Canadian Journal of Public Health (2022) 113:211–221
https://doi.org/10.17269/s41997-021-00576-7

QUALITATIVE RESEARCH

Public health moves to innocence and evasion? Graduate training programs' engagement in truth and reconciliation for Indigenous health

Heather Castleden[1] · Madilyn Darrach[2] · Jia Lin[2]

Received: 14 May 2020 / Accepted: 17 September 2021 / Published online: 16 November 2021

Abstract

Objectives Indigenous peoples are the first peoples of what is now called Canada. Canadians have benefitted from their largesse and contributions in a myriad of ways that remain unacknowledged. Indeed, ongoing colonization and systemic anti-Indigenous racism in all quarters of our society have had heinous impacts on their health and well-being. Despite this reality and multiple calls for redress, Indigenous health is still missing from the Core Competencies for Public Health in Canada, having obvious implications for public health training programs and subsequent practice. Our objective in this paper is to critically explore the reasons behind institutional apathy for reconciliation in Indigenous health.

Methods Interviews were conducted with 19 leaders in Canadian Graduate Public Health Programs (CGPHPs) at 15 universities to explore the extent to which CGPHPs engage with Canada's 2015 Truth and Reconciliation Commission's Calls to Action to address Indigenous health. We used thematic discourse analysis to illuminate the landscape and make recommendations.

Results Participants agree that Indigenous health is important, but our data reveal an uneven landscape for addressing the Calls to Action. Curriculum was limited though we noted modest positive change. On the whole, the non-Indigenous (white) professoriate still needs to educate themselves while not all see the need to do so. Many deflected responsibility. Yet anecdotally, there is desire among CGPHP students who are already unsettling themselves to see such competency in their training.

Conclusion It is a settler evasion to claim lack of expertise, to express a desire to limit the burden on Indigenous academics, and to stand on the sidelines of institutional inertia. Our findings are a call to CGPHPs to do better.

Résumé

Objectifs Les peuples autochtones sont les premiers peuples de ce qu'on appelle maintenant le Canada. Les Canadiens ont profité de leurs largesses et de leurs contributions d'une multitude de façons qui restent méconnues. Cependant, la colonisation en cours et le racisme systémique anti-autochtone dans tous les quartiers de notre société ont eu des effets odieux sur leur santé et leur bien-être. Malgré cette réalité et les multiples demandes de réparation, la santé des Autochtones est toujours absente dans les Compétences essentielles en santé publique au Canada, ce qui a des implications évidentes pour la formation en santé publique et la pratique subséquente. Notre objectif dans cet article est d'explorer de manière critique les raisons pour l'apathie institutionnelle pour la réconciliation en santé autochtone.

Méthodes Des entrevues ont été menées auprès de 19 dirigeants des Programmes de Santé Publique Tertiaire Canadiens (PSPTC) dans 15 universités afin d'explorer dans quelle mesure les PSPTC s'engagent dans les appels à l'action de la Commission de vérité et réconciliation du Canada de 2015 pour améliorer la santé des Autochtones. Nous avons utilisé l'analyse thématique du discours pour éclairer la situation actuelle et faire des recommendations.

Résultats Les participant(e)s ont convenu que la santé des Autochtones est importante, mais nos données révèlent un terrain inégal pour répondre aux appels à l'action. Leur programme était limité mais nous constatons de modestes changements positifs. Globalement, les professeur(e)s non-autochtones (blanc(he)s) doivent encore s'éduquer, alors que tous n'en voient pas la nécessité. Beaucoup ont détourné leurs responsabilités. Des preuves anecdotiques indiquent un désir parmis

Extended author information available on the last page of the article

les étudiant(e)s du PSPTC, qui sont déjà en train de se perturber de manière décoloniale, de voir telle compétence dans leur formation.

Conclusion C'est une évasion de responsabilité de la part des colons de revendiquer le manque d'expertise, d'exprimer le désir de limiter le fardeau des universitaires autochtones et de rester en marge de l'inertie institutionnelle. Nos résultats sont un appel aux PSPTC à faire mieux.

Keywords Indigenous health · Settler colonialism · Institutional reconciliation · Core competencies · Anti-Indigenous racism · Public health education · Truth and Reconciliation Calls to Action

Mots-clés Santé autochtone · colonialisme de peuplement · réconciliation institutionnelle · compétences de base · racisme anti-autochtone · éducation en santé publique · appels à l'action de la Commission de vérité et réconciliation

Introduction

The Truth and Reconciliation Commission (TRC) of Canada, which documented the impacts of Indian Residential Schools on Indigenous peoples across the country over 7 years, released its Final Report and 94 Calls to Action in 2015, the same year the National Collaborating Centre for Indigenous Health commissioned a report titled "*Review of Core Competencies for Public Health: An Aboriginal Public Health Perspective*" (Hunt, 2015). Its author, Sarah Hunt, a Kwagiulth scholar, engaged with Baba and Reading's (2012) proposal to develop curriculum competencies[1] for Indigenous public health, evaluation, and research. Her analysis called for public health professionals to address systemic determinants related to colonialism, anti-Indigenous racism, recognition of Indigenous knowledge systems, and Indigenous health governance. Indeed, calls from Indigenous health leaders, policy-makers, and researchers are continually being issued, yet Indigenous health is still missing from the Core Competencies of Public Health in Canada (see Greenwood et al. 2015; Reading et al. 2016). This has implications for hegemonic priorities in public health education (Yassi et al. 2019).

