

Emergent Principles and Protocols for Indigenous Health Service Evaluation:

Summary Report of a Provincial
“Three Ribbons” Expert Consensus Panel

*“Moving from the tall ship to the canoe: Can we decolonize evaluation?”
~ Knowledge Keeper, Jeanne Hebert*



TABLE OF CONTENTS

Background	2
Panel partners and participants	2
Sponsoring Agencies	2
Panel Co-Chairs	3
Panel Participants	3
Administrative Support	4
Panel Processes and Methods	4
Recruitment and Meeting Schedule	4
Pre-meeting Preparatory Materials and Questions	4
Overview of February 11 th In-Person Gathering	5
February 11 th Discussion Methods	5
Finalizing the Report and Recommendations	6
Summary of February 11 th Panel Discussions	7
Opening reflections	7
Challenges and Issues with Dominant Evaluation Systems	8
Reflections on Wise Approaches to Indigenous Health Service and Program Evaluation – Emergent Approaches and Models	12
Emerging Guiding Principles for Indigenous Evaluation	13
Indigenous Governance	13
Clarity of Purpose: “Who wants to know and why?”	14
Indigegogy	14
Inter-relationality	14
Minobimaatisiwin - Living the Good Life and other Wholistic Concepts of Good Living	14
Collectivity	15
Responsiveness	15
Wise Protocols for Indigenous Evaluation	15
Reflections on American Evaluation Association Guidelines	17
Closing	17
Guidelines for Indigenous Health Service and Program Evaluation	18
Concluding Remarks	20
Please visit www.welllivinghouse.com to view the following references:	
Appendix A: Summary of MOHLTC funded provincial capacity building research program entitled “Urban Aboriginal Health Counts: Advancing Urban Aboriginal Population-Based Health Needs Assessment and Health Service Evaluation in Ontario”	
Appendix B. 3 Ribbon Panel Agenda	
Appendix C: American Evaluation Association Guiding Principles For Evaluators	
Appendix D: Dr. Smylie’s Summary Slide	
Appendix E: Summary of International Systematic Review	

BACKGROUND

High quality and relevant evaluation is foundational to effective and publically accountable health services (Centers for Disease Control and Prevention, 1999). Indigenous populations in Canada experience a double standard with respect to relevant and useful evaluation of health services and programs, compared to the general Canadian population (Smylie & Anderson, 2006). Indigenous specific programs and services have been commonly subject to externally imposed, under-resourced, poorly designed and implemented evaluations that are mismatched to Indigenous community evaluation priorities (Grover, 2008; Scott, 2008). Furthermore, mainstream services commonly exclude assessment of Indigenous specific needs in their performance assessments (Grover, 2008).

In 2015/2016, the Well Living House (WLH), in partnership with four Indigenous health service providers operating in urban and related areas, brought together a group of experienced and respected Indigenous health service evaluators with ***the goal of informing a set of evidence based guidelines for urban Indigenous health service and program evaluations***. We called the panel the “Three Ribbon” panel in recognition of the inter-relational nature of Indigenous knowledge and practice. This report summarizes the panel processes and findings.

This work was part of a larger Ontario Ministry of Health and Long Term Care funded provincial capacity building research program entitled “*Urban Aboriginal Health Counts: Advancing Urban Aboriginal Population-Based Health Needs Assessment and Health Service Evaluation in Ontario*” (see Appendix A for a summary of this larger research program).

The work of the panel was additionally informed by an international systematic review of Indigenous health service and program evaluation.

PANEL PARTNERS AND PARTICIPANTS

SPONSORING AGENCIES



Seventh
Generation
Midwives
Toronto
(SGMT)



De dwa da
dehs nye>s
Aboriginal
Health Centre
(DAHC)



Southwest
Ontario
Aboriginal
Health Access
Centre
(SOAHAC)



Waasegiizhig
Nanaandawe'yewig
amig Health Access
Centre (WNHAC)



Well Living
House (WLH)

PANEL CO-CHAIRS

Pat O'Campo, PhD

Research Scientist, Centre for Research on Inner City Health; Professor, Dalla Lana School of Public Health, University of Toronto; Chair of Intersectoral Solutions to Urban Health Problems

Cherylee Bourgeois, RM

Seventh Generation Midwives of Toronto; Cherylee Bourgeois Director, Clinical and Professional Development, Ontario Association of Midwives; Sessional Lecturer Midwifery Education program, Ryerson University

PANEL PARTICIPANTS

Knowledge Keeper Jeanne Hebert

Aboriginal Patient Navigator Niagara Region of the De dwa da dehs nye>s Aboriginal Health Centre in the Niagara Region

Janet Smylie, MD MPH FCFP

Director, Well Living House Action Research Centre for Indigenous Infant, Child and Family Health and Wellbeing; Research Scientist, Centre for Research on Inner City Health; Staff Physician, Department of Family and Community Medicine St. Michael's Hospital; Associate Professor, Dalla Lana School of Public Health, University of Toronto; CIHR Applied Public Health Research Chair in Indigenous Health Knowledge and Information

