

Provincial Indigenous Leads Network (PILN) CULTURAL FRAMEWORK

PROVINCIAL INDIGENOUS LEADS NETWORK (PILN)

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Acknowledgements:

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*Wellness is a community issue, a national issue... No other [issue] so fundamentally relates to the survival of our people as that of health.*¹

Vice-Chief Tom Iron
Federation of Saskatchewan Indian Nations
Wahpeton, Saskatchewan

PREFACE

The Provincial Indigenous Leads Network (PILN) was established in 2007 as a platform to support LHINs in their efforts to address Indigenous-specific health issues. Each LHIN has a dedicated seat on the PILN whereby their Indigenous Lead is invited to participate. The PILN meet regularly to share knowledge and consultation (engagement) practices to facilitate Indigenous community's participation in guiding system changes on local and regional levels.

During the 2016 annual PILN meeting, the Indigenous Leads agreed to the development of a process framework that represents the cultural principles of Indigenous communities as a model for shared governance. The cultural framework outlined below builds upon the work being done regionally and provincially, and intended to bridge the connections between the LHINs and Indigenous communities. In doing so, the cultural framework will contribute to:

- Clarifying the roles and responsibilities of all PILN members
- Improving information and dialogue between the PILN members
- Strengthening the interaction and collaboration between members
- Enriching community engagement approaches by sharing initiatives and promising practices
- Enhancing individual and collective strategies to address the distinctive health needs of Indigenous people in Ontario
- Promoting wholistic health (physical, emotional, mental and spiritual) models of care
- Educating and reinforcing the messages of the interconnectedness of environmental and social determinants of health as significant factors that affect the wellness of Indigenous people

The cultural framework was created with Indigenous worldviews in mind and was inspired by the traditional clan systems of the Anishnawbe and Iroquois nations. Clan systems established community governance structures by setting out intricate social, political, and spiritual orderings of the entire community. Ensuring the needs of all members were equally addressed, the community was sub-divided into smaller groups otherwise known as clans. Each clan had defined internal processes for managing their affairs; whereas issues having an impact on the entire community were brought forward for consideration by all clans. When matters were brought to the entire community the focus was not on making formal decisions per se, rather, discussions tended to focus on reflecting upon all aspects and perspectives of an issue through a collective thinking process.

This document should be used as a guideline for the PILN on its communications, planning, and decision making / recommendations for working as a collective. Given that the health care system and the needs of Indigenous communities are in constant flux this document should be adapted as needed to reflect the current structure and function of the PILN.

¹ Dussault, R., Erasmus, G. (1996) Report of the Royal Commission on Aboriginal Peoples. Ottawa, Ontario: Canada Communication Group.

BACKGROUND

Although First Nation, Inuit, and Métis² peoples' health has improved, they continue to have considerably poorer health outcomes than their non-Indigenous counterparts³ including in infant and child mortality, maternal morbidity and mortality, infectious disease burdens, malnutrition and stunted growth, life expectancy, diseases and death associated with cigarette smoking, illnesses and deaths linked to misuse of alcohol and other drugs, accidents, poisonings, interpersonal violence, homicide and suicide, obesity, diabetes, hypertension, cardiovascular, and chronic renal disease (lifestyle diseases), and diseases caused by environmental contamination (i.e. heavy metals, industrial gases and effluent wastes).⁴

Indigenous peoples' poor health status can be attributed to legislative policies including the Gradual Civilization Act, 1857, the British North America Act, 1867, the Gradual Enfranchisement Act, 1869, and the Indian Act, 1876 that permanently altered the traditional, social, spiritual, customary, and governance structures of Indigenous communities. Individually and collectively, Federal legislation and policies served three colonialist agendas: 1) land expropriation; 2) assimilation; and 3) control of Indigenous peoples. Each legislative enactment undertaken by the Government was systematically and strategically crafted to remove Indigenous people from their traditional territories (and all things necessary to be self-sufficient) and subjugate them under the British Crown. Subsequently, the continued assimilationist assaults on Indigenous people persisted with the targeted assault on their children in the form of mandatory education (industrial and residential schools) and later, child welfare policies.

