

Health Equity Impact Assessment (HEIA) – Indigenous Lens Tool

The [HEIA Tool](#) is a practical tool to assist decision making using a 5-step process: scoping, impacts, mitigation, monitoring and dissemination. It helps the user identify the potential, unintended impacts (both positive and negative) to a policy, program or initiative, on equity deserving populations. The HEIA Tool identifies Indigenous peoples living in Canada as populations that may benefit from more equitable provision of health and social services. However, specific guidance is needed on how to apply the HEIA Tool in a culturally relevant way to policies and programs that involve Indigenous peoples.

In keeping with the spirit of reconciliation, this document aims to support the HEIA Tool by providing suggestions on how to include Indigenous knowledge and values regarding health and well-being in program and policy development, while also recognizing the diversity within First Nations, Inuit, Métis and urban Indigenous populations. [Table 1](#) summarizes the guiding documents and principles that inform the suggestions made in this document.

The concept of equity that is presented in the HEIA Tool is in and of itself a colonial construct. Indigenous peoples see themselves as part of a collective and this perspective is an important consideration that may not be captured in a person-centered, individualistic approach to health equity. In the absence of a more rigorous equity analysis, led by Indigenous peoples, this document will serve as a placeholder until a more culturally relevant resource is available.

For additional information about the Indigenous Lens Tool, please contact iccu@ontariohealth.ca.

Indigenous Lens Tool – Supporting the HEIA Tool

The Indigenous Lens Tool aims to support the application of the HEIA Tool to programs and policies that include Indigenous peoples. The document is in no way meant to be comprehensive or representative of the health care experiences of Indigenous peoples living in Canada or the social determinants that surround health and well-being of Indigenous peoples living in Canada.

The Indigenous Lens Tool first presents four guiding strategies – planning, communication, engagement and evaluation – that provide suggestions on how apply the HEIA Tool while utilizing an Indigenous lens. This is followed by useful information and supplementary resources that place the need for an Indigenous Lens Tool into context. Finally, four scenarios are presented that provide practical examples of how to implement the Indigenous Lens Tool when applying the HEIA Tool to a project or policy. These scenarios are in no way meant to replace meaningful engagement with Indigenous peoples and they are in no way meant to be comprehensive or representative of the situation or experience of Indigenous peoples. Rather, the scenarios intend to provide context for applying each step of the HEIA Tool.

Indigenous Lens Tool – Guiding Strategies Framework

The following principles for planning, engagement, communication and evaluation will help encourage more equitable outcomes for Indigenous populations.

Planning

As a result of a long and ongoing history of discrimination and systemic racism in Canada, distrust of health care services is common among Indigenous peoples.

- Indigenous populations must be included in the first steps of any program or policy development, aligning with the principle “Nothing for Us without Us”
- Situate your organization as an ally to support Indigenous initiatives rather than trying to lead them
- Talk to those in your organization with expertise in Indigenous health or with relationships with Indigenous communities for guidance and support, but do not rely on your colleagues to do the engagement work for you

Engagement

Pan-Indigenous solutions are not appropriate as Indigenous peoples living in Canada are not one homogeneous entity. The term Indigenous describes many distinct groups within Canada have unique histories, languages, cultural practices, and spiritual beliefs.

- Take the time to learn about the Indigenous communities in your area
- Building meaningful relationships is key to understanding the needs of the communities affected by policies and programs
- Co-lead the tailoring of policies and programs with the Indigenous community or communities that are served by your organization

Communication

Education and literacy levels are lower among Indigenous individuals over the age of 50 but are increasing among younger Indigenous individuals. These inequalities are rooted in systemic racism, socio-economic marginalization and inequitable education funding. In addition, English and/or French may not be the first language of many Indigenous peoples.

- Consider the tone and literacy level to ensure effective communication with Indigenous audiences
- Co-lead the tailoring of communication strategies and program/policy materials with Indigenous communities (e.g., Target communication strategies to media that are available in communities as many communities do not have high-speed internet but do have access to local radio)
- Produce program / policy material in the local Indigenous language that is specific to the community you are working with

Evaluation

Historically, data regarding Indigenous health has not been collected or used ethically by non-Indigenous institutions. It is essential to respect the rights of Indigenous communities to own, protect and control how their information is used for research, evaluation and other purposes (e.g., Principles of Ownership, Control, Access and Possession, for First Nations data, Métis ethical research principles for Métis data, and Inuit Qaujimajatuqangit principles for Inuit data). See

Appendix B – Indigenous Ways of Knowing for further information.

