

Indigenous Health Service Evaluation: Principles and Guidelines from a Provincial “Three Ribbon” Expert Panel

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Abstract: *A group of Indigenous health and social service evaluators called the “Three Ribbon” panel came together in Toronto in 2015/16 with the goal of informing a set of evidence-based guidelines for urban Indigenous health and social service and program evaluation. The collective knowledge and experiences of the Three Ribbon panel was gathered through discussion circles and synthesized around the following areas: barriers to conducting Indigenous health and social service evaluation; decolonizing principles and protocols that support community self-determination and centralize Indigenous culture and worldviews; and guidelines to inform health and social service evaluation moving forward. The wisdom and contributions of the Three Ribbon Panel creates space for Indigenous worldviews, values, and beliefs within program evaluation practice and has important implications for evaluation research and application.*

Keywords: *decolonization, guiding principles, Indigenous, Indigenous experience, self-determination*

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Résumé : *Un groupe d'évaluateurs et d'évaluatrices dans le domaine de la santé et des services sociaux autochtones, appelé le groupe « Three Riboon Panel » s'est réuni à Toronto en 2015-2016 avec l'objectif d'établir des lignes directrices fondées sur la recherche pour l'évaluation de programmes et de services en contexte autochtone. L'expérience et les connaissances collectives du groupe ont été présentées lors de cercles de discussions et portaient sur les domaines suivants : les obstacles à l'évaluation des programmes de santé et services sociaux en contexte autochtone; la décolonisation des principes et des protocoles afin d'appuyer l'autodétermination des communautés et centraliser la culture et les points de vue autochtones; et les lignes directrices qui orienteront à l'avenir l'évaluation en santé et services sociaux. La sagesse et la contribution du groupe contribuent à la diffusion des points de vue, des valeurs et des croyances autochtones et permettent une réflexion au sujet de leur place au sein de la pratique évaluative. Cette réflexion pourrait avoir des conséquences importantes pour la pratique et la recherche sur l'évaluation.*

Mots clé : *décolonisation, principes directeurs, autochtone, expérience autochtone, autodétermination*

BACKGROUND

In Canada, evaluations of programs and services that are tailored for and/or include Indigenous peoples are often under-resourced, poorly designed, and fail to take community evaluation priorities into account (Grover, 2008; Scott, 2008). Mainstream evaluations also tend to exclude Indigenous-specific needs from their performance assessments (Grover, 2008). While there has been a movement toward strengths-based, holistic, and “culturally responsive” evaluations, Indigenous scholars have called for evaluations that are grounded in Indigenous worldviews and ways of knowing and informed by locally defined values, such as sovereignty, reciprocity, and place (Cram, 2018; Lafrance, Nichols, & Kirkhart, 2012; Waapalaneexkweew & Dodge-Francis, 2018). The Well Living House is an action research centre focused on building and sharing evidence to support Indigenous infant, child, and family health and is located at St. Michael's Hospital within the Centre for Urban Health Solutions (C-UHS) in Toronto, Canada. The Well Living House is co-governed by St. Michael's Hospital and a Counsel of Indigenous grandparents (Well Living House, 2017b).

In 2015/2016, the Well Living House and partners brought together a group of experienced and respected Indigenous health service evaluators known as the “Three Ribbon Panel.” The Three Ribbon research project was implemented as a partnership between four Indigenous health service partners: Seventh Generation Midwives Toronto (SGMT), Dedwadadehsnye's Aboriginal Health Centre in Hamilton, the Southwest Ontario Health Access Centre (SOAHAC) in London, and Waasegiizhig Nanaandawe'Iyewigamig Health Access Centre in Kenora. The guiding intention of the Panel was to support the development of “wise” practice guidelines for high-quality Indigenous health service and program evaluation through transformative, shared learning by way

of discussion circles. The term “wise” is used in place of “best” or “evidence-based” to ensure that Indigenous knowledge and practice, which often relies on experiential proofs, is included as a core source of information in addition to evidence emerging from universities and/or non-Indigenous sources. ([Well Living House, 2017a](#))

The name “Three Ribbon” was chosen to honour Indigenous teachings and ceremony. The threefold braid can represent mind, body, and spirit. Braids can also hold prayers and intentions; symbolize strength and wisdom; and illustrate the wholistic, inter-relational nature of Indigenous knowledge and practice ([Abol-son, 2010](#)). Ribbons are a common and important element of many Indigenous communities’ ceremonial protocols and clothing.

