Canadians generally is primarily deficit-based. This situation can be partially attributed to mainstream media influence. The TRC's COA #84 calls upon the federal government to support reconciliation and to ensure that programming is reflective of the diverse cultures, languages, and perspectives of Aboriginal peoples. There are many stories related to the resilience and well-being of Indigenous peoples, and this perspective must balance those related to poor health. Nursing curricula most often emphasizes the gap in health status between Indigenous peoples and their Canadian counterparts. Martin and Kipling (2006) note that dismal epidemiological statistics and negative stereotypes are often included but content regarding historical influences of colonialism and neo-colonialism are absent (p. 694). Issues related to the experience of racism are often absent yet, as noted by Reading (2013), racism and colonization are noted to

be intertwined, and together, they deeply effect the health status of Indigenous peoples (Allan & Smylie, 2015, p. 2). Allan and Smylie (2015, p. 3) echo Lawrence and Dua (2005) in calling for a reframing of the conversation regarding race and health in Canada from one of a harmonious multicultural mosaic to one that acknowledges the foundational and ongoing realities of racism and colonialism.

Inclusion of Indigenous Knowledge

> We need this old knowledge in our teachings to get through this new age.
>
> — Elder William Commanda

The history of colonization is often regarded as the most significant experience shared by Indigenous peoples. Durie (2004) describes "cataclysmic" losses that include loss of culture, loss of land, loss of voice, loss of population, loss of dignity, and loss of health and well-being. On almost all indicators of social well-being, Indigenous peoples are worse off than their non- Indigenous counterparts. However, Durie (2004) argues that neither colonization nor socioeconomic disadvantage are the most defining element of Indigeneity. Rather, a strong sense of unity with the environment is the fundamental starting point and emerges as the most significant characteristic among Indigenous writers. This unity with the environment "is reflected in song, custom subsistence, approaches to healing, birthing and the rituals associated with death" and is described as a "state of fusion between Indigenous peoples and their accustomed environments" (p. 1139).

This relationship to the environment also serves as a "foundation for the organization of Indigenous knowledge, the organization of life experiences and the shaping of attitudes and patterns of thinking" (Durie, 2004, p. 1139).

Durie (2004) argues that the three most distinguishing features of Indigenous knowledge are that it is a product of a dynamic system, is integral to the physical and social environment of communities, and is a collective good. The important link is between how the impact of colonization has fractured a broader perspective of a worldview and the current health status of Indigenous peoples. His position is that alienation of people from their environment or from the natural world may be closely linked to their overall poor health status. The notion is presented that Indigenous knowledge may be applied to modern times and upheld in parallel with other knowledge systems (p. 1139).

Indigenous people have understood their health and well-being within the context of their own Indigenous ways of knowing for millennia. They have also long held their own knowledge-generation and knowledge-sharing systems. They are stewards of important knowledge that yields valuable ecological information. Patients may want to use both Western and Indigenous approaches to health in a harmonized model that reflects both biomedical and Indigenous knowledge worldviews. This approach will require acceptance of Indigenous knowledge as a valid body of scientific knowledge, collaboration, and support from biomedical health care practitioners, and health professional education and health policy reform (Downey, 2014, p. 76).

According to Battiste (2009), a Mi'kmaq scholar and esteemed Indigenous education expert, an important issue related to facilitating the harmonization of Indigenous knowledge with biomedical approaches to health care for Indigenous peoples is a lack of awareness or understanding about Indigenous ways of knowing. This is related to

colonial Eurocentric attitudes of superiority and an assumption that Indigenous languages, cultures, and livelihood are inferior (p. 6). Battiste writes at length about the historical aspect of Indigenous learning. She provides a critical discussion and cites the RCAP regarding the link between the noncompliance of treaty-protected Indigenous education-related aspirations and the systemic discrimination of the federal, provincial, and territorial governments that chose to use education as a tool of forced assimilation. She describes the legacy of the assimilationist policy that included the Canadian residential school system as "a human experiment in cultural erosion and destruction… sapping them of the opportunities that a healthy collective society and a transformative and responsive education could provide" (p. 2). Battiste argues that a "constitutional reconciliation" with Indigenous peoples' constitutional rights to education is needed and that this process must be supported by constitutional power from federal, territorial, and provincial education systems.

