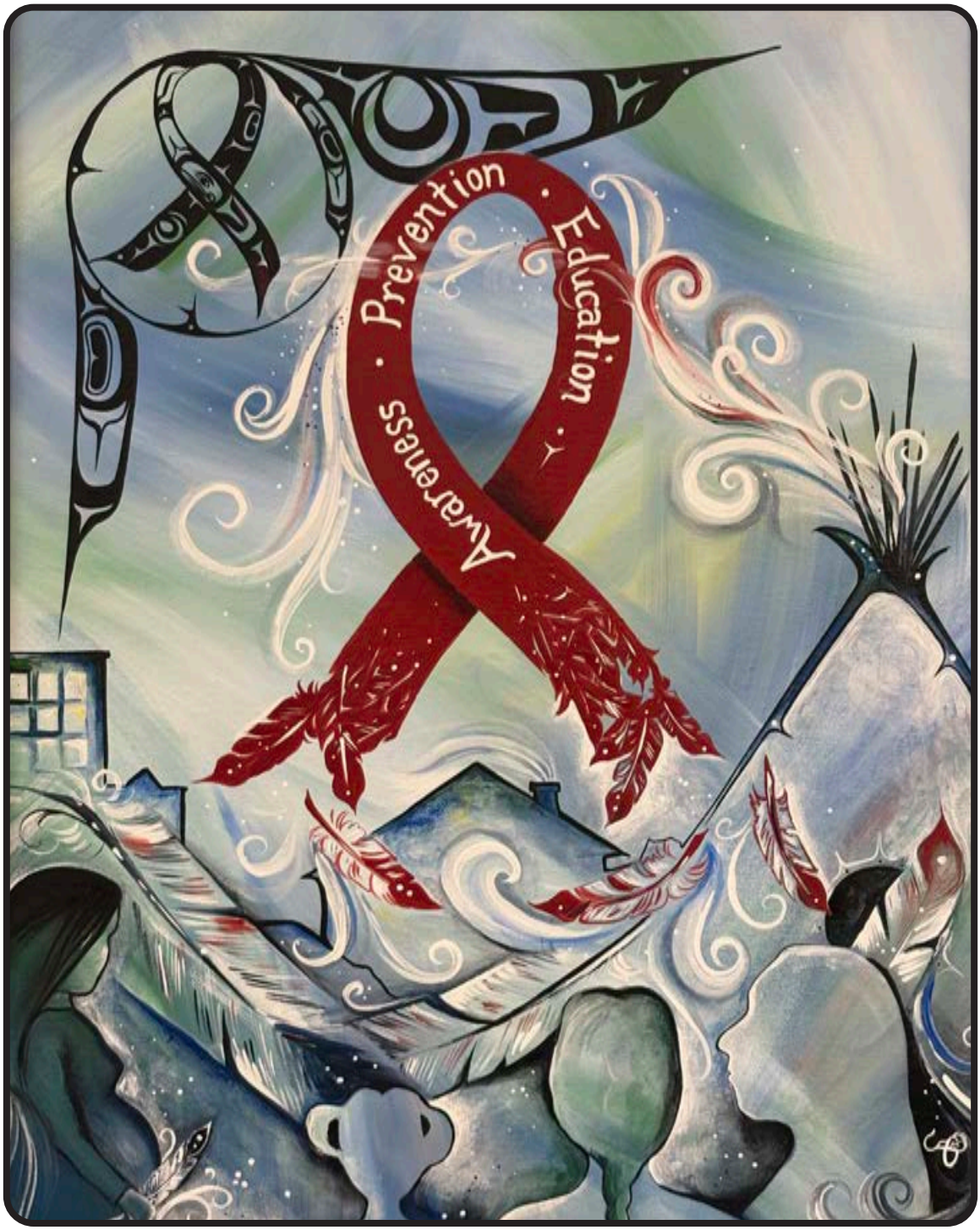
BRIEFING PAPER

Walking the Healing Path: Indigenous Voices and Frontline Realities in Northern BC Healthcare



Positive Living North: No khēyoh t'sih'en t'sehena Society

Cover Image: Carla Joseph.

Briefing Paper
Walking the Healing Path: Indigenous Voices and Frontline Realities in Northern BC Healthcare

Developed by
Positive Living North: No khēyoh t'sih'en t'sehena Society (PLN)

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A legacy of the project
HIV/HCV-related Stigma in Healthcare: Addressing Indigenous Specific Concerns in Northern British Columbia

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CONTENTS

LAND ACKNOWLEDGEMENT

The work for this demographic assessment was conducted in Prince George, Fort St. John, and Smithers. We would therefore like to not only make the following land acknowledgements but also recognize the involvement of Indigenous peoples from other communities and nations.

In Prince George we would like to acknowledge the traditional and unceded territories of the Lheidli T'enneh First Nation, part of the Dakelh/Carrier nation. We honour their deep connection to the lands and waters

In Fort St. John, we would like to acknowledge the traditional and unceded territory of the Dane-zaa nation, comprising the Doig River First Nation, the Blueberry River First Nation, and the Halfway River First Nation. We honour the deep connection to the lands and waters, where everyone's rights are respected, and opportunities are available for all to thrive as promised in Treaty No. 8.

In Smithers, we would like to acknowledge the traditional and unceded territory of the Gidimt'en Clan and the Witsuwit'en people.

As members of the Tsay Keh Dene First Nation of the Tsek'ehne nation, co-authors stand at the edge of your camps until you invite us in to visit.

PERSONAL REFLECTIONS

Melani Lansall is a member of the Tsay Keh Dene Nation, and Mental Health Provider, and a senior Lab Instructor in the Department of Social Work and sessional instructor in the First Nations Department at the University of Northern British Columbia. She is currently a PhD Student in Human Health Sciences at UNBC. Her passion is community mental health and working to develop community capacity. She is working hard to change the legacy left for the ones behind her and help and support in a good way. She is a mother, daughter, auntie, cousin and glimmer. Seeking knowledge and medicine from the land is where you will find her when she is not working.

Dr. Daniel Sims is a member of the Tsay Keh Dene Nation, and an associate professor in the Department of First Nations Studies and adjunct professor in the School of Education at the University of Northern British Columbia. He has held a number of positions over the years, including as interim academic co-lead of the National Collaborating Centre for Indigenous Health. His research focuses on northern British Columbia, considering it not only in the local context but also from regional, national, and international perspectives.

Dr. Ujunma Egbuawa is a diasporic feminist scholar, educator, and community-based researcher with extensive experience in public health, harm reduction, and social justice advocacy across Northern British Columbia. She currently serves as Support Services Manager at PLN, where she leads community-based initiatives addressing HIV, hepatitis C, stigma reduction, and healthcare access for marginalized communities. She is also a part-time Instructor at College of New Caledonia, teaching courses in ethics, critical thinking, and social philosophy.

Her work bridges academic scholarship and frontline community engagement, with a particular focus on de-colonial feminist thought, health equity, leadership development, and culturally responsive education. As a Black feminist scholar and advocate, she is committed to advancing equity and amplifying the voices and experiences of marginalized populations in Canada.

Within this project, Dr. Uju serves as Co-Lead, Co-Editor, and Co-Project Coordinator. She has contributed significantly to the design and implementation of the assessment framework, community engagement initiatives, and knowledge mobilization efforts. She also helped guide the development of the publication, ensuring that principles of equity, lived experience, and culturally grounded perspectives were meaningfully integrated throughout the project.

Vibusha Madanayake is a public health and gender equity practitioner working at the intersection of community-based research, education, and policy advocacy. She currently serves as the Interim Co-Executive Director and Education Manager at Positive Living North: No khēyoh t'sih'en t'sehena Society, where she leads education, research, and knowledge mobilization initiatives across Northern British Columbia.

With over a decade of experience across the Global South and Canada, her work focuses on culturally safe health education, gender justice, peacebuilding and decolonial approaches to community development.

In this project, Vibusha served as Co-Lead and Co-Editor, supporting the design and implementation of the demographic assessment, including community engagement and knowledge mobilization. She helped shape the publication and ensured that equity, lived experience, and culturally grounded perspectives were central to the work.

FUND ACKNOWLEDGEMENT

This publication and project were made possible through the generous support of the Provincial Health Services Authority (PHSA).

Positive Living North: No khēyoh t'sih'en t'sehena Society (PLN) gratefully acknowledges PHSA's commitment to advancing culturally safe, community-driven, and equity-focused health initiatives across British Columbia. This support has enabled the development of community-based research, knowledge mobilization, and advocacy efforts aimed at addressing HIV and HCV-related stigma experienced by Indigenous peoples in Northern British Columbia.

We recognize that meaningful change requires sustained investment in community-led solutions. Through this partnership, PLN has amplified lived and living experiences, strengthened culturally grounded approaches to care, and contributed to ongoing efforts toward safer, more inclusive healthcare systems.

ACKNOWLEDGEMENTS

This publication is grounded in the courage, wisdom, and lived and living experiences of Indigenous community members, people living with HIV and/or HCV, and frontline service providers across Northern British Columbia.

We extend our deepest gratitude to all participants who shared their stories through surveys, focus group discussions, and community engagement processes. Your voices are the foundation of this work. Your openness in speaking about healthcare experiences, stigma, and resilience continues to guide meaningful pathways toward healing and systems change.

We acknowledge the leadership and contributions of our research consultants and co-authors, Melani Lansall (MSW, RSW) and Dr. Daniel Sims, whose Indigenous-led research approaches ensured that this work remained grounded in community, culture, and relational accountability.

We also recognize the co-project leads and editors, Dr. Ujunma Egbuawa and Vibusha Madanayake, for their leadership, vision, and ongoing commitment to decolonial, feminist, and community-based practice.

Our sincere appreciation goes to the Elders, staff, members, peer workers, frontline warriors, and leadership of Positive Living North: No khēyoh t'sih'en t'sehena Society, whose longstanding work in harm reduction, education, and support services made this project possible.

We also extend our gratitude to our community and institutional partners, including frontline service providers, health authorities, First Nations bands, Indigenous and non-Indigenous social and community organizations and higher educational institutions across Northern BC, whose collaboration strengthened this work.

Finally, we honour the lands, communities, and Nations who welcomed this work. We remain committed to continuing this journey in ways that are respectful, relational, and accountable.

ABOUT THE PROJECT

Briefing Paper: Walking the Healing Path: Indigenous Voices and Frontline Realities in Northern BC Healthcare is part of a broader community-led initiative titled *"HIV/HCV-related Stigma in Healthcare: Addressing Indigenous-Specific Concerns in Northern British Columbia,"* implemented by Positive Living North: No khēyoh t'sih'en t'sehena Society (PLN).

