GEORGE & FAY YEE

Centre for
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RADY FACULTY OF HEALTH SCIENCES

ONGOMIIZWIN–
INDIGENOUS INSTITUTE OF
HEALTH AND HEALING

Recognizing our Humanity

2nd Report of the Indigenous Advisory Council

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Overview

We were so thankful for the opportunity to gather together once again, setting time for us to share our thoughts and perspectives on this work. Relationships are the foundation of our lives as Indigenous people, so it is important that we continue to build and nurture these connections. When we started thinking about building a framework for Indigenous healthcare quality, we knew that we could not do this work without first turning to community. Since the establishment of our council, there has been increasing interest in including our council in research and other projects. As we continue to work on the establishment and grounding of our council, we can also begin to look forward to the work that the council can consider for the future.

Appreciative Inquiry Follow-up

At our first meeting, we discussed and use of the appreciative inquiry methodology, with the purpose of focusing on positive healthcare experiences. During this first stage, which is called the Discovery stage, we imagined what "the best possible" healthcare experience could be, what is positive about healthcare, and what was considered a good healthcare experience.

Though the analysis we saw the development of groups and themes and began the transition into the Dream phase, the "what could be", where participants share their dream of the system that supports the highest attainable standards of health. Through this discussion we are starting the process of Design, where we create guidelines and frameworks which direct the systems in how to respond to the needs of Indigenous peoples within the healthcare system.

Interestingly, while we specifically utilized the methodology of appreciative inquiry for the first meeting of the council, during the second meeting, the discussion on the analysis of the data was given more space to go where it naturally flowed. Without specifying the activity as one focused on positive healthcare experiences, the conversation naturally developed into a discussion about issues within the healthcare system and a more deficit based discussion. While we aware that the goal of our work is to move forward our ideas and perspectives of a desired healthcare system, it is also important to highlight the fact that often, as Indigenous peoples, our experiences with the healthcare system are layered by multiple forms of racism, discrimination, and ignorance, leading to barriers and ultimately to negative healthcare experiences.

Activity

The Indigenous Advisory Council gathered together for a second time to share their voices and perspectives on the topic of Indigenous healthcare quality. The purpose of this meeting was to review and provide feedback on the report that was prepared following the first meeting of the council.

Leads Amanda Fowler-Woods and Dr. Marcia Anderson presented each portion of the report to the council, discussing how the shared knowledge was analyzed and organized.

Following the presentation of each section of the report, the Council members were organized into smaller groups where they wrote down and then shared their feedback on that section of the report. Council members used sticky notes provided to document their thoughts and perspectives and then choose one member to share their notes with the larger group. All sticky notes were collected from each group following the sharing for that section.

This group activity was audio-recorded for the purpose of review following the meeting. All council members gave their consent to this recording. The audio recording was then transcribed for further analysis. While the council members had agreed to recording the first portion of the meeting involving the sharing of personal reflections and stories, the digital recorder did not record the session. Since this portion of the discussion was also not recorded during the first meeting, we have decided that it was meant to be and that portion of the meeting remain only in the minds and memory of those in the room that day.

During the thematic analysis of the data from our first meeting, the exercise of mapping the emerging themes against the Dimensions of the Manitoba Provincial Quality and Learning Framework allowed us to see that the priorities of Indigenous Manitobans did not align with those set out by the Province as priorities for all Manitobans. Rather, the priority was concentrated around the two dimensions of Client-centered care and Safety. It became clear that our most urgent priorities as Indigenous patients is to, first, be fully seen and cared for, and second, be cared for in a culturally safe manner.

During our second meeting we took the time and created the space for the Indigenous Advisory Council to share their thoughts on the themes that had emerged and the organization of the shared knowledge. Through this discussion we refined, edited, and added more details to this work, making more clear the necessary distinction of an Indigenous healthcare quality framework.

The resulting development and expansion of groupings and themes from this activity will be shared in the following section.

As with the analysis of the data following the first meeting of the council, Council the Leads examined all of the words and stories and perspectives that were shared during our second meeting to get a deeper understanding of what had been shared. Working once again with the sticky notes and the transcribed digital recording, a two rounds of analysis were completed.