On September 28, 2020, the Calls to Action rang out again concerning the horrific and needless death of Joyce Echaquan, a 37-year-old Atikamekw mother of seven from Manawan, who died soon after broadcasting racist abuse and discriminatory neglect from her healthcare providers as she sought treatment for stomach pain. While a coroner's public inquiry has been arranged, the footage was clearly damning and all too familiar for Indigenous peoples facing anti-Indigenous racism in our healthcare system. Janet Smylie, a Métis clinician and public health researcher, posits that public health professionals must be advocates, and be responsible for engaging in difficult discussions on self-reflections of settler complicity and culpability, listening to Indigenous peoples, and challenging racist beliefs (Smylie, 2015). Smylie's position, one of many expressing the same (e.g., Lamb, 2020; Ninomiya et al. 2021; Sylvestre et al. 2019; Wylie & McConkey, 2019), the TRC Calls to Action, and our own experiences as witnesses, researchers, and educator/trainees[2] in Public Health Sciences compelled us to investigate Indigenous health/Indigenization, decolonization, and Truth and Reconciliation in graduate public health education.

In this paper, we explore the extent to which Canadian Graduate Public Health Programs (CGPHPs) engage with the TRC Calls to Action, specifically Indigenous health and reconciliation, by interviewing 19 leaders in CGPHPs at 15 universities to identify their perceived challenges to responding to the TRC's Calls to Action. We link our analysis to a broader need to implement Indigenous health, decolonization strategies, and anti-Indigenous racism training in public health education.

Truth and reconciliation in public health education

The TRC's 94 Calls to Action provide tangible "calls" for governments, institutions, and all Canadians to act upon in order to reconcile the intergenerational trauma caused by residential schooling and advance Indigenous-settler relations. These calls have guided our research, especially Calls #18–24 regarding health (see Table 1). We believe CGPHPs are valuable and capable actors in answering these Calls

[1] Curriculum competencies are the essential knowledge, skills, and attitudes necessary for students to attain/demonstrate for the practice of public health (Government of Canada, 2019).

[2] Author1: white settler scholar working in solidarity with Indigenous peoples for 20 years at the nexus of health and the environment and former faculty member in the Department of Public Health Sciences at Queen's University. Author2: white settler educated in political science and public health at Queen's University. Author3: settler of Asian descent educated in public health at Queen's University.

Table 1 Truth and Reconciliation Commission of Canada (2015). Calls to Action #18–24 (P 2–3)

Calls to Action: Health	
Call 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 healthcare rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.
Call 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 long-term 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.
Call 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.
Call 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.
Call 22	We call upon those who can effect change within the Canadian healthcare 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.
Call 23	We call upon all levels of government to: (i) increase the number of Aboriginal professionals working in the healthcare field; (ii) ensure the retention of Aboriginal healthcare providers in Aboriginal communities; (iii) provide cultural competency training for all healthcare professionals.
Call 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.

through establishing competencies on Indigenous health and addressing anti-Indigenous racism.

Through Calls 18 and 19, the field of public health has both an explicit and implicit role in recognizing and addressing the colonial roots of health inequities. Systemic forces are acknowledged within the Social Determinants of Health (SDOH) framework; however, some (e.g., Blacker, 2014; McPhail-Bell et al. 2013) have pointed out that the neoliberal and neocolonial tendencies of public health and health promotion focus on individual behaviour change, thus constructing and blaming the victim. This process absolves settler responsibility, and therefore, it is imperative for CGPHPs to educate their students on the manifestations of political forces (i.e., settler colonialism, structural, systemic, and individual anti-Indigenous racism) and social processes before entering the field (see Gaudry & Lorenz, 2018; Ninomiya et al. 2021; Sylvestre et al. 2019; Tuck & Yang, 2012; Yassi et al. 2019).

In terms of Indigenous health, many students in the health professions learn the statistics about higher rates of chronic and infectious disease, mental illness, substance use, and the effects of colonial strategies like residential schooling (Wilk et al. 2017). But, as Senator Murray Sinclair has noted, while non-Indigenous Canadian children were learning these stereotypes and racism in the classroom, Indigenous children were removed from families and put in harsh and abusive environments and stripped of language and culture. This distinction and divide goes to the heart of racism in policy in Canada and its impacts on life expectancy and health status. Thus, the connection of poor/limited education of public health experts in Canada's history of treatment of Indigenous peoples until and including the present day still needs to be made. For example, these statistics are not typically measured or analyzed using Indigenous ways of knowing or methodologies (King et al. 2009; Reading & Wien, 2009). Nevertheless, this is the picture painted for most CGPHP students, as we illustrate in our findings. This process of "asterisking/at-risking" (see Tuck & Yang, 2012) keeps Indigenous peoples in the footnotes and at the margins. Indeed, this minoritization is another working of settler colonialism and a function of racist, colonial education.

In Australia, Coombe et al. (2019) studied the integration of Indigenous public health competencies in Master of Public Health programs across the country and found that necessary curricular reform was lacking. In Canada, Baba and Reading (2012) proposed the Competencies for Indigenous Public Health, Evaluation and Research (CIPHER) approach, which would seek to improve cultural safety, implement standardized training, and formally integrate Indigenous perspectives of health into education, practice, and governance through Indigenous-led Core Competency development. Yet, there seems to be a lack of commitment from the Public Health Agency of Canada (PHAC) in operationalizing such competencies, or to make the broader, more substantive changes required for advancing various kinds of

indigenization, which trickles down to the institutions delivering professional public health training programs.