Funded by the Provincial Health Services Authority (PHSA), this project was developed in response to longstanding and deeply rooted inequities experienced by Indigenous peoples living with, at risk of, and affected by HIV and HCV in Northern British Columbia. Over the years, PLN has witnessed firsthand how stigma, racism, geographic isolation, and systemic barriers continue to shape access to healthcare and overall well-being.

This initiative was designed as a multi-phase, community-informed project grounded in cultural safety, trauma-informed practice, and Indigenous-led knowledge. The project unfolded through five interconnected components:

- A demographic assessment exploring lived experiences and barriers to healthcare access across Prince George, Smithers, and Fort St. John and the development of this Briefing Paper to translate research findings into actionable knowledge.

- A documentary project amplifying Indigenous voices and highlighting the importance of Indigenous healing practices in healthcare

- The enhancement of PLN's Cultural Safety Module, alongside educational interventions delivered to current and future frontline service providers across Northern BC

Together, these components aimed to bridge the gap between community experience and institutional practice, while strengthening culturally safe, anti-racist, and relationship-based approaches within healthcare systems.

At the heart of this work is a commitment to centering lived and living experiences. Indigenous peers, Elders and frontline workers were meaningfully engaged throughout the project - not only as participants, but as knowledge holders, storytellers, and contributors to system change. This approach reflects PLN's longstanding practice of working alongside communities through programs such as harm reduction outreach, support services, education services and the Fire Pit Cultural Drop-In Centre, where relationships, trust, and cultural connection are foundational to care.

Guided by principles of equity, intersectionality, cultural humility, and non-judgmental care, this project recognizes that HIV and HCV-related stigma cannot be addressed in isolation. It is deeply interconnected with broader social determinants of health, including poverty, substance use, housing instability, intergenerational trauma, and systemic racism.

This publication is both a knowledge product and a call to action. It contributes to ongoing efforts to strengthen culturally safe, community-informed healthcare systems that are responsive to the realities of Indigenous peoples in Northern British Columbia. Ultimately, this work is part of a larger vision - one that seeks to transform healthcare from a system that has historically caused harm into one that fosters trust, dignity, and healing.

EXECUTIVE DIRECTOR'S MESSAGE

Hadih,

My name is Alexandria West and I hold the position of Executive Director at Positive Living North: No kheyoh t'sih'en t'sehena Society with the utmost gratitude. I am the third generation of Indigenous women in my family to be working in the HIV/HCV in the Northern region of British Columbia. I have the privilege of working in this capacity within my traditional territory of the Lheidli T'enneh First Nation.

I would like to start off by holding space for all of our people with lived and living experience with HIV/AIDS/HCV that have walked alongside us during this project, lending their voices and experiences around the healthcare system in Northern BC. Without their courage to share, we would not have gotten to the point that we are at currently.

Healthcare inequality in Northern British Columbia is a pressing issue, deeply rooted in systemic barriers and disparities that disproportionately affect Indigenous communities, rural populations, and other marginalized groups. Among these challenges, the prevalence of HIV in the region underscores the urgent need for targeted action. Northern BC has some of the highest rates of HIV in the province, often linked to factors such as limited access to testing, prevention services, and treatment, as well as the stigma surrounding the disease.

These barriers are further compounded by geographical isolation, poverty, and systemic racism, which prevent many individuals—particularly Indigenous peoples—from receiving timely and appropriate care. Addressing this crisis requires a commitment to culturally safe healthcare practices that respect and incorporate the diverse cultural identities and lived experiences of the region's populations. By breaking down barriers to care and fostering trust, the healthcare system can play a critical role in reducing HIV rates and improving overall health outcomes for people in Northern BC.

Snachaliya

Alexandria West
Executive Director
Positive Living North: No khēyoh t'sih'en t'sehena Society

EXECUTIVE SUMMARY

Property of PLN, artist unknown.

This demographic assessment was based on three sources. The literature review was written in November 2024, the surveys completed by individuals living with HIV/AIDS/HCV and accessing services from Positive Living North: No khēyoh t'sih'en t'sehena Society (PLN), Frontline Service Providers (FSP) and healthcare workers at focus group discussions held in Prince George in December 2024, Fort St. John in January 2025, and Smithers in March 2025.

Being the only Indigenous-led AIDS Services Organization (ASO) in Northern British Columbia, PLN services are primarily accessed by people with Indigenous ancestry. In this regard, the anonymous survey gave an opportunity for the members (People who are living with HIV/HCV - PLWHIV/HCV) to express their concerns in accessing healthcare services. While the focus group discussions across the Northern Interior, Northwest and Northeast gave the FSPs and the healthcare workers an opportunity to express their concerns on work ethics and legalities in providing care for Indigenous persons living with HIV/HCV.

This demographic assessment would provide recommendations to develop an updated cultural safety/cultural competency module for Positive Living North in October 2025. Of note, it identified issues regarding HIV/AIDS/HCV care in Northern British Columbia that were beyond our control and issues regarding HIV/AIDS/HCV care in Northern British Columbia that are the scope of our research requirements. Indeed, all three sources of information highlighted the need for culturally relevant, culturally specific, and culturally safe care to deal with issues surrounding the stigma associated with living with HIV/AIDS/HCV, thereby improving holistic care and overall health outcomes.

POSITIONALITY

Positive Living North: No khēyoh t'sih'en t'sehena Society (PLN) was established in 1992 as AIDS Prince George; in 2003, the name was changed to Positive Living North: No khēyoh t'sih'en t'sehena Society (PLN). Our scope of work includes people who are living with, affected by, and at risk of HIV and HCV across our three branches located in Prince George, Fort St. John, and Smithers, in Northern British Columbia. Currently, we serve an estimated 140 individuals living with HIV/HCV across these locations.

Over the years, PLN has served as a primary Frontline Service Provider (FSP) in the region. We have observed a profound reluctance among our members to access healthcare, and unfortunately, we have lost members due to these systemic barriers. During our interventions in rural and remote communities, we have witnessed how the trauma of historical colonial structures creates a lack of enthusiasm for testing and treatment. As an organization, our positionality is defined by these first-hand experiences alongside our members, staff, and the general public. To bring balance to this research, we have taken into serious consideration the perspectives of other FSPs and healthcare workers who provide vital services for our members across Northern British Columbia.

Our research consultants, as two Indigenous scholars, aim to utilize an Indigenous lens to support opportunities that uplift the communities where we work and live. To this end, it is important for us to situate ourselves.

Dr. Daniel Sims is an Indigenous scholar who has served as a faculty member in the fields of history, Indigenous studies, and education at the University of Alberta and the University of Northern British Columbia. His work has included collaborations with numerous First Nations, including his own. He has served on several national councils, including Parks Canada's Indigenous Cultural Heritage Advisory Council, and served as academic co-lead of the National Collaborating Centre for Indigenous Health. In addition to these activities, he works as a consultant and expert witness.

Melanie Lansall is an Indigenous scholar who has worked as a senior lab instructor and is the Field Director in the School of Social Work at the University of Northern British Columbia. She operates a private mental health practice, providing services to numerous First Nations in Northern British Columbia. She has served on provincial and national boards with the British Columbia College of Social Workers and the Canadian Association of Social Workers. Recently, she received the Bridget Moran Award, an illustration of how social justice and advocacy are central to her work with Indigenous, rural, and remote communities.

Both consultants for this research are band members of the Tsay Keh Dene First Nation. Dr. Sims' *aatsoos* (grandmothers) are the sisters of Lansall's *aatse* (grandfather). They are all members of the Pierre family, although Dr. Sims is a member of the Tomah-Izony family through his father. Given our connection to the community, it goes without saying that we have numerous familial connections to the other Great Families of Tsay Keh Dene, as well as other First Nations in Northern British Columbia and beyond. For example, Melanie's *aatsoo* is from the Kwadacha Nation, but also lived and married into the Tsay Keh Dene Nation.

As band members, our research consultants recognize that they do not speak for or represent all Indigenous peoples in Canada or British Columbia. Nonetheless, it is important to locate their Indigeneity in this demographic assessment, as it is imperative that more Indigenous voices are held up in academic activities. They wish to hold space for their relations and their communities who have gone before them—many of whom were rendered silent in their interactions with the healthcare system. It is their firm belief that more work must be done, as they have only just carved off the top layer of these discussions.

Complementing this Indigenous-led research framework, this briefing paper and the demographic assessment are the result of a collaborative process led by Dr. Ujunma Egbuawa and Vibusha Madanayake, who oversee Support Services and Education at Positive Living North. Their work is grounded in the necessity of shifting power dynamics within healthcare. Central to this assessment are the collective voices of our staff and FSPs, who navigate the complexities of stigma alongside our members every day. Together with our research consultants, our team recognizes the responsibility to ensure these findings remain rooted in the lived realities of Northern BC.

As research consultants and as an organization, we liken this demographic assessment to a totem pole; we are carving a narrative of the experiences shared by the communities, groups, and patients involved. We are slowly etching out the time and space to create the modules that the community has long demanded. In doing so, we recognize that frontline staff require greater support and time to provide the level of service they eagerly desire. We offer our findings through the stories of this pole. We invite you to view each graph and each quote as one aspect of a pole that will eventually be transformed into cultural modules of creativity and healing.

LITERATURE REVIEW

It is also important to situate the demographic assessment itself. A literature review is meant to situate the work, clearing indicating how it interacts with our pieces of work. To return to the totem pole analogy it is the landscape – the environment – the pole finds itself in.

As Reading (2015) reports, "Although [Indigenous] people represent just over 4 percent of the Canadian population, in 2008 they accounted for 12.5%of all new HIV infections and 8 % of its prevalence in Canada, with women representing half of all [Indigenous] peoples infected (p.11)." A decade later not much has changed. Indeed, the number of HIV/AIDS related deaths reported per year between 2018 and 2023 has remained constant (Statistics Canada, 2022). Nationally, it is the thirtieth highest cause of death, however, after reviewing the Statistics Canada website, there was no specific statistics for British Columbia. This gap is one of many we have noticed in our review of the literature. Our review has also highlighted a number of barriers for Indigenous peoples when it comes to HIV/AIDS treatment. Unlike other population groups, the prevalence and infection rate of HIV/AIDS amongst Indigenous identifying groups remains consistent. "In 2016, the rate of newly diagnosed HIV was three times higher in First Nations living on reserve than the overall Canadian population." (The Public Health Agency of Canada and Indigenous Services Canada, 2016). This is alarming as the identified Indigenous population in Canada is much lower, representing 5% of the total population. (Crown-Indigenous Relations and Northern Affairs Canada, 2024). Nor is it just an on-reserve issue. As McPhedran reported in 2016 "more First Nations people over the age of 15 living off reservations are reporting poor health and more chronic conditions in comparison to the total population of Canada." Still the situation is not without hope. Murdock (2024) reports that while urban Indigenous people have poorer health outcomes, they nonetheless demonstrate resilience, characterized by strong connections to the land, to their languages and cultural practices.

