**Situational Assessment**

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| 1. **What is the situation** |
| **What impact does the current situation have on health outcomes, quality of life and other societal costs, such as noise, air pollution or increased healthcare spending?**   * Ischemic heart disease (a type of cardiovascular disease) was the number 1 cause of death worldwide in 2020 (WHO, 2021) * Of the 18.5 million men and women who died of cardiovascular disease 6.1 million deaths occurred between the ages of 30-70 years of age (Roth et al., 2020) * The majority of the cardiovascular disease burden is attributed to modifiable risk factors (Roth et al., 2020) * Cardiovascular disease (CVD) substantially reduces quality of life (Lui et al., 2023) |
| **Which groups of people are at higher risk of health problems and poorer quality of life?**   * CVD burden has improved but outcomes for women (especially <55 years) have remained the same (Jaffer et al., 2021) * Women are more likely to die 1 year after a heart attack (Jaffer et al., 2021) * Women are more likely to die, develop heart failure, or stroke within 5 years of a heart attack (Jaffer et al., 2021) * Some CVD risk factors (DM2, HTN, DLD, smoking) present a greater risk of complication to women than men (Jaffer et al., 2021) * Indigenous, Afro-Caribbean, and South Asian women are at a greater risk of CVD and outcomes (Jaffer et al., 2021) * Rural, remote, and on-reserve Indigenous women have greater risk factors and increased morbidity and mortality of CVD (Jaffer et al., 2021) * Women with lower socio-economic status have a greater CVD risk (Jaffer et al., 2021) * Compared to non-indigenous women, Indigenous women experience a 2-3 times greater risk of CVD (Jaffer et al., 2021) * First Nations women have a 76% higher risk of dying of CVD compared to non-Indigenous women in Canada (Norris et al., 2024) |
| **Which settings or situations are high risk, or pose a unique opportunity for intervention?**   * Social, political, and economical inequalities experienced by Indigenous women increase the risk of CVD (Jaffer et al., 2021) * Colonialism and the subsequent trauma from residential schools, racism, and loss of culture, influence Indigenous peoples’ health significantly (Jaffer et al., 2021) * Indigenous women living in rural, remote, and Northern communities (intersecting with lower income levels) create barriers to healthcare access (Jaffer et al., 2021) * People living in rural and remote locations are 2.5x less likely to have access to a regular health provider compared to non-rural and remote locations (Norris et al., 2024) * Various barriers to healthcare are experienced by Indigenous Peoples (Norris et al., 2024) * Indigenous women who are less connected to traditional practices are more likely to experience hypertension (Norris et al., 2024) * First Nations peoples who are more connected to their culture are more likely to engage in health-conscious behaviors such as physical activity (Norris et al., 2024) * Ongoing effects of colonialism, racism, social exclusion, residential school and foster care experiences result in Indigenous peoples being disconnected from their culture and identity (Norris et al., 2024) |
| **How do local stakeholders perceive the situation? What is their capacity to act? What are their interests, mandates, and current activities?**   * “There is sufficient evidence, nationally and internationally, that collaborative, multidisciplinary, and integrated models of care have improved Indigenous Peoples’ access to a diverse range of health and social services by facilitating the seamless fusion of program and services at the delivery level and ensuring that Indigenous traditions are considered” (Halseth & Murdock, 2020, p. 58) * Indigenous women in Canada experience a disproportionately higher burden of heart disease relating to colonization and systemic oppression (Diffey et al., 2019) * Moving away from the biomedical approach to risk factors and lifestyle choices is essential and instead, an approach that is culturally meaningful and relevant is necessary (Diffey et al., 2019) * “…a women’s right to self-determination as fundamental to their heart health. This is the key to developing programs, training health professionals, and transforming institutions and systems, all of which are needed to close the existing gap in heart health that profoundly impacts the lives of First Nations women” (Diffey et al., 2019, p. 24). |
| **What are the needs, perceptions and supported directions of key influential community members, and the community-at-large?**   * Needs: self-determination, culturally relevant and holistic healthcare, care that transitions to a “two-eyed seeing” approach versus a traditional Western biomedical approach, the avoidance of racism in healthcare, * Strategies to better meet the needs of Indigenous women:   + A relational approach to heart health   + Honouring the traditional roles   + Gener-responsive health promotion   + Trauma-informed approach   + Addressing power imbalances   + Centering Indigenous worldviews   + Emphasis on self-care   + Addressing barriers such as education for anti-racist, and anti-oppressive care, colonial-based power imbalances and racial hierarchies, structural and systemic racism that re-enforce health disparities (Diffey et al., 2019) |
| 1. **What influences are making the situation better and worse?** |
| **What high-risk or negative health behaviours by various groups of people are affecting the situation?**   * Indigenous people experience a higher incidence of diabetes and obesity, and is attributed to diet and physical inactivity (Leclerc et al., 2019) * higher incidence of biomarkers for CVD, obesity and diabetes (Jaffer et al., 2021) * social, political, and economic inequality exert a significant risk for CVD development of Indigenous women (Jaffer et al., 2021) |