Constance McKnight

Executive Director, De dwa da dehs nye>s Aboriginal Health Centre

Vicki van Wagner, RM, PhD

Founding director of Ryerson University's Midwifery Education Program (MEP), Associate Professor

Michelle Firestone, PhD

Well Living House Research Scientist, Assistant Professor Dalla Lana School of Public Health, University of Toronto

Raglan Maddox, PhD, MPH Well Living House Post-Doctoral Fellow

Sara Wolfe, RM

Seventh Generation Midwives of Toronto founding partner; Adjunct Professor Midwifery Education program, Ryerson University; MBA candidate, Rotman School, University of Toronto

Susan Snelling, PhD

Evaluation Specialist, Public Health Ontario; lead consultant of Social Research Consulting

Heather Manson, MD MhS

Chief Health Promotion, Public Health Ontario; Assistant Professor Dalla Lana School of Public Health, University of Toronto

Wayne Warry, PhD

Director of the Centre for Rural and Northern Health Research (CRaNHR), Professor at Laurentian University

Roger Boyer II

Primary Health Care Manager at Maamwesying North Shore Community Health Services; Assistant District Governor at Rotary International; Doctoral Candidate, Ashbury Theological Seminary

Conrad Prince

Masters of Sociology Candidate, Carlton University; Well Living House Research Program Manager

ADMINISTRATIVE SUPPORT

Jothi Shanmugam, MA
Well Living House Research Assistant

PANEL PROCESSES AND METHODS

RECRUITMENT AND MEETING SCHEDULE



The Three Ribbon Panel members were identified and recruited by the project leads from the four sponsoring Indigenous health service agencies with the support of the WLH research team. We aimed to select a mixed group of Indigenous and allied evaluation researcher specialists; public health and health service practitioners; Indigenous health service managers; and Indigenous knowledge keepers. All participants were experienced in the evaluation of Indigenous health services and programs.



Potential members were invited to participate through an email that described the overall research project and the intent of the expert panel, with f/u phone call as required. Once the panel members confirmed their interest and availability in participating, arrangements were made for travel and meeting logistics.



All panel members attended a one-day gathering in Toronto at the Li Ka Shing Knowledge Institute of St. Michael's Hospital on February 11th, 2016. (See Appendix B for the meeting agenda).



A follow-up teleconference meeting to review the summary of the face-to-face gathering and further develop recommendations was held on May 12th, 2016.

PRE-MEETING PREPARATORY MATERIALS AND QUESTIONS

In order to provide some relevant background information and to focus the content of the panel discussion, our research team circulated reading material and 'homework' questions to the Three Ribbon Panel members several weeks before the in-person gathering. The American Evaluation Association (AEA) Guiding Principles for Evaluators (Appendix C) and the following accompanying questions were shared through email:

In your knowledge and experience what are the major problems or challenges that arise in the evaluation of Indigenous health services and programs? (please list and give examples).

The American Association of Evaluation has outlined guiding principles for evaluators, prefaced by a set of underlying assumptions (attached). How do these need to be modified for Indigenous health service and program evaluation? Are there underlying assumptions that also need to be added/modified?

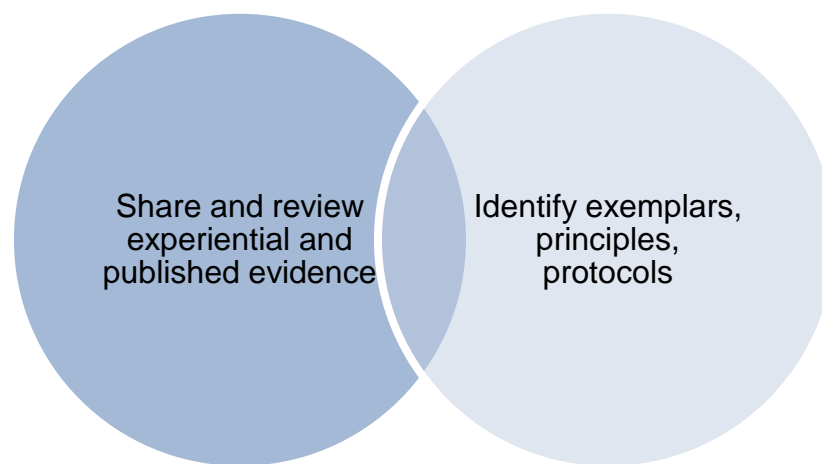
What approach(es) are you aware of that have been successfully used in Indigenous health services and program evaluation? How was/were/they successful?

OVERVIEW OF FEBRUARY 11TH IN-PERSON GATHERING

Co-chairs Pat O'Campo and Cherylee Bourgeois welcomed participants and Elder Jeanne Herbert opened with a smudge, teaching, and prayer. This was followed by round table introductions during which participants shared their motivation for attending the meeting.

Janet Smylie, who is the nominal principal investigator (lead researcher) for the project, then provided an overview of WLH and the larger *Urban Aboriginal Health Counts* research program including the I-HIKE (Indigenous Health Information, Knowledge and Evaluation) network. She then described the proposed processes (pre-meeting questionnaire, one day face to face meeting, post-meeting questions and synthesis of findings, follow up teleconference, review and finalization of documents) and outputs of the Three Ribbon Panel (academic publication & community friendly fact sheet).