- Engage with Indigenous communities on research, program monitoring, and evaluation
- Consider incorporating Indigenous-based research or evaluation methods into the program or policy

- Work with individuals within your organization who have expertise in Indigenous research or program monitoring to adapt and revise the initiative to better meet the needs of the Indigenous community that is being engaged

The Truth and Reconciliation Commission (TRC)

The Truth and Reconciliation Commission of Canada identified [94 Calls to Action](#) that outline first steps to remediate the historical injustices that have been, and continue to be, perpetrated against Indigenous peoples living in Canada (TRC 2015). The Calls to Action have been informed by both the Royal Commission on Aboriginal Peoples ([RCAP](#)) and the United Nations Declaration on the Rights of Indigenous Peoples ([UNDRIP](#)) which was adopted by the Government of Canada in 2016. Seven of these Action statements pertain directly to health. Call to Action 19 directly addresses health inequities and closing the gap in health outcomes while Calls to Action 23 and 24 address the education of health care professionals (TRC 2015).

Table 1. Guiding Documents

Governing Body	Document
Ministry of Health	<ul style="list-style-type: none"> • Health Equity Impact Assessment (HEIA) Tool Template • Health Equity Impact Assessment Workbook
Ontario Health	<ul style="list-style-type: none"> • First Nations, Inuit, Métis and Urban Indigenous Cancer Strategy • Ontario Cancer Plan 5
First Nations Information Governance Committee	<ul style="list-style-type: none"> • OCAP® Principles (Ownership, Control, Access, Possession)
Inuit Tapiriit Kanatami and Nunavut Research Institute	<ul style="list-style-type: none"> • Negotiating Research Relationships with Inuit Communities, A Guide for Researchers • National Inuit Strategy on Research
Métis Centre at the National Aboriginal Health Organization	<ul style="list-style-type: none"> • Principles of Ethical Métis Research
Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council	<ul style="list-style-type: none"> • Tri-Council Policy Statement 2
Government of Canada	<ul style="list-style-type: none"> • Truth and Reconciliation Commission of Canada Final Report • Truth and Reconciliation Commission of Canada What We Have Learned: Principles of Truth and Reconciliation
United Nations	<ul style="list-style-type: none"> • United Nations Declaration on the Rights of Indigenous Peoples

Indigenous Ways of Knowing

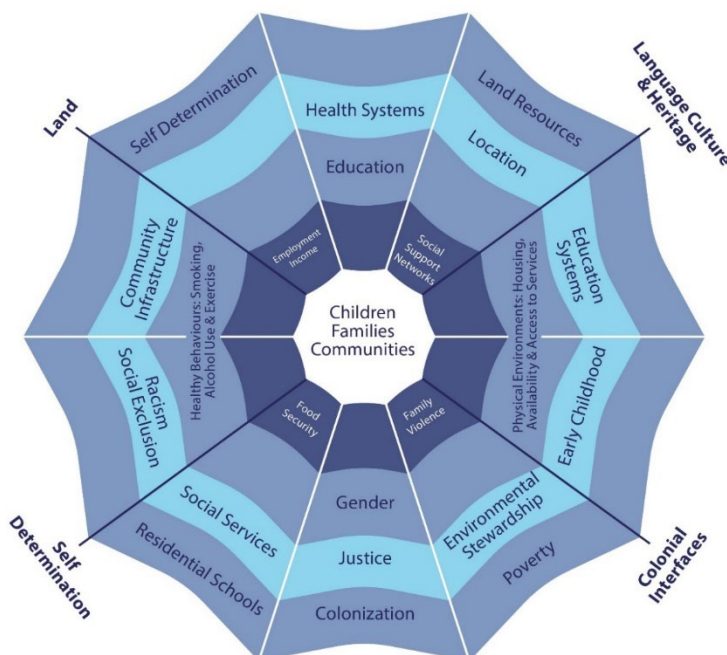
Prior to colonization, Indigenous peoples in Canada had established knowledge systems, cultural practices, values and beliefs. This included knowledge and practices that promoted well-being. Colonization interrupted and de-valued these traditional ways of knowing.

The Public Health Agency of Canada (PHAC) explains that “health is determined by complex interactions between social and economic factors, the physical environment and individual behavior.” (PHAC 2003). The HEIA Workbook outlines the PHAC social determinants of health. This approach does not fully capture Indigenous conceptions of health, nor does it reflect the growing body of work exploring Indigenous-specific determinants of health (Loppie Reading and Wien 2009; Greenwood and de Leeuw 2012; Greenwood et al 2015; Smylie and Firestone 2016).