Stage 1

In keeping with the previous three thematic grouping of Provider Characteristic, Systems Characteristics, and Patient Experiences in Positive Healthcare Encounters, we organized the sticky notes to see how the discussions from this second meeting further explained or added to what had emerged from the first meeting. This exercise was helpful to see that it was necessary to further the discussion about how the data had been organized, and to fill the gaps pointed out by the council by adding in themes that had not yet been included. The theme of forgiveness be added to the experiences in Patient Experiences in Positive Healthcare Encounters.

Stage 2

Once again, the sticky notes were mapped onto the dimensions of the MQLF. Through this exercise, and through the qualitative analysis of the transcribed meeting discussions, the themes of Rights Based Healthcare and Communication emerges as overarching themes which connected all of the other under existing themes together. Through shifting and reorganization of the data it was evident that there was a need to add a two new Dimensions to the Indigenous Health Quality Framework. The strong perspectives around the importance of acknowledging these categories led to the development of the dimensions of: Rights-Based Healthcare and Communication.

The exercise also confirmed our previous findings that the majority of focus still centered around Client Based Care and Safety. However, through this work, we have highlighted how there is a need to differentiate between safety as positioned by the MQLF and safety, more specifically cultural safety as positioned by the Council. The concept of Cultural Safety in particular must hold a place of importance in a framework for Indigenous healthcare quality.

Rights Based Healthcare

Through our discussion of the themes and how ideas were organized, it was mentioned multiple times that an overarching determination of positive healthcare experiences is the practice of rights-based healthcare. For many Indigenous people, barriers to exercising rights-based healthcare are experienced often within the healthcare system. This can impact the quality of healthcare often leading to negative healthcare experiences, and in some cases, determine life and death. As an example, the issue of jurisdiction came up often as stories were shared regarding how federal vs provincial systems of healthcare impact Indigenous people's health in significant ways.

It was suggested that Rights-Based Healthcare is an overarching theme under which all of the other themes should follow. While there was agreement that rights-based healthcare is the foundation from which everything else flows, it was also understood that mapping out how this looks and flows will take more time than what we had during our meeting.

" *We recognized that when it came to the section of rights-based healthcare, so there were three excellent points that surfaced. However, asking the question, do these three points encompass rights-based healthcare in its totality, would be great. The answer is no, therefore we agreed that it's a big subject, requires more thought. We couldn't do it within eight minutes, and nobody could.*

But we recognized that these are an excellent starting point, but more needs to be added to this piece – just a lot more conversation."

" *And I've seen up north too, it's like, when I've been in one of the First Nation communities, we had to call an ambulance out, but it would only come to where the provincial highway ended. So we had to find someone to take this person to go to meet the ambulance and I thought, oh my gosh, it's a five more minute drive and it's just crazy.*

And we had a big meeting with the CEO at the NRHA with Northern Regional Health, and they said that's why we would only go that far, because that's where the provincial highway ended.

Oh, we've also had incidents where the nurses will not leave the nursing station when there's an emergency, that could be maybe five minutes down the road, they will not leave their nursing station.

Or, we're always talking about life – like, emergencies, it takes minutes, right, and those minutes' count. And some of the nurses will not leave the station, because "I cannot leave". To me, it doesn't make sense, like, I just said, bring back humanity as part of healthcare, you have to because people are losing their – I know with up north they're losing their lives, because from all those little postings about where you can work and where you can't work."

" *Yeah, the jurisdictional issue was the whole thing.*

And I think that's why I was saying we needed a better description of what system means with regards

Yeah, because we're treaty and we're not treaty got some treaty. And we're always made aware it says, well, you're federal jurisdiction, not provincial, so there's an issue there in the healthcare system".

" *Okay, so we talked about, I guess, that the flexible and adapting be highlighted life givers, that change is continuous. Lisa pointed out that there's a difference for when only having a couple of people in the birthing room, now it's different. I think we need to respect what mothers want and help Mum and baby kind of attach and form that bond.*

Also a different kind of highlight, the different, like, how CFS involvement needs to change, like, social workers in the hospital need to do. As a CFS worker myself, I think that's a huge thing. And you know, what do birth words mean, and what can we do for changing that?"