Context

There are over six hundred distinct First Nations in Canada, plus the Métis, and the Inuit. These six hundred First Nations represent over three thousand reserves, First Nations settlements, and an ever increasing urban Indigenous population. Over two hundred of these First Nations are located, either fully or partially, within the Province of British Columbia, which has over one thousand six hundred of these reserves. And while some of these First Nations may be related, they are nonetheless distinct legal entities which can affect what programs are available to band members as well as how they are delivered. It is

more than just politics though. It must be remembered that there are over sixty Indigenous languages in Canada, representing thirteen different language families. Thirty-five of these languages are found in British Columbia, representing seven of the thirteen distinct language families. As a result, although with a reported total population of 180,085 in 2021 (Statistics Canada, 2022) First Nations are the largest Indigenous group in the province, but they are neither a unified group nor the only Indigenous group.

The second largest Indigenous group is the Métis. When it comes to the Métis it is important to recognize that while there is an ongoing debate over who is and who is not Métis, the vast majority of Métis governments agree that the term does not mean anyone of mixed First Nations and European ancestry, especially when this mixture happened in the last one hundred and fifty years. In 2021 there were reportedly 97,865 Métis in the province (Statistics Canada, 2022) and while in the past it could be assumed that most of them were represented by the Métis National Council (MNC) at a federal level and Métis Nation BC at a provincial level, this situation is no longer the case with Manitoba Métis Federation, Métis Nation - Saskatchewan and Métis Nation BC having left the MNC in 2021, 2024, and 2024 respectively. And while most Métis governments/organizations bar someone from having Métis membership/citizenship and Indian status at the same time, it is also important to remember that while some of these Métis governments/organizations have a geographic designator in their name, this use of an adjective does not mean the members/citizens of that organization are from and/or live in that geographic area. For example, the Manitoba Métis Federation has many citizens in this province. And so far we have only talked about larger Métis organizations. There are many smaller Métis organizations and/or governments that exist with varying levels of recognition. In short, while there are not numerous Métis nations per se, there are numerous Métis governments and organizations, and they do not necessarily have a unified Métis voice or perspective.

And finally, there is the third Indigenous group in British Columbia: the Inuit. While no part of the Province of British Columbia overlaps with a nunagat, there is nonetheless a Inuit population in British Columbia. Indeed, in 2021 Statistics Canada reported a total population of 1,720 Inuit (Statistics Canada, 2022). Still, given the small size, they are often overlooked, which can cause problems since Inuit culture is not necessarily similar to the cultures of local First Nations or the Métis.

Victor Morris.

History

In 2021 the Canadian Historical Association released a “Canada Day Statement” stating that the history of Indigenous peoples in Canada can be described as a genocide. Over three thousand reserves might sound impressive, but it must be remembered that prior to 1492 all of the land was Indigenous owned[1], with numerous Indigenous states in existence and governing their territory in their own way. How these states became bands and their land was reduced to reserves representing less than 1% of the land is the history of Canada. As Reading (2015) states, “Over the past 400 years, Indigenous societies across Northern America have experienced similar patterns of colonial oppression” (p.5). Following the Truth and Reconciliation Commission, more and more Canadians are aware of the atrocities of the past, including, but not limited to, Indian

1 Please note many Indigenous peoples do not use the term ownership in no small part because the term is an English word. What is important to remember, however, is that ownership is simply a relationship to the land. In this instance it is a relationship within the context of English culture, which evolved over time to include things like deeds and legal land surveys. Indigenous peoples had their own relationship to their land, which for want of space in this document and an appropriate English word will be referred to as ownership.

residential school system (1883-1997), the Indian day school system (1863-2000), the Indian hospital system (1830-1981), the 60's Scoop (1951-1980), the Millennium Scoop (1991-present), the sterilization of young Indigenous women against their will, and the missing and murdered Indigenous women and girls crisis. A common aspect of these atrocities is the family. As Social Work Professor Dr. Sarah Maiter states, "Indigenous populations bore the initial brunt of inappropriate government intervention in the lives of children and families" (1999). As a fundamental social unit that is tasked with early education and basic healthcare, this attack on the family has negatively impacted Indigenous health both directly and indirectly. As Hillier et al. (2020) state (2020), "Colonial policies have produced inequities across social determinants of health tied to trauma, lack of funding, and limited services to Indigenous peoples" (p.49). What's more, as Reading (2015) states, "For the most part early Indigenous health policy was based on notions of "white" racial superiority..., disease prevention sought only to minimize colonial burden of sick Indigenous peoples and to contain disease, thereby protecting Euro-Canadians" (p.7). In other words, far from being an altruistic endeavour, when non-Indigenous peoples first provided healthcare to Indigenous peoples it was selfish, aimed at reducing costs, and thoroughly racist. Yet, many do not consider those traumatic experiences as a reasonable explanation for the inequities that exist or that many Indigenous individuals live a less privileged life in general. Still, one of the good things about the Truth and Reconciliation Commission is that it made more people aware of the situation and the last decade has seen governments and private organizations take steps to reconcile the mistakes of the past and deal with the contemporary problems caused by these mistakes.

Intersectionality

In 1989 legal scholar Kimberlé Crenshaw published "Demarginalizing the Intersection of Race and Sex" in the University of Chicago Legal Forum. Commonly seen as the article that introduced the concept of intersectionality to academic research, it argues that treating race and gender as mutually exclusive is not only misleading, but harmful when it comes to fighting racism and sexism. This concept is seen in many of the works we reviewed. For example, while Barlow et al. (2008) argue that HIV/AIDS prevention and care is affected by not only other health issues, like addiction, but also cultural issues, cultural identity, Wilson et al. (2016) are far more direct and attribute cultural loss with contemporary social and health problems. In this sense the HIV/AIDS crisis in Indigenous communities can be connected historical events that eroded or effaced Indigenous cultural identities, such as the Indian Act (1876-present) and Indian status (1850-present), the Indian residential school system, Indian day school system, 60's Scoop, and the Millenium Scoop. Similarly, Jaworksky et al. (2012) point out that when it comes to who tends to get infected the patients are generally identified as female and have lower education levels, have lower employment levels, and lower income levels. Indeed, Sanderson et al. (2021) reported that from "2004-2008 Indigenous women were 19.7 times and Indigenous men 3.6 times more likely to be diagnosed with HIV than white women and men." Or in other words, it is not only related to education levels, which are still affected by legacy of the Indian residential school system and Indian day school system, but also gender, with arguably many of the reasons why Indigenous women are overrepresented among patients being similar to the – if not the same – factors contributing to the ongoing missing and murdered Indigenous women and girls crisis. These factors include things like food security, which Purdy (2023) points out is often determined by the same factors that can result in one being infected by HIV/AIDS, including income level and impacts of colonization.

But it is more than just a matter of the impacts of colonization. The way people deal with these impacts affects their health. As Wilson et al. (2016) point out, the trauma associated with colonialism in both the past and present, be it direct or indirect (intergenerational), often results in individuals partaking in high risk activities in an attempt to cope with said trauma, which in turn puts them at a higher risk of being infected with HIV virus. Nor is it just a matter of these high risk activities leading to infection. As Barlow et al. (2008) point out, those with addictions have to deal with both health issues with

addictions complicating their ability to get treatment for their HIV infection. Even when addiction is not a problem, a 2014 study by Masching et al. found that all too often racist assumptions are made about Indigenous patients, which only serves as a barrier to getting treatment. No one wants to be viewed as an addict, especially if they are not. And it is important to remember that from a historical perspective prohibition has been used to undermine Indigenous sovereignty and/or autonomy (Dertadian 2024).

Barriers – General

Stereotypes and assumptions about Indigenous patients form a barrier to getting the necessary healthcare treatment once a person is infected with HIV. Our literature review found that numerous other barriers were identified by researchers when it came to accessing medical services. Indeed, as Jaworksky et al. (2012) found in their study Indigenous patients tend to be diagnosed with HIV or AIDS later than non-Indigenous patients. Not only does this delay affect the ability of healthcare providers to prevent HIV from transitioning to full blown AIDS, but it also increases the possibility that patients will unknowingly spread the infection to others. As Negin et al. (2015) argue, some of the barriers/determinants include colonialism, racism/discrimination, stigma, domestic violence, and drug use. Kemp (2024) provides a similar list, noting geography, mistrust/confidentiality, language, and stigma. And while at first glance many of these may seem unrelated, when examining them it is clear they are related. Colonialism, particularly settler colonialism, contributes to issues of racism/discrimination and can easily create a language barrier, with both leading to issues regarding trust and/or confidentiality. The end result is that as McPhedran (2016) reports, "Many First Nations people are afraid to see doctors or go to the hospital because of intergenerational trauma… this fear persists among many First Nations people." Indeed, Heidebrecht et al. (2022) state that healthcare in general is shaped by settler colonialism. As Sanderson et al. (2021) state it is:

> a settler colonial project that has created and continues to create poor health for Indigenous and racialized people through coordinated, imposed systems that privilege witness and Eurocentric belief systems including but not limited to criminal justice, health, education and economic systems. (p.269)

A good example of this project is seen in Dertadian's article "The Coloniality of Drug Prohibition" (2024), which argues that the prohibition of drugs and alcohol when it comes to which are prohibited and how. Indeed, Dertadian argues that among other things, prohibition has been actively used by settler colonialism to the disadvantagement of Indigenous peoples. Oddly, the only source we found that stated most Indigenous peoples were getting the services they needed was also the one that noted that sometimes healthcare workers mistakenly assume Indigenous patients are alcoholics without any evidence other than that they appear to be Indigenous (Masching et al., 2014).