Within the Indigenous framework of wellbeing, the importance of layered and interrelated aspects of physical, mental, emotional and spiritual dimensions of health is emphasized (Loppie Reading and Wien 2009; Greenwood et al. 2015). Structural determinants, including historical and ongoing colonialisms, are the root causes of Indigenous health/wellbeing, and must be contended with in order to understand and address Indigenous health inequity.

Figure 1 depicts the interrelated determinants of Indigenous peoples’ health, from the Health Professionals Working with First Nations, Inuit and Métis Consensus Guideline (Wilson 2013). Relationships between factors affecting Indigenous peoples’ health are shown in four web-shaped concentric rings surrounding Indigenous children, families and communities which form the centre of the web. The layers of web intersect with four cross cutting themes: language, culture and heritage; colonial interfaces; self-determination; and land (Wilson et al 2013).

Figure 1. Web of Being: Determinants and Indigenous Peoples' Health



Moving from Cultural Competency to Cultural Humility

Cultural Competency

- Attain skills, knowledge, and attitudes to work in more effective and respectful ways with Indigenous patients and peoples of different cultures (Indigenous Physicians Association of Canada 2009)
- Work at an organizational leadership level to provide the right resources and policies to guarantee equitable health outcomes for all (Nova Scotia 2015)

Cultural Safety

- Move beyond cultural knowledge to being aware of our own positions of power (Ramsden 2002)
- Reflects whether those that receive the service feel comfortable, respected, and able to be themselves (Brascoupé and Waters 2009)
- Challenge the inherent power differential in patient-provider relationships by fostering a “two-way relationship built on respect and a bicultural exchange which aims for equality and shared responsibility” (Brascoupé and Waters 2009)

Cultural Humility

- Engage in critical self-reflection about our personal and the systemic relationship with Indigenous peoples living in Canada (First Nations Health Authority 2018)
- Move toward developing respectful programs and policies based on mutual trust (First Nations Health Authority 2018)

Watch this video from Northern Health BC for more information: [Cultural Safety: Respect and Dignity in Relationships](#)

Organizational Awareness, Allyship and Decolonization

A critically important request made by the TRC Commissioners was to challenge us as individuals and as institutions to understand our relationship to Indigenous peoples living in Canada. The process whereby we reflect on our relationship with Indigenous peoples living in Canada is the first step towards Indigenous allyship and decolonization. The process of decolonization demands that we not only critically examine policies and deconstruct institutions that perpetuate the privilege and superiority of the dominant culture, but also value and revitalize Indigenous knowledge and Indigenous ways of being (Antoine et al 2019).

Culture informs how we think and act. However, the effect of culture on our thoughts and actions is not conscious. As a result, we are not aware of how culture may bias how we think and act. This is true not just for individuals but also for organizations. Organizations have cultures, which exist within, and are shaped by, the broader dominant culture. Organizational culture can be understood as the visible artifacts (e.g., architecture, language used, dress codes), shared values (e.g., organizational goals, strategies), and basic assumptions (e.g., taken for granted beliefs, perceptions) of an organization (Schien, 2010). When an organization creates policies or provides services, the organization “often unconsciously exclude[s] others who don’t share the cultural frame of mind from which we operate.” (Nova Scotia 2016). Acknowledging that the culture of an individual and the culture of an organization affect decision-making is the first step to developing more equitable programs and policies. Identifying these cultural biases is the next, more difficult step.

Indigenous allyship, as defined in emerging literature, is a state of being actively engaged in decolonizing processes (Hyett et al 2019; Swiftwolfe and Shaw 2019). An ongoing, self-reflexive process that examines how the person seeking to engage in allyship’s lifestyle and choices impact Indigenous peoples both directly and indirectly is required. An ally ideally has a desire to actively support social justice and promotes the rights of non-dominant groups and works to eliminate social inequality that allies benefit from. Allies offer support through the establishment of meaningful relationships with people and communities of the non-dominant group that they are working with. It is about supporting and not leading the work for social change and inequitable systems and institutions.

Application of the Indigenous Lens Tool to the HEIA Tool

The Indigenous Lens Tool was developed to assist with the application of the HEIA framework to policy and program development. In this section, four scenarios are presented that illustrate how the principles presented in the Indigenous Lens Tool may be applied to different scenarios. Each scenario addresses a particular step in the HEIA Tool.

