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The Toolkit is one of three resources developed to support this work (also see IPAC-AFMC First Nations, Inuit and Métis Health Core Competencies and Critical Reflection Tool). All materials can be found in English and French on the IPAC and AFMC web sites: http://www.ipac-amic.org/publications.php - or - http://www.afmc.ca/social-aboriginal-health-e.php

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Introduction

The intent of the IPAC-AFMC curriculum implementation toolkit is to assist the faculties of medicine in Canada in advancing the First Nations/Inuit/Métis (FN/I/M) Health Core Competencies: A Curriculum Framework for Undergraduate Medical Education. IPAC and AFMC recognize the complexity of addressing the health and healing needs of Canada’s diverse multicultural First Nation, Inuit and Métis communities. The implementation of the FN/I/M Health Core Competencies will necessitate the use of old and new resources, varied approaches to teaching, robust evaluation and sustained, equitable participation from those affected by these changes.

This toolkit is thus established on a premise of collaboration with the diverse FN/I/M communities served by the faculties of medicine. It is formatted on the sacred symbol of many peoples, the circle; a recognition of the cyclic nature of development, change and revision. Medical schools and FN/I/M communities will need patience for this process; it will take time, effort and investment.

Your feedback is welcome and encouraged:
info@ipac-amic.org – or – indigenoushealth@afmc.ca
Implementation Algorithm

1. Community Engagement
2. Collaborative Vision
3. Pedagogy
4. Implementation
5. Evaluation
Community Engagement – Rationale

Relationship building with the communities your institution serves is the cornerstone of a successful process of developing and implementing curriculum congruent with the FN/I/M Health Core Competencies and those distal and proximal First Nation, Inuit and Métis communities’ values served. The process of community engagement promotes:

1. **Decolonization** - Many of the health disparities which FN/I/M people face are a result of the colonization process. In order to avoid repeating this harmful dynamic, it is imperative to entrench FN/I/M voices on matters related to our own health and well-being.

2. **FN/I/M Knowledge Recognition** - FN/I/M communities have a wealth of expertise and knowledge with respect to health and healing. Traditional beliefs, values and practices are sacred and can encompass elements not commonly represented in the biomedical model – e.g. Spirit. The value of the unique worldviews and pedagogy of the FN/I/M communities your faculty serves must be recognized and diligently respected.

3. **Accurate Representation** - Unfortunately, racism and discrimination against FN/I/M people is still prevalent within the health care system. Engaging communities will shift the view of FN/I/M people from a deficit perspective, which reinforces stereotypes, to a more accurate strength based perspective. Working with communities in partnership will highlight their resilience, capacity and strength.

4. **Role-modeling** - The community engagement process allows the faculty to role-model the core competencies in a different context. Establishing an equitable, collaborative relationship with FN/I/M communities demonstrates to medical students the value of working in partnership with FN/I/M people.
Community Engagement - Process

The process of community engagement will be unique to each faculty and the populations it serves. It will be complex and will require considerable time and attention. Here are some suggestions and examples on how your faculty may approach this critical step:

1. **Reflection** - It is important to begin by identifying all of the communities that your faculty serves. The Canadian Institute of Health Research has defined community “as a sense of belonging together.” They also state that FN/I/M communities are not homogenous and due to historical influences may or may not be located in their original homelands. As such, it’s important to include all of the groups your faculty serves in this process – urban, reserve, Arctic etc.

2. **Local resources** - If your institution has FN/I/M faculty and staff, it would be beneficial to involve them early. While a single individual cannot adequately represent the varied community voices required in this process they may be able to assist in making initial contacts in a culturally sensitive way. Increasing the number of medical FN/I/M faculty and collaborating trans-disciplinarily with other FN/I/M faculty is strongly encouraged.

3. **Initial contacts** - Initiating the partnership is the responsibility of the medical school. Formal or informal linkages may already exist between your institution and communities or organizations; explore these. Follow the direction of others on campus who have community partnerships. Initial contacts may be made with only a few FN/I/M communities and organizations, but as the process evolves these groups will help you to identify other partners that need to be included.