It is perhaps the emphasis on the legacy of cultural erosion and destruction that Battiste presents that is a critical component relative to the development of Indigenous health curricula. Battiste (2009) notes that before formal schooling, an approach that was responsive to the needs of families was "within an ecology that cultivated holistic lifelong processes that were the foundations of Indigenous knowledge and culture" (p. 1). The important link is made between how Indigenous people learned and the contribution to their civilizations that were based on multiple competencies in Indigenous languages and knowledge that facilitated Indigenous peoples' connections with their own communities and beyond. Battiste and Semeganis (2002; as cited in Battiste, 2009) note that the success of this holistic approach towards lifelong learning created a collective and sustainable lifestyle, one that contributed to the needs of the present and acknowledged the needs of the future seven generations.

The discourse on the need to acknowledge and facilitate the integration of plural knowledge systems into nursing education and practice includes the voices of both Indigenous and non-Indigenous nurse scholars. The CINA-CASN-CNA (A.N.A.C., 2009) core competency framework calls for the acknowledgement of Traditional knowledge, oral knowledge and Indigenous knowledge "as having a place in higher learning along with literate knowledge" (p. 7). It also notes that a best practice nursing curricula should prepare all students with competencies to work effectively with Indigenous peoples. Further, curricula "should privilege and respect Indigenous knowledge and expose students to these epistemological and ontological foundations" (p. 7).

For example, Downey (2014, p. 162) makes the case for the development of a harmonized Indigenous health literacy approach and proposes a culturally relevant model that can be used in the care of Indigenous people with cardiovascular disease and potentially other chronic illness. Central to the proposal of a harmonized model is the facilitation of access to Indigenous knowledge and Traditional healing by non-Indigenous health care practitioners. Ojibwe teachings regarding *Bimaadiziwin* (good way—healthy life) are offered as an example of how Indigenous people can draw on traditional values and concepts of personal and inner well-being to achieve *Nibwaakawin* (wisdom) and personal empowerment regarding their chronic illness.

Bourque Bearskin and colleagues (2016) draw on Cree/Métis understanding through Indigenous research methodologies to explore how Indigenous knowledge systems and identity are embedded in the nursing practice of four Indigenous nurse scholars. She gives attention to Cree ways of being, knowing, and acting when situated at the intersection of nursing and the hierarchy of Western nursing knowledge. Evelyn Voyageur's work as described in Bourque Bearskin et al. (2016. pp. 23–24) emphasizes the centrality of community to her worldview where the community is the teacher. The case is made for how a community-based Indigenous knowledge teaching and learning approach can potentially provide mutual benefits to cultural continuity and community development in nursing education.

Stansfield and Browne (2013, p. 143) note that the nursing profession has always embraced flexibility by drawing on diverse epistemological perspectives. They advocate that Indigenous knowledge can complement epistemologies that are central to nursing curricula. Their work looks at how nursing educators might access and integrate Indigenous knowledge in respectful and sustainable ways. The use of appropriate partnerships, protocols, and processes to support the incorporation of Indigenous knowledge is promoted as an opportunity for educators and students to attain broader perspectives about the world, ways of being, types knowledge, and nursing care through the exploration of divergent epistemologies, philosophies, and worldviews. Aikenhead and Elliott (2010) describe the development of science education since 2006 that is related to an agenda to decolonize a pan-Canadian science framework by recognizing Indigenous knowledge as foundational to understanding the physical world. The curriculum renewal efforts in Saskatchewan integrate Indigenous knowledge into science taught in school through the collaboration and guidance with Indigenous communities (p. 321).

Authentic Indigenous Partnership: Nursing Professional Organizations and Collaboration

The CINA-CASN-CNA (A.N.A.C., 2009) have been working both independently and collaboratively to address First Nations, Inuit, and Métis health inequities. These policy-level partnerships have been re-charged with the release of the TRC's COAs. Nursing professional organizations are engaging to both educate and support their nurse members in diverse professional practice environments, including education. The demand for collaboration with both individual Indigenous nurses and organizations with Indigenous health mandates has greatly increased at local, regional, provincial, territorial, and national levels.