In this paper, we present a synthesis of the collective knowledge and lived experiences of the Three Ribbon Panel, which spanned multiple dimensions of Indigenous program evaluation practice. This innovative synthesis challenges and extends program evaluation research and practice and fills a knowledge and practice gap in ways that align with the goals of the Truth and Reconciliation Commission of Canada, including the call to action for the federal government, in partnership with Indigenous communities, to identify and close gaps in health outcomes between Indigenous and non-Indigenous people ([TRC, 2015](#)).

FACILITATION OF THE THREE RIBBON PANEL

Panel members were identified and recruited by the Three Ribbon project leads with the aim of selecting a mixed and representative group of Indigenous and allied evaluation researcher specialists, public health and health service practitioners, Indigenous health service managers, and Indigenous Knowledge Keepers/Elders. Eight identified potential members agreed to participate as Panelists. Panelists were then invited to a one-day meeting, with arrangements made for travel and logistics. Panelists represented tribal councils, local Indigenous health services, and various government bodies from across Ontario.

To provide background information and focus the content of the Panel discussion, the research team circulated the initial findings from a recent international systematic review ([Maddox et al., Under Review](#)) and the following pre-meeting questions:

1. In your knowledge and experience what are the major problems or challenges that arise in the evaluation of Indigenous health services and programs?
2. What approach(es) are you aware of that have been successfully used in Indigenous health services and program evaluation? How was/were/they successful?
3. The American Evaluation Association (AEA) has outlined guiding principles for evaluators ([American Evaluation Association, 2007](#)): systematic inquiry, competence, integrity/honesty, respect for people, responsibilities for general and public welfare. 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?

During the panel, the Three Ribbon Project lead facilitated a discussion circle that drew on Indigenous-specific methods, such as dialogue circles (Crowshoe & Mannes Schmidt, 2002; National Aboriginal Health Organization, 2006) and talking circles (Weber-Pillwax, 2004; Wilson, 2008). Indigenous protocols were followed, with the day starting with a smudge, prayer, and traditional teaching led by an Elder. The discussion circle began with roundtable introductions, followed by progressive go-arounds to explore the pre-meeting questions. The facilitator tracked discussion ideas on a flip chart, summarizing and encouraging additional thoughts after each question. As mutual agreements and common ground emerged, the facilitator invited further reflections. Syntheses were emerging during the conversations and the process. Before closing the circle, Panelists were asked to share final thoughts, and the Elder closed the panel with a song.

Three months later, a follow-up videoconference was held to review and refine the summary report of the discussion circle and develop preliminary recommendations for Indigenous health service and program evaluation. Emerging recommendations were shared electronically, and a final videoconference was held to finalize the report and recommendations.

INSIGHTS FROM THE THREE RIBBON PANEL

Challenges and issues with dominant evaluation systems

Reflecting on the major problems or challenges that arise in the evaluation of Indigenous health services and programs, there was strong agreement among Panelists that existing non-Indigenous and dominant systems, processes, measures, and tools for evaluations are being externally imposed on Indigenous communities. Consequently, this divides the goals and methods of the evaluations from community utility and relevance. Much of this disconnect can be traced back to the funding agencies that control the flow of resources and commonly prescribe evaluation theory and primary outcome measures. Indigenous health and social services and their evaluations are systematically under-resourced (Lavoie, Forget, & O'Neil, 2007). Inadequate resourcing hinders the development of service and program infrastructure and limits capacity for sustainability, evaluation quality, and collection of sufficient data to support wise health services and programming in Indigenous communities (Smylie, Anderson, Ratima, Crengle, & Anderson, 2006; Smylie & Firestone, 2015). The explicit and/or implicit evaluation goals of funding bodies may also be in tension and outweigh those of Indigenous communities, making evaluations theoretically faulty. 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 has resulted in what Sara Wolfe from Seventh Generation Midwives Toronto described as "evaluation fatigue" and Indigenous health practitioners and communities having an "allergy" to evaluation.

When evaluation processes, tools, and measures are designed and implemented without input, involvement, or governance from Indigenous communities, it fosters false narratives about Indigenous people. As Sara Wolfe noted, “often, consultation happens at isolated points during evaluation rather than as an iterative process.” If the “measuring stick” is externally developed and imposed, inappropriate measures are applied and the result can be an incorrect assessment of program failure.