HEIA Tool Step	Description
1a Population	<ul style="list-style-type: none"> Using evidence, identify which populations may experience significant unintended health impacts (positive or negative) as a result of the planned policy, program or initiative.
1b Determinants of Health	<ul style="list-style-type: none"> Identify determinants and health inequities to be considered alongside the populations you identify.
2 Potential Impacts	<ul style="list-style-type: none"> Unintended positive impacts. Unintended negative impacts. More information needed.
3 Mitigation	<ul style="list-style-type: none"> Identify ways to reduce potential negative impacts and amplify the positive impacts.
4 Monitoring	<ul style="list-style-type: none"> Identify ways to measure success for each mitigation strategy identified.
5 Dissemination	<ul style="list-style-type: none"> Identify ways to share results and recommendations to address equity.

Scenario 1 – HEIA Tool Steps 1a (Populations) and 2 (Potential Impacts)

You are the Executive Director of an urban cancer centre and you are engaged in an update of existing policies with a focus on care of diverse patient populations:

- Patient population profile from medical records
- Patient family advisory group involvement
- Outreach to local community centres and organizations within your catchment area
- Health and allied health professional engagement
- Promotion of direct patient involvement in strategic plan within the cancer centre through posters advertising online and paper questionnaires in the waiting rooms

Planning proceeds and, after extensive consultations, the final draft is ready to be tabled. Your assistant says she received a patient feedback form that you need to see before presenting the final draft of the revised policies to the board. After the demographic data section, which identified the patient as Indigenous, the form reads:

“I’ve been seeing my doctor for four years. I don’t like to come to the city because it’s so big, so sometimes I avoid going to see my doctor. Everyone is so busy in the city, and it can be hard to ask questions. My aunty said maybe they have a cancer navigator in the city who could help me. My aunty got the nursing station to arrange for an escort to come with me to the city, to help me out. Having someone come with me helps, but I still don’t like to stay long, because I want to get home to be with my family.”

You look at your assistant in shock. Your research and consultations for the policy review had never identified Indigenous peoples as a population that was served by your cancer centre.

Scenario 1 – Discussion

In this scenario, the policy review team felt that they had engaged in a thoughtful process to develop a document that reflected the diverse community that they serve. However, consideration of Indigenous peoples came as an afterthought once the document had already been written. In many policy or program development processes, Indigenous voices are often left out because of our own personal biases, institutional biases and cultural biases against Indigenous peoples that have resulted from our history of colonization. Many people are not aware of the unique socio-historical context of the relationship between Indigenous peoples and the Canadian government that yielded the residential school system and an inter-generational legacy of discrimination and oppression, historical trauma and inequality. The inclusion of the Indigenous perspective without meaningful consultation, and at the end of a process, further devalues the contributions of Indigenous peoples and entrenches into institutional ethos that Indigenous viewpoints are not worthy of being heard.

By applying the HEIA Template to the strategic planning process at the outset, Indigenous peoples would have been identified as a population that deserves consideration (HEIA Template step 1a). However, it is not sufficient to simply identify that the policy document or program that you are developing may affect Indigenous peoples. Indigenous peoples do not represent one group but rather it is a term that describes many distinct groups with unique histories, languages, cultural practices, and spiritual beliefs. Indigenous peoples living in Canada are not one homogeneous entity and therefore pan-Indigenous solutions are not appropriate. The first step is engagement with the Indigenous community or communities served by your organization and then co-leading the work of tailoring or developing new policies and programs together. Furthermore, there may be overlap with Indigenous peoples and other identified populations within the HEIA template e.g., Indigenous and living in a rural community, Indigenous and Two-Spirited etc. These intersecting identities and the impacts of these intersections also need to be considered and accounted for in the development of any program or policy.

Additional Resources

Appendix A – Cultural Safety Training Programs

Appendix B – Indigenous Ways of Knowing

Scenario 2 – HEIA Tool Step 1b (Scoping) and 3 (Mitigation)

You are a member of a provincial cancer screening policy team assessing the effectiveness of a new component of a cancer screening program – mailed letters that invite screen-eligible people to participate in colorectal cancer screening based on the address associated with their provincial health insurance card. Health administration databases were used to determine which proportion of letters sent out are returned to your organization (e.g., because the address information is incorrect) and whether the letters have had an impact on colorectal cancer screening participation rates. You find that less than 10% of mailed letters are returned, and there is a modest increase in screening participation after the introduction of the letters. You are pleased to report that the correspondence initiative may be

positively impacting cancer screening participation and present the findings of your assessment at an internal meeting.

