



Federation of Saskatchewan Indian Nations

CULTURAL RESPONSIVENESS FRAMEWORK



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Executive Summary

For many years now, various reports have appeared which have shed light on the less-than-desirable treatment received by Indigenous peoples in many of the world's mainstream health systems (e.g., the United States and Australia), with stories of inappropriate health services, misconceptions, and even racism being experienced by Indigenous patients and their families. The situation is similar in many regards to First Nations and other Aboriginal (Métis and Inuit) peoples accessing health services in many Canadian jurisdictions, the province of Saskatchewan included. The reasons for this current state of affairs are many and they are complex and they are deeply rooted in history. In some cases the poor treatment may be the result of systemic, institutional or individual racism; in most other instances it is simply due to misunderstanding, miscommunication and a general lack of awareness of, and respect for, Indigenous peoples, their histories, traditions, values and belief systems. A consistent message delivered in most, if not all of these, reports has been that culture is critical to both understanding and remedying the issue, that culture is key to health and healing. In line with this idea, it has been shown that when the health care received is sensitive to, and respectful of, culture the health outcomes are vastly improved. It is this background context that sets the stage for the Cultural Responsiveness Framework.

Many terms have been used over the years to describe health services which have culture as an underlying principle, from cultural sensitivity and appropriateness to safety and competence. Cultural responsiveness is but another of those terms. According to some, cultural responsiveness implies an understanding of, and respect for, a person's culture, and that meaningful efforts are made to ensure that culture is factored into the health care services that are being delivered and to the health system as a whole. This is the overarching purpose of the following document.

In the summer of 2008, a Memorandum of Understanding (MOU) on First Nations Health and Well-Being was signed between the Governments of Canada (Health Canada-First Nations Inuit Health Branch) and Saskatchewan (Ministry of Health) and the Federation of Saskatchewan Indian Nations (FSIN). A main aim of the MOU partnership is to improve First Nations health status and eliminate the health disparities that exist between First Nations and non-First Nations people in the province. As the MOU work unfolded, culturally appropriate and competent health services quickly emerged as one of the top priority areas that needed to be addressed for this to occur, with the creation of a framework being a foundational project. To this end, a Project Advisory Team, with membership from First Nations communities and the MOU partners, was established and engagements with First Nations community members were held. The result is the Cultural Responsiveness Framework, or CRF for short.

Throughout the development of the CRF and the engagement that occurred with First Nations community members, mention was frequently made of the presence of the First Nations health system, within which exists a great deal of strength and diversity of traditions and beliefs, medicines and approaches to health and healing, and to how this system interacts with, and is impacted by, the mainstream western health system, with

its multiple layers of government, regional health authorities, health providers, health professional organizations, unions and educational institutions. While there is a need to recognize these systems and how they serve First Nations peoples, it was also felt by many that for real progress to happen and for health services to become truly culturally responsive meant that the two systems would have to engage differently. The concept of the “middle ground” eventually arose as a place where the two systems could come together as equals to work together in a way that would be to the benefit of all. It was from this conceptual space that the CRF was formed.

The Cultural Responsiveness Framework is intended to inform and promote dialogue on First Nations health and health care and the importance that culture plays in the health and well-being of First Nations peoples. It is also meant to initiate, and assist in building upon, actions that will result in improvements to the delivery of patient-and-family-centered health services and programs. Central to the CRF are the First Nations community voices that were heard; it is from these voices that the CRF is grounded and that its objectives and recommended actions flow.

Based upon the input received from the meetings of the CRF Project Advisory Team and the community engagements that were held, the following three strategic directions were developed:

- Strategic Direction 1: Restoring First Nations community-based health and wellness systems
- Strategic Direction 2: Establishing a “middle ground” for engagement between mainstream and First Nations systems and worldviews
- Strategic Direction 3: Transforming mainstream health service delivery to be culturally responsive

Within each of these directions, there are objectives and actions which are designed to result in optimum health and health care for Saskatchewan First Nations peoples. As partnerships are formed and strengthened between the First Nations and mainstream health system representatives, and as pieces of the CRF are further discussed, elaborated upon and implemented, there will be a need to monitor and measure progress so that we can say that the CRF actually accomplished what it originally set out to do. The CRF is a plea to readers to imagine themselves as agents of change, be it within themselves or the health organizations of which they are a part, working together to ensure health and health care that is culturally responsive.

I. INTRODUCTION

What is the Cultural Responsiveness Framework?

Many terms have been used to explain the idea of better understanding and respecting First Nations’ cultures, traditions, values and belief systems in health and health care. Cultural sensitivity, appropriateness, congruence, competency, and safety are but a few

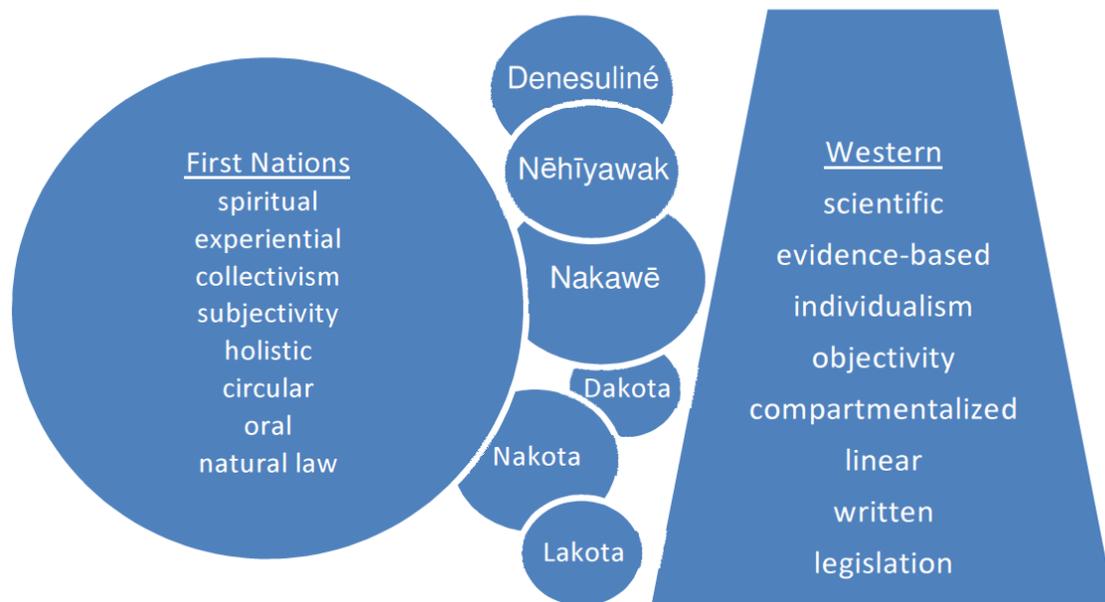
examples of these terms. One of the more recent additions to this list has been cultural responsiveness. According to various sources, cultural responsiveness has been described as “respecting where people are from and including their culture in the design and delivery of services” or an “active process of seeking to accommodate the service to the client’s cultural context, values and needs.”¹ The disclaimer here is that in most cases terms such as these have come from outsiders and have been imported and borrowed to describe the quality of health services and programs provided to First Nations individuals, families and communities. The terms do not originate from First Nations. While cultural responsiveness qualifies as such a term it will be used to describe the current framework because it is the term that has been used throughout the development of this framework and also because there has been no alternative term provided in the First Nations languages that is agreeable to all First Nations.