Communication

2

Throughout the discussion of all three main groupings and their themes, the concept of communication was central in all of the feedback. Recommendations were made to add Communication as a theme. Council members agreed that most aspects of positive healthcare experiences are tied to having clear and quality communication. Therefore, Communication should be added as a dimension of Indigenous healthcare quality. Because the discussion of Communication carried through the discussions of all three main groupings, the quotes here will be organized by grouping.

Provider Characteristics

" *Some of the key areas that continue to resonate, being cultural safety and communication – transparent communication – and just how – yeah, how those struck us again, and brought back a lot of things that we were thinking of for the cultural safety, the education component, people going in.*

Because we talked a little bit about having indigenous physicians or practitioners, and on the one hand there's really great positive things that happen and on the other, there's times when it was like, you can see that they've been through a system, and the system's trained them to de-indigenize – leave their values and beliefs behind, sort of thing.

And then in that happening, you know, patients are still being ignored and not listened to, and that's where communication can flow to as well, and like, how great it would be if people could speak the language of the community to communicate with people in that community using their language. And just how – see the actual positive impact that has on someone physically, to experience being heard"

" *We looked at the Provider Characteristics and we found the common theme in all of the seven points, it was basically communication. You know, the providers, talking about Aniisnashnaabe necessarily. There has to be a better understanding and maybe an ability to speak the language as well – because there is a lot of missing translation.*

Let's say when you're asking an older person, you know what is the general aailment wrong, they don't understand anything they tell them it got to be easy to understand something, that's medical terminology.

So we were discussing if the advantage of having somebody, if it's a translator or a relations or something, there, being able to clearly communicate between the two. Because if you talked about cancer, how do you say that in Cree or Anishinaabe, it's kind of hard to describe that, so …

But then there's always the sense of body language, like, sharing a story about people that the doctors and healthcare workers up north are basically foreigners and newcomers, so they don't really know the culture. So the first thing they heard from white society is that white society looks down on indigenous people so that's inherent…

Body language is key, the way you stand and stuff like that so that message about that its ….. when you look at some people and come here and they are not looking at you or not listening to you, so you have to have that connection. So that's what we found is that communication is key to all of this."

" *Actually, we similarly about the communication, not just the dialect, right, but just the communication style, that you're not going to talk to an elder using words that you're going to talk to a teenager about, right. So just the communication style".*

" *But we also – about efficiency, right, like, often times things won't be explained and the patient's just wondering what's going on, and maybe – I guess that ties into communication as well, so a lot of our stuff was communicate".*

" *It's like in the report, where it specifically says, like, language. But to me, communication is more than just the dialect of a language, right. Like, which is the words you use and the medical terminology part of it too, right, to try to avoid that".*

" *Communication, appropriate language so it's not buried –*

In other words, at the beginning of the – instead of – I noticed it was at the bottom, so people sometimes don't read to the bottom – maybe make sure it's at the top and it stands at the forefront.

And also the whole entire health system needs to be – with communication, also culturally-sensitive, so that maybe includes training, inclusive language such as feminist language, LGBTQ2* language, like, ablest language, like, avoiding those kinds of things, just to make sure that everybody is feeling included and not maybe triggered with those kinds of things".

Systems Characteristics

" *So our group really saw communication as, like you said, just completely throughout this whole section. We talked first about point number two, which is collaborative and continuous. Maybe focusing on the communication between healthcare professionals, so making sure that patients don't always feel like they have to explain themselves to each healthcare professional. Making sure that that is fluid throughout your care.*

And I think that that really allows for the healthcare provider to read and know of your situation beforehand, so in case, for example, you go through a traumatic event, you don't have to re-explain yourself again. And that kind of played right into number five, the approachable and comfortable one.

We said maybe having some focus on safety, like, you mentioned it a little bit within it, but we all felt that safety plays a huge role, and that even safety plays into communication. Making sure that the patient feels safe, and how your healthcare provider can allow you to feel safe. And in case someone doesn't feel safe, then they're not comfortable, and probably won't get the right kind of care. So maybe just safety integrated into the approachable and comfortable piece of that".