Indigenous nurses hold a unique expertise that they bring to both their nursing practice and partnership engagements, comprising both their Indigenous knowledge and how that knowledge is cultivated and harmonized in their practice. Indigenous nurses in Canada have been harmonizing their Western-based nursing education with a firm grounding in their own languages, cultures, and healing traditions to shape the field of Indigenous nursing knowledge. This unique nursing knowledge is used to advance and shape the current context of nursing practice CINA, 2016, pp. 6–7). Dion Stout and Rojas (2001, p. 2) note that Indigenous people must maintain the integrity of their Traditional knowledge and that this contributes to an Indigenous paradigm that begins with a common vision guided by the values and priorities of the community.

Nursing scholars Bill and Gillis (2018) and Dion Stout and Downey (2006) note that nursing knowledge stems from nurses' experiences located within the traditions and customs of their people and has links to our ancestors, land, and mental, emotional, physical, and spiritual relationships. Further, that knowledge is intergenerational and cyclical and manifests compassion and respect in "the development of our self-understanding associated with identity formation, which is central to the creation of Indigenous knowledge" (CINA, 2016, pp. 6–7).

An important element in the development of collaborative partnerships is the need for authentic Indigenous engagement (AIE). This approach is in keeping with the reconciliation principles framework proposed by the TRC. The notion of "nothing for us without us" captures the principle of self-determination and should be applied in the collaboration process. The concept of allyship is implicit in the relational dynamic of AIE. Partnerships should be guided by the knowledge and expertise of Indigenous nurse experts and organizations who have been advancing change in the interest of Indigenous peoples and health education reform for half a century. The partnership needs to be reflected in co-created agreements that clearly specify leader, collaborator, and governance roles. Knowledge ownership that is generated through collaboration should also be negotiated according to self-determining principles and guidelines (e.g., ownership, control, access, and possession guidelines).

Summary

The TRC has identified the important role of nurse educators in the collective work to identify and close the gaps in health outcomes between Indigenous people and their non-Indigenous counterparts. It also call for several areas of health education reform, including increasing the number of Indigenous health professionals, providing cultural competency and safety training for all health care professionals, and developing Indigenous health curriculum that includes the colonizing history and legacy of residential schools and the self-determining efforts of Indigenous peoples to redress colonizing influences. The TRC's work was informed by the collective input of Indigenous peoples across the country via previous reports, such as RCAP (1994).

To date, while there has been a "dawning of awareness" (Manuel et al., 2017, p. 56) regarding what happened to Indigenous peoples through assimilative government policies and religious doctrine and a recognition of the need for reform, the response by both nurse policymakers and educators has been more incremental and piecemeal than systemic and comprehensive. In part, this is due to the shared experience in Canadian society of the lack of exposure to the history of relations between all levels of government and Indigenous peoples, a racist relationship dynamic that can be described as having served to advance an oppressive and assimilative agenda.

As nursing schools across the country are organizing to respond to the TRC's COAs, a reconciliation path forward presents itself. However, the way forward requires the establishment of respectful relationships among all nursing stakeholders, a process that must start with the identification of "truths," namely, an understanding of the harmful impacts of residential schools on Indigenous peoples' well-being. This requires education of decision makers and all health practitioners and the development of partnerships that are grounded in the principle of "nothing for us without us." The education of nurse administrators and educators is vital; they need to be prepared to lead the reconciliation work ahead in a culturally safe way. Five areas of systemic change are needed to achieve true reform: Indigenous faculty recruitment and education of non-Indigenous faculty; enhancement of student services beyond bridging support; comprehensive decolonization of curricula; redress of systemic barriers; and development of authentic partnership with Indigenous communities and Indigenous nursing stakeholders.

Conclusion

While the Commission has been a catalyst for deepening our national awareness of the meaning and potential of reconciliation, it will take many heads, hands and hearts working together at all levels of society to maintain momentum in the years ahead.

— Truth and Reconciliation Commission of Canada, 2015

As noted previously, there is a longstanding recognition of the need to further understand the cultural context of Indigenous health and effectively prepare nurses to provide culturally safe care. However, the uptake of national-level nursing policy and educational reform has not been robust or consistent among many nursing schools across the country.

Factors that contribute to this situation include a lack of awareness among nursing policy and decision makers, a lack of a comprehensive Indigenous health nursing curriculum, a dearth of Indigenous faculty, and the presence of postsecondary institutional structural barriers that impede the development of a progressive and culturally relevant approach to change in nursing education.