And so, this brings us to our central question. What is the Cultural Responsiveness Framework (CRF)? In one sense it is, as the above definitions imply, a document that will assist in ensuring Saskatchewan’s health care system respects the cultures of Saskatchewan First Nations patients and their families and employees and factors them into the mainstream system and the delivery of services and programs. But the framework is meant to be much more than that. It is also about restoring and enhancing First Nations’ own health systems. Systems which have existed for time immemorial but which have been diminished in the last hundred or so years as a direct result of European contact, policies of assimilation and the establishment of the western medical system. While it is important to make reforms to mainstream health policies, services and programs that recognize and respect First Nations cultures, it is equally important to keep in mind *nuhēch’alániē* (Dene “our way of life”), that is the fact that distinct First Nations systems (e.g., *mitēwiwin* or grand medicine society) still exist, systems which are guided and shaped by their own protocols (or *ē-nācinēhikēt* in Cree), languages, healing approaches, medicines and practitioners, and which continue to be accessed and utilized by many First Nations peoples for their health and well-being.

These two contrasting health systems, or worldviews, the Western and First Nations, have always co-existed rather uncomfortably even though the aim of both has been directed at achieving positive health outcomes. For the most part, this underlying tension has been because each system derives its legitimacy from different orientations

¹Susan Armstrong, “Culturally Responsive Family Dispute Resolution in Family Relationship Centres,” *Family Relationships Quarterly*, Issue 13 (2009), 1.

(see diagram on world views)

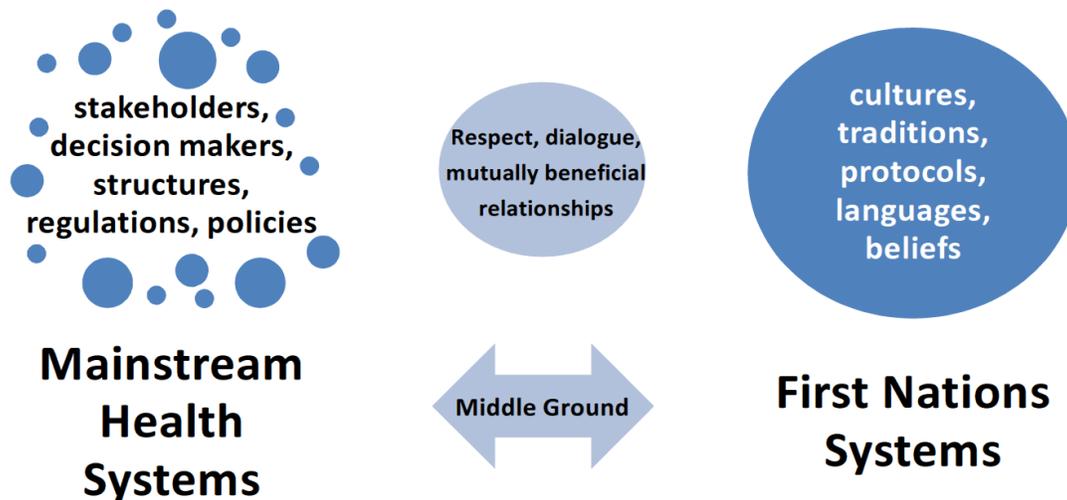


It has been said by many First Nations that their own people have become dependent on the western system and forgotten about the systems within their own communities, that there is a need for First Nations to once again take ownership for their own health and return to their native ways and traditions. Acknowledging this in no way diminishes the value and contributions of the western medical system. Instead, it is about recognizing and promoting the parity of the two systems. Perhaps an alternative way of explaining what the CRF is might be to describe what it is not. To describe it another way, it is not about “giving away” traditional and sacred First Nations knowledge to “feed” the other system nor is it about converting one system’s way of thinking to the other.

The Cultural Responsiveness Framework is about mutually beneficial co-existence, about complementing rather than controlling. It is about drawing from the best that both worlds have to offer. Herein lies the biggest challenge of this framework. To move towards this state demands a different quality of relationship, similar to the one envisioned when First Nations signed the treaties with the newcomers (“the Crown”). It calls for the two systems to come together and engage as equals, sharing and establishing appropriate linkages when necessary. This foundational stage for reconciliation and respectful engagement could be viewed as a sort of middle ground or “ethical space.”

The diagram provided below (Figure 1) will be used to capture what the framework is, and what it is intended to do, and will serve as a point of reference throughout the document. The circle on the left-hand side represents the mainstream health system with its numerous stakeholders and decision makers, structures, regulations and policies. The circle on the right represents the First Nations system in all of its diversity,

with its unique cultures, traditions, protocols, languages, values and beliefs. The area in between the two circles symbolizes the middle ground where the potential for respectful dialogue and mutually beneficial relationships resides.



At its core, the Cultural Responsiveness Framework is meant to serve as a tool for respectful cross-cultural engagement and reciprocity between the two systems, where neither one controls but supports one another in common efforts to enhance the health and wellness of Saskatchewan First Nations peoples.

Who is the Cultural Responsiveness Framework for?

As suggested by the title of this document, the focus of the framework is on the health and wellness of Saskatchewan First Nations people. Throughout the framework reference is made to First Nations communities, a term which will be used to encompass all First Nations peoples in the province of Saskatchewan whether they are reserve or urban-based, rural, remote or northern dwellers, status or non-status members, treaty and non-treaty nations, traditional or non-traditional peoples. It is inclusive of all kinship patterns and all tribes and linguistic groups, whether they be of the Nēhiyawak (Cree - Plains, Swampy and Woodland), Nakawē (Saulteaux/Anishnaabe), Denesuliné, or Lakota, Dakota and Nakota descent. In other words, it is a document that speaks to, and is for all First Nations in the province.

It has also been reiterated that this framework should be for the non-First Nations people working within the mainstream health system (or who may wish to access the First Nations system), for those people who determine, monitor and enforce health legislation, standards and policies, those who educate and train the future health providers and the ones who manage and deliver frontline health services and programs. In the First Nations system, importance is always given to the need to maintain balance. Although the primary emphasis of this framework is obviously on better serving First Nations people and their distinct health systems it is also about building the capacity of

those within the mainstream health system to better understand and respect First Nations cultures. It has been shown that when this occurs, significant improvements and efficiencies follow, not only to First Nations but to the mainstream system as a whole. Enhancing First Nations health and wellness therefore has benefits for everybody. In the spirit of *Mitákuye oyás'íŋ* (Lakota for “all our relations”), this framework is inclusive, and for the benefit, of all people.