While these events occurred over a span of five hundred years, the impacts are longstanding and pervasive. Canada's treatment of its first peoples is a black mark on the country's otherwise stellar reputation. The outcomes cut across social determinants of health, they impact access to education, housing, food security and employment, and permeate societal systems and institutions including healthcare, child welfare and criminal justice systems.⁵ In an effort to address Indigenous peoples' poor health status it is "important to understand the impact of the historic, collective and intergenerational trauma in the lives of Indigenous people as a necessary precondition to improving health care access and service delivery."⁶

KEY MESSAGES FROM THE LITERATURE

A review of legislation, recent reports, inquiries, and directional documents of the Ministry of Health and Long Term Care (MOHLTC) was conducted as part of the cultural framework development. Each document stressed the importance of improving access to care and establishing and maintaining health

² NOTE: throughout this document reference will be made to "Indigenous" as an all-inclusive term. It is not intended to be exclusionary or offensive to the political, social, jurisdiction and sovereignty rights of the original inhabitants of North America.

³ National Collaborating Centre for Aboriginal Health. (2013). An Overview of Aboriginal Health in Canada. Prince George, BC: University of Northern British Columbia.

⁴ Ibid

⁵ Allan, B., Smylie, J. (2015). First Peoples, Second Class Treatment: The Role of Racism in the Health and Well-being of Indigenous Peoples in Canada. Toronto, ON: The Wellesley Institute.

⁶ Ibid

care systems that are more relevant and effective in meeting the health care needs of Indigenous people. Specifically, four key messages emerged from the literature:

1. Shared Control

The best way to create positive change and improved health outcomes for Indigenous people rests with communities being actively and meaningfully engaged in all decision making processes. The concept of “shared control” as it applies to Indigenous health is not new. It is rooted in goals of self-determination and basic human rights, and applies to all aspects of community life including policy, planning, programming, information management, research, governance, etc. As wards of the state, Indigenous people have historically been treated as children with no control over their own lives and futures. However, this is slowly changing as leadership continue to advocate for less government intervention and more control over their own affairs.

Engagement is meaningful when Indigenous people are “valued and equal partners.”⁷ It should be emphasized that inclusion of Indigenous people as partners is more than the act of engagement; rather it is about recognizing their “inherent rights which derive from their political, economic and social structures and from their cultures, spiritual traditions, histories and philosophies, especially their rights to their lands, territories and resources.”⁸

Building mutually supportive relationships with Indigenous communities begins with acknowledging that the “current state of Indigenous health in Canada is a direct result of previous Canadian government policies, and recognize and implement the health care rights of Indigenous people as identified in international law (United Nations Declaration of the Rights of Indigenous Peoples), constitutional law, and Treaties.”⁹

2. Health Equity

Health equity involves recognition of and responding to the unique needs of vulnerable populations (inclusive of the distinct health needs of First Nation, Metis, Inuit¹⁰), and making health care investments that are proportional to those needs. More effort must be made to address the ongoing health disparities among the Indigenous population as they continue to face the highest levels of risk (for example, there is a 10-year difference in average life expectancy between Indigenous and non-Indigenous people¹¹).

The advancement of health equity will require a significant shift in the way people think about health care and more importantly the ways in which health programs and services are designed, developed, and delivered. Undoubtedly, this shift will require a great deal of support and commitment from all levels of government and Indigenous leadership alike. Formalizing commitments to address inequities begins by establishing measureable goals to close the gaps in health outcomes. These efforts should focus on indicators like Infant mortality, maternal health, suicide, mental health, addictions, life

⁷ Ministry of Health and Long Term Care. (2015). Patients First: Action Plan for Health Care. Toronto, ON.

⁸ United Nations Department of Economic and Social Affairs. (2007). Declaration on the Rights of Indigenous Peoples. New York, NY.

⁹ National Centre for Truth and Reconciliation. (2015). Summary of the Final Report of the Truth and Reconciliation Commission of Canada. Winnipeg, MB: University of Manitoba.

