As a profession-specific follow-up to the 11 B.C. Health Regulators' apology and commitment to action on Indigenous-specific racism, the College of Dietitians of B.C. (CDBC) pledges to continue reflecting, sharing information, raising awareness, and taking action on the collective need to address Indigenous-specific racism as individuals and organizations.

As part of the system, CDBC needs to be part of the solution [1] [2]. Our role is to protect the public, including Indigenous people, by regulating dietitians in a way where Indigenous voices and experiences are heard, valued, and respected. This short document addresses the history and impact of colonialism within dietetics and what CDBC is doing to contribute to a better future. It is meant to support non-Indigenous BC dietitians in their cultural safety and humility journey and create a space to have ongoing productive conversations on this topic.

The use of the term "Indigenous" within this document is meant to be inclusive of the diverse First Nations, Métis, and Inuit peoples in BC and Canada.

History and impact of substandard nutrition in residential schools

Photo 1: New classroom building at Kamloops Indian Residential School, Kamloops, British Columbia, ca. 1950

Indigenous self-governance, land rights and land use, traditional knowledge, cultural practices, and health were devastated by European colonialism [3] [4]. Furthermore, appropriated knowledge was used to build the Canadian food system on stolen land (with stolen bodies) [5]. As part of the residential school programs of Canada, numerous Indigenous children were subject to starvation and were exploited in unethical nutrition experiments that were used towards the development of the Canadian Food Guide [3] [4]. Additionally, physical, emotional, psychological, and sexual abuse in residential schools have been well documented. These types of abuses show a strong correlation with the development of substance use problems in adulthood, both in Indigenous and non-Indigenous people [6][7]. The prolonged malnutrition, as well as the lasting trauma caused by other forms of abuse, has negatively impacted the growth and health of residential school survivors and their descendants, as well as caused intergenerational trauma that impacts peoples' relationships with food [4]. It is clear that sustained exposure to caloric restriction, such as that experienced by children at Canada's residential schools, produced a multitude of biological sequelae such as height stunting and metabolic changes that lead to greater risk of chronic diseases. This has resulted in elevated incidence of stillborn and prematurely born babies and infants born with low birthweight as this malnourished generation matured into adulthood [4]. The consequences of these circumstances at birth, in addition to insulin resistance, increased risk of childhood diabetes development, and risk of other chronic diseases have impacted current and future generations [4]. Moreover, the rate of household food insecurity among Indigenous Peoples (28.2%) is more than double that of the rest of the population (12.6%) in Canada. Food insecurity and risk of chronic diseases among Indigenous Peoples were increased by the severing and dispossession of their land and by extension, their traditional foodways of hunting, fishing, harvesting, and gathering [8]. Today, systemic racial injustice remains embedded in inequitable access to education, housing, employment, healthcare, healthy and traditional food, clean water, and economic resources. Intergenerational trauma continues to impact the health and wellness of Indigenous Peoples in BC. Health issues experienced by Indigenous Peoples should never be viewed in isolation from the ramifications of colonization and the impact of the social determinants on health [9].

Barriers associated with a lack of equity, diversity, and inclusion (EDI) in the dietetics profession, with a specific focus on Indigenous people

As the regulatory body for dietitians in BC, we acknowledge that there are barriers to equitable entry into the dietetic profession and diverse representation in dietetic leadership positions today.

In Canada, systemic barriers and practices related to the dietetic profession that translate into discrimination have been identified most prominently in the last decade [2] [10]. They include, but are likely not limited to, inequitable education program admission processes, which can include a requirement of volunteer time, programs that enrol based on grades alone, a range in ability to access career counselors in high school and thus, unclear requirements for application and admission. It is also pertinent to consider the low profile that the dietetic profession may have in a marginalized and underserved population. In combination with the nature of the relatively small size of the profession, as compared to most other regulated healthcare professions, economically disadvantaged communities may not even be aware of dietitians or dietetics as a profession. In Canada, entry-to-practice dietetics education is offered as an undergraduate or graduate degree, which includes an unpaid, tuition-charging dietetic practicum of 1250 hours minimum. Dietetics degree programs are much more expensive than standard four-year degree programs, which can already prove to be cost-prohibitive for many, and are typically only offered in-person at university campuses in urban centres. Looking specifically at the dietetics program in BC, with the recognition that barriers in BC may be similar to those across the country, many Indigenous students are required to leave their community and relocate on their own since the only accredited dietetics program is at UBC's Vancouver campus. While there may be funding available to Indigenous students who are enrolled in eligible university programs (including UBC), there are many barriers to accessing funding. For example, funding may be band-specific, may only cover partial costs associated with expenses related to school, may require annual re-submission, and the application process may not be well known or accessed by the population.