Why is the Cultural Responsiveness Framework needed?

It has usually been the practice of First Nations strategies and frameworks to concentrate on the health deficits of First Nations peoples (i.e., the high rates of disease and illness faced by First Nations) as a way of making an argument that the current system is not working and that something different must be done. This framework departs from that practice. As one advisor aptly summed up the framework's purpose, this is not a First Nations “sickness” document, it is a “health and wellness” document. The Cultural Responsiveness Framework thus begins with a simple premise, that “culture is good medicine” (RCAP 1996), a premise which First Nations have always known to be the case and which people working within the mainstream health system have come to gradually learn and accept over the years. To this end, the focus of this framework will be on accentuating the cultural strengths and teachings that are present in the individual and collective First Nations communities in this province.

Unfortunately, culture has all too often been underestimated, neglected and misunderstood when it comes to the health and health care of First Nations peoples. The damage that not providing culturally responsive care can do has become increasingly apparent. When First Nations people are discriminated against, when there is a lack of awareness of, or appreciation for, First Nations experiences in history and their impacts on health, when there is poor or disrespectful communication in health care settings, and when the care that is provided discounts, and is insensitive to, culture, it invariably leads to issues of access as well as increased human and financial costs to both First Nations communities and the mainstream system as a whole.

Reports in Saskatchewan and elsewhere have recognized this to be true and, as a result, calls have been repeatedly made for such things as cultural competencies (i.e., knowledge, skills and training) and cultural safety (i.e., empowering the cultural identity and well-being of an individual). On the flip side of the coin, reports and research have also indicated what can happen when culturally responsive care *is* provided: improvements to health status, greater levels of understanding, trust and respect, more effective health interventions and outcomes and cost savings. While we have come a long way in recognizing how important culture is and how powerful it can be in maintaining and bringing about the health and wellness of First Nations peoples, there still remains a long way to go. This is where the Cultural Responsiveness Framework comes in.

The approach to developing the Cultural Responsiveness Framework

The idea for a Saskatchewan First Nations Cultural Responsiveness Framework has been floating around for several years now but the concept began to really take root and gain momentum following the signing of the Memorandum of Understanding (MOU) on First Nations Health and Well-Being by the Federation of Saskatchewan Indian Nations (FSIN) and the federal and provincial governments in Fort Qu'Appelle in 2008. As the MOU began to unfold and consultations were held throughout the province regarding a First Nations Health and Wellness Plan, culturally appropriate and responsive care immediately rose to prominence as a foundational priority to be addressed by the MOU partners. Through the use of developmental funding from the provincial Ministry of Health, a Project Advisory Team was formed, with representation from both the mainstream and First Nations health systems, which could provide input and guidance in the creation of a framework.

From the beginning of the framework project, efforts were made to engage with men, women and youth from a broad array of First Nations communities through attendance at cultural camps, conferences, ceremonies and other community events. Particular importance was placed on seeking permission from and involving the cultural “experts” from communities, that is the Elders (*mitēw* or *kēhtē-ayak*)², ceremonialists (*otisāpahcikēwiyiniw*), medicine people/herbalists (*maskihkīwiyiniw*) and helpers (*oskāpēwis*) from the various tribes and linguistic groups. In accordance with traditional practice, Elders were approached with tobacco and invited to contribute as advisors and leaders of this sensitive process. The Elder advisors made it clear from the outset of the project that “whenever life is spoken about, ceremony leads the discussion and gathering.” In keeping with these words, pipe ceremonies and other ceremonial cultural protocols became essential to the framework process. Another Elder put it this way:

Ceremonies are the way we deal with good health. We do these things to seek health, happiness, help and understanding”. Spiritual growth “comes from the inside out” and spiritual learning and strength “comes from the heart.” Long ago our people lived a simple life that encompassed total spirituality. Everything that was done was with the traditional teachings. Today, our people are facing hardships because they have forgotten the old ways. There is a need to bring this back if one wants to survive and to have a healthy community.

Throughout the document the term traditional healing is used, thus it should be noted for consistency purposes the definition provided by the Report of The Royal Commission on Aboriginal Peoples (1996) is applied as the definition within the context of this document. According to RCAP,

²As stated in the “Gathering Strength” volume of the Report of the Royal Commission on Aboriginal Peoples (1996) elders are: “Keepers of tradition, guardians of culture, the wise people, and the teachers. While most of those who are wise in traditional ways are old, not all old people are Elders, and not all Elders are old.” RCAP, Vol. 3 (1996), 527.

Traditional healing has been defined as practices designed to promote mental, physical and spiritual well-being that are based on beliefs which go back to the time before the spread of western, scientific, bio-medicine. When Aboriginal Peoples in Canada talk about traditional healing, they include a wide range of activities from physical cures using herbal medicines and other remedies, to the promotion of psychological and spiritual well-being using ceremony, counselling and the accumulated wisdom of elders.³

Another point of clarification is the definition of traditional medicine people and/or traditional knowledge keepers as there are many ideas and understandings around this concept. In today's society the term Elder is broadly used and can often be confusing. As one traditional-knowledge keeper from File Hills recalled,

A long time ago there wasn't such a name as Elder. Each community or village determined their own specialist based on a variety of things. The chosen ones were given the right because of the lifestyle they lived, while others were given the gifts to help through dreams and visions. These gifted ones specialized in one or more areas and were herbalists, pipe carriers, medicine man/woman, story tellers and practitioners of traditional and sacred ceremonies. Each of these people were given and earned that right to be that messenger and helper of the peoples.

At the same time community engagement was occurring, a literature review and environmental scan (see Appendix A) was carried out to provide some background on the subject of "cultural responsiveness" and related terms and to determine how they have been understood and practiced in Saskatchewan and other jurisdictions. The review revealed an enormous amount of literature on the subject stretching back to the 1970s and earlier, with a confusing collection of culturally specific terms, each with their own meanings, interpretations and practical applications.

During the Project Advisory Team meetings and community engagement sessions, it became immediately clear that community people struggled with the cultural responsiveness term. What did it mean? Where did it come from? Who is it for? Can First Nations expect a "response" to their needs from a system and institutions that are not First Nations? Did there exist a comparable word in First Nations language? Following this initial semantic hurdle, community representatives began to delve into the subject, discussing at length the two systems and how they operate and affect First Nations health. Through these engagement processes, challenges were identified and suggestions for resolution put forth.

All of those consulted were in agreement that something more had to be done regarding First Nations culture in health and health care, be it through comprehensive, multi-level education, a strengthening of community-based systems, changes to existing health services and programs or the creation of new avenues for "bringing together the two worldviews."

³RCAP, Vol. 3 (1996), 348.