Positive Feelings from Healthcare Experiences

❝ *We're want to echo our friend here, and the message that she has shared, you know, she had said, bring humanity back into healthcare. I guess it was mentioned in one of the previous lines, that the overarching thing is communication. We kind of feel that the overarching theme here is bringing humanity back into healthcare."*

❝ *So that's where all the dignity, the patient… to me, I sit on a patient caregiver board with research and doctors, and we want to make sure that the patient and caregiver is always at the forefront. Because if we're at the bottom, we're not being talked to, so we need to make sure that our voice is…"*

Forgiveness

3

The council suggested that forgiveness be added as an additional theme under the grouping Feelings from Positive Healthcare Experiences. It is believed that the ability to experience forgiveness within the healthcare system is strongly connected to the ability to experience a positive healthcare encounter.

❝ *Maybe an additional word here is to add forgiveness. So forgiveness is just so often overlooked in healthcare, and it shouldn't be, because when people are homeless and struggling, trauma, anything that is going on that is painful within their life… is the human experience. Sometimes they're at 12, right, and we expect everybody to be respectful and caring and loving and all those things – you can't be that when you're going through some stuff.*

And so when you end up having an experience like that, and somebody is struggling, then the idea is forgiveness, right, that you can forgive the situation, because of the situation, and then have an opportunity to say, you know what, I know things are really hard for you right now. Maybe I can help you and situate you here, or connect you with someone else. Or just come back when you're a little bit more calm, as opposed to security is being called, then were going to call the police. Don't come back, we're putting a memo onto your file, yeah, bye, good luck finding …. So forgiveness".

Workforce

There are often differences in meaning or definitions of terms when discussion an Indigenous understanding compared to the understanding or definition stated by the province within the MQLF. The concept of Workforce in relation to healthcare quality is one where from an Indigenous perspective, there is different meaning than what is defined in the MQLF. From the perspective of the council, the idea of workforce was focused on the need to address racism targeted against Indigenous healthcare workers by non-Indigenous workers and how Indigenous healthcare workers are not experiencing cultural safety in their practices nor are they receiving respect or being treated well compared to non-Indigenous staff. In addition, there was a need to support Indigenous healthcare workers in order to provide appropriate care to patients because the rules and policies of the system are not supportive.

> *One of the things, again, that came up right away is, there's a missing voice in this theme, that the indigenous workers themselves are not – they experience, they are experiencing the lack of cultural safety, the racism between workers and how it's impacted their ability to just do their job, period"*

> *But that seems to be – yeah, there was just too much bureaucracy to even allow – and, like, it's not an efficient service as it is, so those nurses and whatever, who can address things immediately, are forced to go through various levels of bureaucracy to get back to patients, and screenings back to patient care. So that seems to be a voice that's missing in this section."*

There were concerns with how western based health professional training programs often impact the ability for Indigenous people to follow their own belief systems.

> *Because we talked a little bit about having indigenous physicians or practitioners, and on the one hand there's really great positive things that happen, and on the other, there's times when it was like, you can see that they've been through a system, and the system's trained them to de-indigenize – leave their values and beliefs behind, sort of thing."*

There were also discussions the positive impacts of having Indigenous healthcare professionals within the workforce.

> *And also having an aboriginal liaison worker present, especially when it's a traumatic event. Say if you have youth that are coming in at attempting suicide, and then they're not allowed to leave. You have a police present there, and then the situation is scary, and getting your aboriginal liaison workers there and being more supportive to help our indigenous nations, yeah, so that's what we were discussing."*

Client Centred Care

5

While this was one of the more robust categories in the analysis of the data after the first meeting, our conversations during the second meeting added more details and strengthened the need to have Client Centered Care recognized as a central component of an Indigenous healthcare quality framework. Even further than centering the care around the client, there is a need to shift the perspective so that Indigenous people are seen as fully human. The idea of a lack of humanity when it comes to the care for Indigenous patients came up frequently with discussion of how healthcare needs to return to seeing a concern for humanity as the upmost reason to care.