Drawing from her lived Indigenous experience and many years in Indigenous health management and executive roles, Gertie Mai Muse identified a high level of “inherent community accountability” as fundamental to the success of the health centre she directed. This community direction was the result of an integrated and comprehensive community engagement process and strong, reciprocal community member-service provider relationships. It would be easy for an external evaluator unfamiliar with Indigenous social systems and the robust nature of local Indigenous knowledge and practice to miss or even dismiss these critical processes and relationships. Panelist Vicki Van Wagner offered similar reflections on the evaluation of midwifery in Nunavik, Canada:

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, that when evaluating Indigenous health services, the stories of community engagement in defining the project, the outcome measures, doing the work of the research and owning the results and even the tools that are developed is very important.

An additional challenge was the need to address different literacies, interpretations of language, and understandings of core concepts between evaluators and Indigenous communities. 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.

Decolonizing principles and protocols for evaluation

Panelists confirmed that Indigenous communities want to define, decolonize, and prioritize Indigenous knowledges and processes in their own service and program evaluation. Decolonized evaluation centralizes Indigenous knowledge and values, ensures that processes and outcomes are aligned with Indigenous community goals and worldviews, includes active participation and leadership of Indigenous communities, and focuses on relevance as defined by Indigenous communities (Chouinard & Cousins, 2007; Johnston-Goodstar, 2012). According to Roger Boyer II, “There is a fever, a thirst for our own [Indigenous] data and evaluation.”

While many evaluation methods are rooted in non-Indigenous, mainstream approaches to science and public health, there are examples that bridge Indigenous ways of knowing and doing and enable effective evaluation. Panelists recommended the use of stories (Geia, Hayes, & Usher, 2013), Photo-Voice (Castleden, Garvin, & Huu-ay-aht First Nation, 2008), and concept mapping (Firestone et al., 2014). 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 throughout their healing journey.

Emerging guiding principles for Indigenous evaluation

Building on the findings of an international systematic literature review and the principles of the AEA, Panelists identified the following emerging principles:

Indigenous governance: The program evaluation must be community-led and governed. Local Indigenous communities must drive the entire process, set the priorities for evaluation, and lead or co-lead program and evaluation implementation. This supports community self-determination and upholds program evaluation rigour, leading to more positive program outcomes. Indigenous communities must also be central in decision-making and governance processes at broader institutional and systemic levels to achieve effective and community-relevant evaluation.

Clarity of purpose: “Who wants to know and why?”: The integrity of an evaluation in an Indigenous context is dependent on the disclosure and transparency of the evaluator. Whether the evaluator is external to or a member of a particular community, they must be self-reflexive about their position and relationality to those using, delivering, and funding the service. Evaluators must also acknowledge their limitations, motivations, and purpose for conducting the evaluation. Bringing a clear purpose, along with an understanding of the unique local context, can inform and enhance sharing of the evaluation within and between Indigenous communities. We use the term local context understanding 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, economical, and socio-political background, and/or environment relevant to a particular Indigenous community.

Indigegogy: The term “Indigegogy” reflects approaches that are foundationally grounded in Indigenous knowledge and practice, simultaneously recognizing innate colonial contamination (Hill & Wilkinson, 2014). Indigenous knowledge and practices include the diversity of current and lived Indigenous knowledges, skills, values, and beliefs relevant to the Indigenous community or population involved in the evaluation. They should not be externally inscribed; such an imposition process could be considered a recolonization. Respect for local protocols and culture, then, is required. The use of Indigenous languages is important, but not always essential to this foundational integration of Indigenous culture in its multiple and varied expressions. Indigegogy will influence how evaluations are developed, implemented, analyzed, reported, and utilized and can ensure that findings are culturally sensitive and accurate.

Inter-relationality: Inter-relationality, or the connection and interdependence between all things including information, is an important and cross-cutting concept in Indigenous knowledge systems and practice (Carjuzaa & Fenimore-Smith, 2010; Kirkness & Barnhardt, 1991). Applying the concept of inter-relationality to program evaluation requires significant adjustment to mainstream methods and measures that privilege and categorize questions and outcomes. An inter-relational approach is deeply concerned with the interconnection between and across domains of inquiry and bits of data.

Minobimaatisiwin —Living the good life and other holistic concepts of good living: Holistic models of wellness such as *Minobimaatisiwin*, the Anishnaabe worldview of living a good life, represent the application of inter-relationality to health and to Indigenous service and program evaluation. Panel Elder and Knowledge Keeper Jeanne Hebert spoke about the Indigenous Peoples' Great Law, which is the oral constitution that bound the Iroquois Confederacy together. Iroquois laws were recorded using wampum symbols to support narratives that specified laws and ceremonies to be performed at specific times. One of the main principles of the Great Law was peace and the balance of mind and body in life. Vicki Van Wagner explored these ideas with her colleagues in Nunavik who explained the Inuit concept of *Qanuinnngisiarniq*, which means “everything is okay” in the broadest sense of everything and the most meaningful sense of “okay,” and also “wellness,” taking care of yourself and “living well in a healthy way.” Evaluations committed to understanding how Indigenous community governance, laws, and ceremonies affect health outcomes would be wise to build on local Indigenous governance frameworks such as these.