Guiding Principles

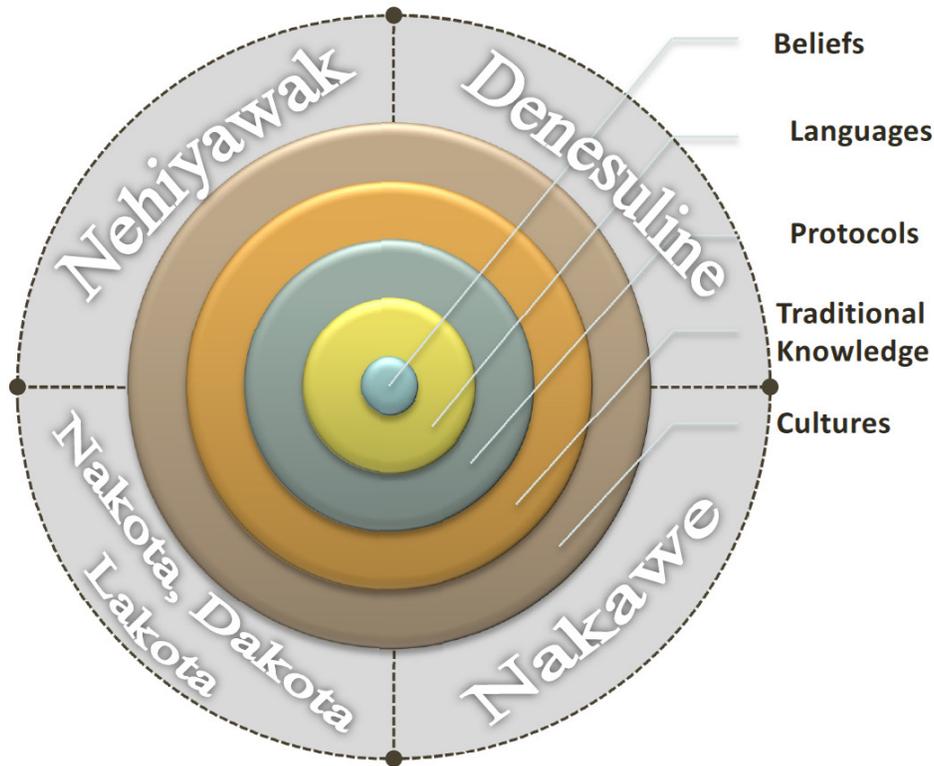
The Cultural Responsiveness Framework began with a basic premise, that it would be led, developed and owned by Saskatchewan First Nations communities, in the same spirit as the now well-known OCAP principles (Ownership, Control, Access and Possession). With this guiding principle as its cornerstone, the CRF was created out of the community voices that were heard at the Project Advisory Team meetings and the various ceremonies and engagement sessions. In addition, at a ceremony held in Fort Qu'Appelle it was said that the framework, and the work that it entails, will be shared with our Non-First Nations brothers and sisters (Métis, RHA's etc.). Another important element of the CRF is that emphasis always be placed on treaty and the treaty relationship.

During the first meeting of the Project Advisory Team, members discussed how they understood culturally responsive health care and what it meant to them. This initial discussion produced a list of principles and it is with these principles in mind that it is hoped the CRF, and any work flowing from it, will be carried out:

- Respect;
- Caring;
- Teamwork
- Dignity;
- Honesty;
- Good Faith;
- Open Minds; and
- Trust

II. Framework Engagement: What was heard – The two Worldviews

(1) The First Nations systems



When discussing the First Nations system, many of those engaged were adamant that more had to be done to strengthen and protect the community-based health systems in place. They spoke of reinstating traditional teachings and empowering First Nations to assume a greater role in their own health. As one advisory team member put it, there are many First Nations people who have “negated their own sense and understanding of self” and that it was time for First Nations to take responsibility and ownership over their own health. Elders, ceremonialists, medicine people, and helpers expressed dismay over the fact that even people within some of their own communities were lacking knowledge of, and respect for, their own traditions but they were also heartened by the revival that has been taking place in communities that had long forgotten and abandoned their spiritual and traditional ways. Elders elaborated on the need to educate their own people, speaking of the importance of going back to the land (*Makhá uŋčí*, Lakota for “Grandmother Earth”), the medicines and ceremony as vital teaching tools. As they put it, many of life’s lessons are contained within and revealed through the *nipākwēsīmowin* (Cree for sundance), *inípi* (Dakota/Nakota/Lakota for sweat lodge), *cīhsahkīwin* (Anishnaabe for shake tent), pipe and other sacred ceremonies.

Language was stressed as being critical to the survival of First Nations cultures, for it is largely through language that the traditional knowledge, ceremonies, stories and songs are passed on. As one Cree elder commented, “once you lose language 99% of culture is gone.” Another Dene elder told of the destructive influence alcohol had in the northern communities, that once people began drinking their languages ceased to be spoken. At one particular Gathering of Elders hosted by Piapot First Nation it was

stated that "naming is an important part of the identity and contributes to wellness." For this reason, First Nations should "use appropriate terminology according to the way we know them....[t]he terminology used in the past honours the ceremonies" and First Nations need to "use the actual names in the language... for example *mawimoscikēwiyiniwak* (Cree – persons who pray in the traditional way)." First Nations languages therefore are something that must be regained, taught to (*kitahamāwasowin* Cree teaching children) and instilled in future generations. Efforts are being made in the province to restore indigenous languages in the province through classroom instruction, culture camps, and language workshops but increased support is needed to sustain, strengthen and multiply these efforts.

During the engagement sessions, repeated mention was also made about the framework having to be grounded in treaty and the treaty right to health. Between the years of 1871 to 1921, eleven numbered Treaties were signed between the Crown and First Nations across Canada. Saskatchewan is covered by the "sacred blanket" of the Treaties (2, 4, 5, 6, 8, and 10) and the First Nation signatories range from Saulteaux, Dene, Cree, Dakota, Lakota, and Nakota/Assiniboine descent. Although there are conflicting views on Treaties, it remains clear that the Crown and First Nations entered into Treaty for purposes of mutual respect and benefit, that "the parties agreed that their citizens would not only survive but prosper..." and a positive future would be secured for future generations.⁴ These rights are constitutionally protected under Section 35(1) of the Constitution Act, 1982, and have also been recognized by the Canadian Courts.

First Nations maintain that the Treaties are a sacred covenant in which sovereign nations exchanged solemn promises (*kihci-asotamātowin*, meaning "sacred promises to one another, the treaty sovereigns sacred undertakings") that were formalized by pipe ceremony. In particular, the Treaty 6 signatories agreed to share land in exchange for relief and medical services – these are most commonly known as the 'Medicine Chest' and 'pestilence' clauses of Treaty 6. In signing the Treaties, First Nations did not surrender their traditional healing practices and medicines. Instead the First Nations stood to protect their health system and supplement this section with western medical care and medicines.⁵ According to the Office of the Treaty Commissioner,

both the modern Western medical practices and traditional First Nations healing systems have important contributions to make to the well-being of Treaty First Nations people. The FSIN wishes to explore how Treaty First Nations governance in the area of health might help First Nations optimize the benefits of both the Western and medical systems. One possibility suggested by First Nations is to establish institutions that integrate both systems.⁶

⁴As quoted in Yvonne Boyer, "No. 1 Aboriginal Health: A Constitutional Rights Analysis", Discussion Paper Series in Aboriginal Health: Legal Issues, 2003, 18.