Beyond competencies, it is increasingly clear that anti-Indigenous racism is a deadly systemic determinant of health that cannot be ignored in public health curriculum. TRC Call 22 calls upon those with power in the healthcare system to recognize the value of Indigenous healing practices, and Call 24 calls on all medical and nursing schools to implement a course on Indigenous health, focussing on skill-building in "intercultural competency, conflict resolution, human rights, and anti-racism" (p. 3). CGPHPs can address these calls by building on the seven "Core Competencies" identified by PHAC, by utilizing a strengths-based lens and implementing anti-racism training. According to Hunt (2015), the PHAC Core Competency "Diversity and Inclusion" is relatively generic and unclear with respect to cultural competency and social determinants, and would benefit from a focus on cultural safety. This is an example of contemporary public health assuming that disciplinary grounding in equity is enough without a focus on dismantling anti-Indigenous racist skills and practice (Ndumbe-Eyoh, 2020). Furthermore, the PHAC competencies only call for *recognition* of social determinants, rather than a commitment to *transformation*.

We do not have to accept the status quo of anti-Indigenous racism, exclusion, erasure, evasion, inequity, and "settler moves to innocence" (Tuck & Yang, 2012, p. 1). But resistance among faculty and students to talk about racism is already well documented (Sylvestre et al. 2019). And racism, as a population-level cause of morbidity and mortality, cannot be ignored. Introducing an anti-Indigenous racism framework to students of public health can assist with the development of reflexive practice, socio-political education, structural analysis, systems-change approaches, and more (Breny, 2020; Came & Griffith, 2018). In addition to cultural competencies, anti-Indigenous racism education can help CGPHPs answer the TRC's Calls to Action by shifting the focus to action rather than mere acknowledgement (Ninomiya et al. 2021; Sylvestre et al. 2019). Our goal, to identify, understand, and explain the reasons behind the well-documented institutional sluggishness to build competency for action on Indigenous health in CGPHPs (see Ahuriri-Driscoll et al. 2021; Ninomiya et al. 2021; Reid et al. 2019), aligns with Call to Action #53: to evaluate post-apology progress on reconciliation across all sectors of Canadian society.

Methods

In summer 2018, Castleden led a desktop scan of 25 CGPHPs identified through the Public Health Agency of Canada (PHAC, 2017). With two assistants, they examined publicly accessible materials from university websites to determine (1) available courses on Indigenous health, (2) commitments to Indigenous health research, (3) Indigenous admissions policies, (4) the extent of self-identifying Indigenous faculty, and (5) formal TRC responses at the university, faculty, and program levels. This gave some scope to understand the extent of CGPHP engagement with Indigenous health, recognizing that some of these actions may have occurred before, and some after, the TRC released its report. In summer 2019, we began participant recruitment after receiving ethics approval from the General Research Ethics Board at Queen's University and employed purposive and snowball sampling to recruit Department Heads.

In the first round of recruitment, we approached 26 Department Heads (or similarly named leaders) from 25 universities. Of those contacted, 8 agreed to participate, 7 referred us to representatives who also said yes, and 11 did not respond to our invitation (we ceased contact after the third attempt). During the interviews with the 15 individuals, we received 5 additional snowball-recruited participants. Darrach and Lin conducted 20 interviews, but the final number included in this analysis is 19 (13 females and 6 males) as one withdrew citing discomfort with speaking "for or about" their Indigenous colleagues. Not every school studied in the desktop scan participated in the interview phase.

Semi-structured phone interviews lasted 45 to 110 min. Interviews were audio-recorded and transcribed verbatim; field notes were taken following each interview and were brought into team discussions. Participants were offered the opportunity to review their transcripts and quotations in context to enhance the credibility of the findings (Tracy, 2010). Twelve participants elected to review their transcripts, and twelve (not all the same) elected to review their quotations. No contestations to our analysis were raised.

Data analysis began with a round of open exploratory coding to identify concepts present in the data. We carried out this work through the lens of anti-Indigenous racism, both individually and then collaboratively, by reading the transcripts to identify significant statements or concepts. We then turned to focused coding, where key statements and concepts were mapped to facilitate inductive coding. We piloted the draft codebook by independently coding the same transcripts and comparing results to ensure the stability of the codes. The revised codebook was then used to analyze the discourse of each transcript. Data were entered into NVivo software to facilitate data organization. Codes were reviewed, summarized, and analyzed to result in a set of descriptive and thematic findings.

Findings

Our findings are organized to highlight CGPHP leaders' (or their designated representatives) perceptions of their programs' engagement with Indigenous health and the

TRC Calls to Action, as well as the perceived challenges to addressing both. We do not identify interview participants or institutions; where quotations are present, we refer to individuals as "P-#." We also note that the focus of this article is less upon the desktop scan and more on the qualitative findings related to the interviews, which explains our brevity regarding this aspect below. Finally, we stress that commitments made by universities in the form of their missions, visions, and strategic plans and the (in)actions of individual professors or departmental administrators should be differentiated. This is an important distinguishing note because "the institution" is often a major stumbling block with respect to addressing anti-Indigenous racism. Such apathy permits "passing the buck" between faculty and institutions, which is then reproduced in healthcare settings. "Responsibility" becomes repeatedly tabled and such "moves to innocence" (Tuck & Yang, 2012) demands closer scrutiny and exposure.