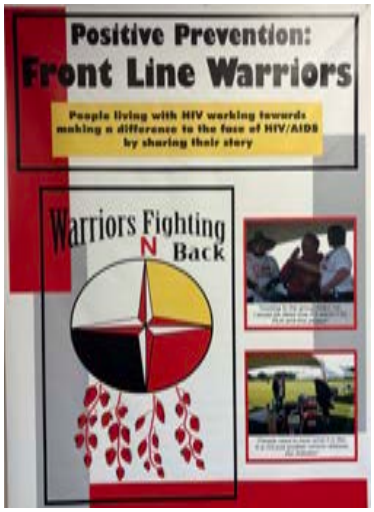
Barriers – Geography

One of the key barriers (Kemp 2024), which we will discuss separately is geography. As Jordan (2013) notes HIV treatment requires a strict adherence to antiretroviral therapy, which can be hard to achieve for those living in remote and/or northern communities. Northern British Columbia, defined as everything north of Williams Lake and Highway 20 contains over sixty Indigenous communities, including both First Nations and Métis population centres and a small Inuit population. While many of these communities have healthcare clinics and urban centres usually have at least one doctor's office, if not a general hospital, it is still quite common for major medical services to be provided in major urban centres like Prince George, Kamloops, Kelowna, and/or the Greater Vancouver Area. As such, many patients have to leave their community and often their support network to access the

healthcare they need. The latter can include not only friends and family, but also culturally relevant treatment, a fact easily overlooked if one assumes that all Indigenous peoples are the same and either share the same culture or have cultures that are similar. Already a less than ideal scenario, it is not helped by "Indians" being a federal responsibility, while healthcare is a provincial responsibility. And while the federal government has increasingly gotten involved in healthcare in Canada, it should be noted that in the case of healthcare for those defined as "Indians," federal funding is often lower than provincial funding (Hillier, 2019). It is one of the reasons why Hillier et al. (2020) and the Building More Bridges Team (2023) calls for not only increased funding, but also localized care.

Barriers – Relationships

All of these barriers affect a key component of healthcare that can often be easily overlooked – the relationship between patients and healthcare providers. To bring the infection rates down, and to help support the Indigenous patients who live with it and have to navigate the health system it is important for them to know that their information is confidential and that the provider is someone they can not only trust, but who has some knowledge about language, culture, and traditional territory. They need to acknowledge different ways of living and being. To this end Place (2012) recommends "health service policy and planning should be on ensuring programs are culturally safe and minimize jurisdictional barriers." (p.8). The alternative is to perpetuate existing systems that most scholars agree are failing Indigenous patients in general, and those with HIV/AIDS in particular.



In 1991 Verna Kirkness and Ray Barnhardt published "First Nations and Higher Education: The Four Rs - Respect, Relevance, Reciprocity, Responsibility" (1991). Now see as a seminal work for introducing the Four R's to Indigenous research, it is important to remember that it was simply documenting best practices when it comes to working with Indigenous peoples. Starting in 2004 this would expand, with scholars like Harris and Wasilewski (2004), Restoule (2008), and Sandra Styres and Dawn Zinga (2013) added a fifth R, relationship, arguing that it unified and informed the original four. And more recently scholars like Tsosie et al. (2022) have added a sixth R, representation, arguing Indigenous peoples need to be involved in some way, shape, or form. Ultimately, though, it does not matter how many Rs there are, what is important is that anyone working with Indigenous peoples needs to form a good relationship. This axiom is true for scientists, social scientists, and even healthcare workers. It is fundamental not only for patients with relatively simple life stories, but also for patients with complex life stories – perhaps more so for the latter.

Unfortunately at times, due to the past treatment of many Indigenous individuals in the healthcare system people may be less likely to seek medical treatment. In Lansall's professional experience working in mental health with Indigenous populations, trust is imperative and the worry of confidentiality and stigma is prevalent. As "The Promising Practices" documentary (Canadian Aboriginal Aids Network, 2024) describes, these worries may impact the ability of patients to seek support and may lead to a lack of treatment. In addition, these worries can create distrust for Indigenous peoples encountering a Eurocentric approach to their care. Indeed, there can be concern that an HIV diagnosis can lead to the criminal justice system getting involved in the lives of those diagnosed. As noted by Sanderson, et al. (2021) Canada's assertive approach to criminalizing HIV non-disclosure, which requires people living with HIV to disclose their status to sexual partners prior to any sexual activity that has a "realistic possibility" of HIV transmissions, results in amongst the highest number of convictions globally.

DEMOGRAPHIC ASSESSMENT

The literature review, which was completed in November 2024, set the stage for the demographic assessment. To be clear it did not determine our findings, but it did help us formulate the survey for people living with HIV/Aids and accessing services from PLN and write prompting questions for the workshops involving FSPs and healthcare workers. In turn the demographic assessment was meant to inform our work when it comes to developing an updated cultural safety/cultural competency module for PLN. For emphasis, we want to make sure we have heard from both PLWHIV/HCV and FSPs so that we have made an attempt to put something together that meets local community needs.

It should be noted that we have made every effort to make sure this report protects the identity of PLWHIV/HCV who completed the survey, FSPs and healthcare workers who participated in focus group discussions. To this end we would like to clearly state that we describe the individuals who participated in the workshops as participants or some variation of healthcare worker. The latter takes a more holistic approach to health, although it should be noted that everyone is a doctor, nurse, or professional universally seen as part of healthcare. The only exception to referring to people as participants or healthcare workers is when we refer to a specific subgroup.

SURVEYS

Thirty-five (35) surveys were conducted with PLWHIV/HCV and accessing services from Positive Living North in Prince George and Smithers. Despite operating in Fort St. John, no surveys were conducted there due to lack of persons who are ready to self-identify as PLWHIV/HCV. Therefore it is impossible to say whether or not the findings apply to the Northeast area (Peace River region). That being said, it was clear from some of the focus group discussions that there is a divide between the Indigenous and non-Indigenous community due to lack of cultural understanding. The surveys consisted of six demographic questions and twelve questions related to HIV/AIDS/HCV care. Participants were free to answer the questions they felt comfortable and/or end the survey at any point in time. Reflecting this option, one person ended the survey after answering the first two questions related to HIV/AIDS/HCV care, and many others left at least one question blank and/or provided a non-answer[2].

Demographics

The six demographic questions were meant to provide a snap-shot of the average HIV/AIDS/HCV individuals in PLN not only for its own sake, but also allow for comparisons to the literature on HIV/AIDS/HCV care. As noted in the literature there is not a lot of statistical information from British Columbia, let alone Northern British Columbia. Based on the information provided, most respondents are aged 40-64[3]. When it comes to gender, twenty-one (21) are male, thirteen (13) are female, and one (1) is two-spirited. This ratio bucks the trend of most individuals living with HIV/AIDS/HCV being female found in the literature.

The average annual income of respondents was $0-27,000, with only three making $27,001-54,000, and only one noting they are a recipient of disability benefits. Perhaps related to income level is education level with respondents reporting their highest level of education to be anything from Grade 5 to a post-secondary certificate/diploma. That being said, only four had received the latter, and only six received a high school diploma. It should be noted that one participant did not answer and one answered “other,” which might mean a whole host of things.

2 We define a non-answer as an answer that does not actually answer the question and/or indicates the question was read, but not responded to. The most common non-answer was “N/A,” which means not applicable.

3 Only two were aged 24-39 and only one was aged 65 and above.

Most of the individuals surveyed are Indigenous, with twenty-two (22) being First Nations – most of whom identified their First Nation and have Indian status, six being Métis, and two being First Nations and Métis. It is important to recognize that this last grouping is distinct from the first two since it is quite possible for an individual to have both First Nations and Métis ancestry, especially when you consider that despite ongoing disputes over who is Métis, the vast majority of Métis governments and organizations are adamant that it is not just someone of mixed European and Indigenous ancestry. We did not receive any surveys from an individual who identified as Inuk, which is not surprising given the relatively small Inuit population in British Columbia as whole (Statistics Canada 2016).

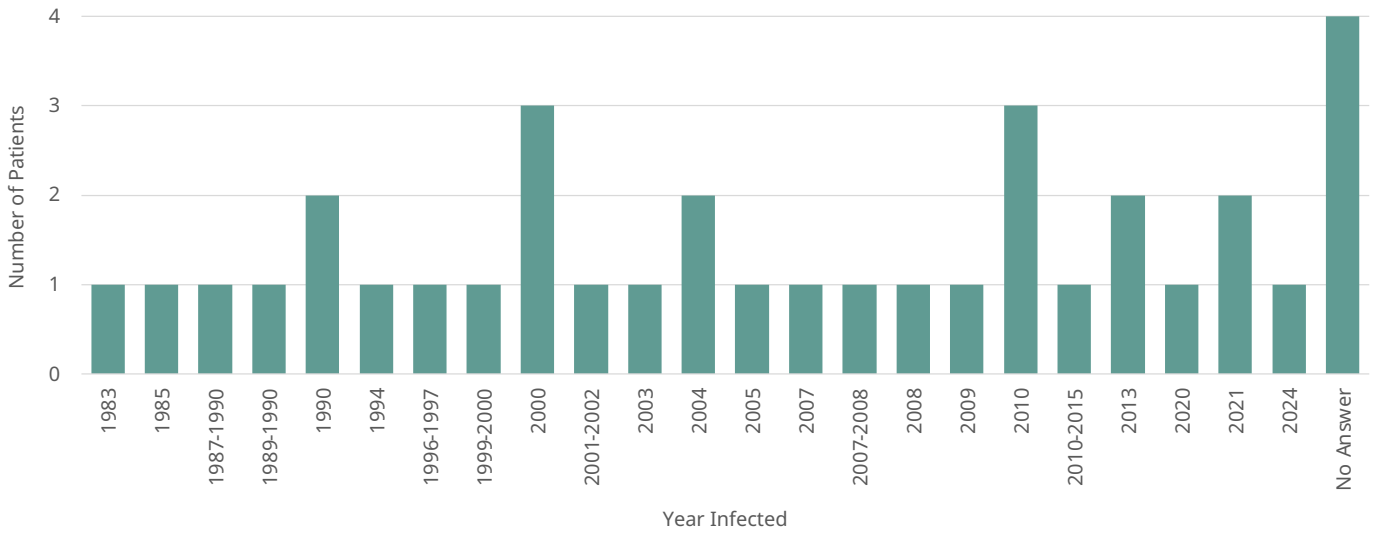
Twenty-four (24) live in Prince George and surrounding areas, ten (10) live in Smithers, and one (1) live in Telkwa. These locations may negatively impact five of the individuals, since they are from Indigenous communities located outside of British Columbia, and the geographic distance may hinder access to any programs offered by their community. That being said none of the respondents that this applied to indicated this situation was the case. It is also important to note that all of the individuals receive care in the community they live in, with seven (7) noting they used Central Interior Native Health Society (CINHS), one referencing PLN, and the Victoria Medical Building, and one noting they avoid the hospital. Of course, given that the surveys were conducted by PLN it is clear that all the respondents access at least some of their health care needs from them through referral services and taking individuals to their medical appointments.