4. **Respect protocol** - How community organizations and their representatives are approached will determine the dynamic of the subsequent partnership. It is important to be respectful of local traditions. Although you may not be familiar with local custom initially, it would be appropriate to confirm with your initial contacts how protocol can be respected.

5. **Reference group** - Once all of the communities served by the faculty have been identified and invited to participate, it would be helpful to form a reference group. This group would be composed of representatives from all of your key community stakeholders. To be successful and relevant, communities must guide this process; having a reference group is one way this can be facilitated.

6. **Continued reflection** - The process of community engagement is constantly evolving. The partnership must be nurtured and supported to remain sustainable. We must scrutinize our partnership and our balance of power by asking ourselves if all members have the opportunity to meaningfully contribute and are equally respected. Communications must be two-way and ongoing. Working together will require patience and mindfulness. The rewards of this investment will be the advancement of FN/I/M health. The Northern Ontario School of Medicine and the Northern Ontario First Nation and Métis communities demonstrate one such successful and ongoing collaboration.
Collaborative Vision

Defining your group’s collaborative vision around FN/I/M health will coordinate and guide your efforts, in addition to maintaining accountability throughout the process.

1. Define FN/I/M Health Strategy - As a group, you must clearly articulate and distill your overall goal. This strategy can and should be larger than simply adopting the FN/I/M core competencies. In order to achieve balanced input from all participants you may involve an outside facilitator with expertise in strategic planning.

2. Core Competencies in Context - Within the scope of your newly defined inclusive FN/I/M Health Strategy you can now review the core competencies. Reflect on how the core competencies relate to your overall strategy and specifically what they mean to your FN/I/M Reference Group. Each group will view the competencies differently and will have unique ideas of how a practitioner will demonstrate their competence. Clarify at the outset, what a culturally safe practitioner will look like to the community members you serve.

3. Personalize - In order to successfully operationalize your strategy each participant must have a clear understanding of how they are going to contribute. Take time to reflect on what the process will mean to participants; and how they view themselves working towards the common goal. An expert facilitator will greatly enhance this step.
Pedagogy

Pedagogy is the art, science or profession of teaching. Respecting the differences of Non-First Nation, Inuit or Métis and FN/I/M pedagogies by maintaining balanced input from all participants will ensure that the curriculum enhancement process is culturally safe. Aim to bring teaching into culture, not culture into teaching.

1. **Define current curriculum** - Map your current curriculum to identify where FN/I/M health themes are already being addressed. With the group, reflect on the strengths of your program in the area of FN/I/M Health. Work to maintain and enhance these areas. Also work to identify gaps or areas of the curriculum that could be enriched to reflect your FN/I/M Health Strategy.

2. **Core Competencies in Context** - Reflect on where the core competencies must be threaded into the curriculum map. Realizing that curriculum time is highly valuable, we suggest adopting an enhanced approach whereby current curriculum is not withdrawn completely but rather modified to express FN/I/M perspectives. The core competencies are broad and complex. Any efforts to teach them will require multimodal approaches (problem based learning PBL, didactic, experiential) and openness to FN/I/M pedagogies.

3. **Personalize/Operationalize** - At this stage, members of your group with expertise in curriculum development can complete the creation of the content, which was agreed upon hopefully through consensus. If your faculty does not have a dedicated curriculum developer, you may consider contracting someone with expertise in this area, ideally who has demonstrated ability to respect and uphold FN/I/M pedagogies. Remember, certain elements of FN/I/M knowing (e.g. Spirit) cannot be translated in a lecture. Therefore, at this stage it will be important for members of your group to work closely with FN/I/M Elders to find a way to respectfully and appropriately incorporate these teachings.

4. **Member check** - Being meaningfully engaged with community will require a constant flow of information back and forth to ensure evolving curriculum continues to reflect the group’s overall objectives. We recommend that once lecture materials, readings, PBL cases and proposed experiential teachings have been developed they must be brought to the group for review. Although working in this way will be time intensive, the resultant curriculum will be rich and grounded in culture.
Successful knowledge translation and employment of the core competencies requires a variety of implementation strategies. Both parallel and integrative approaches are suggested. As with all other steps, the centrality of community voice is a key step.