The CGPHP landscape

During the desktop scan, we found all 25 institutions offering CGPHPs had published university-wide responses to the TRC Calls to Action. Sixteen (64%) health faculties and five (20%) public health programs within these institutions also released a response to the TRC. Ten (40%) of the 25 CGPHPs offered Indigenous health courses in their curricula; only three were required as part of specializations in Indigenous health. Ten (40%) programs had faculty who identified as having expertise in Indigenous health. Two (8%) programs encouraged Indigenous applications on their websites and eight (35%) employed self-identifying Indigenous faculty. These Indigenous scholars made up only 2% of all core, adjunct, assistant, and cross-appointed CGPHP faculty members (whereas Indigenous peoples represent nearly 5% of the Canadian population).

When participants were asked about the importance of teaching about Indigenous health in their programs, we learned that for the most part, content was often scattered among courses. One participant described: "It's not like an organized way… It's just now we recognize, and when it looks like you can cover, we do" (P-8). Some participants referred to general core courses where students are introduced to the links among history, health disparities, and research ethics.[3] For example, another participant noted: "I think colleagues occasionally will introduce [Indigenous health in] the Social Determinants of Health [course] […] It's really an introductory framing course […] where you're able to read these issues, and help people see the wider picture within which they'll do their work" (P-15). However, most participants did not refer to reflexive practice, strengths-based teaching, or Indigenous methodologies within these general core courses, despite some mentioning the need. Worth noting, one participant acknowledged that, "Schools of Public Health, in general, are thin on the ground with respect to… well-grounded, critically, theoretically-informed analyses of the structural drivers of inequality" (P-16).

In many cases, Indigenous health was reduced to examples and cases: "[Indigenous health will] be used as an example of you know when you're developing examples and case studies and… that's something that's very easy to integrate" (P-14). But there were also examples of engagement beyond "textbook examples." But in other instances, participants discussed bringing in Indigenous Elders and knowledge keepers to teach classes. One participant said:

> "We felt that having Indigenous messages and Indigenous wisdom woven through our courses wasn't enough, and we were very fearful that by having one session or part of a session on Indigenous approaches, in each of our courses, sort of made it look like, 'oh yeah we can teach you everything you need to know about Indigenous health research in an hour and a half', which wasn't the case. So, we decided that there needed to be a place where that was the sole focus" (P-6).

During the interviews, participants were asked to grade their CGPHPs' efforts regarding prioritizing Indigenous health within their curricula. Grades were given as follows (grade, followed by number of participants assigning that grade): A, 2 participants; B, 10 participants; C, 3 participants. Many participants referred to limited resources and capacity, and rated their efforts relative to other institutions: "if I gave a grade based on comparisons with other institutions in Canada, I'd give it an A. I don't think we are where we need to be, but I think we're... fairly well placed in comparison to our peers" (P-6). Yet another participant said: "I think currently we're, we're well ahead of the curve so to speak because we began early in our curriculum to incorporate sort of an Indigenous component... Those were prior to any… reconciliation reports" (P-20). Interestingly, four participants declined to provide a grade and others questioned whether Indigenous health should even be a priority within public health education.

Having an understanding of the varied CGPHP landscape, we turn to the perceived challenges to supporting engagement that would link public health education to colonization, anti-Indigenous racism, and Indigenous health.

[3] Yassi et al. (2019) note that only 25% of the programs they surveyed had a "required course related to social theory or social determinants of health."

Perceived challenges

According to our data, the main challenges to operationalizing Indigenous health in CGPHP curricula, particularly for the many who were not offering such content, were: a lack of expertise, too few Indigenous scholars in the academy, and (what we interpret as instances of Tuck and Yang's (2012) "settler moves to innocence"—which is essentially no movement at all) deflections of responsibility and inertia due to perceived structural barriers of the academy.

Discomfort and lack of expertise lead to inertia

On the whole, participants wanted to "do the right thing" (P-16), but expressed uncertainty and hesitancy. When asked, for example, if there were barriers in designing an Indigenous health course, several participants stated that addressing Indigenous health was difficult because their current faculty did not receive training in this area themselves. One participant said: "I think it's reasonable to say that no faculty members currently in this department […] would have had any training in Indigenous health. […] It's just not what they were taught" (P-1). This was explained in other words by another participant: "So, if individuals don't have any knowledge, uh, don't have any background, their ability to bring up examples and bring up cases, uh, then becomes much more limited" (P-5).

Some participants spoke about how teaching Indigenous health and ways of knowing was incommensurable with western epistemology: "How [Indigenous health] should be introduced… it's not like, it's not like one of those additional, typical, academic topic area you have to have to cover […] I think if you are very serious about incorporating Indigenous perspectives, you might have to be prepared to discuss that and how that contradicts with the, the way we formulate our knowledge structure" (P-8). Still another participant said: "One of the issues is […] how to engage with healing practices and traditions and, and cultural diversity in a respectful and sensitive way without romanticizing everything" (P-9).