❝ *I just said, bring back humanity as part of healthcare…"*

❝ *We're want to echo our friend here, and the message that she has shared, you know, she had said, bring humanity back into healthcare. I guess it was mentioned in one of the previous lines, that the overarching thing is communication. We kind of feel that the overarching theme here is bringing humanity back into healthcare."*

❝ *And so we were talking about if we could just reframe the question and how we provide healthcare, to creating a question per se and saying, is your behaviour and your words, are those working towards that humanity, or not? And then you can imagine that responses like that will break down walls of jurisdiction. It would also keep people accountable, so we felt that was really powerful".*

❝ *and that healing and health have to be the forefront, and being treated as human beings, who we are".*

❝ *Okay, so efficiency – so Lisa pointed out a great point about all appointments for results for those who maybe don't have access to phones, internet. Maybe they don't have stable housing. I think the healthcare system needs to realise that those who are maybe homeless or transient, or living with addiction or mental health issues, you know, aren't always in a stable residence, and that these need to be followed up, because they can't have access to internet – people don't have that."*

Safety & Cultural Safety

6

This was another dimension that already held a robust amount of data but through our conversations agreed that there was more to be added. The definition of safety that we have as Indigenous peoples in regards to quality healthcare is different than how safety is defined in the MQLF. In addition, the council addressed both the topic of cultural safety and safety more generally. It was decided that Culturally Safety specifically needs to be acknowledged within the framework when discussing the dimension of safety.

❝ *And then having your healthcare provider too, as well, like, there's a lot of – there's physicians that are immigrants, and a lot of our nurses are immigrants as well, and not indigenous; having them say, like, in that safety aspect, to say, you know, I have a cultural understanding and knowing – like, the ways of knowing are our ways of knowing and living. Having that cultural understanding and letting the patient know that they understand."*

" *Like they say when we're talking about the immigrant population, they really want to know how to work with us, but they're being told a different way. So it's up to us to make sure our voice is heard in all these areas, and we need to take that initiative to educate them when we can, to address those things."*

" *And then what we see – acknowledging racism, like, calling it out, having it visible in your triage, in your room, when you're sitting there, waiting to see your healthcare provider, your clinics, so that it's being spoken about with your groups of healthcare providers, then you know, it can be called out and complained about. And not having to go through so many different layers when you want to file a complaint.*

" *Because I know that happens in the RHA up in The Pas often, in the. Like, you can't just go to a person to say, I want to file a complaint, you have to go through so many levels to get there."*

" *Things that we've discussed was a little similar to what's already been said, but it might not just come in through a strong – but – just there's no fear …. There is an acceptance of what our current circle of care, an individual's current circle of care is, which is in part respecting indigenous knowledge and ways of being and not fearful of it.*

So if somebody can go to their doctor and say, well, I'm also going to see my traditional medicine – my doctor – and they are positive about it, that's a really positive experience, as opposed to having the other resources people are using, slapped, shut down, you know, and being discredited as not really valid medical advice, or medical care.

So maybe it's just not clearly coming out of what that is. So if, you know, people are seeing traditional doctors or practitioners or different methods, also just being – assume that they are. Or not being fearful, that that's what they're doing in their own healthcare. So yeah, an inclusion, a sense of inclusion, then that is a positive experience for someone, if they have that sense of inclusion, you know."

" *So we talked about health and healing ceremony as a part of the healing process, in healthcare facilities. …and that healing and health have to be the forefront, and being treated as human beings, who we are."*

" *And also, under fully seen is, I guess, leaving the healthcare facility with their dignity intact – a big part."*

" *Well, one of the things I look at in regards to the health healing and healing in ceremonies, is that where you touch base on it, like, we're going to see our medicine man, or our healer outside of the facilities that are here, why is that? I question that all the time? Why is that?*

Well, we used to have something across here on William Avenue, where they'd have to go to the basement. In other words, it's not even in the forefront – it needs to be at the forefront. Because the way I look at it is that you have somebody that's not responding to modern medicine, but when somebody comes in and does a ceremony and all of a sudden, now they're responding to that modern medicine.