¹⁰ Ibid

¹¹ Statistics Canada. (2013). Health Profile. Statistics Canada Catalogue no. 82-228-XWE. Ottawa, ON. Retrieved from: <http://www12.statcan.gc.ca/health-sante/82-228/index.cfm?Lang=E>

expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.¹²

Societal inequities exact a high personal toll in the form of disease, disability, violence, and premature death. Thus, while we may talk about Indigenous populations in general terms, we must appreciate the individual effects of the collective burden of a history of discrimination, unjust laws, and economic and political disadvantage. There are far too many Indigenous people in this country who suffer as a result of a shared history of inequality with non-Indigenous Canadians.

There is a direct correlation between health status and socio economic status, i.e., the higher your income the better your health outcomes. Enhancing health equity has achieved international political importance with endorsement by the World Health Assembly in 2009.¹³

Health disparities are intimately tied to social, economic, and political inequities, which stem from the intergenerational impacts of colonial legislation that has actively dispossessed and dislocated Indigenous communities from their families, lands, language, and culture. These inequities can be exacerbated by mainstream health care systems that remain largely rooted in Euro-Canadian standards of care¹⁴ with the expectation that all patients conform to a health care system almost exclusively designed without Indigenous input. As a result, mainstream health models have intrinsic cultural bias and often do not fully comprehend the worldviews, health needs, models of care, self-determination, and serve to sustain these inequalities.¹⁵

The LHINs in Ontario have yet to establish a common understanding of what health equity is, and therefore usage of the term as it applies to community engagement is lacking. Further, there is little consistency in terms of data collection, retrieving socio-demographic information, inclusion of health equity in health service plans, usage of the Health Equity Impact Assessment (HEIA) tool within LHINs and within HSP's. The Indigenous community is one of the most disadvantaged and marginalized sectors of the population in Ontario (and Canada), with the greatest of health inequities. It is therefore incumbent upon the PILN to raise awareness of the realities and promote health equity for Indigenous communities located across the province.

3. Cultural Inclusion

At the heart of cultural inclusion is the need to “bring to an end all forms of discrimination and oppression wherever they occur.”¹⁶ Unfortunately, many Indigenous people experience or encounter racism within the health care system in a multitude of subtle and blatant ways such as through

¹² Ibid

¹³ Welch V¹, Tugwell P, Petticrew M, de Montigny J, Ueffing E, Kristjansson B, McGowan J, Benkhalti Jandu M, Wells GA, Brand K, Smylie J. (2010). How effects on health equity are assessed in systematic reviews of interventions. Cochrane Methodology Review Group. Ottawa, ON: Centre for Global Health, Institute of Population Health, University of Ottawa.

¹⁴ Patychuk, D. (2011). Health Equity and Racialized Groups: A Literature Review. Retrieved from: https://en.healthnexus.ca/sites/en.healthnexus.ca/files/resources/healthequityracializedgrps_literature_review.pdf

¹⁵ Adelson, N. (1992). Being Alive Well: Indigenous Belief as Opposition. Retrieved from:

http://digitool.library.mcgill.ca/webclient/StreamGate?folder_id=0&dvs=1554912541991~29

¹⁶ United Nations Department of Economic and Social Affairs. (2007). Declaration on the Rights of Indigenous Peoples. New York, NY.

professional or personal biases (implicit and explicit), presumptions, prejudice, discrimination, and stereotypes.

In order to effectively respond to this issue it is important to acknowledge that racism exists in many forms within the health care system. There is a need to advance “comprehensive anti-racism efforts to address systemic and structural racism and its impacts on Indigenous peoples’ health and well-being.”¹⁷ All too often “racism serves as a serious barrier to health care access that can lead to delayed treatment or a lack of treatment altogether, either of which can have devastating effects on Indigenous people, their families and communities.”¹⁸