⁵Ibid, 17.

⁶Office of the Treaty Commissioner, "Statement of Treaty Issues: Treaties as a Bridge to the Future," Oct. 1998, pg 50-51.

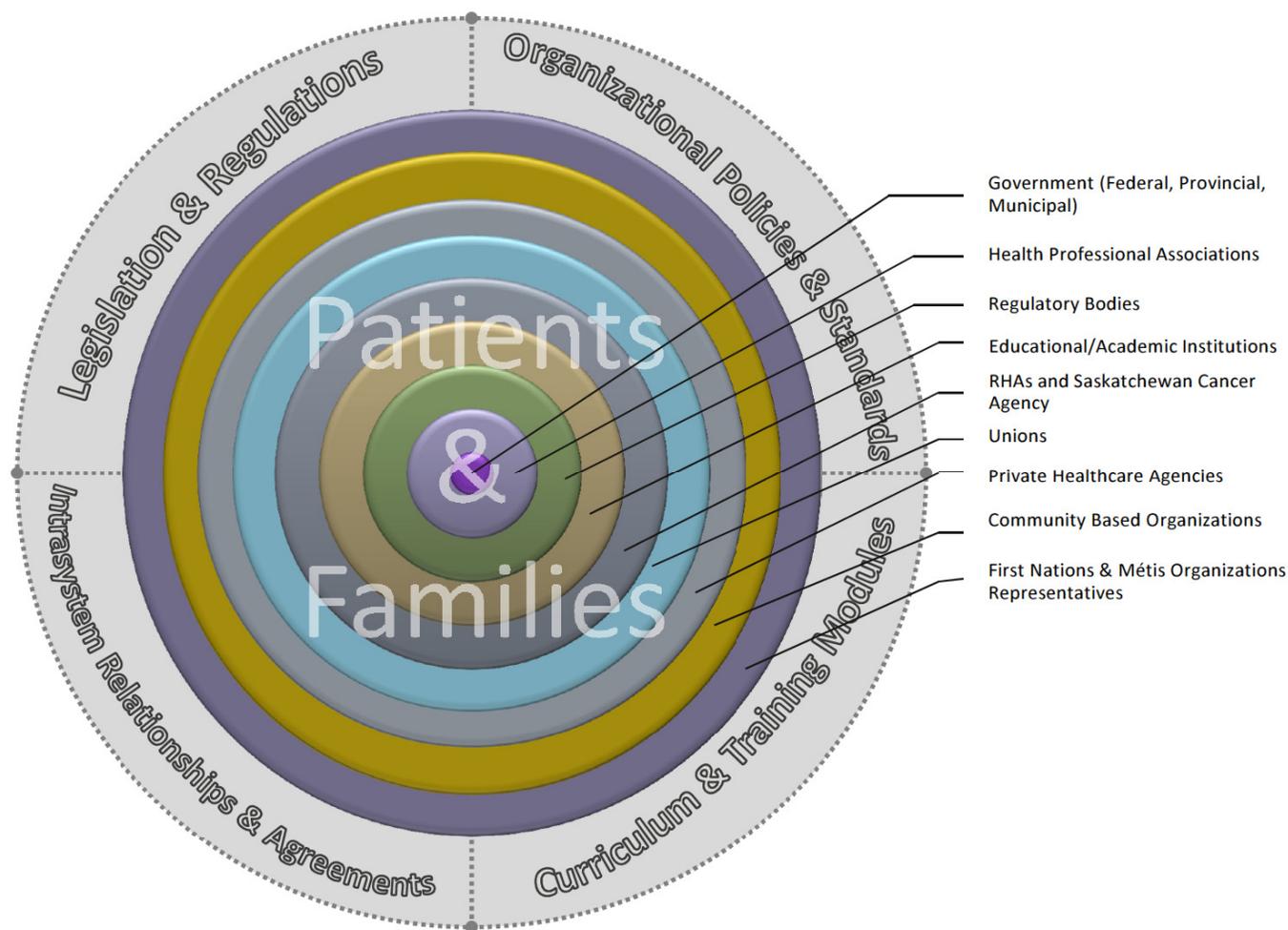
The understanding held by the First Nation's people of the Treaty is comprehensive and is reflected in the way the framework development was approached and carried out. As part of this Treaty understanding, "proper specific ceremonial protocol was followed in terms of approaching Elders for their involvement on the Project Advisory Team. In addition, the pipe ceremonies are held prior to the meetings."⁷ These were seen as a necessary component to assure respectful, clear intentions were a part of the process. In keeping with this understanding, the Project Advisory Team endeavoured to apply the treaty principles (*miyo-wīcēhtowin*, meaning "getting along well with others, good relations, [and] expanding the circle") throughout the engagement process. In the "spirit and intent" of the Treaty relationship, the Cultural Responsiveness Framework seeks to apply the concept that "we are all Treaty people" and that the framework, and whatever flows from it, bestows obligations and benefits that are shared by all.

A great deal of sensitivity surrounded the discussion about traditional knowledge and medicines. Elders and others wanted clarification and assurances that what was being done with the framework was not a "giving away" of medicines, as they were all too familiar with examples where knowledge and medicines were shared and later plagiarized, stolen or used without permission. There were concerns about the appearance of "fast trackers," those First Nations people who had inappropriately or prematurely taken on the role of elder or healer and the "selling" of the medicines, practices which can have negative implications not only for traditional knowledge but also legitimate traditional practitioners. It was still acknowledged, however, that there needs to be education on traditional knowledge and the proper harvesting, storage and use of medicines but in a way that guarantees that they remain in the control of First Nations communities and are carefully managed, honoured, protected and kept sacred. Historically, in many First Nations, women played a key role in this area and emphasis was placed on the need to remember and bring this back and restore women to their rightful place as teachers and keepers of the medicines and medicine ways.

All in all, a clear and resounding message was delivered: restoring and rebuilding First Nations health systems are of paramount importance. It needs to be triggered by and within community and leadership, health managers and workers and other community members need to come together and stand behind what is being said and fully support its coming into being.

(2) The Mainstream System

⁷Piapot Ceremonial Elders Gathering, 2012 "Speaking Notes" October 18 & 19, 2012 Piapot First Nation



Throughout the framework engagement sessions, many stories were shared by First Nations community participants about the experiences of patients and families within the mainstream health care system. Participants recounted stories of the fear and intimidation regularly faced by First Nations people when entering mainstream health care facilities and of a system fraught with difficulties and barriers, many of them directly related to culture. It was heard again and again that there is a need to make significant improvements within the mainstream health system, to deal appropriately with the systemic, institutional and individual racism, stereotypes and assumptions First Nations people encounter on a daily basis and to generate greater respect for, and understanding of, First Nations cultures among health professionals and the system's decision makers. In the eyes of many, one of the biggest obstacles preventing meaningful change from happening has been the absence of a "First Nations voice" and perspective in health policies, oversight mechanisms and decision-making tables and processes, many of which eventually deal with and impact the health of First Nations people.