Collectivity: Local community leadership is intrinsic to community well-being. Collectivity requires the meaningful engagement and participation of the local community across service domains and subpopulations. Broad-based Indigenous leadership and community participation linked directly to evaluation activities (e.g., the hiring of Indigenous staff, consultants, advisory boards, reference groups, and working groups, or mentorship by Knowledge Keepers and Elders) are essential.

Responsiveness: Evaluations must reflect local community context and should be flexible to respond to the specific needs and environment within that community. Responsiveness demands an understanding of the historical and current socio-political context in which a person, community, program, or policy operates (e.g., scheduled evaluation activities may need to be postponed/adapted to accommodate emergencies and other circumstances that arise, such as unexpected death).

Wise protocols for Indigenous evaluation

The protocols that uphold Indigenous evaluation principles vary across community settings and are adhered to and recognized in different ways. Reflecting

on the literature and the insights from the Panelists, the Panelists identified the following core protocols:

- **ethics and governance** (e.g., establishing Indigenous/trial ethics boards, community advisory boards, research, and data-sharing mechanisms; following Indigenous research ethics frameworks);
- **integrated evaluation frameworks** (i.e., ensuring that evaluations build on individual, community, organizational, and system-level capacities, and multi-dimensional understandings of health);
- **cultural safety** (e.g., training and support for evaluation team, community-defined measures and tools); and

Table 1. 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 Minibi-maatisiwin, the Great Law, and Qanuinnigisiarniq.
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 contextual constraints.

- **leadership and engagement** (e.g., ensuring local leadership and involving in decision making across all stages of evaluation development, implementation, and knowledge translation).

This is not an exhaustive inventory of protocols, but it highlights tangible, culturally appropriate, and effective applications of the principles. Detailed explanations and examples of each protocol are included in the Summary Report ([Well Living House, 2017b](#)).

Guidelines for Indigenous health service and program evaluation

The Panel drew on their collective knowledge and experiences to put the following guidelines forward (see [Table 1](#)). The statements below can be understood as a set of “trail-markers,” defining several unique evaluation pathways that are relevant and useful to diverse Indigenous communities.

CONCLUSION

We have highlighted principles, protocols, and guidelines for Indigenous health service and evaluation that draw on the lived experiences of an expert Panel and what is known about working with and building relationships with Indigenous communities. Commonly, governmental evaluations have been and continue to be the source of negative experiences. However, as the Three Ribbon Panel confirms, there is potential to do evaluations in a meaningful way that benefits Indigenous communities. The collective wisdom and contributions of the Panel creates the necessary space for Indigenous worldviews, values, and beliefs to be centred within evaluation practice and lends insight that ought to be considered by evaluators, funding agencies, and Indigenous communities moving forward.

While efforts were made to ensure that the Panel was comprehensive and inclusive, it is anticipated that ideas and strategies for specific contexts may have been missed. There may also be community contexts, constraints, and priorities that will result in choices and actions that differ from what are proposed here. This paper is thus a living document. This approach to Indigenous knowledge development and sharing is well aligned with the “wise” practice of health service and program evaluation, which must be holistic and iterative to adequately reflect contextual complexity and dynamism.

ACKNOWLEDGMENTS

Support for the Three Ribbon Panel was provided through a Ministry of Health and Long-Term Care (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.” Dr. Smylie was supported by a CIHR Applied Public Health Research Chair in Indigenous Health Knowledge and Information. The agencies that sponsored the

Three Ribbon Panel gathering were Dedwadadehsnye>s Aboriginal Health Centre (DAHAC), Seventh Generation Midwives Toronto (SGMT), Southwest Ontario Aboriginal Health Access Centre (SOAHAC), Waasegiizhig Nanaandawe'yewigamig Health Access Centre (NIHAC), and Well Living House (WLH).

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The Three Ribbon Panel, whose members co-authored this paper, represents a diverse group of Indigenous and allied experts who came together to share experiential knowledge and to identify exemplars, principles, and protocols around Indigenous health and social service and program evaluation. As a result of existing, long-standing relationships among members and through an Indigenous-led and -governed process, the Three Ribbon Panel facilitated shared learning, information exchange, and transformative knowledge translation.