1. Define Implementation Process - Each faculty will have a unique process for curriculum change. Review this process and clarify the steps involved. Ensure that someone directly involved with decisions for undergraduate medical curriculum is a member of your team. The FN/I/M health curriculum will be unique; try and identify potential barriers in your current process that may impede implementation. For example, is there a precedent to have FN/I/M community members deliver curriculum, or is this role restricted to medical faculty?

2. Core Competencies in Context - At this stage, your FN/I/M Reference Group will be intimately familiar with the upcoming changes. Other stakeholders will also need to be prepared for the shifts in curriculum. Faculty and learners will need to be advised of the rationale behind the proposed changes. Prior to Elders or community members delivering curriculum, learners must be advised of the context of these teachings and how they can expect them to differ from their usual educative experience. Preparing students and faculty by contextualizing changes will allow them to understand the need for revised curriculum.

3. Operationalize - Due to the necessity to embed the enhanced curriculum throughout the medical student experience and the need to use multimodal approaches the administrative demands of implementation will be significant. Integrative and community based experiences will demand substantial resources both human and financial. The goal of graduating physicians who can provide culturally safe care is intended to be enduring, therefore funding must also be stable and sustainable. As you will see in the Evaluation step, the cycle of promoting FN/I/M Health is continuous therefore core funding to support this is strongly recommended.
Evaluation

Evaluation is another important step in the process of implementing the FN/I/M Health Core Competencies. Analyzing the outcomes of your curriculum change is critical. It’s important however not to equate change in your curriculum with success. The purpose of the change is to try and fulfill your FN/I/M Health Strategy therefore you must reflect broadly.

1. **Revisit FN/I/M Health Strategy** - Begin your evaluation by reviewing the FN/I/M Health Strategy agreed upon by your group in the initial stages of this process. This should be a very brief exercise, as this strategy will have been the guiding focus of your efforts to this point and everyone should be well acquainted with your overall goal.

2. **Capture stakeholder experience** - There will be many experiences generated by the curriculum change process. You will want to understand how this has affected your learners, faculty and importantly the members of FN/I/M communities served by your institution. It will be imperative to gain insight as to whether learners feel more knowledgeable in the area of FN/I/M Health and whether FN/I/M patients under their care believe the learners are culturally safe. Remember, the ‘experience’ of culturally safe care will have been co-defined early on in your process during the Collaborative Vision stage. You may wish to invite faculty with expertise in qualitative research/mixed methods to help design the tools required to capture these varied voices.

3. **Compare experience with FN/I/M Health Strategy** - Once you have gathered information about what effect the transformation has had on the delivery of culturally safe care you can revisit how this relates to your FN/I/M Health Strategy. Have the outcomes of your curriculum change brought you closer to fulfilling your FN/I/M Health Strategy? If not, why not? If so, are the outcomes adequate or could they be further enhanced?

4. **Collaborative vision** - As you can see, at the end of the initial cycle through this process you will naturally re-emerge at the collaborative visioning stage. Together, you can reflect on what the process has been like, how it can be further improved, and re-evaluate how you can continue to work towards the advancement of FN/I/M Health.
Sharing Experiences & Resources

While the curriculum implemented across Canada will be unique to each medical faculty and the communities they serve, there is much to be gained from sharing experiences and resources at a national level and beyond.

IPAC-AFMC has supported a national Indigenous Health Education Working Group made up of educators from each medical faculty and wherever possible, their FN/I/M community partners. As we move into this next phase of curriculum implementation IPAC-AFMC offers an online First Nations, Inuit & Métis Health Education community within the Canadian Healthcare Education Commons (CHEC) to further discussion and sharing.

To join us, look for First Nations, Inuit & Métis Health Education under the community section of the CHEC site:
http://www.chec-cesc.ca

Students are important catalysts for curriculum change and some medical faculties already have student-run Indigenous Health Interest Groups. To help these groups connect and share on a national level they also have an online community on the CHEC site.

We anticipate many resources being shared through the CHEC library, including the Elders Handbook developed by the Northern Ontario School of Medicine which details how the medical school engages and works with Indigenous Elders. For more information, visit their web site: http://www.normed.ca/communities/aboriginal_affairs/general.aspx?id=3850