Participants reflected on their own non-Indigeneity, expressing reasonable concern that because they were not Indigenous, they might "get it wrong" (P-4): "Yeah, a hundred percent. I am a non-Indigenous person, that's a very big issue" (P-4). This was illustrated again by another participant:

> "Speaking for myself, knowing that, you know, I'm not an Indigenous person, how do I, in my role, what does it look like to appropriately answer these Calls to Action, right? Um, that's, that's one big thing. Like, I, I know that I don't know, and so I know that I need to partner with, and so the question always becomes 'who am I partnering with, and what is, what is right and where do I start?'... It'd be great to have, you know, a guidebook to say, this is what you should know in the MPH program, this is what you should do" (P-13).

This participant was, in essence, echoing the need to develop Core Competencies in Indigenous public health (from Baba & Reading, 2012 and Hunt, 2015).

As one participant noted, taking individual and collective responsibility to learn about settler responsibility, as unsettling and uncomfortable as it may be, was necessary: "Ultimately we have to do our own, we have to take charge for our own learning on these issues, but figuring out how to do that in a way that… you know um, dances appropriately around these issues of cultural appropriation is, I think, an ongoing challenge for people" (P-16).

The expertise we have is stretched thin

Where there were Indigenous faculty present in a program, those interviewed identified challenges with workload as well as who should be doing the work. For example, one participant noted:

> "I've heard from my colleagues […] who are Indigenous, 'we've got enough to do, like we're so stretched already, you're going to have to figure out how to do this.' So, it's that sense of what is respectful, inviting you to have your own voice, and not speaking for you but at the same time, making sure the content is covered when there's not, when it's—if I don't teach it, it's not going to get taught" (P-4).

With the limited available time from Indigenous professors and a lack of expertise from non-Indigenous faculty members, some participants reflected on the struggle to find "bodies" to teach such content: "We are a small department, and, and, we don't really have enough bodies to teach everything that we should be teaching, […] So, it's a perennial frustration for me, is finding people to teach the courses which in a perfect world we would be teaching" (P-1). Thus, at least in this case, the leadership is determining what is a priority (and what is not, i.e., Indigenous health).

In a similar vein, another participant said: "One [challenge] is, um, how do you not be kind of trite and tokenistic about this? Um, without anybody saying, 'well, we don't want to be tokenistic so we're not going to do anything,' which of course is not an acceptable response" (P-9). And still others made similar explanations: "It's hard also to offer a course if there's just one professor whose kind of an expert in that area like if they go on sabbatical like in terms of planning" (P-14).

It's a "hot potato" topic

Some participants perceived that there was a lack of interest in engaging in critical reflexivity or settler responsibility in their program: "My colleagues don't talk about, we don't often talk about ourselves as settlers and as benefiting from privilege that meant other people were directly harmed. I don't think we have those conversations very frequently" (P-19). This participant went on to say: "I don't see very many of my colleagues at those conversations, but certainly I think many of them care […] I don't think they're involved in those groups at least that I can tell" (P-19).

Another participant shared that "It's kind of like people are like generally 'okay yeah that's important we should do that' but then how much actually gets taken up is another question and I don't know actually it's been more of a suggestion, it's been more suggestions of what people can do individually in their own, you know, in their own courses" (P-18). In essence, there was no talk or only some talk, and in most cases very little action that participants were able to get excited about.

Particularly noteworthy, another participant reflected upon the ways in which epistemological dominance rooted in western approaches can, by simply ignoring the absence of Indigenous health, anti-Indigenous racism, and the Calls to Action, allow the status quo to remain:

> "There is of course pushback, and there's resistance, and there's people who are wedded to the dominant view. And resistant in ways that they don't often vocalize. Because you know, when you're the dominant perspective, you don't necessarily have to make your resistance visible. […] At some point we either take [Indigenous health] on board seriously and really use it, to reflexively overhaul and revolutionize… our own work, or you know, it just becomes another exercise and politically correct social inclusion" (P-16).

When participants were asked about how their department, faculty, and institution were responding to the TRC Calls to Action on Indigenous health, many acknowledged the need to respond, but were stymied with what actions were to be taken and who was going to take them—much like a game of "hot potato." For example, one participant remarked: "Who's going to take initiative? […] If someone were to take it on as an initiative, it would happen. I don't think there would be any challenges to people being on board or participating. It's just a matter of putting it at the top of the list" (P-3). Another noted: "People tend to be focused on what they know, and that doesn't mean they're opposed to it, they just—it's just not part of their world" (P-5).

Still others recognized the relevance of responding to the TRC but questioned the priority within their institution: "I'm willing to give you, to concede that it's relevant. But the bigger issue is what kind of a priority it is, right? […] So, to open that up and to say, actually there are… social accountabilities, um… It's, it's really quite a radical, um, challenge that either never gets understood or gets ignored, or, or, or whatever. So, I think it's extraordinarily difficult to, to re-stitch conversations that have been happening for a very long time about what the priorities are" (P-15).

While not a common sentiment among participants, there was explicit resistance to seeing Indigenous health as a priority: "There is a[n] assumption that we should. […] And then I…don't know, um, whether every department of our kind, should have [an Indigenous health course in the curriculum]" (P-8).

Blame the bureaucracy

Participants rationalized that even "taking charge" would become difficult when institutional bureaucracy gets in the way. For example, one participant noted that "When you want to change a program and change the required courses for a program, it has to go through many different steps, in terms of being […] approved across the university. So, that actually is a challenge because you have to jump through a lot of hoops in order to secure whatever you want to change" (P-1). Other participants reflected on how budgets determined what changes were feasible: "We just have no money to pay them. (Laughs) So we can't ask people to do full courses" (P-14). A lack of student demand was also cited as a bureaucracy barrier: "It comes down to sort of, uh, demand. You know, we work with our students to try and understand what future needs are, uh, of students" (P-5).