The Brian Sinclair inquest is an example of the indifference and disregard that Indigenous people receive from the health care system and sadly in this case, it had fatal consequences. The inquest was initiated after Brian Sinclair died in the emergency department of the Health Science Centre (Winnipeg) after waiting 34 hours in the triage area without being assessed or treated. While the inquest did not go so far as to indicate racism was a direct or contributing factor in the death, it did clearly emphasize that he died as a result of being overlooked and not receiving the care he required despite his health issue being a treatable ailment. The inquest was conducted by Justice Timothy J. Preston. The final report was released on December 12, 2014 and included 63 recommendations. The following recommendations are relevant to improving Indigenous patient care:

1. Increasing Indigenous staffing and support services within the hospitals as a means to enhance patient communications, respond to cultural requests/needs, and build connections with community health service providers, and
2. Implementing mandatory and on-going cultural safety training for all health care workers.

Two Indigenous physicians addressed the need for a more culturally safe hospital environment for Indigenous patients at the inquest. Dr. Janet Smylie, a Toronto-based family physician and health researcher of Métis heritage, outlined the differences between cultural awareness, sensitivity, competency and safety. She said, “Cultural awareness is the acknowledgment of difference, cultural sensitivity is the recognition of the importance of respecting difference, and cultural competence focuses on learning about the culture”.¹⁹ Cultural safety requires health professionals to examine their own cultures, lived experiences, beliefs and attitudes and acknowledge how these perspectives shape their approach to practice. Cultural safety requires health care providers to recognize that real and perceived power differentials exist between themselves and the patient. Addressing power imbalances requires, among other things, valuing the patient’s way of knowing and being. The patient must be a partner in all decision-making processes about their health care, and they should also determine whether or not the care they received was culturally safe.²⁰

¹⁷ Allan, B., Smylie, J. (2015). *First Peoples, Second Class Treatment: The Role of Racism in the Health and Well-being of Indigenous Peoples in Canada*. Toronto, ON: the Wellesley Institute.

¹⁸ Ibid

¹⁹ Aboriginal Justice Implementation Committee. (1999). *Report of the Aboriginal Justice Inquiry of Manitoba*. Winnipeg, MB. Retrieved from: <http://www.ajic.mb.ca/volume.html>

²⁰ Allan, B., Smylie, J. (2015). *First Peoples, Second Class Treatment: The Role of Racism in the Health and Well-being of Indigenous Peoples in Canada*. Toronto, ON: The Wellesley Institute.

4. Wholistic Health

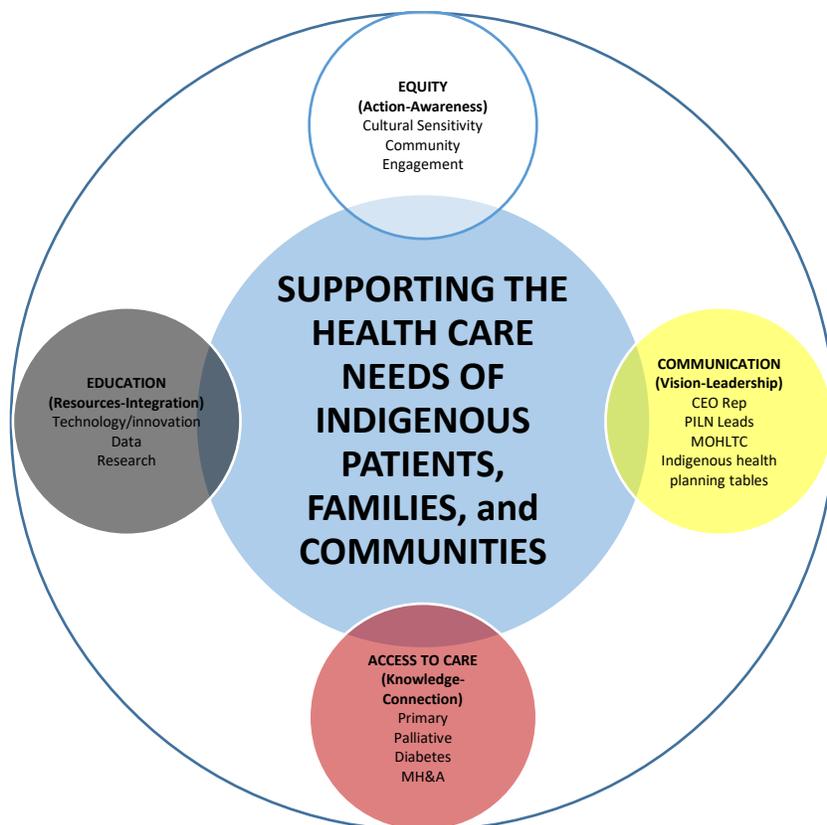
New and more innovative strategies are needed to change how the health system responds to Indigenous peoples' continued poor health status, and understanding Indigenous people's perspectives on health and wellness will be critical to success. For many Indigenous people, good health is possible only once all aspects of the individual are in balance, i.e., the physical, emotional, mental, and spiritual. Wellness is derived from social, economic, and environmental conditions which are regarded as precursors and determinants of a quality of life. While these concepts are distinct they are also intertwined and cannot be viewed or addressed separately.