So it needs to be at the forefront, it can't be put in the back, and I guess that's where I come from my perspective, is another way of knowing too I've seen, is combining Western science with indigenous science. But going forward, thinking on our healing together."

> *And another way of knowing is that patience is always the centre of our healing process, and that's within all the medical field, that may be with a doctor, your psychologist, your physiotherapist. So all of them need to be working together, but with us, it's the central focus.*
>
> *And if that's our way of knowing, when we talk about that way of knowing – so we need to make sure at this table, and as researchers, that we recognize right at the beginning – because in Western science, unfortunately, we go to a doctor, we ask them to heal us, and if they don't heal us, we blame them.*
>
> *In our culture, the other way of knowing, we are part of the healing. So it's also our responsibility to be part of that healing and working within all these different areas. So we need to make sure our voice is heard, that we want this."*

> *And from that indigenous perspective, we're all different, so we've got to make sure that we help educate them as we're going along. And not even saying is that, let's be a little bit more mindful to have that positive experience; we can be positive too when we're dealing with them, so it also comes back to us. So that's just to add to that health and healing portion of it so …"*

> *Okay, ethical conduct: We talked about including maybe instead of just the practitioners' ethics, including maybe indigenous ethics and natural laws into that. And then ensuring that patient and caregivers are at the forefront in these decisions at research."*

> *And then another thing we talked about is relationships, and that when practitioners meet indigenous people, being approachable, comfortable and just kind of starting from there. And working where the client is at, and acknowledging maybe not all indigenous people are at that point where they're culturally involved. And a lot of us a Christianized. Maybe they don't want that at this moment, and acknowledging that."*

> *The other one is collaborative; recognize there's other ways of knowing, that there's two-eye seeing, so when we go into the world, the collaborative; when you're working, you're working from a Eurocentric lens as well as an indigenous lens. And then that's what is adapting and flexible, kind of Indigenizing, that not all indigenous people are the same. We have different teachings, we have different ways of learning, we have different celebrations.*
>
> *And if the Anishinaabe and the Mi'kmaq person, like, we're different, we're not all the same. And I think a lot of practitioners need to realize that as well. So that's…"*

While the focus was on the concept of Cultural Safety, the council also spend some time discussing the need to also focus on the idea of Safety within the healthcare system in general.

> *So what we did as a group, we added feeling safe. But it ties into validation, like, when you're, as a patient, believing that your healthcare providers have your back, or supported – they keep you supported and listened to. Validated, listening to, and I guess as a patient, it helps you – it motivates you to heal, I guess, when you're listened to and validated. And then as you're being validated, then you feel better, so that's a safety – yeah, when you're being heard."*

> *We said maybe having some focus on safety, like, you mentioned it a little bit within it, but we all felt that safety plays a huge role, and that even safety plays into communication. Making sure that the patient feels safe, and how your healthcare provider can allow you to feel safe. And in case someone doesn't feel safe, then they're not comfortable, and probably won't get the right kind of care. So maybe just safety integrated into the approachable and comfortable piece of that."*