One participant articulated that upstream change requires time: "It's going to take time to... have higher graduation rates from high schools in Indigenous communities, to have those kids understand that a university education is accessible to them, is achievable by them. […] And that will then evolve into more people making it into university, hopefully more making it into their Masters, PhD, which will lead to new [Indigenous] faculty down the road. But time is needed" (P-6).

While CGPHPs were largely effuse in articulating the public health field's responsibility to engage with Indigenous health, matching actions were not strategic and in many cases were not actions at all. Our data show the many ways in which participants engaged in "a set of evasions" or "settler moves to innocence" that problematically attempt to reconcile settler guilt and complicity and rescue settler futurity (Tuck & Yang, 2012, p. 1). Yet many participants (though not all) acknowledged how their efforts were insufficient. For the most part,

there was a lack of meaningful interrogation of their privilege. This deflection of responsibility and inertia due to perceived structural barriers of the academy (i.e., apathy) points to a complex network of sociological relations and histories we discuss below.

Discussion

The current CGPHP landscape is scattered, with some Department Heads reporting little to no engagement with Indigenous health and others reporting a range of courses taught by Indigenous faculty. In many cases, participants pointed to Indigenous health teachings through examples and cases to highlight the systematic nature of SDOH causing health inequities, but oftentimes without interrogating beyond disparities. Greenwood et al. (2015) argue that in many instances, the SDOH model favoured by health researchers and practitioners is insufficient to recognize colonialism as a structural or upstream cause of illness and inequity for Indigenous peoples. Indeed, through wilful or passive exclusion and mischaracterization of Indigenous health from and within CGPHPs, focussing on deficits rather than strengths reinforces discriminatory attitudes and insufficient knowledge, as well as a lack of skills to address structural, systemic, and individual anti-Indigenous racism. This all negatively impacts Indigenous health and well-being (Breny, 2020; Came & Griffith, 2018).

As mentioned, we asked participants to grade their institutional efforts in prioritizing Indigenous health within their curricula. More than one participant responded that they believed their institution was "ahead of the curve." This response begs the question: What is the curve? What does it mean to be "doing" Indigenous health "well" in CGPHPs? For example, one participant noted that even though their educational content had undergone substantive and meaningful transformation to address Indigenous health, systemic racism within the institution still made this progress difficult. Gaudry and Lorenz (2018) put forth treaty-based and resurgence-based decolonial indigenization as a solution to the mainly discursive turn that post-secondary indigenization has taken. The former are strategies based on collaboration with local communities and seek to affirm Indigenous worldviews and implement them through land-based learning and the re-empowerment of Indigenous sovereignty; the latter seeks to rebuild and reinvent the university in a new image (Gaudry & Lorenz, 2018).

We acknowledge that broad institutional and systemic change in the post-secondary education system may seem daunting, but transformation within public health education in tandem with the healthcare system is necessary so that Indigenous peoples do not continue to die as a result of core *incompetencies* about Indigenous health, Truth and Reconciliation, and anti-Indigenous racism. We know this is a formidable challenge; as one participant said: "Change is really an uphill battle" (P-20). In order to change, we need to identify the hill that we are climbing. The hill in this case is centuries of settler colonialism, neoliberalism, apathy, and systemic anti-Indigenous racism. Per the TRC, in order to "do" Indigenous health well, we do not simply acknowledge the hill, but bulldoze through it. Acknowledgement and awareness is not the same as action (Gaudry & Lorenz, 2018; Tuck & Yang, 2012). But how do we begin to meaningfully invert an entrenched power system in public health education?

We can begin by stopping the "asterisking/at-risking" (Tuck & Yang, 2012, pp. 22–23) of Indigenous peoples, by engaging with Indigenous ways of knowing about health, educating CGPHP students about the importance of the TRC's Calls to Action, role modelling our rejection of epistemological dominance and anti-Indigenous attitudes, and showcasing areas of Indigenous strength in health, healing, and well-being. More space also needs to be made in the academy for Indigenous scholars, which requires the removal of the aforementioned evasions and perceived and actual barriers. It also means changing policies and bureaucracies to foster Indigenous self-determination. Multiple participants noted the overburdening of the Indigenous professoriate when it came to incorporating Indigenous content or speaking on Indigenous issues. While attempts to incorporate Indigenous health content may be "good intentions," by overburdening Indigenous professors, they become a resource whose intelligence and experience are extracted, which is a deeply neocolonial process (de Leeuw et al. 2013).

For the non-Indigenous professoriate, particularly those who are white and unfamiliar with settler colonialism and systemic racism, they must undergo the process of unlearning/learning/relearning (Koleszar-Green, 2019). We saw a significant amount of uncertainty from participants around foregrounding Indigenous health in their curriculum. First, non-Indigenous educators and administrators must be comfortable with being uncomfortable, or as Regan (2010) puts it, being "unsettled," and institutions need to support this practice. Second, to say there is no money to hire Indigenous experts is a misnomer; there is always money at the university. It simply (and we do mean "simply") requires shifts in budget prioritization. Third, shifting responsibility, claiming a lack of knowledge or money, waiting for certain individuals, or relying on Indigenous people to take the lead and constantly educate are all problematic "settler moves to innocence" designed to absolve non-Indigenous peoples and their institutions of responsibility (Tuck & Yang, 2012).