Enhancements to the health care system that promote shared control, equity, cultural inclusion and wholistic health are necessary starting points to begin the process of addressing the health disparities and poor health outcomes within Indigenous communities. In practical terms, this translates into health system reforms aimed at:

- 1) Including Indigenous people (as leaders and community experts) in the design and development of health services at all system levels;
- 2) Improving patients' access to health and health promotion services;
- 3) Improved patient experiences premised on equitable health care treatment through education and training of health care providers; and
- 4) Building collaborative partnerships and integration with community supports that promote a sound quality of life.

CULTURAL FRAMEWORK²¹

This cultural framework reflects key messages as identified above and incorporates them into an applied and harmonized model of governance for the PILN.



The actualization of the clan system into a harmonized governance approach requires that the model be foundationally entrenched in principles of respect, reciprocity, equity and inclusiveness. While it is recognized that Indigenous communities have distinct cultures there are common understandings of wellness that span across many nations. This cultural framework aims to depict these similarities (by illustration of the medicine wheel) by taking a wholistic approach to the health planning process and honoring Indigenous community's rights to self-determination.

APPLICATION OF THE CULTURAL FRAMEWORK

SUB-GROUP DIAGRAM AND COMPOSITION

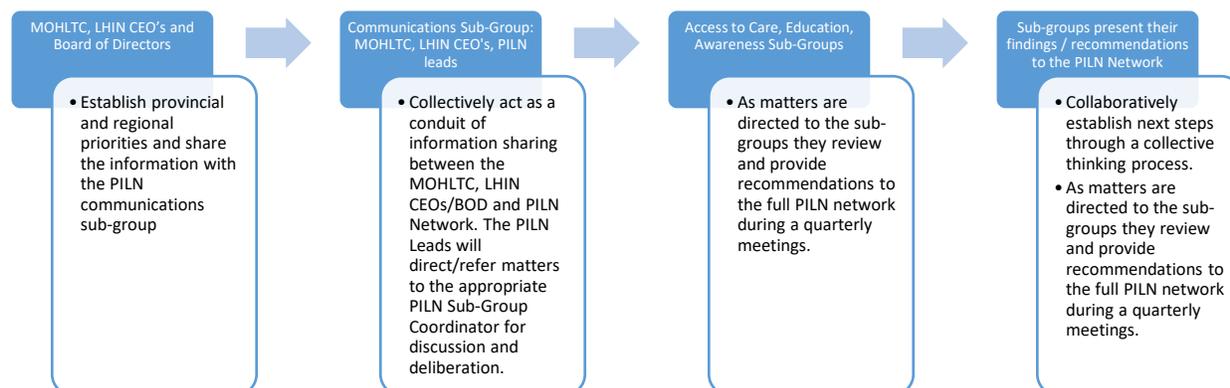
Borrowing from the brilliance of the clan system is the concept of taking matters of mutual interest of the entire group and breaking it up into smaller areas of focus by sub-groups has been adopted as a planning process for the PILN. At the root of the framework is the notion of shared responsibility by all with emphasize on the exchange of information and collective decision making.