> *…service providers also not working collaboratively enough to help patients get from point A to point B, and just kind of sending them on their way and not communicating between different agencies.*
>
> *So for example, elders, being left to come into a building like this and just find where they need to be. And then not … providing them the support that they - the family or whoever – say for example they're coming from a community to the city, not following through on providing – letting family members come in as supports to be there"*
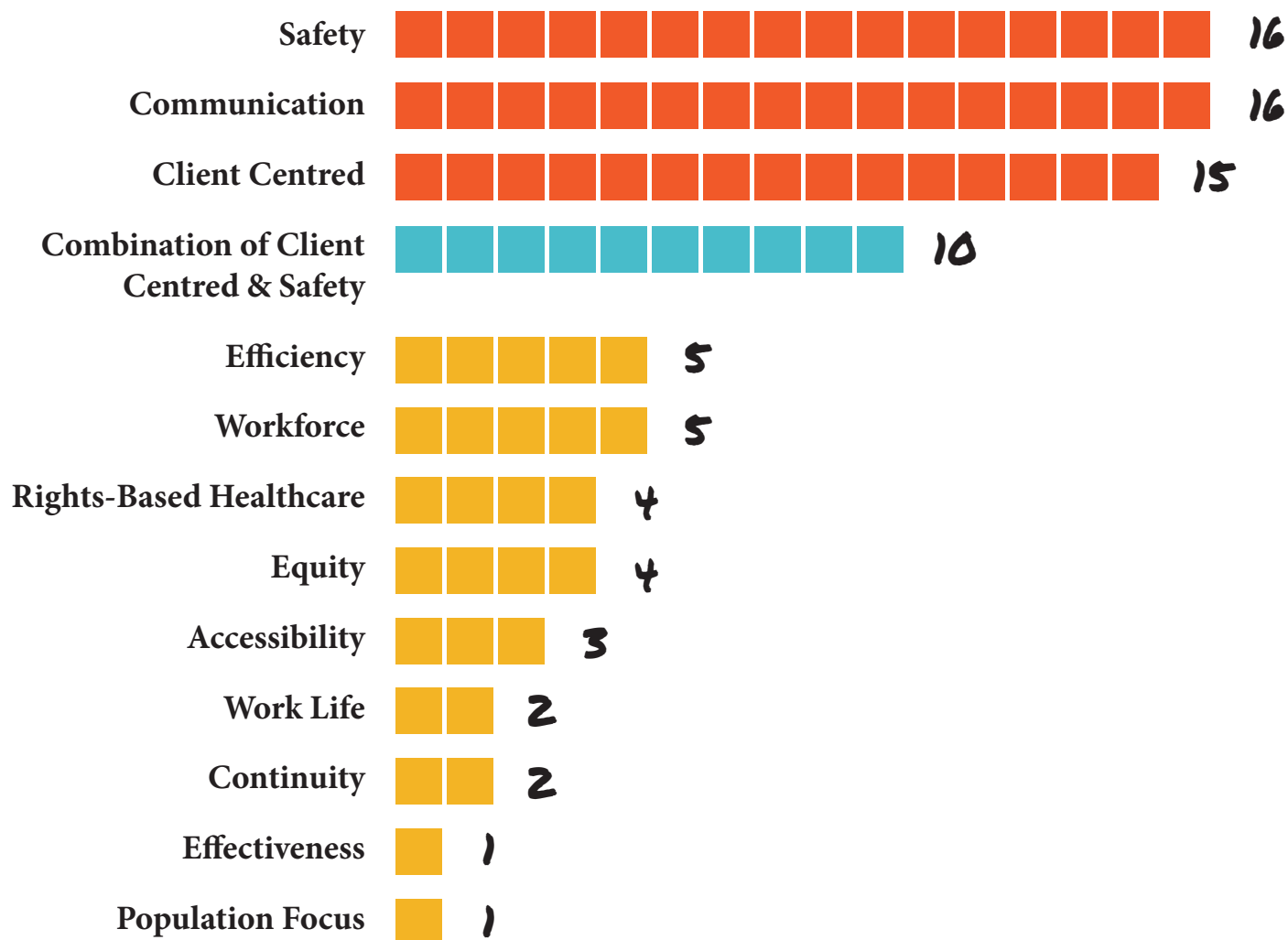
Efficiency

Within the theme of efficiency, the Council suggested an immediate action item to be address in the healthcare system. It was pointed out that there needs to be consistency in EMR systems so that patients and providers in the healthcare system can have access to consistent information. When the systems cannot talk to each other there is a disconnect in continuity which has a direct effect on quality of care for Indigenous patients.

> *And then just simply, if I may add, you guys, I'm just listening to some of the comments. One of the biggest things I think would be important to come off of this document, just for some of the tables that I've listened to. So we need to get on the same digital platforms.*
>
> *We talk about how – because there's disruption, if you will, to HSC versus St Boniface – we're not using the same computer systems. So there's no reason to expect that any doctor or provider in HSC is going to know what conversation they would have at St Boniface, because there is no portal that connects those. So until we get onto that systems level of, we're all sharing information, then there's going to be mess ups"*

Category	Value
Safety	16
Communication	16
Client Centred	15
Combination of Client Centred & Safety	10
Efficiency	5
Workforce	5
Rights-Based Healthcare	4
Equity	4
Accessibility	3
Work Life	2
Continuity	2
Effectiveness	1
Population Focus	1

Beyond the discussion of the organization and analysis of the data, there were also a number of suggestions for clarity and development of a number of concepts that will be important for our future work and the goals we hope to accomplish as a council.