A colleague from the Indigenous Health Team at your organization asks how this initiative is working for Indigenous peoples, as they are aware that their incidence of colorectal cancer is significantly higher. Through regional engagement with Indigenous communities, they have heard that some community members are not familiar with the screening letters at all, while others report not knowing what to do about the letters when they get them. You are surprised by this comment and realize that your assessment of the correspondence program did not identify this as an issue. An assessment of how the correspondence initiative impacts specific populations who are ‘under or never screened’ was not completed. You lose confidence that the new correspondence initiative is capturing all the screen-eligible people in the province.

Scenario 2 – Discussion

In this scenario, the cancer screening policy team member was not aware of the specific health contexts of Indigenous community members in the province, or of cancer incidence or screening patterns among Indigenous communities. As a result, they did not seek input from knowledge holders in this area about key considerations that should have shaped both the screening correspondence initiative, and their assessment of the initiative. Because an equity lens was not applied at the outset, a key population that may experience unintended health impacts as a result of the initiative was not identified (HEIA step 1a). Consulting with an Indigenous advisory group, Indigenous health delivery partners or communities, or the experts within your organization on Indigenous health at the development stage of the project would likely have uncovered key determinants of health that shape the way that Indigenous peoples experience the colorectal cancer screening correspondence initiative (HEIA step 1b). A few key determinants of health that may be relevant to the correspondence initiative are discussed below.

Health Determinants Discussion

Physical environment

- In many remote northern communities, the mailing system works differently than in the rest of the province (e.g., one centralized mail office in a community) and there are many opportunities for individual mail not to arrive at its intended recipient.

Housing shortages and high levels of mobility (e.g., between one’s reserve and an urban centre where one goes to school or works) among Indigenous peoples throughout the province (not just in northern communities) also mean that the address associated with one’s provincial health insurance card may not be the best address to send screening correspondence.

Education and health literacy

- The tone and reading level of the screening correspondence letters may not be suitable to communicate effectively with Indigenous audiences.
- There are many Indigenous peoples for whom English and/or French are not their first language.

- Education and literacy levels are lower among Indigenous individuals over the age of 50 but are increasing among younger Indigenous individuals. These inequalities are rooted in the deep structural determinants of health, including socio-economic marginalization, inappropriate education systems (that do not acknowledge or reflect Indigenous ways of knowing and being) and inequitable education funding.
- If the intent of the screening correspondence is not clear to recipients, and they do not have sufficient context about the screening program, the letters could create fear and confusion.

Trust in health care

- As a result of a long and ongoing history of discrimination and racism in the healthcare system, distrust of the healthcare services is common among Indigenous peoples.
- With this underlying lack of trust, and without sufficient context or awareness about the colorectal cancer screening program, some Indigenous peoples may receive the screening invitation letters with caution or skepticism (which would be compounded by the health literacy challenges noted above).

Local relevance

- As the letters were not designed to target Indigenous peoples, or with them in mind as potential recipients, they may not actually make sense in the health context of Indigenous community members.
- For example, they may suggest a course of action to participate in screening that is not applicable for the way in which healthcare services function in their community and may not acknowledge several additional steps or hurdles that a community member would need to take in order to access colorectal screening, leaving them with unanswered questions that could serve as barriers (e.g., where do I go to get screened? What is involved with the screening test? Do I need to get the test right away? Do I need to wait until next month when the doctor visits next?)

The most important way to mitigate the possible unintended negative impacts of a screening correspondence program that did not initially acknowledge or seek to include Indigenous contexts or perspectives in its design (HEIA Step 3) is to engage with Indigenous communities and teams within your organization that have expertise in Indigenous research and surveillance and relationships with communities, and to work with them to revise the initiative. This might include revisions to the correspondence letters themselves or/and in the delivery mode employed. It might also be important to explore how to raise awareness about screening and how to increase screening uptake among Indigenous communities more broadly. You could also consult with existing resources that may provide further insight into the ways that such an initiative is likely to be experienced by diverse Indigenous communities. It would also be useful to re-examine your assessment strategy to ensure that it captures the effectiveness of the initiative in Indigenous populations in particular.

Additional Resources

Appendix D – Indigenous-specific Determinants of Health

Scenario 3 – HEIA Tool Step 4 (Monitoring)

The cancer centre leadership identified equity as a guiding principle in a planned overhaul of programming and has employed the HEIA Tool to guide program development. Equity, with respect to Indigenous patients was a particular focus as this group was identified as having lower rates of screening participation and lower rates of follow up after a positive screen. Furthermore, Indigenous patients were found to under-utilize programs and services at the cancer centre compared to the general population. The Indigenous Advisory Committee at your hospital was involved from the outset and recommended substantive changes to existing policies and programs that were implemented. A suite of patient-based key performance indicators was developed to monitor the impact of these changes.