She identified the two key objectives for the day:



She then reviewed linked Indigenous evaluation activities at WLH (systematic reviews of published, grey, and online literature; national consensus paper) and invited all participants to be authors on the panel outputs. The slides for Dr. Smylie's presentation can be found in Appendix D.

This was followed by a roundtable discussion of the three pre-meeting preparatory questions (listed above). Raglan Maddox then summarized the preliminary results of an international systematic review of published literature on Indigenous health service and program evaluation (Appendix E).

After lunch, participants broke into two smaller group to discuss exemplars, principles, and protocols for Indigenous health services and program evaluation. Smaller groups reported back to the larger group and then the meeting was closed with a song from Elder Jeannie Herbert.

FEBRUARY 11TH DISCUSSION METHODS

We drew on Indigenous protocols, including the support of Indigenous knowledge keeper and Elder Jeannie Herbert to create a welcoming, grounded and respectful space for panel members to share their ideas. We sat in a circle in a room with windows around a large table. Jeannie opened the day with prayer, smudge and teaching. This was followed by roundtable introductions, which included background information about the participants. The facilitator (Janet Smylie) then initiated the first of

several rounds of conversation by asking the first guiding questions (In your knowledge and experience what are the major problems or challenges that arise in the evaluation of Indigenous health services and programs?).

Each person in the circle had a chance to speak and contribute. The facilitator took flip chart notes, tracked the discussion and summarized after each subsequent discussion question and round. As mutual agreements and common ground emerged, the facilitator invited the circle to reflect on them. Before closing the circle, participants were asked to share any last thoughts. Then Jeannie closed the day with a song.

FINALIZING THE REPORT AND RECOMMENDATIONS

We held a panel videoconference on May 12th during which we reviewed and refined the report summarizing the February 11th discussion and developed preliminary recommendations for Indigenous health service and program evaluation. Emerging recommendations are documented near the end of this report. We had one final teleconference in June during which we finalized this report and its recommendations.

SUMMARY OF FEBRUARY 11TH PANEL DISCUSSIONS

OPENING REFLECTIONS

The guiding intention of the Three Ribbon Panel was to support the development of “wise” practice guidelines for Indigenous health service evaluation using the vehicle of transformative shared learning through consensus building discussion circles. We decided to use the term “wise” in place of “best” or “evidence-based” to ensure that Indigenous knowledge and practice would be included as a core source of information and to challenge the notion of robust and scientific “evidence” as something that emerges only from universities and/or non-Indigenous sources. “Wise” practices are just as effective as ‘evidence-based’ practices.

There was consensus that Indigenous communities have a richness of knowledge and wisdom that can contribute to evaluation research and practice.

Early discussion also included:

- The need to use Indigenous languages, concepts, and worldviews to define and describe wise practices in health service evaluation. This included a discussion of the term “Aboriginal” versus “Indigenous” and the importance of recognizing and articulating the distinctness of local Indigenous worldviews.
- The importance of recognizing and applying past and existing Indigenous systems of accountability and proof.
- Existing gaps in Indigenous population health data and how these data gaps interfere with the identification and ability to address Indigenous/non-Indigenous health inequities
- The complexities of comparisons for Indigenous peoples (i.e. Who are we comparing and why; situations when there is not a relevant comparison group due to local diversity)

One panel member eloquently posed the following questions and overarching goal for Indigenous health service and program evaluation at the opening circle:

“When I look at my community, how do I compare to other communities and what can I learn from what they are doing? How can they learn from us, and how can we engage in a collective analysis, and begin to move together? The goal is “Minobimaatisiwin”, the good life.” (Roger Boyer II)

CHALLENGES AND ISSUES WITH DOMINANT EVALUATION SYSTEMS

When asked to reflect on *the major problems or challenges that arise in the evaluation of Indigenous health services and programs*, many examples and experiences of tensions and barriers were raised. There was strong consensus overall from the panel that existing non-Indigenous and dominant systems, processes, measures and tools for health service and program evaluation are currently being externally imposed on Indigenous communities. This commonly results in significant disconnects between the goals and methods of the evaluations and their utility and relevance for Indigenous communities.

Much of this disconnect stems from the role and influence of funding bodies that control the flow of resources for programs, services and their evaluations. Indigenous health and social service programs, services and evaluations are systematically underfunded and under-resourced and this directly impacts the infrastructure and capacity for sustainability of programs and services, as well as the quality of the evaluation. These gaps in adequate resourcing also result in insufficient data sets and evidence to support wise health programming and services in Indigenous communities. Finally, funding bodies have explicit and/or implicit evaluation goals that may be in tension with those of Indigenous communities and Indigenous health service providers, making the evaluations theoretically faulty. For example, the evaluation may be explicitly or implicitly designed to ensure that funder expenditures are justified, while the community may be more interested in understanding how to optimize relevance and effectiveness of local health services and programs. As Heather Manson from Public Health Ontario stated, *"evaluations that describe activities justify funding, but don't tell us if we are doing a good job."* This current situation is creating what SGMT midwife Sara Wolfe described as "evaluation fatigue" and it is making Indigenous health practitioners and communities have an "allergy" to evaluation.