Care

The twelve questions related to care can be divided into six categories: infection and knowledge level, barriers to care, racism, cultural safety, desire for change, and overall experience. The intent of these questions is to get a sense of the interactions respondents have had with the health care system and based on their response get an understanding of where things are working well and where they are not.

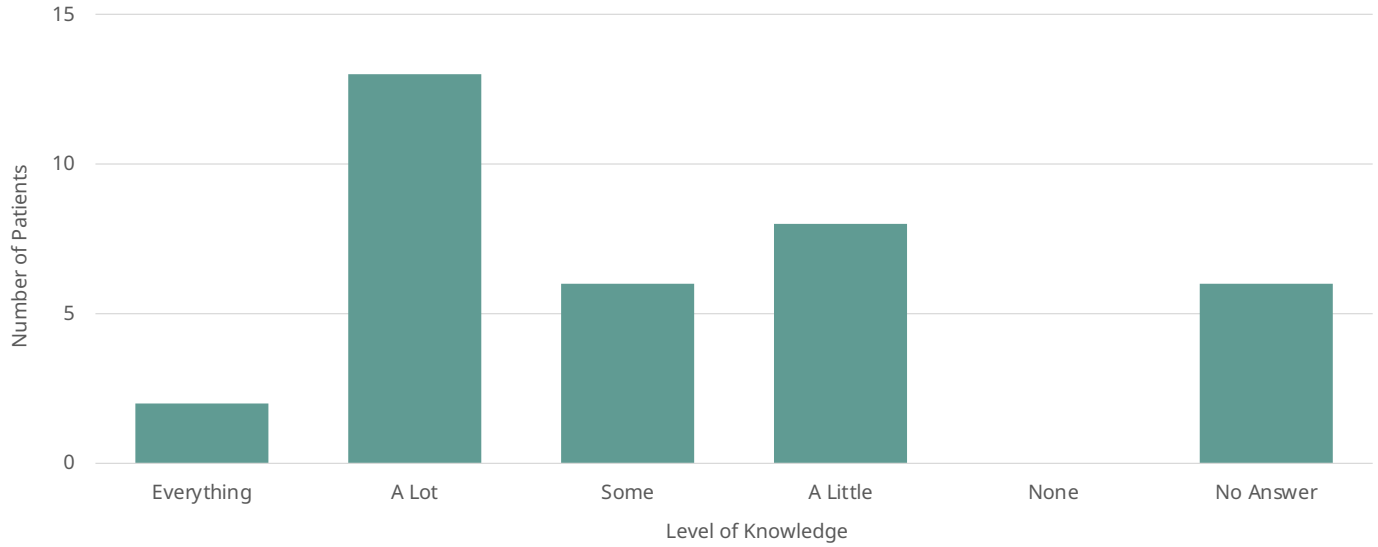
Infection and Knowledge Level

What year did you become infected with HIV/Aids?



One thing the surveys revealed is that at least among the respondents there is no clear pattern of infection. As can be seen in the chart above the closest thing we found with regard to a grouping was the response labelled as “no answer.” It should be noted, however, that this answer includes people who were not sure. What is perhaps more disturbing is the general lack of a decline as time goes on, something that bucks the overall trend of HIV/AIDS/HCV infections declining in recent years, but falls in line with trends of HIV/AIDS/HCV infections in the Indigenous community. Why there is no drop in recent years is unclear, although it should be noted that one respondent indicated that they thought women could not get infected with HIV/AIDS/HCV. Where this misunderstanding arose is unclear, although it is possible it is connected to the old belief that HIV/AIDS/HCVs was a disease that only affected the gay community.

Reported Level of Knowledge



While the lack of a decline in infections is concerning, one good thing was the level of knowledge each individual reported as having. Before we begin discussing our findings, however, it should be noted that we standardized the answers given. In other words, while some respondents said they know “everything,” not everyone in that category used that wording. That being said, we used a reasonable understanding of the responses given to categorize them into the six categories above.

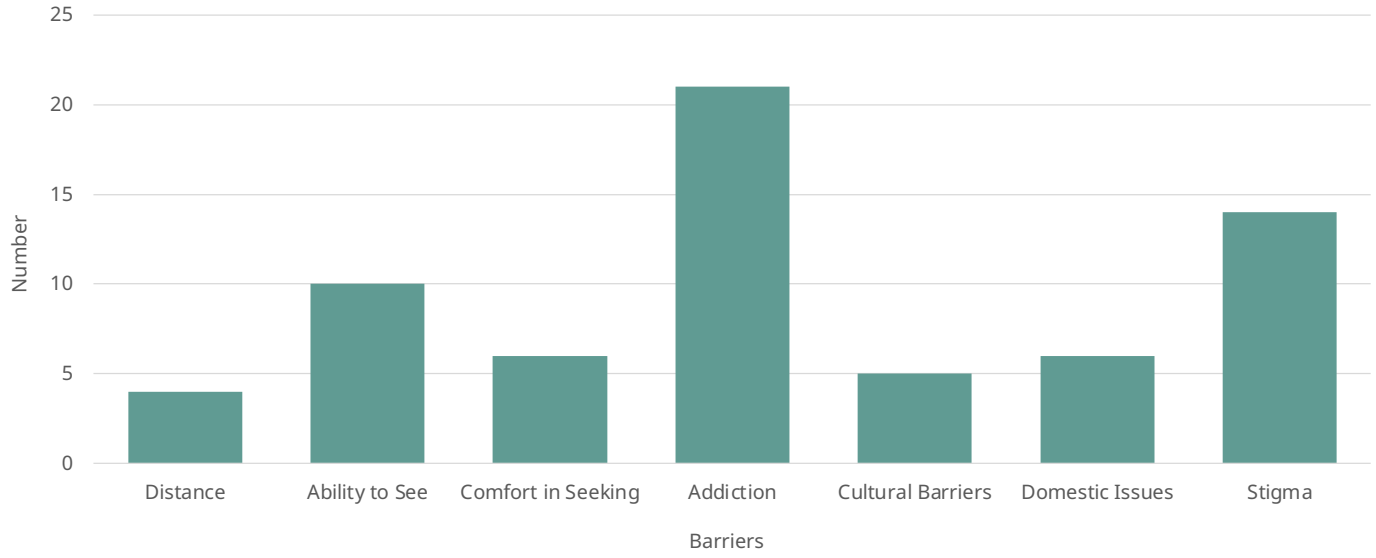
The vast majority of respondents – thirteen (13) – reported having a lot of information, with two (2) noting the programs offered by PLN as providing them with at least some of it. It was also good to see that for at least two (2) of the people who reported having “a little” information were only infected in the last five years, so it is possible that their level of knowledge will increase as time goes on. What is problematic, however, is the fact that of the ten respondents from the Smithers and Telkwa area, that half (5) indicated their level of knowledge was “a little.” Nevertheless, it is good to see that no one said they had no level of knowledge, although in theory it is possible some who did not answer fall into that category. Of course it is equally possible that they fall into other categories too.

Barriers to Care

One issue repeatedly mentioned in our review of literature was barriers to care that not only affect the ability of individuals to find out if they are infected with HIV/AIDS/HCV, but also receive the care that is necessary for them to live with it. Identifying seven common barriers, we asked participants which ones they encountered. When looking at their responses there are a few things to note. First, not everyone

answered this section of the survey. Second, many respondents identified more than one barrier. So the numbers below not only exceed the number of respondents, but also do not reflect all the respondents.

What factors affected your ability to find out that you were infected?

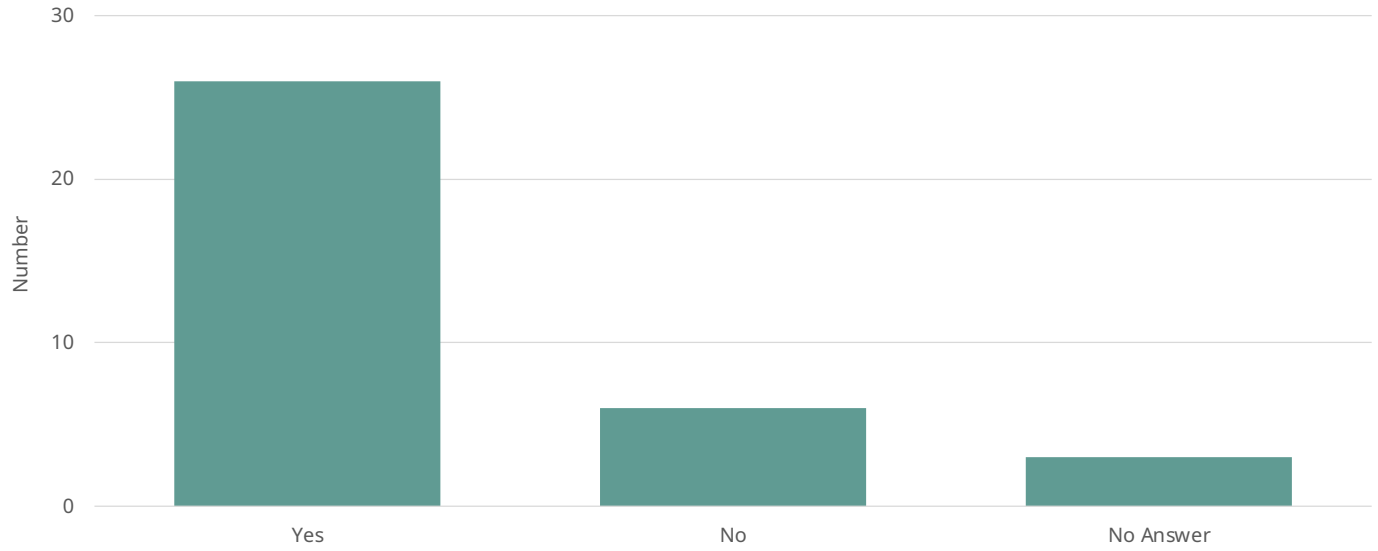


Looking at the information above it is clear that addiction is one of the biggest barriers to care and it should be noted that more than one respondent stated it was also the cause of their infection and/or prevented them from seeking help when they should have. One respondent also directly connected addiction to the second highest barrier – stigma. This statement, however, should not be read as stating no one else connected the two barriers together, only that one individual felt the need to directly connect them. Furthermore, presumably the stigma associated with being infected with HIV/AIDS/HCV is connected to comfort in seeking care, although it is impossible to say with absolute certainty. This potential correlation highlights issues with accessing healthcare in general and it is interesting to note that while four (4) respondents noted that distance was an issue, they all live in the Prince George area and not – as one might assume – the Smithers or Telkwa area. Indeed, the biggest issue identified when it comes to access healthcare was the ability to see a healthcare worker, with four noting the difficulty of making an appointment, one noting that healthcare workers can change, and one calling for more healthcare workers who deal with HIV/AIDS/HCV. All three are particularly interesting as it can be said that they have more to do with staffing issues than HIV/AIDS/HCV care in general.