Solutions to many of the issues could be as straightforward as improving communication with individual patients and families and helping them to better understand foreign medical and clinical terminology so as to avoid misunderstandings

and misdiagnoses. Or it could entail more serious and thoughtful assessments of patient-provider interactions, treatment methods and hospital policies that would lead to greater flexibility around, and respect and awareness of, certain cultural practices and beliefs, for example, the spiritual importance of the placenta when a baby is born, the thinking around organ transplant and sensitivities with certain surgical procedures and being “cut open” or the ceremonial protocol of some First Nations when it comes to the disposal of amputated limbs or end-of-life care.

Concerns were raised about the health system’s de- or undervaluing of elders, ceremonialists and other traditional specialists, their years of training and knowledge and the services they had to offer to the care of First Nations patients and families. While some concessions have been made within certain hospitals and health care organizations which allow for the incorporation of aspects of traditional knowledge and healing approaches, it was felt by many that the control of such services still remained largely in the hands of health managers and providers and subject to organizational restrictions. There were also concerns with how some elders and helpers were being used in the system, many times without fair or appropriate compensation for the services and knowledge being provided. For some, an alarming trend has been the use of self-appointed elders which can often result in problems for both the health facility in question and the patient being cared for. In cases such as these, it is important that the mainstream health system people work closely with First Nations patients and families as well as local and surrounding communities to ensure that when elder services are provided that they are done so according to protocol and in a respectful and safe manner.

While many of those engaged agreed that it was important to educate and train non-First Nations people in the health system to be more culturally competent and safe, the point was also made about the positive impact having First Nations people providing health services and programs can have in bringing about culturally responsive care. It is of vital importance to have First Nations people in the mainstream system who can assist in educating colleagues and mediating cultural issues when they arise and bridging the cultural divide between the two systems. As one community participant said, “seeing our own people providing service is comforting.” This means ensuring First Nations health students are assisted in getting into the mainstream system and that, once there, employees are supported so that they have the ability to move beyond entry-level positions in organizations to positions where they can exert a positive influence and help to create more culturally responsive work environments.

Despite the numerous criticisms of the mainstream health system, it was acknowledged that there are examples of progress and good work occurring in Saskatchewan within certain regional health authorities, educational institutions and other health care organizations that is directed at the provision of culturally responsive health and health care. Some of these examples have included culturally specific curricula, training and awareness opportunities, cultural policies (e.g., smudging), First Nations health liaison positions and health offices and facilities providing space for both western and traditional healing methods. Questions remain, however, whether the various initiatives

have been the most appropriate to meeting First Nations needs and whether they have gone far enough, especially in the wake of troubling reports of First Nations continuing to deal with many of the same issues in the mainstream system that they were dealing with twenty and even thirty years ago.

Many project advisory team members and other community representatives realized that it cannot be left up to the mainstream system itself to instill cultural change because it is a system which is more bureaucratic and technological than human (e.g., “a MRI does not know your culture, your language...”). Ultimately, the kind of change that has to happen in order to make a system culturally responsive will only be through the people who are trained and practice in that system, through attitudinal change and appropriate education. Granted, there are many who work within the mainstream system who are sensitive to this reality and are genuinely interested in learning more about First Nations culture and applying it in practice so that more culturally responsive care results. For example, there are health students, professionals and others who have specific and practical questions about First Nations, their traditions, ceremonies and protocol and who do, or would like to, incorporate this understanding in health care settings and patient care plans. Depending on the situation, and the policies and regulations in place, this may be more feasible in some health care organizations than others.

One can certainly pick up useful information from text books and other written material on First Nations culture but this approach has its limitations. As one elder commented, those in the system “can understand culture from books but they don’t understand it from the heart.” One also has to be cautious in this pursuit so as not to make assumptions that all First Nations people coming through the system’s doors are connected to their culture and follow some or the same traditions. This general pan-First Nations approach will not be overly helpful to either the patient or the provider. There is no Saskatchewan First Nations mono-culture and one will find that significant variation exists from one First Nations tribe and community to the next and from one individual to another. Not all First Nations people are traditional but there are many who may indicate an interest in combining aspects of western and traditional medicine in their care plan and others who may opt for taking a completely traditional route to care. The least that the health provider can do in such instances is to critically assess what “hidden” values and beliefs he/she brings to the interaction and to respect and facilitate as best as possible whichever is the preferred road to health. As one of the project advisory team members defined cultural responsiveness, it happens “when you understand where the person is coming from, who they are and provide care sensitive to culture.”

For those in the mainstream system who are interested in learning more about First Nations culture, the best teacher by far is experiential learning, by making time to sit with and learn from individuals, families and communities to find out more about local cultures, what the health care needs and preferences are and how to go about achieving them in a way that benefits all involved. Terms like cultural competency and

safety then are not end states so much as they are a continuous journey. Travelling on this path requires more than just words, it requires action.

Throughout this document, it has been emphasized that culturally responsive health care demands a different quality of relationship between those within the mainstream and First Nations systems, a relationship that is based upon mutual trust and respect and nurtured through ongoing, open and transparent engagement. This framework has suggested the concept of a neutral middle ground or “ethical space” as the starting point for these relationships to evolve, a space where representatives from both the mainstream and First Nations health systems can come together on equal footing to dialogue on issues related to culture and its place in the health and health care of First Nations peoples and jointly work towards meaningful and transformative change in each respective system. This is a space of possibilities, of what optimum culturally responsive health systems in Saskatchewan could be.

The meetings held with the Project Advisory Team and First Nations community members provided what many felt to be a first step in this process, for representatives to hear from and engage with one another on what cultural responsiveness means in thought and action. It was through these gatherings and conversations that participants shared their ideas for the framework, its principles and objectives and potential actions. The work that went into developing this framework began with a recognition that if the document is for and about the health and health care of First Nations people in this province then it would have to be owned, led and determined by First Nations themselves. This framework stands by this as a guiding principle because anything less than this defeats and demeans the purpose of what this framework is about and what it is meant to accomplish. Respect (*minaandendamowin* in Anishnaabe) was seen as instrumental to the success of the framework, and any future initiatives and projects tied to it, as was the ability of health care representatives, First Nations and non-first Nations alike, to step outside of their predetermined boundaries and meet as human beings in a way that could “humanize” the health care systems currently in place. As human beings, attention must also be given to an holistic approach to all that is done, focusing on the physical, mental, emotional and spiritual aspects of what it is to be human, and the interrelatedness of all of these areas in the health and health care of First Nations peoples.