When evaluation processes, tools, and measures are designed, adapted and implemented without input, involvement or governance from Indigenous communities, it fosters false realities and stories about Indigenous people. As Sara Wolfe described, *"often, consultation happens at isolated points during evaluation rather than as an iterative process."* If the measuring stick is externally developed and imposed, the wrong measures are used and outcomes can be interpreted as failed programs and services. For example, as Susan Snelling of Public Health Ontario explained, when a program in a First Nation was evaluated based on poor attendance, the funder considered it as both a failed evaluation and a failed program, instead of as an opportunity to learn about what would work better and why. Another example provided by Gertie Mai Muse is described in Textbox 1. When community members avoid programs, this too is an outcome.

Case Study: Indigenous health service accreditation process

In addition to lived Indigenous experience, Gertie Mai Muse has worked for many years in a management and executive role for multiple Indigenous health services. She has identified a number of challenges of imposed accreditation systems. It was clearly evident to Gertie Mai and to the staff and community involved in programs at an Indigenous health centre where she was in an executive management role that their organizational processes and implementation of services were working well. Gertie Mai described a high level of 'inherent community accountability' that was the result of an integrated and comprehensive community engagement process and subsequent strong and reciprocal community member – service provider relationships. Participant community members knew what they wanted and had been able to ensure that these needs were prioritized and addressed in the development and implementation of health services since they were actively engaged and involved in these processes.

However, articulating these inherent community accountability mechanisms in the accreditation process was challenging – perhaps because they were “built-in” and strength of relationship and reciprocity are things that external evaluators may be less accustomed to measuring.

When external reviewers engage in the process of accreditation, and evaluate performance based on national standards of best practices in health and social services, local and longstanding Indigenous capacity and strengths may not be captured or acknowledged. There needs to be support and guidelines in place for Indigenous communities to more accurately identify, describe, and evaluate practices and processes such as community engagement and participant- service provider relationships - ensuring that these important local accountability mechanisms are not overlooked.

In an effort to address these challenges, Gertie Mai Muse chaired a National Indigenous committee with the Canadian Centre Accreditation (CCA) (<https://www.canadiancentreforaccreditation.ca>) to put in place meaningful and relevant accreditation standards for Indigenous and non-Indigenous providers delivering services to the Indigenous community.

There were several examples and support for evaluation to focus on methods and measures that are meaningful and relevant for participant Indigenous communities. For example, measures that capture when an individual is learning about their identity, language and culture, rather than what might be considered a failure if that individual continues to misuse substances. Vicki Van Wagner provided some reflections on the importance of the 'how's in Indigenous evaluation in textbox 2.

Missing the 'how's' in Nunavik midwifery: Reflections by Vicki Van Wagner

I have been inspired by participating in the 3 ribbon panel to reflect on how important it is to report about how evaluation is done. In some of my past experiences, the teams I have worked with have focused on the outcomes and we left the story of *how* untold. It is more clear to me now, after our panel's discussions and our review of the literature, that when evaluating Indigenous health services the stories of community engagement are just as important as the outcomes we report. Community engagement in defining the project, the outcome measures, in doing the work of the research and owning the results and the tools that are developed is a very important outcome in and of itself. We are currently launching the second phase of the evaluation of remote midwifery services in Nunavik, and the local midwives whose work will be described were excited to talk about the "hows" and what they mean.

Bringing the findings back to the community is also so important to make visible. When Mina Tulugak and I reported our findings about the successful outcomes in for the Nunavik midwives to the Board of the Inuulitsivik hospital, most of whom are Inuit Elders, the pride in the work of the local midwives was palpable. Elders talked about how they themselves had been born on the land in igloos or summer tents cared for by midwives; they spoke strongly about how returning birth and midwifery to Nunavik was a source of strength and pride for the people and an expression of Inuit knowledge.

The Three Ribbon Panel strongly agreed that Indigenous communities want to define, decolonize and Indigenize their own program and service evaluation. As stated by Roger Boyer II from Maamwesying North Shore Community Health Services: *“There is a fever, a thirst for our own [Indigenous] data and evaluation.”* Sara Wolfe felt that a part of this shift might also require re-naming evaluation to reflect that it can be a meaningful process and that measurement can be about incremental change. Pat O’Campo from the Centre for Research on Inner City Health proposed the potential for evaluative thinking as a way to share and create space for community-led and governed program and service evaluation.

This discussion led to many questions about how to measure Indigenous knowledge, Indigenous identity, access and use of Indigenous language and ceremony. Other questions that were raised around the circle included: How do we measure what are grandmothers are telling us, or traditional

“There is a fever, a thirst for our own [Indigenous] data and evaluation.”

