CFMS National Officer of Indigenous Health (NOIH)

CFMS Local Officers of Indigenous Health (LOIH)

Proposal

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**Introduction**

The CFMS is committed to engaging with Canada’s Indigenous peoples and advocating for their cultural and health-related rights on both a local and national level. We recognize the inequities that exist in the health status of Indigenous people and how the history of colonialism in Canada has continued to contribute to these inequities. Further, the CFMS recognizes the necessity for an organized mobilization of Canadian medical students to help reverse these inequities through collaborative local and national initiatives.

With these realizations in mind, the Aboriginal Health Liaison (AHL) role was created by the CFMS in 2010 through mandates made within the Global Health Program. The AHL role was designed to be a National Officer role whose primary directives were to advocate for improvements to Aboriginal health, representation within medical education, facilitation of awareness/discussion of Indigenous health-related issues, and to foster connections between interested students or faculty of CFMS member schools.

For the past four years, the AHL role has acted as the primary contact for the CFMS’ Indigenous Health portfolio and has been mandated to work within the aforementioned primary directives.

**Rationale for Proposed Changes**

An Environmental Scan was conducted in January and February 2015 to characterize Indigenous health engagement structures at each member school. Simultaneously, feedback on an early draft of proposed changes was gathered from each member school in terms of proposed changes. All member schools had at least one respondent and the information gathered was incorporated into the development of an expanded Terms of Reference and this proposal. Major findings from this scan included:

* Strong variation in the local structures of Indigenous health engagement, with responses ranging from elected officials to leaders within student-run interest groups to selected positions within local Global Health programs. All schools reported at least some form of local engagement, but not all had a definite leader.
* Approximately half of the schools had some sort of connection to local Global Health programs and half had connections to their Medical Society in terms of funding or information flow.
* All but one respondent outright supported more involvement by the CFMS on a local level.
	+ “As [Indigenous Health] is such an important topic, I think it is essential to have the CFMS involved.”
	+ “The [LOIH] roles would give the students a feeling of formality."
* Many mentioned the benefits of idea sharing and mobilization on national issues as strengths of the proposed changes:
	+ “Events or workshops could be standardized across the country, and information sharing could take place.”
	+ “I see the national role as helping to share the successes at other schools so that others may attempt to implement these strategies.”
* Two pieces of feedback given was the uncertainty of how this structure would be incorporated into existing structures of Indigenous health engagement and questioning the efficiency of the changes:
	+ “I would have concerns about how the local members would be elected and how that would tie into the existing [local] structure … [W]e would have to figure out a process for elections or hiring at the local level that still fulfilled [our local interest group’s] mission while following CFMS guidelines for elections.”
	+ “I think [having CFMS involvement] would be inefficient”

Given the results of the Environmental Scan, feedback on proposed changes, and upon review of the successes and challenges of the AHL position thus far, it is apparent that there are a number of areas where opportunities exist for improvement. In terms of the CFMS’ mission, the current state of the AHL role and Indigenous Health portfolio is inadequate in its ability to *connect*, *support*, and *represent* Indigenous Health within the larger goals of CFMS.

* *Connect*: A paucity of communication exists between the AHL position and students engaged in Indigenous health locally at member schools. As well, no platform exists between member schools to connect local leaders in Indigenous health. This leads to difficulty in member mobilization on national issues and resource sharing between schools.
* *Support*: Students wanting to affect change on a local or national level in Indigenous health are not systematically supported by the CFMS. With the current system, they would be required to seek out support ad hoc from the AHL, and the AHL lacks guiding principles for how to support members locally.
* *Represent*: The CFMS Indigenous health portfolio is designed to be flexible and to accommodate change based on the landscape of Indigenous health at any given time. It is vital that input from member schools be considered when deciding what initiatives should be focused on and what partnerships should be made within the portfolio. Currently, no system for this collaboration and decision-making exists.

To summarize, the AHL does not have mandated local representatives at each member school, unlike other national officers within the Global Health Program. Furthermore, guiding principles to facilitate national-local and local-local communication and collaboration do not exist. To this end, it is apparent that a re-structuring of the AHL position and Indigenous Health portfolio is needed.

**Summary of Proposed Changes**

A number of changes are proposed to the Indigenous Health portfolio, including naming changes, modification of the structure, and the creation of actionable responsibilities for all representatives. A Terms of Reference has been created to outline the changes in full, but a brief summary is provided here. This Proposal and the Terms of Reference were re-circulated to participants of the Environmental Scan for further feedback, which was incorporated into the final draft of both documents.

*Naming: Using “Indigenous” as opposed to “Aboriginal”*

We propose to change the terminology of the portfolio from “Aboriginal” to “Indigenous”. The use of the term “Indigenous” is an umbrella term intended to represent the vast number of distinct and different Indigenous groups in Canada, including the First Nations, Inuit, and Metis peoples. Other terminology continues to be used to describe these peoples, including “Aboriginal” or “FNMI”, but the CFMS recognizes the need for decolonization of the terminology used to describe the Canada’s Indigenous people. The use of “Indigenous” has become increasingly a more accepted decolonized term and we hope will be adopted by the CFMS in our continued commitment to decolonization. Decolonization refers to the process by which Indigenous peoples understand and re-establish pre-colonial ways of thinking, practices, and structure of self-determination.

*Structure: Creation of a National-Local Structure*

We propose the adoption of a local-national structure, similar to other Global Health portfolios. This involves having one national position (National Officer of Indigenous Health, NOIH) for the entirety of the CFMS and two local positions at each member school (Local Officers of Indigenous Health, LOIH). The NOIH position will be a fourteen-month position that is selected through the existing application process. LOIH positions will be two-year terms and will be selected within each school through various selection processes. Given that Indigenous health engagement structures differ between each member schools, we have allowed each school the ability to decide their own fair and objective means of selecting LOIHs, while having the NOIH provide support in mitigating challenges in choosing a selection strategy should they arise.

*Actionable Responsibilities: Outlining Roles*

We propose a Terms of Reference that will outline the distinct responsibilities of both the NOIH and the LOIHs. In doing so, we hope to both provide actionable items that facilitates accountability for each officer in their position, while simultaneously allowing each officer to use their personal strengths and assets in affecting change as they deem appropriate.

**Timeline for Proposed Changes**

These proposed changes will be presented at the Spring General Meeting in Vancouver in April 2015. If passed, we aim to implement these changes in September 2015. A mandatory review of the Terms of Reference will be completed one year following its implementation.

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