You are a program manager at the regional cancer centre attending the first annual screening performance meeting following implementation of the new initiatives. For the first time, screening and cancer centre utilization data are available for Indigenous communities served by your centre. The leadership team is pleased to hear that participation in programs located at the cancer centre has increased and that patient evaluations have also been positive. The data for screening, however, is less favourable. There has been no change in screening rates among Indigenous patients and no improvement in the rates of follow up after a positive screen. There is discussion around the table as to why the programmatic changes and the focus on equity did not yield results. You are tasked with understanding what happened.

Scenario 3 – Discussion

In this scenario, a regional cancer centre has taken a number of steps to improve the programs and services they provide:

- Recognizing gaps in service provision
- Applying the HEIA Tool to program and policy development
- Buy in from senior leadership
- Engaging Indigenous partners at the outset of program and policy development
- Implementing a framework for data collection and patient-centered evaluation
- Working with Indigenous communities to improve cancer and screening education/awareness

In spite of taking all of these steps, the cancer centre has not been able to change screening rates among Indigenous patients in their catchment area. A key step in monitoring (HEIA Template Step 4) is going back to assess how the program or policy affected equity. In this example, the regional cancer program was able to increase equity in access to programs delivered at the cancer centre. However, equity was not increased in cancer screening activity that occurs outside of the cancer centre in the communities. As such the ability for the regional cancer centre to effect change in screening rates

depends on a number of factors that may not be within the direct control of the cancer centre.

New programs do not always work the way we expect them to. Because screening occurs in the community, the cancer centre may have had more success increasing screening rates if more community level input had been obtained (e.g., engagement with community members, or local health care providers, beyond the organization's Indigenous Advisory Committee). In the framework of the HEIA Tool, this is an example of better understanding the population the cancer centre is serving (HEIA Step 1b) and circling back to improve the programming at the cancer centre (HEIA Step 3.) Even with successful aspects of a program, such as the improvement in utilisation of programming occurring at the cancer centre, it may be helpful to understand which aspects of the engagement strategy resonated most with Indigenous patients. Furthermore, it may be helpful to bring the learnings from that aspect of the program back to the partners (e.g., the Indigenous Advisory Committee, Indigenous patients accessing care and Indigenous communities served by the cancer centre). Their additional input may help to further tailor the program to the specific needs of the Indigenous individuals and communities served by the cancer centre.

Another consideration is the timeline over which the project is evaluated. The impact of an intervention aimed at increasing screening rates may not be adequately measured in months but rather in years. There are many factors that contribute to the hesitancy of Indigenous peoples to participate in screening. In addition, there is limited capacity in communities to raise awareness and increase education around the importance of screening. Changing people's perspectives and behaviours towards screening takes time and this recognition must be built into the evaluation. As a consequence, it may take longer to see measurable results in Indigenous communities – even an incremental increase in screening rates in a community is a positive sign. Whereas, assessing changes in knowledge and attitudes toward screening may be possible over a shorter time frame.

Whether or not changes in screening are observed following an intervention, it may be worthwhile to create space in the evaluation to look at other factors that may have impacted the final outcome. For example, the evaluation may show that there was no impact on screening but that there was increased knowledge about screening. This may provoke a more nuanced look at why knowledge did not translate into action, including further consideration of what may make screening participation particularly challenging for some Indigenous community members and what factors contribute to hesitancy to participate. At this point, revisiting the social determinants of health may provide a framework to understand why access to screening did not increase while knowledge about screening did increase.

Additional Resources

Appendix C – Cultural Safety & Health Equity Programs

Appendix D – Indigenous-specific Determinants of Health

Scenario 4 – HEIA Tool Step 5 (Dissemination)

You work at a regional cancer centre that has developed a wellness and cancer survivorship program that offers supports to patients recovering from cancer and their families. You used the HEIA Tool at the outset of program development, to ensure that your program will serve your regional cancer centre community equitably. You identified Indigenous peoples as a key population that might experience unintended impacts of the program (HEIA step 1a). Through your own research, discussion with Regional Cancer Program (RCP) team members with expertise in Indigenous health, and through direct engagement with the diverse urban and rural Indigenous communities in your region, you have pulled together resources and worked with Indigenous partners to co-develop programming that reflects the diversity of languages, cultural practices, and systems of knowledge among the RCP population (HEIA Steps 1b, 2 and 3). You have also worked with community partners to set up an ongoing data collection and monitoring process so that you will receive regular data about program participation and experiences, in an effort to support the evolution of the program as necessary to continue to meet the needs of the diverse population.