*“We don’t have Indigenized frameworks or have the ability to self-Indigenize or evaluate what we are doing; we need more Indigenous frameworks-in our own languages.”
(Roger Boyer II)*

knowledge or our resiliencies? How do we measure a cyclical and inter-relational journey?; and what are the landmarks or signposts on that journey? For several Three Ribbon Panel members, it feels like Indigenous knowledge and practices regarding evaluation are being lost in translation: *“We don’t have Indigenized frameworks or have the ability to self-Indigenize or evaluate what we are doing; we need more Indigenous frameworks-in our own languages.”* (Roger Boyer II)

Building on this perception that important Indigenous knowledge and practice is being lost in translation, the panel discussed literacy challenges. Differing literacies and interpretations of language and concepts between evaluators and Indigenous communities is a common barrier. Mainstream evaluation terminology as expressed in oral and written English may not translate into local Indigenous languages or represent familiar concepts and local ways of knowing and doing. Likewise, mainstream evaluators are commonly unfamiliar with, or even dismissive of the diverse complexities and robust nature of local Indigenous knowledge and practice regarding evaluation, which may be expressed in Indigenous languages. Elder and Knowledge Keeper Jeanne Hebert brought up the example of spirituality - which is defined and interpreted differently for everyone. Jeanne also described misinterpretations of concepts like ‘success’ which can for Indigenous peoples and communities can be about strengthening of Indigenous identity and self-awareness.

In an attempt to respond to this discussion, including the questions raised and the need to develop more Indigenized tools and frameworks, the next part of the Three Ribbon Panel dialogue focused on exploring existing wise approaches to Indigenous health service and program evaluation.

REFLECTIONS ON WISE APPROACHES TO INDIGENOUS HEALTH SERVICE AND PROGRAM EVALUATION – EMERGENT APPROACHES AND MODELS

For the next part of the Three Ribbon Panel, the discussion focused on approaches and models that have meaningfully been used in Indigenous health services and program evaluation. First, Raglan Maddox, a post-doctoral fellow at the WLH presented the preliminary findings from the systematic review, which included emerging methods or approaches, principles and protocols for Indigenous health service evaluation. After breaking for lunch, panel members broke up into two smaller groups to share an example from their own experience and/or from the literature that they think is exemplar and to identify key principles and protocols in the discussed exemplars.

This summary is divided into emergent approaches/methods (below) followed by guiding principles (next section). It is important to note that these different components of health service and program evaluation often overlap or are interconnected to form one whole.

Evaluation in Indigenous settings must stem from theory and frameworks that focus on how we live our lives. Evaluation methods are often rooted in non-Indigenous specific or mainstream science or public health, but there are examples of approaches that build on Indigenous ways of knowing and doing. Examples include: empowerment evaluation and building capacity so that community takes on evaluation as a natural part of what they do and Plan-Do-Study-Act (PDSA). Wise methods might include Concept Mapping; Photovoice; Use of stories and narrative and using the Medicine wheel as a health assessment tool and wellness plan to support people to learn about who they are and where they are at.

Pat O'Campo provided the example of the Rebel Evaluation Course which she has co-developed and taught to community based health and social service providers in Toronto. This course is founded on the premise that anyone can do evaluation and gives communities the tools to ask their own questions. Elder Jeanne Hebert supported this approach by saying, "We are always evaluating." This approach would also support sustainability as communities, organizations and programs have the skills and capacity for ongoing, continual evaluation work.

Roger Boyer II suggested drawing more from business models/business intelligence and leveraging technology. He cited the Plan-Do-Study-Act (PDSA) Cycle as a relevant approach that allows for baby steps, rapid testing, and monitoring of smaller changes that might be facilitated by a longer term research grant.

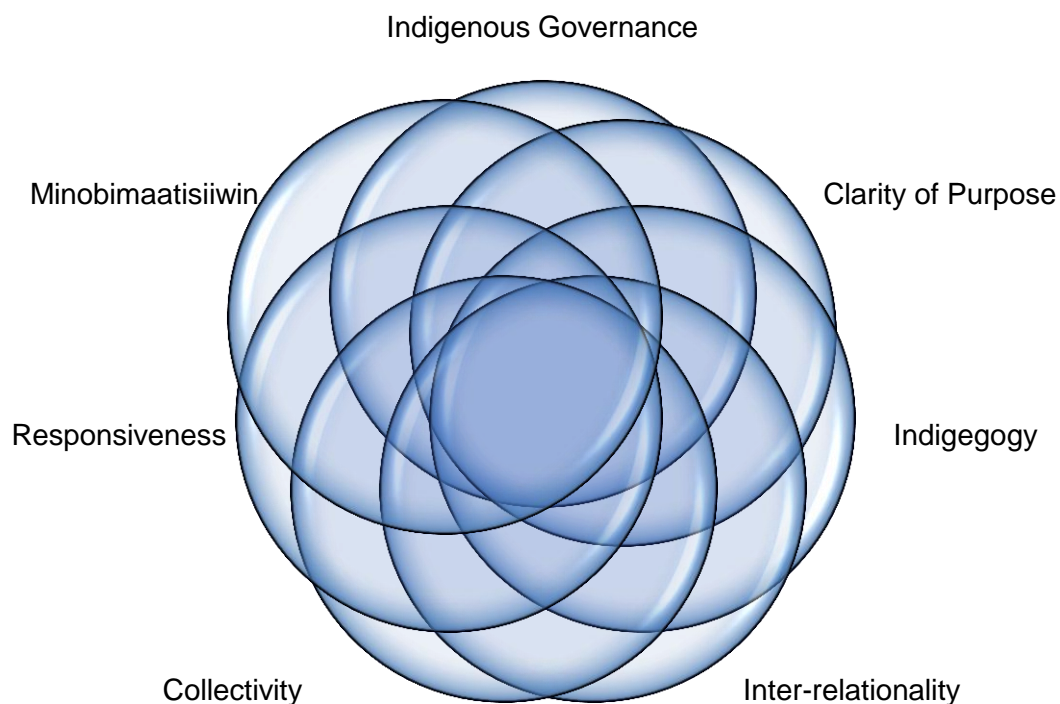
An important discussion point that was raised in one of the smaller groups was around the importance of linking appropriate methods to specific Indigenous community setting or context¹ and finding the right balance between evaluator(s) who are completely integrated with the Indigenous communities in which the evaluated intervention has occurred (i.e. they are local community members, but as a result may have some "blind" spots with respect to local systems that they take for granted) and the excessive detachment of an external evaluator.