In the same way the proposed middle ground signifies a space for possibilities so, too, does the framework. The Cultural Responsiveness Framework should not be viewed as a completed project but a beginning, what some have likened to planting a seed that can take root and grow within and across both systems. For some mainstream health organizations and First Nations communities this seed has already been planted and is growing but it will be some time before cultural responsiveness as a concept and practice is truly embedded within all of Saskatchewan. For those who are already moving in this direction, it is hoped that the framework will provide some additional food for thought on what First Nations community people have said regarding how to make culturally responsive health care more than just a token reality. Perhaps the framework will spark some further consideration and cross-cultural dialogue on how present-day

cultural initiatives could be strengthened and improved; for others, it may reignite interest and inspiration in the matter where commitment and momentum have been lacking or lost.

III. Strategic Directions, Objectives and Actions

Throughout the course of the Project Advisory Team meetings and community engagements, a number of common themes and recommendations appeared. These went into the formulation of the list of strategic directions, objectives and actions provided below. The purpose of the list that follows is to guide and inform the development of culturally responsive health care systems and health practitioners as well as the refinement and strengthening of culturally sensitive health services and programs that currently operate in the province. The intent of this list is to assist those who are serious about moving forward in embedding culturally responsive health and health care in their respective communities and organizations. It is meant to provoke further conversation and reflection on the subject and is not about prescribing actions or specifying standardized roles and responsibilities of certain health partners. What may be required in one area of health care, region or community may be entirely different from what may be required in the next. Upon reading the framework document, people should be able to see themselves, their communities and organizations in the various directions and actions and from there begin to consider the next stage, the development and implementation of framework activities and monitoring progress of what will be done.

Strategic Direction 1: Restoring First Nations community-based health and wellness systems

Objective 1: Revitalize First Nations languages

Objective 2: Teach the medicines

Objective 3: Restore First Nations ceremonies as the source of education and health in First Nations communities

Objective	Action
(1) Revitalize First Nations languages	<ul style="list-style-type: none"> • Expand upon First Nations language immersion courses offered within community schools and training institutions (K-12, secondary and post-secondary) • Working closely with elders, ceremonialists and medicine people, develop introductory education courses and training curricula specific to the place of the languages in overall health and wellness, the

	<p>communities that offer interested clients opportunities to "return to the land," sit with elders and ceremonialists and participate in culture camps and ceremony (e.g., Prairie Spirit Connections-Regina)</p> <ul style="list-style-type: none"> • Provide community-based mentorship and instruction to children, youth and their families as helpers (<i>oskāpēwīw</i>) in the ceremonies
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Strategic Direction 2: Establishing a “middle ground” for engagement between mainstream and First Nations systems and worldviews

Objective 1: Building relationships and partnerships between and within First Nations and mainstream health systems

Objective	Action
(1) Building relationships and partnerships between and within First Nations and mainstream health systems	<ul style="list-style-type: none"> • Host regular provincial and/or regional gatherings that bring together health partners to discuss the subject of culturally responsive care, highlight promising practices in the area and explore opportunities for potential partnership models. • Establish and/or strengthen agreements that formalize partnerships between First Nations communities and representative organizations and mainstream health system organizations that clearly establish shared roles and responsibilities and accountabilities of each in improving the health and health care of First Nations patients, families and communities (Saskatoon Health Region and Saskatoon Tribal Council Memorandum of Understanding). • Partner with First Nations communities and representative organizations to establish and/or build upon liaison/navigator-type positions which can bring about more effective linkages, communication and understanding between mainstream and community-based health systems (e.g., Prairie North Regional Health Authority liaison partnership with Thunderchild First Nation, Onion Lake Health Board Inc., Meadow Lake Tribal Council, and Battleford Tribal Council Indian Health Services). • Explore the establishment of an independent office or body which First Nations patients and families can approach with their health care complaints and which can mediate issues between mainstream and First

	<p>Nations health systems.</p> <ul style="list-style-type: none"> • Examine the feasibility of establishing a provincial Centre of Excellence, or advisory body, on Cross-Cultural Medicine co-managed by mainstream and First Nations system representatives and with a mandate to improve communication and collaboration between western and traditional approaches to health.
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Strategic Direction 3: Transforming mainstream health service delivery to be culturally responsive

- Objective 1: Foster education in culturally responsive health care
- Objective 2: Develop culturally competent and safe policies and programs
- Objective 3: Strengthen the First Nations health workforce
- Objective 4: Create space in health service delivery for First Nations knowledge and approaches to health and wellness

Objective	Action
(1) Foster education in culturally responsive health care	<ul style="list-style-type: none"> • Increase understanding of, and respect for, culture as a key determinant of health through the use of First Nations-led training and workshops – with an emphasis on providing a First Nations perspective on Saskatchewan First Nations history, traditions, evolution and structure of health care services, treaty right to health, health practices, protocol etc. • Collaborate with First Nations communities and representatives to create, and/or strengthen cultural components in health professions curricula that are specific to Saskatchewan First Nations peoples (e.g., Saskatchewan College of Medicine). • Move towards embedding culturally appropriate and safe practice as a requirement of health practitioner accreditation. • Support First Nations community determined and directed health research initiatives that are designed, implemented and evaluated in a way that meets local First Nations needs. • Educate regional health system senior management and staff on local and surrounding First Nations communities, their unique cultures, values and traditions. • Provide mainstream health system senior management and staff with experiential-based learning opportunities in First Nations communities.

Objective	Action
<p>(2) Develop culturally competent and safe policies and programs</p>	<ul style="list-style-type: none"> • Work with First Nations communities and organizations to design and offer individual and multidisciplinary and/or team-based clinical placement opportunities. • Provide supports to First Nations health trainers (i.e., preceptors) and non-First Nations mentors who have experience working with and in First Nations communities. • Increase outreach to First Nations communities to promote a better awareness and understanding among community members of the provincial health system, its services and programs. • Provide First Nations-based orientation and regular professional development opportunities to health professionals who have, or will have, frequent contact with First Nations individuals, families and communities. • Support the revitalization of First Nations languages and recognize their importance to First Nations culture and the health and health outcomes of First Nations peoples. • Work with First Nations partners to (i) review existing guidelines, policies and programs to determine the presence/adequacy of cultural appropriateness and what effects current organizational policies and practices have on the mental, physical, emotional and spiritual well-being of First Nations patients and their families; and (ii) explore effective measures to reduce barriers to providing culturally competent and safe health care services and programs. • Increase the participation of First Nations communities and their representatives in health policy development and decision-making processes which impact the health and health care of First Nations individuals, families and communities. • Increase First Nations membership on mainstream health system boards and committees so that it is representative of the local/regional First Nations population served.
<p>(3) Strengthen the First Nations health workforce</p>	<ul style="list-style-type: none"> • Build upon and strengthen the foundation for First Nations people enrolling in health professional training programs through education-based initiatives and supports (e.g., career fairs, math and science camps,