Furthermore, leading public health organizations and PHAC need to set a precedent by integrating existing calls for indigenization and anti-racism education into the existing Core Competencies for public health. Indigenous stakeholders need to be involved in Core Competency development (Baba & Reading, 2012). Core Competencies and SDOH frameworks that are only guided by western ways of knowing about health and do not address racism and colonialism are insufficient for Indigenous health (Greenwood et al. 2015; Hunt, 2015). Adding anti-Indigenous racism as a Core Competency would help to shift the focus from content knowledge on disparities to skills-building on addressing and dismantling racism and discrimination as a cause of disease and death.

If post-secondary institutions enforced those competencies at an institutional level, it would indicate that Indigenous health and Indigenous ways of knowing are valued within the program and set an expectation for students (Hagopian et al. 2018). However, some of our participants questioned settler institutional responsibility altogether. Such mentalities stymie change towards social justice, which is a core value in public health (Edwards & Davison, 2008).

Conclusion

In making transparent CGPHPs' responses to Indigenous health in post-TRC times, we hope to illuminate the major shortcomings of public health education, and the Core Competencies that guide it. By shining light on existing (in) actions within CGPHPs, we seek to contribute a response to the TRC's Call to Action #53, which asks for research into the reconciliation progress across all sectors of Canadian society. We would be remiss if we did not reiterate that our focus in this study was on a particular scale: departmental responses to the TRC. We must stress that the macro-scale institutional commitments, in the form of their missions, visions, and strategic plans, must be differentiated (and critiqued) from the (in)actions of individual professors or departmental administrators. Regardless, in passing responsibility up the line or down the line, settler evasion becomes perpetual.

Canada is in the midst of what is likely to be remembered as the greatest public health crisis of our generation. Massive, sweeping social changes have been enforced to allow pandemic adaptation. However, last year when Indigenous peoples and their allies organized for an economic shutdown in response to the injustices in the Wet'suwet'en Yintah that had the potential to have massive health and social consequences for them, Canada's response was police raids and violence. It comes down to what colonial governments and institutions are willing to prioritize. In reality, this is about widespread denial, bureaucratic apathy and inertia; there is no movement to something (i.e., innocence), just a decision not to act, which is part and parcel of how systemic racism works.

We know what happens when justice and equity are held as empty statements—systemic racism remains and people die. In addition to the TRC's Calls to Action, this is our own unapologetic call to action to our colleagues and peers in public health and public health education: we cannot allow our institutions, networks, and curricula to remain as they are. We must recognize systemic anti-Indigenous racism for what it is, and make a commitment to address and dismantle the violence of its and our inaction, and we must insist that Indigenous knowledge and leadership are essential to this work.

Contributions to knowledge

What does this study add to existing knowledge?

- This study contributes novel findings evaluating the post-apology progress on reconciliation in Canada, specifically progress on the TRC Calls to Action #18–24 regarding Indigenous health.
- Furthermore, this study describes the scope of anti-Indigenous racism in academic institutions and the lack of Indigenous health training available for current public health trainees and future practitioners.

What are the key implications of this study for public health interventions, practice, or policy?

- The urgent need for the Public Health Agency of Canada to integrate indigenization and anti-Indigenous racism, including Indigenous health, in its set of Core Competencies. This must be done in collaboration with Indigenous stakeholders.
- The pressing need for meaningful engagement with Indigenous ways of knowing about health, and showcasing areas of Indigenous strength in health, healing, and well-being in public health education.
- The compelling need for critical changes in institutional/academic policies and bureaucracies to foster Indigenous self-determination and spaces in the academy for Indigenous scholars.

Author contributions The first author conceptualized and designed the study. The second and third authors collected the data, and all three authors collectively analyzed the data and prepared the manuscript. The authors gratefully acknowledge and thank the volunteer participants of this study, the anonymous peer reviewers, and the members of the HEC Lab, for their contributions to making this research possible and publishable.

Funding The first author received funding from the Canada Research Chairs program.

Declarations

Ethics approval This research was conducted in accordance to and with the approval of the Queen's University General Research Ethics Board, and is in accordance with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

Consent to participate Informed consent was obtained from all individual participants included in this study.

Consent for publication All participants have consented to having their data published.

Conflict of interest The authors declare no competing interests.

References

Ahuriri-Driscoll, A., Lee, V., & Came, H. (2021). Amplifying Indigenous voice and curriculum within the public health academy–The emergence of Indigenous sovereign leadership in public health education. *Higher Education Research & Development, 40*(1), 146–161.

Baba, L. Y., & Reading, J. L. (2012). Core competencies for Indigenous public health, evaluation and research (CIPHER): A health inequity mitigation strategy. *Canadian Journal of Nursing Research, 44*(2), 123–128.

Blacker, S. (2014). "Your DNA doesn't need to be your destiny": Colonialism, public health and the financialization of medicine. *TOPIA: Canadian Journal of Cultural Studies, 30-31*, 123–146.

Breny, J. M. (2020). Continuing the journey toward health equity: Becoming antiracist in health promotion research and practice. *Health Education & Behavior, 47*(5), 665–670.

Came, H., & Griffith, D. (2018). Tackling racism as a "wicked" public health problem: Enabling allies in anti-racism praxis. *Soc Sci Med, Feb, 199*, 181–188.