¹ We understand that Indigenous **communities** are self-defined groups of Indigenous peoples linked together by diverse characteristics that can include kinship, land ties, language, culture, geographic residence, historic and/or current governance systems, and other collective causes. By Indigenous community **context** we mean the whole situation, historical and socio-political background, and/or environment relevant to a particular Indigenous community.

Using or adapting evaluation methods that resonate with Indigenous communities can be an effective and relevant way to engage in Indigenous health program and service evaluation. For example, using stories, photo-voice or concept mapping as research tools can support local participation, uphold collective values and establish a conceptual foundation upon which measurements and evaluation processes can be grounded. Elder and Knowledge Keeper, Jeanne Hebert shared her experiences drawing on the medicine wheel as an evaluation tool for wellness planning and understanding where people are at.

EMERGING GUIDING PRINCIPLES FOR INDIGENOUS EVALUATION

Building on the principles shared by Raglan Maddox as part of the systematic review and their own lived experiences and involvement with evaluation, the Three Ribbon Panel members came up with the following list of emerging principles to guide Indigenous program and service evaluation.



INDIGENOUS GOVERNANCE

There are several different layers to governance with Indigenous health service and program evaluation. On one level, the evaluation process itself must be community led and governed, meaning that communities drive the entire process and sets the priorities for the evaluation. This not only supports community self-determination, but has also results in more positive program outcomes. Truly effective and community relevant Indigenous program and service evaluation require that Indigenous people are central to the decision making and governance at broader institutional and systemic levels in addition to the level of program and evaluation implementation.

CLARITY OF PURPOSE: "WHO WANTS TO KNOW AND WHY?"

Several panel members discussed the integrity of the evaluator and the importance of self-locating and transparency around the relationships and connections between evaluators, program staff and community. Whether an evaluator is external to a community or a member of the community where a program or service is being evaluated, self-reflexivity about their position and relationality to the people using the service, delivering the service and funding the service is critical. This also includes an acknowledgement of their limitations, motivations and purpose for conducting the evaluation. This information, along with information regarding the unique local context of the community in which the evaluation was conducted will inform sharing of the evaluation beyond and across Indigenous communities.

INDIGEGOGY

Roger Boyer II introduced the term "*Indigegogy*" to reflect approaches that are foundationally grounded in Indigenous knowledge and practice – at the same time recognizing that there is innate colonial contamination. Indigenous knowledge and practices include the diversity of current and lived Indigenous knowledge, skills, values and beliefs relevant to the Indigenous community or population involved in the evaluation and should not be externally prescribed (for such an imposition process could be considered a recolonization). This requires a respect for local protocols and culture and recognition. The use of Indigenous languages is important but not completely essential to this foundational integration of Indigenous culture in its multiple and varied expressions. Indigegogy will influence how evaluations are developed, implemented and analyzed and will ensure that findings are culturally sensitive and accurate.

INTER-RELATIONALITY

Inter-relationality (the connection and interdependence between all things including information) is an important and cross-cutting concept in Indigenous knowledge systems and practice. Applying the concept of inter-relationality or the foundational importance of the connection to all things to the evaluation of Indigenous health services and programs commonly requires significant adjustment to mainstream evaluation methods and measures, which commonly attempt to focus questions and outcomes.

MINOBIMAATISIIWIN - LIVING THE GOOD LIFE AND OTHER WHOLISTIC CONCEPTS OF GOOD LIVING

Roger Boyer II spoke about Minobimaatisiiwin as a whole, and the importance of these issues when bringing forward Indigenous knowledge and worldview and ensuring it an integral part of program evaluation. Holistic models of wellness, such as Minobimaatisiiwin, represent a benchmark framework for Indigenous health service and program evaluation and represent the application of inter-relationality to health. Elder and Knowledge Keeper, Jeanne Hebert spoke about the Haudenosaunee Great Law, which is the oral constitution, whereby the Iroquois Confederacy was bound together. The laws were first recorded by means of wampum symbols as part of a narrative noting laws and ceremonies to be performed at specific times. Vicki Van Wagner explored these ideas with her colleagues in Nunavik who explained the Inuit concept of Qanuinnngisiarniq, which means variously 'everything is OK' in the broadest sense of everything and the most meaningful sense of OK, and also 'wellness', taking care of yourself and 'living well in a healthy way'. Again, evaluations wishing to

understand how community governance, laws, and ceremonies impact health outcomes would be wise to build on local Indigenous governance frameworks such as the Minobimaatisiwin, the Great Law, Qanuinnngisiarniq and other wholistic concepts of living a good life.