| **Which underlying causes or conditions are driving these behaviours (e.g. individual, community, organizational or system-level causes)? Are there protective factors that can help avoid or alleviate the situation (such as ensuring walkable communities or encouraging strong parent-child relationships)?**   * Social determinants of health influencing Indigenous health and well-being can be classified into three categories: root, core, and stem determinants   + Root determinants: colonization (the Indian Act, residential school systems, reservations and settlements), colonial ideologies (white supremacy, Christianity, patriarchy, individualism), colonial governance, Indigenous self-determination   + Core determinants: systems (child welfare, criminal justice, healthcare, education), land resources and capacities, environmental stewardship,   + Stem determinants: health activities (smoking, diet, sedentary activity, poor prenatal health), geographical environments (community resources and services, housing, water and waste management, safety, transportation), employment and income, education, food insecurity (Loppie & Wien, 2022) * Access to healthcare services is a critical determinant of health for Indigenous people and is further complicated by social access that is limited by systemic and individual racism that exists within the healthcare system (Loppie & Wien, 2022) * Colonization and its effects have the most significant affect on Indigenous health and wellbeing (Halseth & Murdock, 2020) |
| **Which strengths and weaknesses present in your organization may affect your course of action? Which opportunities and threats in your environment may affect your course of action?**   * Weakness   + Engaging in partnership with Indigenous communities when the organization has a reputation for being racist and discriminatory towards Indigenous Peoples (e.g., the “Price is Right” game being played in British Columbia hospitals to guess the blood alcohol content of Indigenous patients) (Turpel-Lafond, 2020) * Strength   + Aboriginal Health Strategic Plan 2017-2021 (updated plan currently being revised)     - Goal: to improve health services and outcomes for Aboriginal People on Vancouver Island via six strategies |
| 1. **What possible actions can you take to address the situation?** |
| **What are other organizations doing, or what have they done in the past, to address this situation? Specifically, what local policies, programs and environmental supports are being developed or implemented within the community? What evaluation data are available for these activities?**   * Dr. Jeff Reading (BC First Nations Health Authority Chair in Heart Health and Wellness at St. Paul’s and Simon Fraser University) leads research to develop health promotion strategies, health research, and evidence for policies and programs that are culturally safe (Heart and Stroke Foundation of Canada, n.d.) * University of British Columbia engaged in culturally relevant activities (drum circles and talking circles) to communicate cardiac risk to Indigenous women while developing new collaborations between academic researchers and Indigenous Elders for heart health promotion (University of British Columbia, n.d.). |
| **What is the best available evidence that exists to support various courses of action?**   * Indigenous-led models of health are more effective at improving Indigenous health and well-being than traditional Western (biomedical) approaches (Halseth & Murdock, 2020) * Indigenous models of health are often holistic, comprehensive, and culturally appropriate (Halseth & Murdock, 2020) * When designing programs, consider the following: cultural values, customs, and beliefs, traditional healing and practices, Indigenous language and communication preferences, and employing local Indigenous staff (Halseth & Murdock, 2020) * for quality approvement consider cultural outcomes and indicators (Halseth & Murdock, 2020) * Optimizing Indigenous cardiovascular care requires four pillars: * Recognition of the upstream determinants: historically, Indigenous Peoples experience lower rates of CVD; current trends of increased risk is a result of colonization, trauma, and systemic racism (Aziz et al., 2022) * Culturally responsive engagement: incorporate Indigenous customs and communication preferences; respect traditional healing practices; demonstrate collaborative “two-eyed seeing” approach; use local language and contexts (Aziz et al., 2022) * Collaborative Indigenous research: perform Indigenous-focuses research; collaborate with Indigenous stakeholders; engage in research identified by and to benefit Indigenous communities (Aziz et al., 2022) * Enhancing Access to cardiovascular care: Intervene in services and strategies as identified by Indigenous communities; improve digital access to healthcare; increase Indigenous healthcare providers (prioritizing self-determination); engage in long-term relationships with Indigenous communities (Aziz et al., 2022) * In the Coast-Salish Indigenous community, there is a community-identified need for traditional knowledge and land-based practices to promote health and wellness (Oppliger et al., 2024) * Cultural safety is paramount for health promotion intervention; community partnership in development of health interventions is essential for the adoption (and ultimately success) of the intervention; communities need to be given the opportunity to lead their own health agendas to limit the notion of saviorism while prioritizing Indigenous ideologies over Western ideologies (Wali et al., 2023)   ***Please note this section is a work in progress as research is still being reviewed*** |

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