Racism/Discrimination

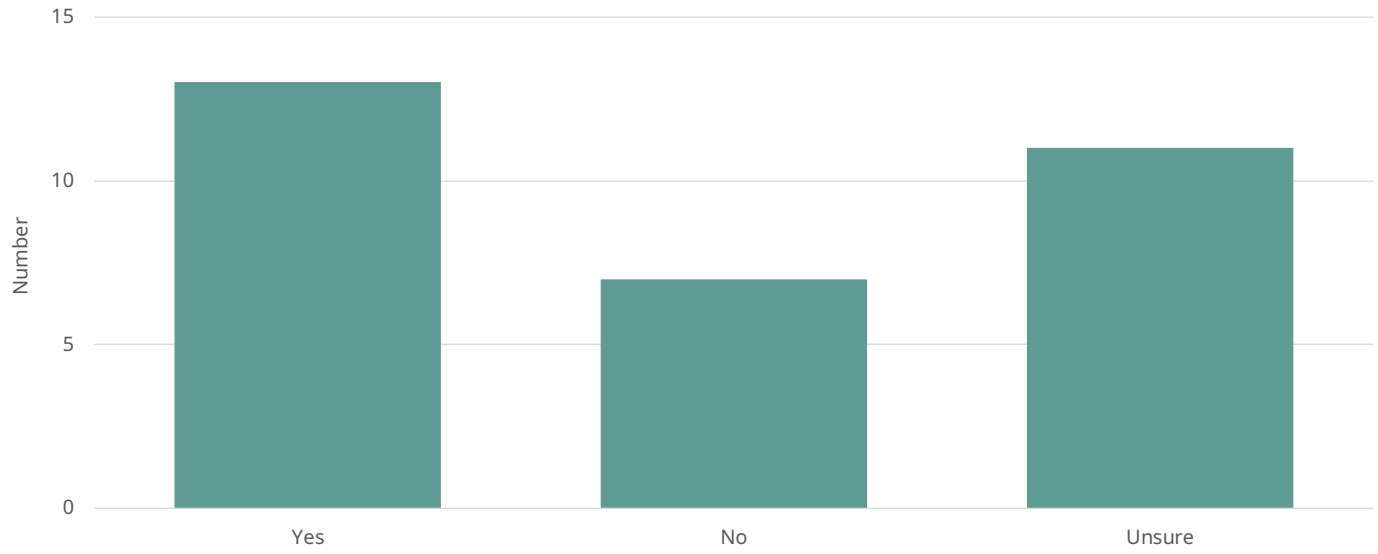
Before discussing racism and discrimination, it is important to note that there are multiple definitions of term, with some referring to prejudicial statements, remarks, and/or actions, and others further defining it as those statements, remarks, and/or actions in the context of an unequal power relationship with the individual, group, and/or institution having more power than those on the receiving end. In this context, while it cannot be safely stated which definition the respondents were using, it should be noted that in accessing healthcare it can be said that healthcare workers have by definition more power than PLWHIV/HCV. That being said, it is important to note that it is dangerous to use one definition of racism given the multiple definitions that exist.

Have you ever experienced racism or discrimination based on your health status while seeking/receiving healthcare?



Of the thirty-five (35) respondents, twenty-six (26) reported that they have experienced racism or discrimination based on their health status while accessing care, with six (6) stating that they have not, and three (3) providing no answer. Of note, there is no clear correlation between the ethnicity or race of the respondent and their experience. Nor does it appear to matter when the individual was infected. When regard to location, it does not appear that respondents experienced more racism in the Smithers and Telkwa area. Rather it appears that the eleven (11) respondents are less likely to experience racism there compared to those living in the Prince George area4. In other words it does not appear racism and discrimination more commonly occur in smaller communities. That being said, it is important to remember that we did not receive any surveys from Fort St. John as currently PLN do not have any members in the Northeast region. As a result it is hard to make any firm conclusions.

Do you think the individual in question was aware they were being racist or discriminatory?



4 Of the twenty-four respondents in the Prince George area, three reported not experiencing racism, while of the eleven respondents in the Smithers and Telkwa area, three reported not experiencing racism.

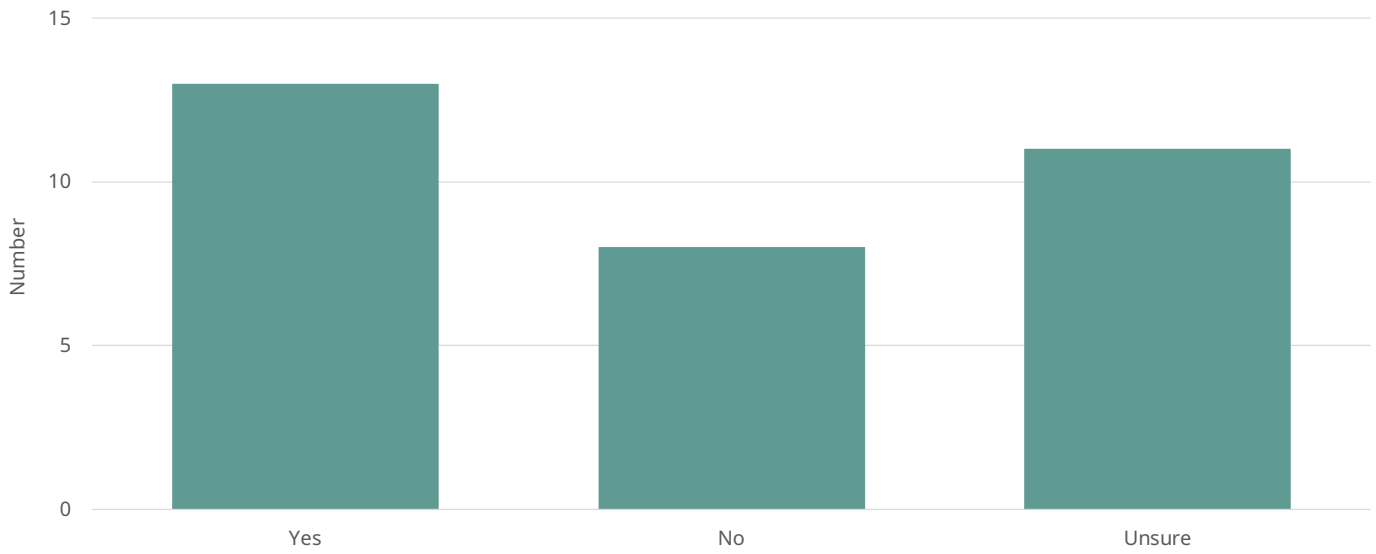
The next question we asked was whether or not the individual being racist or discriminatory was aware of it. Of course this question is incredibly hard to answer and this reality is reflected by the fact that eleven respondents were unsure. Of note, three of these respondents not only said they were unsure, but that they had not experienced racism. It is unclear what this response means. It is possible they both thought the individual was not being racist and was not aware of the fact they were not being racist. It is also possible, however, that they are unsure how to answer. Indeed, in a similar vein the remainder of the respondents who said they had not experienced racism also said the person was not aware.

Perhaps most concerning, though, is that thirteen of the respondents who reported experiencing racism or discrimination in accessing healthcare were certain that the individual being racist towards them was aware of the fact they were being racist or discriminatory. Of note, one respondent noted that it took the form of lateral violence, a simple fact that highlights that racism is not just a settler-Indigenous issue. What's more, seven of the thirteen, were certain that their experience was occurring despite cultural safety training being in place.

Cultural Safety

According to Northern Health's website, cultural safety is designed to provide culturally safe services, and involves related concepts like cultural humility, cultural awareness, cultural sensitivity, and cultural competence (Indigenous Health 2025). One thing to note is that of the thirty-five respondents, twenty-eight were adamant that cultural safety training is necessary. This number is potentially higher, though, since one respondent responded by saying what is needed is a brief discussion, one respondent said they use the Central Interior Native Health Clinic because it is safe, and two respondents did not answer this question.

Do you feel Indigenous cultural aspects are being utilized by the healthcare facilities/sector?



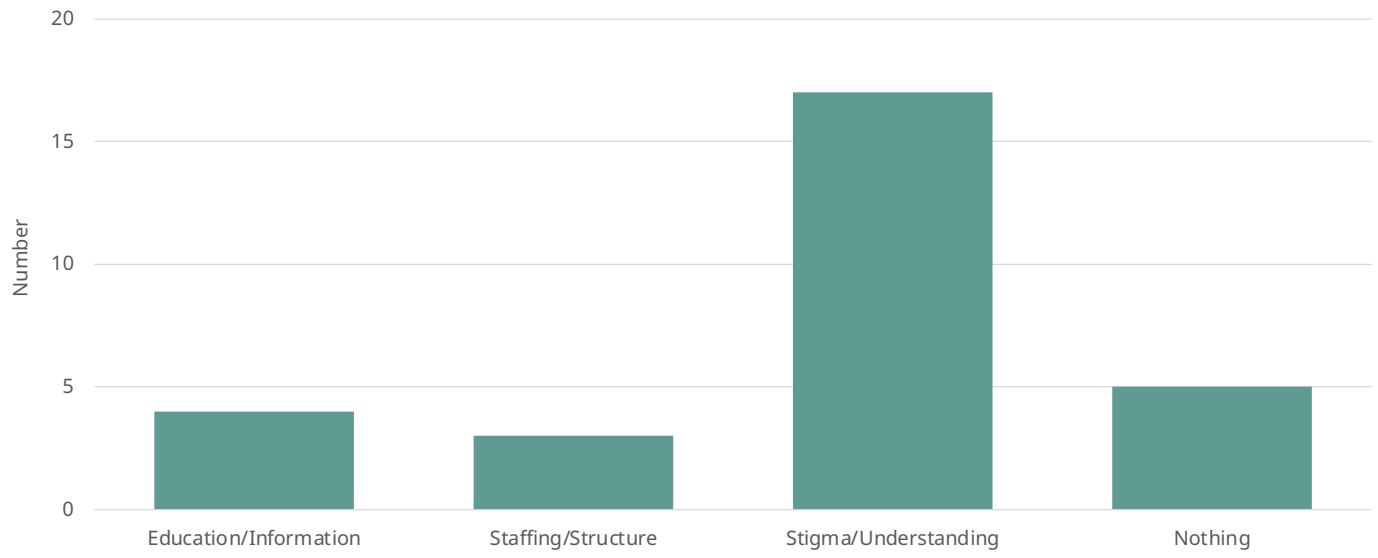
While most respondents support cultural safety training and think it is important to have, it is important to note that most of them either think that Indigenous cultural aspects are either not being utilized in the Prince George, Smithers, or Telkwa area or are not sure. It is hard not to see these responses as a critique of current cultural safety training, especially in the context of reported racism. Two other questions, however, provide some context.