COLLECTIVITY

Local community leadership is intrinsic to community wellbeing. The principle of collectivity requires meaningful engagement and participation of the local community in all aspects of health service and program evaluation across service domains and subpopulations. This involvement can include broad based Indigenous leadership and community participation linked directly to the evaluation activities such as hiring of Indigenous staff, consultants, advisory boards, reference groups, working groups or mentoring from Elders.

RESPONSIVENESS

Evaluation needs to reflect local community context and should be flexible to respond to the specific needs and environment in that community. This must include the historical and socio-political context in which a person, a community, a program or a policy operates.

WISE PROTOCOLS FOR INDIGENOUS EVALUATION

The processes and protocols that uphold evaluation principles are varied across community settings and are adhered to and recognized in different ways. Drawing from wise examples in the literature and those shared by Three Ribbon panelists, the following list of protocols was developed.

Protocols that uphold ethical requirements and standards in Indigenous health research and evaluation may include local, Indigenous/Tribal ethics boards (e.g. Six Nations, Manitoulin Island), a Code of Ethics (e.g. Kahnawake Schools Diabetes Prevention Project), Community Advisory Boards (Kahnawake Schools Diabetes Prevention Project) and Research and Data Sharing agreements (e.g. WLH and SGMT for Our Health Counts Toronto). Research agreements explicitly address issues of project governance, community expectations, benefits of the research, ownership, control, access, and possession of research information, and dissemination of project results, including academic publications. In addition to Ownership, Control, Access and Possession (OCAP®), there are other frameworks being applied in different Indigenous contexts including the Principles of Ethical Métis Research and Inuit Tapiriit Kanatami guide for researchers around negotiating research relationships.

The Māori health model Te Whare Tapa Wha or ‘four-sided house’ describes the four dimensions of health that encompass the whole person: te taha tinana (body), te taha hinengaro (mind, emotions), te taha wairua (spiritual) and te taha whānau (extended family). In a traditional Māori approach, the inclusion of the wairua, the role of the whānau (family) and the balance of the hinengaro (mind) are as important as the physical manifestations of illness and are therefore embedded in all aspects of health program and service delivery as well as evaluation (e.g. measures of health and wellness).

Wise approaches to evaluation include protocols that ensure culturally safe ways for people to tell their story (e.g. training and support for a diverse, community-based interviewer team for Our Health Counts Toronto) and community defined measures and tools (e.g. Minobimaatisiwin, community defines what being well means to them).

Protocols that ensure local leadership across all stages of health service and program evaluation development, implementation and knowledge translation result in successful outcomes for individuals, families and communities. This could include hiring local community members and seconding front line health workers to conduct the evaluation (Kahnawake Schools Diabetes Prevention Project, SGMT evaluation)

REFLECTIONS ON AMERICAN EVALUATION ASSOCIATION GUIDELINES

While the AEA is not an Indigenous-led or governed organization, there is synergy and potential for bridging mainstream and Indigenous values and principles for evaluation, such as honesty and respect. During the Three Ribbon Panel, the members drew more from their own direct involvement with health service and program evaluation than the AEA Guiding Principles for Evaluators, however several members felt this document did provide a useful starting point with potential learnings to be gained. There were some aspects of the AEA Guiding principles that were not in keeping with Indigenous ways knowing and doing, so several panel members provided suggestions for ways to adapt the principles and 'Indigenize' some of language in this document to make it more relevant to the Indigenous context? For example, as one panel member explained, "Stakeholders" as defined by AEA are individuals or small groups of individuals, however this does not translate into an Indigenous context, when we need to think about our responsibility across communities." (Susan Snelling, Public Health Ontario). Another suggestion was to shift the language around 'democracy' to community governance to more accurately reflect Indigenous governance arrangements (Wayne Warry, CRaNHR)

CLOSING

The closing circle of the day allowed all the participants to share final thoughts and reflections on the work accomplished as well as aspirations for moving forward. There was strong consensus among the Three Ribbon Panel around the significance of the discussions and the power of the knowledge gathered throughout the day.

We arranged to follow-up with panel participants for a videoconference in three months' time to review the meeting summary report and co-develop recommendations/guidelines for urban Indigenous health service and program evaluation. In preparation for this follow-up meeting, panel participants are asked to reflect on the following question:

If I could write the rules for Indigenous health service evaluation, what would they be?

Knowledge keeper Jeanne Hebert ended the day with a final prayer and song.

GUIDELINES FOR INDIGENOUS HEALTH SERVICE AND PROGRAM EVALUATION

At the May 12th video conference the panel provided feedback on this summary report and developed the following recommendations. We also identified a scholarly manuscript, fact sheets for Indigenous communities and policymakers, and an Indigenous community evaluation “tool kit” as the mutually desired outputs of the panel. All panel members would be offered authorship on these publications.