Coombe, L., Lee, V., & Robinson, P. (2019). Educating for Indigenous public health competence–How do we stack up in Australia? *Australian and New Zealand Journal of Public Health, 43*(2), 143–148.

de Leeuw, S., Greenwood, M., & Lindsay, N. (2013). Troubling good intentions. *Settler Colonial Studies, 3*(3-4), 381–394.

Edwards, N. C., & Davison, C. M. (2008). Social justice and core competencies for public health. *Canadian Journal of Public Health, 99*(2), 130–132.

Gaudry, A., & Lorenz, D. (2018). Indigenization as inclusion, reconciliation, and decolonization: Navigating the different visions for indigenizing the Canadian Academy. *AlterNative: An International Journal of Indigenous Peoples, 14*(3), 218–227.

Government of Canada. (2019). Core Competencies for Public Health in Canada. Retrieved on March 23, 2021 from https://www.canada.ca/en/public-health/services/public-health-practice/skills-online/core-competencies-public-health-canada.html.

Greenwood, M., de Leeuw, S., Lindsay, N. M., & Reading, C. (Eds.). (2015). *Determinants of Indigenous peoples' health in Canada: Beyond the social*. Canadian Scholars Press.

Hagopian, A., West, K. M., Ornelas, I. J., Hart, A. N., Hagedorn, J., & Spigner, C. (2018). Adopting an anti-racism public health curriculum competency: The University of Washington experience. *Public Health Reports, 133*(4), 507–513.

Hunt, S. (2015). *Review of core competencies for public health: An Aboriginal public health perspective*. National Collaborating Centre for Aboriginal Health. Resource document https://www.nccih.ca/. Accessed April 28, 2020.

King, M., Smith, A., & Gracey, M., Prof. (2009). Indigenous health part 2: The underlying causes of the health gap. *The Lancet, 374*(9683), 76-85.

Koleszar-Green, R. (2019). "What can I do?": Teaching Indigenous content in an era of reconciliation. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice, 7*(1), 68–81.

Lamb, P. (2020). "We need to do public health differently in this community": A reflexive analysis of participatory video, affective relations, and the policy process. *Agenda*, 1-12.

McPhail-Bell, K., Fredericks, B., & Brough, M. (2013). Beyond the accolades: A postcolonial critique of the foundations of the Ottawa Charter. *Global Health Promotion, 20*(2), 22–29.

Ndumbe-Eyoh, S. (2020). What would it take for health promotion to take structural racism seriously? *Global Health Promotion, 27*(4), 3–5.

Ninomiya, M. E. M., Ward, C., & Firestone, M. (2021). Anti-Indigenous racism training and culturally safe learning: Theory, practice, and pedagogy. *International Journal of Indigenous Health, 16*(1).

Public Health Agency of Canada. (2017). Educational Programs in Public Health. https://www.canada.ca/en/public-health/services/public-health-practice/educational-programs-public-health.html. Accessed April 23, 2020.

Reading, C. L., & Wien, F. (2009). *Health inequalities and social determinants of Aboriginal peoples' health*. National Collaborating Centre for Aboriginal Health.

Reading, J., Loppie, C., & O'Neil, J. (2016). Indigenous health systems governance. *International Journal of Health Governance, 21*(4), 222–228.

Regan, P. (2010). *Unsettling the settler within: Indian residential schools, truth telling, and reconciliation in Canada*. UBC Press.

Reid, P., Cormack, D., & Paine, S. J. (2019). Colonial histories, racism and health—The experience of Māori and Indigenous peoples. *Public Health, 172*, 119–124.

Smylie, J. (2015). Approaching reconciliation: Tips from the field/Comment aborder la réconciliation: Conseils du terrain. *Canadian Journal of Public Health, 106*(5), E261.

Sylvestre, P., Castleden, H., Denis, J., Martin, D., & Bombay, A. (2019). The tools at their fingertips: How settler colonial geographies shape medical educators' strategies for grappling with Anti-Indigenous racism. *Social Science & Medicine, 237*, 112363.

Tracy, S. J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative inquiry, 16*(10), 837–851.

Truth and Reconciliation Commission of Canada. (2015). Truth and Reconciliation Commission of Canada: Calls to Action. Winnipeg. http://www.trc.ca/. Accessed March 17, 2020.

Tuck, E., & Yang, K. W. (2012). Decolonization is not a metaphor. *Decolonization: Indigeneity, Education & Society*, *1*(1).

Wilk, P., Maltby, A., & Cooke, M. (2017). Residential schools and the effects on indigenous health and well-being in Canada-A scoping review. *Public Health Reviews, 38*(1), 8.

Wylie, L., & McConkey, S. (2019). Insiders' insight: Discrimination against Indigenous peoples through the eyes of health care professionals. *Journal of Racial and Ethnic Health Disparities, 6*(1), 37–45.

Yassi, A., Lockhart, K., Gray, P., & Hancock, T. (2019). Is public health training in Canada meeting current needs? Defrosting the paradigm freeze to respond to the post-truth era. *Critical Public Health, 29(1), 40–48.*

Authors and Affiliations

Heather Castleden[1] · Madilyn Darrach[2] · Jia Lin[2]

✉ Heather Castleden
castleden@uvic.ca

[1] School of Public Administration, University of Victoria, Victoria, BC, Canada

[2] Queen's University, Kingston, ON, Canada