The first was regarding how respondents feel when healthcare workers utilize aspects of Indigenous cultures. While some respondents felt it should happen and is important, some did not like it, were not sure how to react, or felt bad when it happened. These responses might surprise some, but some other responses might help contextualize it. For example, one respondent felt that health care workers did not know much about Indigenous cultures, while another characterized the use as being limited to simple words and phrases and without permission from the community. In this instance it appears that the respondent felt like healthcare workers were pretending to be something they are not. Indeed, one respondent simply stated it depended on how it was said. Finally, it should be noted that one Métis respondent even said it made them feel unwelcome.

This last response brings up the second question regarding how respondents feel when the culture being utilized is not their culture. While most respondents were okay with it and some voiced the view that all cultures are equal and they wanted to know more, it was also clear that some respondents wanted their own culture to be utilized. One Cree respondent for example stated it made them a little pissed off as they want aspects of their own culture included. Others noted they felt disappointed or bad when it happened. Again certain answers provide context and as with the previous question it was clear that some respondents felt it mattered how it was handled and that they thought some health care workers use it without permission from the community, for the primary benefit of healthcare workers and not PLWHIV/HCV, and quite shockingly to pretend to be Indigenous themselves. Obviously ethnic fraud is something that should never happen, although it is unclear if this situation is what PLWHIV/HCV are talking about as it is possible that healthcare workers are unaware of how their incorporation and language is perceived.

Recommended Changes by PLWHIV/HCV

Would you like to see anything different when you go to healthcare services?



Perception is key to the changes recommended by patients. First, and foremost it is important to note that five respondents felt nothing should change or that they did not know what should be changed. This number included individuals who reported experiencing racism and/or discrimination in the health care system. As a result, it is unclear if they feel these experiences cannot be prevented and/or are just part of the healthcare system or if these experiences happened in the past and thus are no longer an issue. The former is highly problematic if true, while the latter indicates that positive changes have occurred in at least some instances. Indeed, it could be said that the response is

connected to stigma and understanding. As the most common response, it is a catchall for any response in which respondents indicated that they wanted healthcare workers to have more understanding, be more accepting, treat them better, and generally be kinder. It also includes those individuals who reported that Indigenous PLWHIV/HCV are served after non-Indigenous PLWHIV/HCV. As a response it is interesting given the recognized importance of cultural safety training that is culturally appropriate and meaningful. In short, it appears respondents want more empathy and genuine cultural knowledge that is properly incorporated into the healthcare system. In this sense stigma and understanding is connected to education and information and the challenge is developing opportunities that engage current and future healthcare workers.

Property of PLN, artist unknown.

FOCUS GROUP DISCUSSIONS (FGD)

As part of the demographic assessment three FGDs were organized over the Winter of 2024-2025. The first occurred in Prince George on 12 December 2024, the second in Fort St. John on 24 January 2025, and the third in Smithers on 7 March 2025. Each FGD included a diverse mixture of individuals, including – but not limited to – front-line healthcare workers, public health officials, scholars and students in health related fields, and representatives of local organizations/governments. Unlike the individuals who completed the surveys, most, if not all of the participants were not HIV positive.However, they work as FSPs or healthcare workers directly or indirectly with PLWHIV/HCV. It should also be noted that the workshop in Smithers included the most Indigenous peoples whereas the FGD in Fort St. John included the least. That being said, it is unclear what factors affected attendance at the FGDs, especially given when and where they occurred. That being said, it is important to not jump to conclusions. For example, while statements were made in Fort St. John regarding how far away the nearest reserves were, many of the Indigenous attendees at the Smithers FGD traveled just as far, if not further, to attend[5]. As such, it is possible that the distance is more conceptual than literal, but it is hard to tell.

Prior to engaging in a guided discussion during all 3 FGDs, a short presentation was made by Dr. Sims and Lansall summarized the literature review they conducted into four topics: history, intersectionality, barriers, and recommendations. With regard to barriers, we grouped the barriers identified in the literature review into general barriers, geography, and relationships. We also talked about how they can be interconnected. With regard to recommendations we grouped them into general recommendations, recommendations related to cultural safety/cultural competency, and holistic recommendations.

Once the presentation was done, we opened things up to a guided discussion. To help guide the discussion we displayed a number of prompting questions, although it should be noted that the discussion only loosely corresponded to them and as a result, while the following sections will summarize what was said at these FGDs, it will not, aside from the first section, be based on the questions.

5 For example, according to Google Maps, Doig River No. 206 is 59.2 km away from Fort St. John, while Blueberry River No. 205 is 68 km away. Gitanmaax No. 1 on the other hand is 75.3 km away from Smithers, while Burns Lake No. 18 is 143 km away.

Who Is Doing the Work? How Is It Being Delivered

Based on the discussion that followed from these prompting questions it would appear that participants in all three FGDs agree that when it comes to HIV/AIDS/HCV healthcare that the service is holistic or at least should be holistic. Indeed, it was stated that everyone was doing the work, even if they themselves were not aware of it. This statement was said to be just as true for FSPs as it was for higher level administrators and officials.

One problem that was identified, though, was that at these higher levels policies and procedures could still be quite colonial in nature and/or that individuals and groups at these higher levels could still put forward policies and procedures for individuals at lower levels that were quite colonial. In this latter situation, the existence of these policies and procedures could make it hard to deliver service in any other way. Even when service could be delivered in a good way, the paperwork could at times make frontline workers feel less like nurses or other healthcare workers, and more like accountants.

Another problem identified was funding. More than one participant noted that funding simply was not available for many things. This problem took two forms: the obvious lack of monetary resources and less obvious lack of time. While in a certain sense everyone could always use more time, in this instance it was clear that a lack of funding contributed to a smaller workforce, which in turn meant those in the workforce were busier and therefore had less time when it came to do the work they needed to do. Of note, none of the participants mentioned issues with funding connected to federalism or constitutional jurisdiction. Whether this reflected the successful implementation of policies like Jordan's principle is unsure though.

Compounding the problem was the matter of transportation. More than one participant – particularly at the Fort St. John and Smithers FGDs – noted that patient transportation was an issue. It could result in delays in care and contribute to an unequal and/or increased workload if individuals missed appointments or arrived late. With regard to confidentiality, it could also be difficult to keep things private if an individual was dependent on someone else for their transportation.

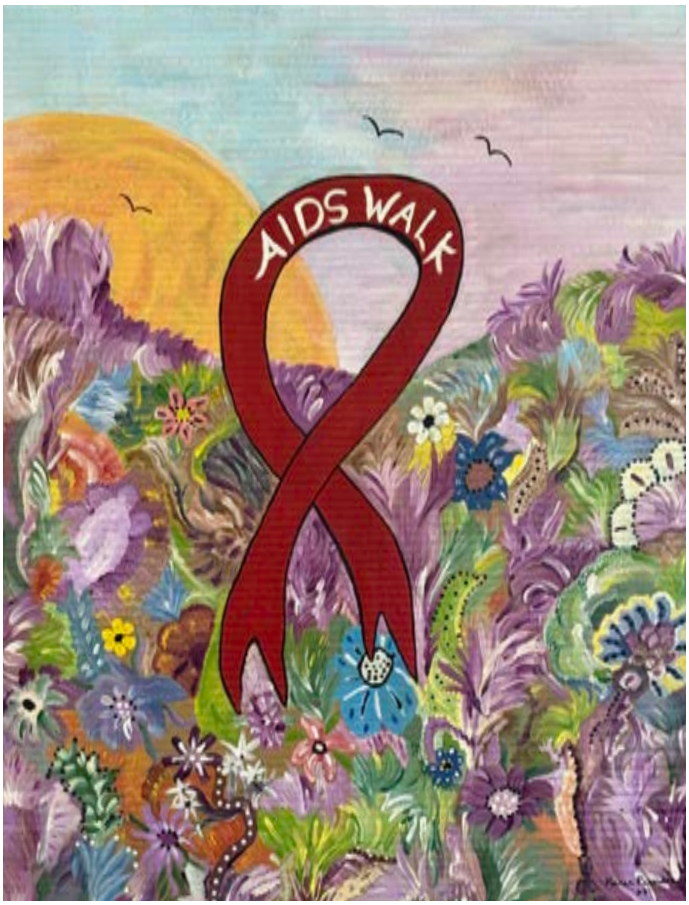
Related to the issue of funding was programming in general and whether it was happening and/or being updated. In the view of one participant at the Prince George FGD, HIV/AIDS/HCV was no longer a primary health concern and as a result, things have not really changed in the last ten to twenty years. It is important to point out here that we kept the surveys and FGD separate, so it is interesting to consider this concern in light of the surveys indicating that the rate of infection had not dropped in recent years.

Cultural Safety/Cultural Competency

This sense of being overworked came up a number of times when discussing educational work. As with the surveys conducted with PLWHIV/HCV there was a general recognition that cultural safety/cultural competency training was important. It was also clear that there was great diversity when it came to community members, their culture, and their views regarding existing care and how it should change. Of note, although the discussion was not limited to Smithers FGD, just like in the surveys, participants at the workshop were keen to point out the importance to make sure things are not only culturally relevant, but also culturally specific.