Scenario 4 – Discussion

Though you have helped to develop a functional, continuously monitored program that meets the needs of the diverse RCP population, the HEIA process is not complete until you have shared your experience in using the HEIA template to develop the community-informed and co-led program. Disseminating your findings (HEIA Step 5) is important both within your organization and with other organizations that might learn from your work in engaging communities to develop effective programming, but also with the communities that you engaged and partnered with throughout the process. Working with community partners to monitor and evaluate the programming, and ensuring that findings from this work are shared effectively, helps to ensure that the wider community is well aware of the programming and about how their involvement in the HEIA process has helped to shape the program. Community dissemination ideas should be co-led with community partners and reflect what you learned about how best to engage with the identified populations.

In addition to conventional information dissemination methods such as including a summary of the HEIA process used to shape your wellness program on your regional cancer website or mailing the summary to communities and community organizations, you might consider using more interactive approaches, such as radio spots or holding community gatherings, as well. By co-leading the work with community partners and engaging the wider communities in the final dissemination stage of the HEIA template, you have the opportunity not only to share the HEIA process and outcomes, but also to increase awareness and interest in your programming. Your work with community partners is not complete until you share what you have learned together in co-leading the program and what this means for the wider communities. This is a key step in maintaining accountability and ensures Indigenous communities have rightful ownership and control of evaluation and programming data.

Additional Resources

Table 1. Guiding Documents

Appendix B – Indigenous Ways of Knowing

Appendix E – Government Resources and Tools

Acknowledgements and Development Team

The team would like to acknowledge the Indigenous community members and organizations that contributed to the development of this resource, including Regional Indigenous Cancer Navigators, Coordinators and Leads across the province, the Joint Ontario Cancer Care Committee (with representation from Ontario Political Territorial Organizations and Provincial Indigenous Organizations) and Indigenous policy stakeholders. The resource was developed by Naana Jumah, Bernice Downey, Laura Senese, Alethea Kewayosh, and Jill Tinmouth. This resource was initiated as part of a Canadian Institutes of Health Research-funded research program focused on supporting cancer screening among Indigenous populations in Ontario.

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Appendix A – Cultural Safety Training Programs

1. Indigenous Relationship and Cultural Awareness Courses - elearning.cancercare.on.ca
2. San'Yas Indigenous Cultural Safety Training - sanyas.ca/
3. Indigenous Primary Health Care Council Indigenous Cultural Safety Training - iphcc.ca/ontario-ics-program/
4. Indigenous Cultural Competency Training (ICCT) - Ontario Federation of Indigenous Friendship Centres - ofifc.org/indigenous-cultural-competency-training-icct
5. EQUIP Healthcare Modules: equiphealthcare.ca/equipping-for-equity-online-modules/

Appendix B – Indigenous Ways of Knowing

1. Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives (2nd Edition)
Authors: James Waldram, D. Ann Herring, and T. Kue Young
2. Research is Ceremony: Indigenous Research Methods Author: Shawn Wilson
3. Indigenous Methodologies: Characteristics, Conversations, and Contexts. Author: Margaret Elizabeth Kovach
4. Our Knowledge is not Primitive: Decolonizing Botanical Anishinaabe Teachings. Author: Wendy Makoons Geniusz
5. Visions of the Heart. Authors: Davig Long & Olive Patricia Dickason
6. Preserving the Sacred: Historical Perspectives on the Ojibwa Midewiwin. Author: Michael Angel
7. Reclaiming Indigenous Voice and Vision. Author: Marie Battiste
8. Two Families: Treaties and Government. Author: Harold Johnson
9. OCAP® fnigc.ca/ocap-training/
10. Indigenous Ally Toolkit. Author: Dakota Swiftwolfe & Leilani Shaw, Montreal Urban Aboriginal Community Strategy Network.