Accountability

Our council posed the question: What does accountability look like?

❝ *And then also, which is on – a discussion that is taking place – it would be nice to see this in this document, in terms of accountability, right. So we talk about these things, and so we have to be able to make space in terms of what does accountability look like as well? So it is a big subject too, but one worth tackling".*

Our council posed the question: What does accountability look like?

This is a conversation that needs more time and space for discussion by the Council. Some of the questions we can explore include: What is accountability? Who needs to be accountable? Who is on the receiving end of accountability? What will accountability accomplish? What are barriers to accountability? What are facilitators to accountability?

A simple definition of accountability includes "having to be answerable to someone, for meeting defined objectives" (Deber14:2014). However, it is now known that accountability can be difficult to achieve, establish and enforce because there are so many different variables including ways to measure, differing recipients, and a range of stakeholders. Deber (2014) notes that "Clarification about the best ways to achieve accountability has been identified as a major priority by governments, providers, and recipients of healthcare services, both in Canada and internationally" (Deber:14, 2014). She goes on to say "A more nuances understanding necessarily begins with clarifying what is meant by accountability, including specifically for what, by whom, to whom, and how" (Deber :14, 2014).

Our need as a council to define and explore the idea of accountability is in line with what is happening on a larger scale within healthcare systems throughout Canada. These will be very important conversations to have and to begin to create guidelines that will serve in the creation of policies and practices for understanding and achieving accountability in healthcare for and with Indigenous peoples.

Systems Definition

The Council requested that we provide a clear definition of "system" as we are using it here in our work.

❝ *And one other thing to that is that, what is the description of system? Is it micro, or is it macro? We need to know, when you're saying, the system characteristics, you don't really have – what the system is, what you're looking at. Even though that would be the entire healthcare, or you're looking at just clinicians, doctors and researchers? So maybe a definition of what system is."*

The World Health Organization defines Health Systems as: "The health system comprises all organizations, institutions and resources that produce actions whose primary purpose is to improve health. The health care system refers to the institutions, people and resources involved in delivering health care to individuals." (WHO: 105, 2003).

WHO (2007) notes that "A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services" (ibid:2).

WHO also lists the 6 building blocks of a health system

Service delivery	Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.
Health Workforce	A well-performing health workforce is one that works in ways thatare responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).
Information	A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.
Medical products, vaccines and technologies	A well-functioning health system ensures equitable access to essential, medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.
Financing	A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.
Leadership and Governance	Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability.

While this is one definition that can guide our understanding of our purpose and goals as a council, there is much more opportunity to continue to define what health systems means to our Indigenous Advisory Council.

Through this work we have been able to take the knowledge that emerged from the first meeting of the Indigenous Advisory Council and build on it so that it captures accurately and fully the perspectives of the Council in representation of Indigenous peoples in Manitoba. From here our Council will continue to work to advocate for the inclusion of this knowledge into our healthcare system in the continued development and implementation of an Indigenous healthcare quality framework.

Next Steps

a) Indigenous Advisory Council leads with work with CHI communications staff to complete the report draft with added design components and graphics.

b) Following the completion of the report, it will be sent out to Indigenous physicians, healthcare providers, etc. for review and feedback.

c) The council will participate in the planning and presenting of a CHI grand rounds presentation in the Fall of 2021. Topics can include: the formation of the council; working together to draft Indigenous healthcare quality framework; and looking forward to participation on research and other projects within CHI and Ongomiizwin.

d) The council will participate in the planning and organizing of a naming ceremony for our council followed by a celebratory feast.

e) The council will continue to prepare for participation in advisory roles within the University and Shared Health. Once we have decided as a council how this should look and work, we will begin our work as advisory members on research and other projects.

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