The framework is depicted in the Medicine Wheel format comprising of the four cardinal directions. Each quadrant of the circle will have a designated number of PILN representatives that will focus on specific areas of specialization: communications, access to care, education, and awareness. These

²¹ This framework is based on a First Nations worldview and does not reflect input by Inuit or Métis.

specialized groups correspond to the identified provincial focus areas but are flexible enough to include new areas as identified in the future.

Each sub-group will be tasked with thoroughly knowing and understanding their areas of concentration to inform and provide a detailed assessment for the entire group to consider. The following flow chart illustrates how information is exchanged and how the different sub groups collaborate:



Sub-groups meet every four to six weeks, depending on the issues at hand, or as requests for information occur between scheduled meetings. The purpose of the sub-group meetings will be to share information that may arise from the sub-group discussions and/or as focus areas are determined by the sub-group. On an annual basis sub-groups will select one or two focus areas the sub-group will work on for the fiscal year.

Each area of focus involves a sub-group consisting of a designated coordinator and approximately four PILN members. PILN members should choose their sub-group based upon their areas of interest, expertise and knowledge. The sub-groups work collectively on their area of focus building an understanding of specific subject matter in relation to PILN priorities thereby contributing to a broader collective thinking process.

Note: Refer to the PILN Process Guide (under development) for access to all related Sub-Group documents (cultural framework, terms of reference, etc.) and documentation (meeting minutes, etc.).

SUB-GROUP COMMUNICATIONS (Vision and Leadership)

FOCUS AREAS: Communication directions between CEO's, PILN Leadership Representatives, and MOHLTC

Responsibilities:

- Ensure the exchange of information occurs between the PILN, CEOs, MOHLTC, and supportive allies/ partners
- Provide and coordinate communications and strategies to effectively engage the PILN and local PILN health communities
- Provide a supportive and leading role in determining appropriate approaches in adherence to local and customary protocols
- Maintaining administrative support and responsibilities between the PILN, CEOs, and MOHLTC

SUB-GROUP ACCESS TO CARE (Knowledge and Connections)

FOCUS AREAS: Primary, Palliative, Diabetes, and Mental Health & Addictions

Responsibilities:

- Identifying and staying apprised of clinical and health quality of standards of care and best practices
- Disseminating health standards and best practices to PILN members (through presentation on research findings and research briefs)
- Supporting and aligning clinical and health quality standards with culturally based approaches to care
- Connecting and building relationships with clinical and health quality networks or agencies

SUB-GROUP EDUCATION (Resources and Integration)

FOCUS AREAS: Technology/Innovation, Data and Research

Responsibilities:

- Identifying education and data needs of PILN members
- Establishing strategies and identifying resources to meet these needs
- Identifying new research and best practices
- Connecting and building relationships with outside agencies such as research centers and technology service providers
- Disseminating education related resources and best practices to PILN members

SUB-GROUP EQUITY (Action and Awareness)

FOCUS AREAS: Cultural sensitivity and community engagement

Responsibilities:

- Build the concept of equity into service delivery and planning processes (for example, outline expectations for service providers and incorporate equity in performance management at the LHIN through indicators and service accountability agreements)
- Strategically target interventions to maximize the impact of equity (for example, reduce barriers to health care and provide comprehensive care for the most vulnerable populations)
- Build equity into system transformation (for example, strengthen services to reduce health disparities, apply an equity lens to health reform activities such as chronic disease prevention and management, drive patient-centered care, health promotion and preventive services, and engage in cross-sectoral collaboration to address the broader social determinants of health).²²
- Disseminate health standards and best practices to PILN members (through presentations, etc. on research findings and research briefs)

FUNCTION:

Cultural safety, competencies and sensitivity training continue to be core areas of work for the PILN, and reflects an overall emphasis on health equity for Indigenous populations. The Equity Sub-Group will lead the PILN to towards a shared vision of health equity across all LHINS. This group will select one to two focus areas of health equity, cultural safety training and community engagement.

²² Health Equity Discussion Paper. Toronto Central LHIN. Bob Gardner, July 2008.