Appendix C – Cultural Safety & Health Equity

1. Diversity Lens Toolkit, Nova Scotia Health Authority June 2016
2. Approaches to Community Wellbeing Model Description, Sioux Lookout First Nations Health Authority February 2015
3. Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. Chapter 9: Research Involving the First Nations, Inuit and Métis Peoples of Canada, December 2010. https://ethics.gc.ca/eng/tcps2-eptc2_2018_chapter9-chapitre9.html
4. The Indigenous Physicians Association of Canada and the Royal College of Physicians and Surgeons of Canada. Promoting Culturally Safe Care for First Nations, Inuit and Métis Patients: A Core Curriculum for Residents and Physicians. Winnipeg, MB & Ottawa, ON: IPAC-RCPSC Core Curriculum Development Working Group; 2009.
5. Solomon R and Orridge C. Defining Health Equity. Healthcare Papers, 14(2) July 2014: 62-65. doi:10.12927/hcpap.2015.24112
6. Braveman, P. What Are Health Disparities and Health Equity? We Need to Be Clear Public Health

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7. Brascoupe S and Waters C. Cultural Safety: Exploring the Applicability of the Concept of Cultural Safety to Aboriginal Health and Community Wellness. *Journal of Aboriginal Health* 2009; 5(2): 6-41.
 8. Ramsden IM. Cultural safety and nursing education in Aotearoa and Te Waipounamu [Doctoral dissertation]. Victoria, AU: Victoria University of Wellington; 2002
 9. Churchill M, Parent-Bergeron M, Smylie J, Ward C, Fridkin A, Smylie D, et al. Evidence Brief: Wise Practices for Indigenous-specific Cultural Safety Training Programs. Toronto, ON: Well Living House Action Research Centre for Indigenous Infant, Child and Family Health and Wellbeing, Centre for Research on Inner City Health, St. Michael's Hospital; 2017.
 10. EQUIP Healthcare Toolkit: equiphealthcare.ca/resources/toolkit/ The EQUIP team is committed to sharing knowledge about equity-oriented care with health care providers and organizations, to support them to adopt equity-oriented practices and provide the best possible care to their patients.

Appendix D – Indigenous-specific Determinants of Health

1. Smylie, J and Firestone, M. 2016. The health of Indigenous Peoples. p. 434-466. In *Social Determinants of Health: Canadian Perspectives*, 3rd edition. Raphael, D. (ed). Canadian Scholars' Press Inc., Toronto ON.
2. Loppie Reading, C and Wien, F. 2009. *Health Inequalities and Social Determinants of Aboriginal Peoples' Health*. Prince George, BC: National Collaborating Centre for Aboriginal Health.
3. Greenwood, M and de Leeuw, S. 2012. Social determinants of health and the future of well-being for Aboriginal children in Canada. *Pediatric Child Health*. 17:7, 381-384.
4. Greenwood M, de Leeuw, S, Lindsay, N, and Reading, C. (eds). 2015. *Determinants of Indigenous Peoples' Health in Canada: Beyond the Social*. Canadian Scholars' Press Inc. Toronto ON.
5. Reading, C. 2015. Structural Determinants of Aboriginal Peoples' Health. p 3-24. In *Determinants of Indigenous Peoples' Health in Canada: Beyond the Social*. Greenwood M, de Leeuw, S, Lindsay, N, and Reading, C. (eds). Canadian Scholars' Press Inc., Toronto ON.
6. Wilson, D, et al. 2013. Social Determinants of Health Among First Nations, Inuit, and Métis. P. S13-S23. In *Health Professionals Working with First Nations, Inuit, and Métis Consensus Guideline*. *J Obstet Gynaecol Can*. 35:(6 eSuppl), S1–S52.
7. What Determines Health? canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html#determinants
8. canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health/what-makes-canadians-healthy-unhealthy.html#unhealthy
9. National Collaborating Centre for Indigenous Health. 2017. Education as a social determinant of First Nations, Inuit and Métis Health. Prince George, BC: National Collaborating Centre for Indigenous Health. [nccih.ca/495/Education as a social determinant of First Nations, Inuit and M%C3%A9tis health.nccih?id=226](http://nccih.ca/495/Education%20as%20a%20social%20determinant%20of%20First%20Nations,%20Inuit%20and%20M%C3%A9tis%20health.nccih?id=226)
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Appendix E – Government Resources and Tools

1. Non-Insured Health Benefits (NIHB): canada.ca/en/health-canada/services/non-insured-health-benefits-first-nations-inuit/administration/about-non-insured-health-benefits-nihb-program.html
2. The Outcome Document: undocs.org/A/RES/69/2
3. National Collaborating Centre for Indigenous Health (NCCIH): nccih.ca/en/
4. Statistics Canada - 'Health indicators by Aboriginal Identity'
150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310045701