Related to this recognition was an awareness that in a best case scenario there was a cultural divide between Indigenous and non-Indigenous individuals and in a worst case scenario outright racism. It should be noted that despite the awareness of the continued racism by some participants that in a few instances, racist views regarding Indigenous peoples were presented as unpleasant truths and/or hard

facts. Rather than mention these comments as proof positive that those saying them are racist, we are mentioning it because more than one participant talked about how racist and colonial views are embedded in the system itself. Indeed, they could be said to be examples of stereotypes about Indigenous peoples that healthcare workers simply took for granted. The whole situation is no doubt affected by confirmation bias in that a limited number of examples could be used to prove the stereotype true. It is als0 possible it is an example of the Dunning-Kruger effect in that actual expertise on Indigenous peoples may not match perceived and/or claimed expertise.



Karen Resends, 2025

Given the workload of many frontline staff and workers, however, the question emerged of how they would find time to take this training, especially when some of the pressure was from outside individuals and organizations. This conundrum appears to have resulted in two additional issues. As noted by faculty members at the College of New Caledonia (CNC) and the University of Northern British Columbia (UNBC) who offer cultural safety/cultural competency, staff were at times hesitant to take the training, but not necessarily due to outright opposition, but rather because they do not think they have the time to fit it in. Even here, though, these concerns were both about finding literal time to fit training into their busy schedule and receiving training that was easy to fit into their practice.

Related to difficulties fitting cultural safety/cultural competency in, were concerns about having time and resources to properly honour people sharing their knowledge. Reflecting the holistic nature of culturally appropriate care, this concern was not about HIV/AIDS/HCV care per se, but rather about cultural knowledge in general. Indeed, many of the responses we received during the FGDs were about care in general. There were some factors that helped in this situation, including being from the culture to being a person of colour, that are impossible to implement if a healthcare worker was not born with it. Still, as community members noted, the biggest indicators of success when it came to interacting with people was not an expert who exuded knowledge, but an authentic, consistent relationship with someone who was informed, but also willing to learn while they shared information.

The concerns with making sure people were properly honoured was also not just about the individual being honoured. Rather it was also about training the new healthcare workers, sometimes through formal training and sometimes through examples. Indeed, it was noted that cultural safety/cultural competency needs to be built into practice and not just fit in. The same is true for trauma informed practice. Not helping the situation was that as faculty members at the CNC and the UNBC noted, their institutions can be quite unfocused and/or convoluted when it came to incorporating either. This lack of focus should not, however, be used as a reason to simplify cultural safety/cultural competency. Indeed, there was a consensus that it should be culturally specific.

During the Smithers workshop it was also explicitly stated by a number of participants that they wanted PLN to continue providing educational workshops in the community so that the residents would understand how people can get infected with HIV/AIDS/HCV and stigma about the diseases could be lessened. It was hoped that achieving both goals would help reduce infection rates in general.

Finally, there was evidence from participants that some healthcare workers are experiencing burnout. At the Fort St. John FGD more than one participant expressed a concern that their attempts to enforce boundaries for their own mental and physical health could be perceived negatively if not racist. At the Smithers FGD a number of participants went on to speak about the many years of historical services they had provided in the Northwest region, but also noted they were tired of working against the system to help alleviate people's suffering and just tired in general. Inversely, however, other participants noted the issue of healthcare workers only working in an area for a limited amount of time and/or finding new work if they found the situation to be undesirable. Indeed, it would appear that these issues surrounding workload and burnout may explain why the patients who responded in the surveys identified actually getting care was one of the major barriers. In other words it appears it is not about healthcare workers not wanting to give care, but rather having a hard time when it comes to doing their job given the resources and support they have.

Rapport

One of the reasons for cultural safety is rapport. As was noted by numerous participants, clients have the right to not disclose information. And while there is not necessarily a causal connection between the two things, as noted by not only the participants, but also the literature and clients, their willingness to share information is related to the level of trust they have. As the participants in the FGDs explained it can be connected to things like their living conditions – both real and perceived – any sort of stigma clients might have encountered, and past experiences of the individual, their relatives and community when it came to interacting with the healthcare system or outsiders in general. And if either are continuing practices from the past that can be described as colonial that can create this problem. Further complicating the matter is the importance of client confidentiality. Sharing information is important to forming a rapport, but not all information can be shared. It should also be noted that trust and confidentiality were discussed in greater detail at the Prince George and Fort St. John FGDs than at the Smithers FGD. Why this difference existed is unclear, although it should be noted that when we tried to get a sense of whether or not participants knew someone with HIV/AIDS/HCV that one participant did not want to answer for fear of identifying the individuals in question.

In response to the issue of trust and stigma, many participants reported trying to meet people where they are at, providing them not only with respect, but also subtle signs of friendliness like soft smiles, friendly greetings, and other non-verbal queues. There was also an awareness among many participants of the intergenerational trauma resulting from colonialism and how this could negatively impact health. One agency in the Fort St. John area also noted that adopting policies, like allowing drop-ins as opposed to making appointments, have proved successful when it came to precarious and/or unhoused clients. In a similar vein, one First Nation in the Smithers area noted that they had developed a welcoming event to help community members return home, either literally or figuratively in the case of individuals who found themselves stigmatized as a result of people finding out their HIV/AIDS/HCV status. This development was key as a number of participants noted that one issue in the Smithers area was the unhoused population, who lacked access to palliative care or even a bed during treatment. It also potentially provided a solution to problems ranging from care being tied to being part of a more popular and/or larger family to accessing traditional medicines.

CONCLUSION

Thirty-five respondents is not really a good number for making grandiose statements about the PLWHIV/HCV experience in Northern British Columbia when it comes to HIV/AIDS/HCV, especially since one respondent stopped fairly early in the survey. That being said, from the information that we did gather it would appear the average PLWHIV/HCV served by PLN is male, has a low income and low levels of education, and is First Nations. The first characteristic stands out as the literature states most HIV/AIDS/HCV individuals are female, although it was interesting that one respondent stated they thought females could not get the disease. The same is true when it comes to the rate of infections, which do not appear to have dropped. That being said, it was good to see that many PLWHIV/HCV have a good level of knowledge and it is quite likely a big part of that is the work being done by PLN. Indeed, both respondents and participants in the workshops praised the work of the organization.

When it came to barriers to accessing care, the respondents did not necessarily challenge the barriers identified in the literature. Most important to consider and highlight that, the biggest barrier in Northern British Columbia was not transportation, cultural barriers, or domestic issues. Rather it was addiction, stigma, and actual ability to see a healthcare worker and receive care. Racism and discrimination were also identified as a problem and as a result it should come as no surprise that PLWHIV/HCV wanted better treatment, more opportunities to access healthcare and cultural safety/cultural competency training.

Curtis Paul, 2009

A similar support for cultural safety/cultural competency training was seen among the participants at the FGDs in Prince George, Fort St. John, and Smithers. Similarly, many healthcare workers described a less than desirable situation in which they wanted to do better, had a strong desire to provide culturally safe and culturally sound care, and yet had to deal with diminished resources and diminished support. It should come as no surprise therefore that a number of participants self-diagnose as experiencing burnout. Still, the general sentiment was not only a recognition that things could be better, but that the participants who attended the FGDs identified that they were doing everything they could to make things better not only now, but in the future.

Larry Parenteau, 2025

RECOMMENDATIONS

Based on the FGDs conducted in Prince George, Fort St. John, and Smithers we make the following recommendations.

First, it is clear that more work – both literal and academic – needs to be done. Steps also need to be taken to make sure that PLWHIV/HCV are not receiving treatment because of things like stigma, lack of funding, and lack of recognition that HIV/AIDS/HCV is still a problem. Related to these steps is the need to find time and money to support cultural safety/cultural competency training that is designed to not only be culturally relevant, but also easy for healthcare workers and others to incorporate it into their day to day practice. If properly implemented, this training will help create a safe space for PLWHIV/HCV in which they feel not only welcomed, but have a sense of belonging. It was even suggested by one participant that a bridging committee be formed to help deal with incidents of racism. This outcome is important as it is key for FSPs and healthcare workers to build connections at diagnosis to help ensure PLWHIV/HCV receive the care they need.

This care in turn needs to be holistic, with PLWHIV/HCV receiving support not only from healthcare workers, but also their families and social network. In the case of Indigenous PLWHIV/HCV this support group should include their nation/band, and when relevant clan, moiety, or phratry. In part the involvement of the nation(s) and other social units is a result of the reality of being an Indigenous person. It also reflects the connection to culture and among community members it was reinforced that proper health care includes connecting/reconnecting with culture and Indigenous ways of knowing/health care. This involvement could include everything from ceremony – including potentially reviving certain ceremonies – to being on the land. It was even suggested that healthcare workers could participate as part of the process of building their relationship to the community. It could also be inclusive of languages and recognition that not all Indigenous communities have the same practices, dialectics, or languages.

Holistic care must also include other organizations like friendship centres. That being said, it is important to note the holistic care does not mean a one size fits all care, and more than one participant noted the need to make care specific to the patient, with some even recommending that certain groups and workshops be limited to specific genders and/or age groups so that issues specific to the gender and/or age group in question can be addressed separate from issues specific to other genders and/or age groups. It was also recommended that opportunities be provided for one-on-one interactions and care if desired. It was even suggested this would help deal with issues regarding confidentiality and trust.

When it comes to change, it was repeatedly pointed out that change needs to start at the top, be systemic, and not superficial. The issue is not superficial or surface level. As more than one participant noted, it is currently failing not only PLWHIV/HCV, but also health care workers too. Related to this systemic approach, relationships need to be created within the institution and go beyond that so that clients can quickly engage with new healthcare workers, especially if these workers only work in an area for a short time.

As we have described in the beginning, we would like to compare our work to carving a pole of knowledge – to sharing and stories to help inform those who come behind us. We too acknowledge that this is a metaphor and it helps illustrate and carve out a picture that totem poles and knowledge takes time to build in a good way, in an intentional way. One of our most important recommendations is having the lens from the perspective of the Indigenous people who are being impacted we have to continue to offer the support at a foundational front line level so that people will want to access care. So while we take this report and build forward we keep in mind our intention is to leave a legacy that others can then add and build upon. There is much work to be done in this area and to have a strong foundation is a priority. Each community offered what they could and with the knowledge they had and from those FGDs it was evident that there needs to be more done on all levels. This is our offering to you to continue to offer to employees, PLWHIV/HCV and the higher levels of management that this illness is still here in the North and we still need the resources, the guidance to ensure that every person is seen as equal in the eyes of the health care system regardless of their cultural identity. This can lead to better outcomes and quality of life for PLWHIV/HCV and their families to be able to support and welcome them home.

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POSITIVE LIVING NORTH

Positive Living North:

No khēyoh t'sih'en t'sehena Society