White students are still 3.8 times more likely to become Registered Dietitians than students from racialized backgrounds according to a Canadian study in Manitoba [10]. This study identified two main barriers for racialized students becoming dietitians: requirement of student loans (given the unpaid practicum in Manitoba) and the stress associated with the application process. However, additional research is needed to elicit more details for Indigenous-specific representation and to determine if this study is representative of a national population. In BC, according to the latest available dietetics major alumni survey (2012-2016), 64% of graduates identified as white. The data obtained by CDBC as part of their Equity, Diversity, and Inclusion (EDI) survey [1] in the Fall 2020 was slightly higher with 77.5% of dietitians identifying as white.

Responses came from 23% of CDBC registrants where the data is considered statistically valid with a margin of error ±4.83% 19 times out of 20. Given the smaller response rate, it remains difficult to explain the variation and identify if there are additional barriers within CDBC and the profession, contributing to a lower number of licensed racialized and marginalized dietitians compared to white counterparts.

In the same survey [1], Indigenous Peoples were poorly represented among dietitians (3.0%) and in dietetic leadership roles compared to the Indigenous population of B.C. (5.9%) [11]. The UBC Dietetics program reports that 3% of its graduates in 2021 identify as Indigenous and that the coming three graduation years will consistently have 3-5% Indigenous-identifying graduates. Moreover, the In Plain Sight report documented that over half of the Indigenous health care workers who responded to the 2020 survey have experienced workplace discrimination themselves. The racism most often came from a colleague or fellow student, or from an individual in a position of authority over them. It is also pertinent to consider the effects identified by lack of diversity and representation among dietitians and in dietetic leadership, lack of education on Indigenous Peoples' history for non-Indigenous dietitians, resulting in poor cultural competence (now referred to as cultural safety) among dietitians [1] [2] [12]. The CDBC EDI survey indicated that 78% of respondents reported working with marginalized communities, yet 60% of respondents did not agree that entry-level was adequate to prepare them in delivering safe services to this diverse population. Moreover, 13% of dietitians suggested that CDBC consider a mandatory training on CSH and include it as a core competency [1]. While CDBC registrants completed their education at various education institutions at different point in time, this data still identifies the need for the CDBC to continue collaborating with education programs to support practice readiness and continuing development of these competencies. CDBC registrants also have a powerful and individual role of self-reflection to assess their own stage of readiness and make conscious efforts to learn and unlearn about bias and personal beliefs contributing to Indigenous-specific racism.

CDBC's Actions

The CDBC Board approved an action plan in response to the In Plain Sight report recommendations (page 49 of this report). The actions are aimed to support existing registrants in their CSH journeys and contributing to safe healthcare access and delivery, as well as decreasing barriers and systemic racism for Indigenous people within the healthcare system. We have published a Cultural Safety and Humility (CSH) page, in addition to an EDI page, where additional resources are listed. Annually, the CDBC also reports on its specific progress and these actions are outlined in pages 13 and 14 of the 2020/21 Annual Report and can be accessed on the CSH webpage.

Additionally, the UBC Dietetics Program and the CDBC meet regularly to share actions being taken and ways in which we can collaborate to produce meaningful results. To read more information about how the UBC dietetics program is working towards decreasing barriers, promoting enrolment, and providing a safe learning environment for Indigenous students, refer to the UBC Dietetics Equity and Anti-Racism website.

On a provincial front, B.C. Health Regulators are considering a mandatory framework for CSH education, which was requested by dietitians in the CDBC EDI survey. The B.C. College of Nurses and Midwives and the College of Physicians and Surgeons of B.C. have recently collaborated to develop standards of practice specific to CSH, which may be adapted for use by allied health, including the CDBC, over the short term, to support our registrants' CSH competencies and their subsequent goal development in this area.

Nationally, the CDBC has been engaged in presenting its action plan with other regulators. Additionally, staff of dietetic regulatory bodies across Canada meet regularly where they discuss and collaborate on CSH and EDI-related topics, such as the wording of the Integrated Competencies for Dietetic Education and Practice (ICDEP), standards of practice, and code of ethics updates.

In parallel and complement, the College is also looking at its EDI practices under the guiding principles of being intentionally inclusive, enforcing competencies, and raising awareness. Please refer to our EDI Commitment Statement for more information on our journey and the actions that we are undertaking. Moreover, for any additional questions, please refer to our EDI webpage for more information, resources, EDI and how we can apply it to the field of dietetics.

Resources

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Appendix:

Photo 1: Library and Archives of Government of Canada, *New classroom building at Kamloops Indian Residential School, Kamloops, British Columbia, ca. 1950* [online]. Available at: New classroom building at Kamloops Indian Residential School, Kamloops, British Columbia, ca. 1950 (bac-lac.gc.ca) (Accessed: 23 February 2022)