We finalized the following guidelines for Indigenous Health Service and Program Evaluation at our June 7th follow-up teleconference.

It is with humility that we draw on our collective knowledge and experiences and put these guidelines forward. While we have done our best to be comprehensive and inclusive, we anticipate that we will have missed some ideas and strategies that are pertinent to specific evaluation settings. We further recognize that there may be community contexts, constraints and priorities that will result in choices and actions that differ from what we suggest below. Our intention is to facilitate transformative change towards high quality Indigenous health services and program evaluations. Our statements below can be understood as a set of “trail-markers” that can be used to identify and travel a multitude of unique evaluation pathways which are relevant and useful to their respective Indigenous communities.

INDIGENOUS HEALTH SERVICE AND PROGRAM EVALUATION GUIDELINES

- 1** Demonstrate Indigenous leadership and a commitment to self-determination, including but not limited to the processes by which the evaluation is funded.
- 2** Demonstrate community governance and leadership at every phase, using OCAP® or other relevant Indigenous community governance and management principles and protocols.
- 3** Have a majority of Indigenous members on the evaluation team.
- 4** Contribute to an enhancement of relevant, useful, and sustainable evaluation skills and capacities that stay in the Indigenous community in which the evaluation takes place.
- 5** Demonstrate reciprocity for both Indigenous and non-Indigenous team members.
- 6** Demonstrate methods, analysis and dissemination approaches that overtly reflect the Indigenous contexts, values, skills, knowledge, and practices of the communities in which the evaluation takes place.
- 7** Desired by participant communities.
- 8** Demonstrate responsiveness to participant community needs and contexts.
- 9** Reflect participant community priorities both generally and with respect to health and wellness.
- 10** Contribute to holistic Indigenous concepts of good living, such as Minobimaatisiwin, the Great Law and Qanuinnngisiarniq.
- 11** Support the recognition and sharing of what is working and what is not.
- 12** Use accessible language to communicate evaluation plans, methods, and results.
- 13** Be appropriately budgeted by funders to support relevant and high quality community leadership, participation, methods, and dissemination.
- 14** Recognize the value of and build on existing intrinsic Indigenous community systems of knowledge and practice. We have always had systems of evaluation and accountability in our communities.
- 15** Leave no community or community member behind. All communities can participate in evaluation activities as long as we start to work with them where they are at and recognize current contextual constraints.

CONCLUDING REMARKS

Bridging the gap between academic/scientific and Indigenous knowledge using the English language rather than Indigenous languages can be challenging due to the way in which language draws on and shapes concepts and underlying epistemology. Our methods for the panel were aimed to support an emergent, collective understanding of Indigenous evaluation that to the best of our ability reflected an Indigenous view of knowing as a process of ongoing awareness and perception; informed by one's experience and location in the larger web of interrelations and enriched by multiple perspectives. This process was constrained by the brief time that we spent together, the physical setting, and the newly developing collective knowledge relationships of our group.

In keeping with these Indigenous knowledge processes, we recognize that this synthesis of concepts and discussion is a living document that we hope will grow and shift over time. This cyclical and iterative approach to Indigenous knowledge development and sharing is in fact well aligned in our minds with the "wise" practice of health service and program evaluation— which needs to be cyclical and iterative in order to adequately reflect contextual complexity and dynamism.

As articulated by the members of the panel, health service and program evaluation can and has contributed to negative and oppressive experiences in Indigenous communities. We recognize that there is potential to do evaluation in a good and meaningful way that can result in positive benefits as experienced within the mainstream. This document highlights wise approaches and guidelines for Indigenous health service and evaluation drawing on our own experiences and what we already know works in our communities.

Our intention is to support communities to engage in evaluation so that it becomes a natural, integral and meaningful process. We aim to ensure that this body of work is constructive and empowering and does not contribute to feelings of inadequacy, judgment or exhaustion. We are highly aware of the constraints and barriers experienced by Indigenous communities and therefore view this body of work as pointing us towards a goal, knowing that, given the realities on the ground, there will be many small steps and it will take time and resources to get there.

REFERENCES

- Centers for Disease Control and Prevention. (1999). Framework for program evaluation in public health. *MMWR. Recommendations and Reports : Morbidity and Mortality Weekly Report. Recommendations and Reports / Centers for Disease Control*, 48(RR-11), 1–40.
- Grover, J. G. (2008). Challenges in applying indigenous evaluation practices in mainstream grant programs to indigenous communities. *Canadian Journal of Program Evaluation*, 23(2), 33–50.
- Scott, S. (2008). Drawing on indigenous ways of knowing: Reflections from a community evaluator. *Canadian Journal of Program Evaluation*, 23(2), 73–92.
- Smylie, J., & Anderson, M. (2006). Understanding the health of Indigenous peoples in Canada: key methodological and conceptual challenges. *CMAJ : Canadian Medical Association Journal*, 175(6), 602. <http://doi.org/10.1503/cmaj.060940>