Objective	Action
<p>(4) Create space in health service delivery for First Nations knowledge and approaches to health and wellness</p>	<p>internships, career pathing and scholarships/grants) while respecting the need to respect and include culture as a key overarching component.</p> <ul style="list-style-type: none"> • Ensure dedicated resources and networks/supports are in place within health workplace environments that will assist in the recruitment, retention and advancement of First Nations employees. • Conduct in-depth analysis of collective agreements to determine the effectiveness and cultural appropriateness of representative workforce clauses and where agreements can be amended to reduce barriers to First Nations entering health careers and the retention of First Nations staff. • Development of ethical guidelines and standards for culturally competent, respectful and safe health care workplaces that ensure compliance of executive management and staff and addresses individual and institutional discrimination. • Explore possibilities for separating out First Nations data from Métis and other cultural groups to determine whether progress is being made in establishing a health workforce that is representative of the First Nations people it serves. • Seek appropriate means (e.g., self-disclosure on license applications) to develop and/or maintain First Nations specific health professional registries that are in keeping with OCAP (ownership, control, access and possession) principles. • Work with First Nations communities and their appropriate representatives (e.g., elders) to facilitate and strengthen access to traditional First Nations diagnostic and healing approaches alone or in combination with contemporary western medical approaches (if it is the patients and families preference to do so) e.g., All Nations Healing Hospital or Native Health Services Regina Qu'Appelle Health Region. • Support the development of First Nations-led health research into healing approaches that helps to establish a better evidence-base for such approaches but which at the same time respects, protects and does not diminish First Nations ways of knowing (e.g., "Honouring Our Strengths: Culture as Intervention in Addictions Treatment). • Promote and build upon access to, and learning from, elders, traditional healers, medicine people, ceremonialists and knowledge keepers so as to

Objective	Action
	<p>improve awareness, understanding and respect for various First Nations healing approaches (e.g., ceremonies), their purpose and the relevant protocols.</p> <ul style="list-style-type: none"> • Establish a formal advisory body to examine the merits of establishing region specific ethical protocols/guidelines that can assist, and build the capacity of, health organizations, their staff and students in working and collaborating with elders, traditional healers, ceremonialists etc. within various health institutions and health care settings.

IV. Communication and Implementation of the CRF

After the Cultural Responsiveness Framework has been shared with all mainstream and First Nations health partners and they have had an opportunity to review and reflect upon its contents, the next step will be to promote further discussion on the framework and, from there, to activate and breathe life into the document. It is hoped that the various partners will take the initiative upon themselves to begin having internal discussions with their members and partners about the framework and what it might mean for them and how it aligns with what they are currently doing in the area of culturally responsive care. Broader engagement will be required within and between the mainstream and First Nations systems about the framework and the strategic directions, objectives and actions which have been put forward. As an immediate first step, one suggestion might be to have a provincial and/or regional gathering on the framework that brings together representatives from both the mainstream and First Nations health systems. The proposed gathering would be presented as an opportunity to discuss and share thoughts on the framework, to profile relevant work that is happening in the province, to make connections and to brainstorm on possibilities for partnerships and how pieces of the framework could be resourced and progress monitored. This event will also enable those in attendance to hear first hand from some of the elders, ceremonialists and First Nations community spokespersons who were a part of the development of the framework.

As has been emphasized throughout this document, implementation of the framework is a shared responsibility. Although some organizations and health partners may have different roles than others and may be able to carry out separate work within their own workplaces, for the framework to be successful, and culturally responsive health care to be a reality in this province, a collective effort by all is needed.

V. Measuring progress in culturally responsive care

For a health organization to be able to say that it provides culturally responsive services and programs to First Nations people, it has to show that its efforts are effective in achieving certain outcomes. This typically involves some degree of evaluation and measurement of indicators. Some health care organizations within the province already have in place some means of evaluation, or markers of patient-centered service, to assist in determining whether targets are being met concerning culturally responsive care. These could include broad health and social status indicators (e.g., life expectancy and child morbidity) or they could include more specific performance measures related to patient access (e.g., emergency room wait times, discharge and readmission rates) and satisfaction, expenditures on culturally relevant programming or the numbers of First Nations employed in the health workforce.

When it comes to culturally competent and safe care, some organizations may even be using tools that allow them to gauge whether health students or providers are demonstrating knowledge, skills and abilities in the area of culturally responsive care. While culturally competent care has been something to be determined by mainstream health institutions and providers, assessing whether health care is culturally safe, on the other hand, can only be answered by the First Nations patients, families and communities that are impacted by health policies and receiving services and programs. Whether or not what is being done now is effective is one thing; determining whether the data that is collected is meaningful and acceptable to First Nations communities another. This is a key question for health organizations to consider.

Ideally whatever will be evaluated regarding the framework and related initiatives will be done in close collaboration with those First Nations populations being served. In some instances, evaluation tools and models from other jurisdictions may have some applications for what is being done in Saskatchewan and sometimes they may not. Again, it is important to consider whether those tools have had significant First Nations community input and are not merely an adopted model from outside of the province. As the work around the Cultural Responsiveness Framework evolves, it will be up to the various partnerships and relationships between the mainstream and First Nations systems and their representatives to:

- (a) Establish and regularly report on measures of culturally responsive care that are important to Saskatchewan First Nations people and communities and
- (b) Based upon the guidance and leadership provided by Saskatchewan First Nations communities and their representatives, come up with performance measures that can adequately determine the quality of health services, programs and initiatives aimed at delivering and ensuring culturally respectful, competent, and safe care.

Appendix A – Glossary of Terms

nuhëch'alánië

Dene - our way of life

mitëwiwin

Cree - medicine society

ë-nācinëhikët

Cree – he/she obtains spiritual help by traditional protocols

Mitákuye oyás'ín

Lakota – all our relations

mitëw

Cree – participant in medicine society

këhtë-ayak

Cree – Elders

otisāpahcikëwiwiniw

Cree – ceremonialist

maskihkīwiyiniw

Cree - medicine people/herbalist

oskāpëwis

Cree – helper

nēhiyawak

Cree – Cree people

Denesuline

Dēne Sų́liné – People of the Barrens

Nakawe (Nahkawēwininiwak)

anihš́ināpē – Anishnabe, Ojibwe, Saulteaux

* Note – Terms to identify oneself is based on regional dialects.

Dakota

Dakhóta – Dakota Sioux

Lakota

Lakóhta – Lakota, Teton Lakota Sioux

Nakota

Nakóda – Assiniboine

Makhá uŋčí

Lakota – (Grand) Mother Earth

nipākwēsímowin

Cree – sundance

inipí

Dakota/Nakota/Lakota – sweat lodge ceremony

cīhsahkīwin

Nakawe – shake tent

mawimoscikēwiyniwak

Cree – persons who pray in the traditional way

kitahamāwasowin

Cree – guiding/teaching/disciplining children

kihci-asotamātowin

Cree – sacred promises to one another

miyo-wīcēhtowin

Cree – Getting along well with others, good relations

manācihitiwin

Nakawe – mutual respect

ka-nācinēhamwak

Cree – they will get the medicine

oskāpēwiw

Cree – he is a helper in ceremonies