In the wake of the TRC, nursing policymakers and educators have the opportunity to address the issues and barriers related to nursing education policy, clinical practice, and research. The TRC presents a way to respond in a more robust and culturally relevant way to the health inequity experienced by Indigenous people—namely, through the understanding of the historical context of health inequality and by facilitating the harmonization of Indigenous knowledge systems and healing ways with biomedical nursing approaches.

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Chapter Appendix 14A

Truth and Reconciliation Commission, Final Report: Calls to Action

Health

#18. We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

#19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess longterm trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

#20. In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.

#21. We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

#22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

Education

#62 ii. Provide the necessary funding to post-secondary institutions to educate teachers on how to integrate Indigenous knowledge and teaching methods into classrooms.

#65. We call upon the federal government, through the Social Sciences and Humanities Research Council, and in collaboration with Aboriginal peoples, post-secondary institutions and educators, and the National Centre for Truth and Reconciliation and its partner institutions, to establish a national research program with multi-year funding to advance understanding of reconciliation.

Health Education

#23. We call upon all levels of government to:

i. Increase the number of Aboriginal professionals working in the health-care field.
ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
iii. Provide cultural competency training for all health care professionals.

#24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

Chapter Appendix 14B

Truth and Reconciliation Commission: Principles of Reconciliation

The Truth and Reconciliation Commission of Canada believes that in order for Canada to flourish in the twenty-first century, reconciliation between Aboriginal and non-Aboriginal Canada must be based on the following principles.

1. The United Nations Declaration on the Rights of Indigenous Peoples is the framework for reconciliation at all levels and across all sectors of Canadian society.
2. First Nations, Inuit, and Métis peoples, as the original peoples of this country and as self-determining peoples, have Treaty, constitutional, and human rights that must be recognized and respected.
3. Reconciliation is a process of healing of relationships that requires public truth sharing, apology, and commemoration that acknowledge and redress past harms.
4. Reconciliation requires constructive action on addressing the ongoing legacies of colonialism that have had destructive impacts on Aboriginal peoples' education, cultures and languages, health, child welfare, the administration of justice, and economic opportunities and prosperity.
5. Reconciliation must create a more equitable and inclusive society by closing the gaps in social, health, and economic outcomes that exist between Aboriginal and non-Aboriginal Canadians.
6. All Canadians, as Treaty peoples, share responsibility for establishing and maintaining mutually respectful relationships.
7. The perspectives and understandings of Aboriginal Elders and Traditional Knowledge Keepers of the ethics, concepts, and practices of reconciliation are vital to long-term reconciliation.
8. Supporting Aboriginal peoples' cultural revitalization and integrating Indigenous knowledge systems, oral histories, laws, protocols, and connections to the land into the reconciliation process are essential.
9. Reconciliation requires political will, joint leadership, trust building, accountability, and transparency, as well as a substantial investment of resources.
10. Reconciliation requires sustained public education and dialogue, including youth engagement, about the history and legacy of residential schools, Treaties, and Aboriginal rights, as well as the historical and contemporary contributions of Aboriginal peoples to Canadian society.

CANADIAN CONTENT FOR THE NURSE EDUCATOR

This comprehensive text offers essential information for excelling in the Canadian academic nurse educator role. Experienced academic educators, as well as novice instructors in nursing education, will find foundational and current practice concepts that include philosophy, learning theories, course and curriculum development, program evaluation, teaching-learning strategies, simulation, interprofessional and intraprofessional approaches, diversity and the indigenous learner, assessment and evaluation techniques, leadership, mentorship, and scholarship. The content reflects the Canadian Association Schools of Nuring (CASN) standards for excellence for undergraduate and undergraduate academic nurse educators and assists the reader with preparing for the Canadian Certified Nurse Educator (CCNE) Certification examination.

The respected contributors from across Canada share research and evidence and provide essential teaching approaches in this landmark text. Each chapter includes learning outcomes and helpful graphics and tables. The theoretical and practice-focused content recognizes the specialized practice of nursing education knowledge and expertise. The text supports the achievement of nurse educator competencies and fosters excellence in this role in Canada.