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Social Accountability in Practice: Breathing and Weaving Together to Build Relationships and Transform Rural Health Services

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Abstract

Rural and First Nations populations bring valuable lived experiences and perspectives to health reform efforts that serve as a powerful form of specialized insight and grassroots knowledge. To address the issue of inadequate and inconsistent inclusion of these populations in health reform planning and decision-making processes in British Columbia, Canada, the Rural Coordination Centre of BC (RCCbc) has adopted Boelen's (World Health Organization 2000) Partnership Pentagram model for socially accountable health systems. This article illustrates Markham and colleagues' (2021) innovative adaptation of the model—the Partnership Pentagram Plus (PP+)—in practice, through the design and delivery of a provincial-level dialogue and deliberation gathering that centered rural and First Nations voices for health system change. In doing so, it highlights four key features: Co-creation, Honouring Indigenous Ways of Knowing and Being, Appreciative Inquiry, and 'Breathing and Weaving'. It also reports on the key outcomes of the meeting: relationship formation and long-term commitments to change.

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Introduction

Rural and First Nations populations bring valuable lived experiences and perspectives to health reform efforts that serve as a powerful form of specialized insight and grassroots knowledge. These strengths co-exist alongside stubborn-but-not-inevitable health inequities, such as lower socioeconomic status (Canada 2018, Courchene 2018), multiple chronic conditions (Rotenberg 2016), and shorter estimated life expectancies than their urban counterparts (Tjepkema, Bushnik and Bougie 2019). Such persistent health differences are largely due to geographical issues of weather and distance (Wong and Regan 2009), unique social challenges such as low-population density and limited resources (Hanlon and Halseth 2005), and the intergenerational effects of colonization (Gone, et al. 2019).

Another key contributing factor to these inequities is the lack of adequate and consistent inclusion of these populations in health reform planning and decision-making processes. To address this issue in British Columbia (BC), Canada, the Rural Coordination Centre of BC (RCCbc) has adopted Boelen's Partnership Pentagram (PP) model for socially accountable health systems (World Health Organization 2000), expanding it beyond the original configuration of health partners (citizens, clinicians, policy makers, educators, and health administrators) to include a sixth, known as linked sectors. This additional partner includes not-for-profits and industries with a vested interest in the health of their community, many of which are rural.

The following article illustrates Markham and colleagues' (2021) innovative adaptation of the PP—the Partnership Pentagram Plus (PP+)—in practice, through the design and delivery of a provincial-level dialogue and deliberation gathering that centered rural and First Nations voices for health system change. To do so, it highlights four key features: Co-creation, Honouring Indigenous Ways of Knowing and Being, Appreciative Inquiry, and Breathing and Weaving. It also reports on the key outcomes of the meeting: relationship formation and long-term commitments to change.

Co-Creation and Honouring Indigenous Ways of Knowing and Being

The Rural Coordination Centre of BC (RCCbc) is a physician-led organization jointly supported by Doctors of BC (DoBC) and the British Columbia Ministry of Health (MoH). In January 2019, the RCCbc, in partnership with the First Nations Health Authority (FNHA), convened a team based on the Partnership Pentagram Plus framework to plan the 2019 Provincial Health Care Partners' Planning Retreat. The planning team, co-led by FNHA and RCCbc, was made up of provincial partners, and comprised a working group and an advisory committee to shape the process and agenda for an event intended to generate collective insights and feedback on a provincewide, MoH-led primary care networks (PCN) initiative one year into implementation. This collaborative gathering was funded within a Rural Equity proposal through the Joint Standing Committee on Rural Issues (JSC), which is co-chaired by the MoH and DoBC.
The planning process also involved consultations with healthcare leaders and other members of the PP+, followed by invitations to participate in the advisory committee to identify the key areas

of focus for the event: team-based care, transport, virtually enabled care, and cultural safety and humility. Taking this time to hear from PP+ partners across rural communities about what matters most to them in healthcare stands in stark contrast to the usual planning processes with this type of event, where agendas are usually pre-planned by a smaller, more homogenous group. As will be seen later, the decisions made at this stage have since flourished into a number of ongoing, innovative projects providing tangible benefits to the long-term health of rural and First Nations populations in BC.

Aside from its generative power however, co-creation in this manner grounded the event in the First Nations perspective that numerous interrelated factors contribute to health and wellness, while also ensuring alignment with the principles of Truth and Reconciliation (2015). The event itself was held on land within the unceded, traditional, and ancestral territories of the Squamish, Musqueam, and Tsleil Waututh First Nations, hosted at the Bill Reid Gallery of Northwest Coast Art with an opening welcome from Elder Syexwaliya. While the welcome and location set the tone and intention to respect unceded First Nations territory and honour Indigenous perspectives on health and wellness, to ensure wellness throughout, teachings from Elders and Cultural Knowledge Holders were also woven into each day's agenda. Each day opened and closed with a First Nations Elder providing prayer and story. Space was held in the agenda for First Nations Cultural Knowledge Holders to lead the participants into reflection and learning. All participants were invited to spend time with Traditional Wellness Practitioners and Healers from the Tsow-Tun Le Lum Society.

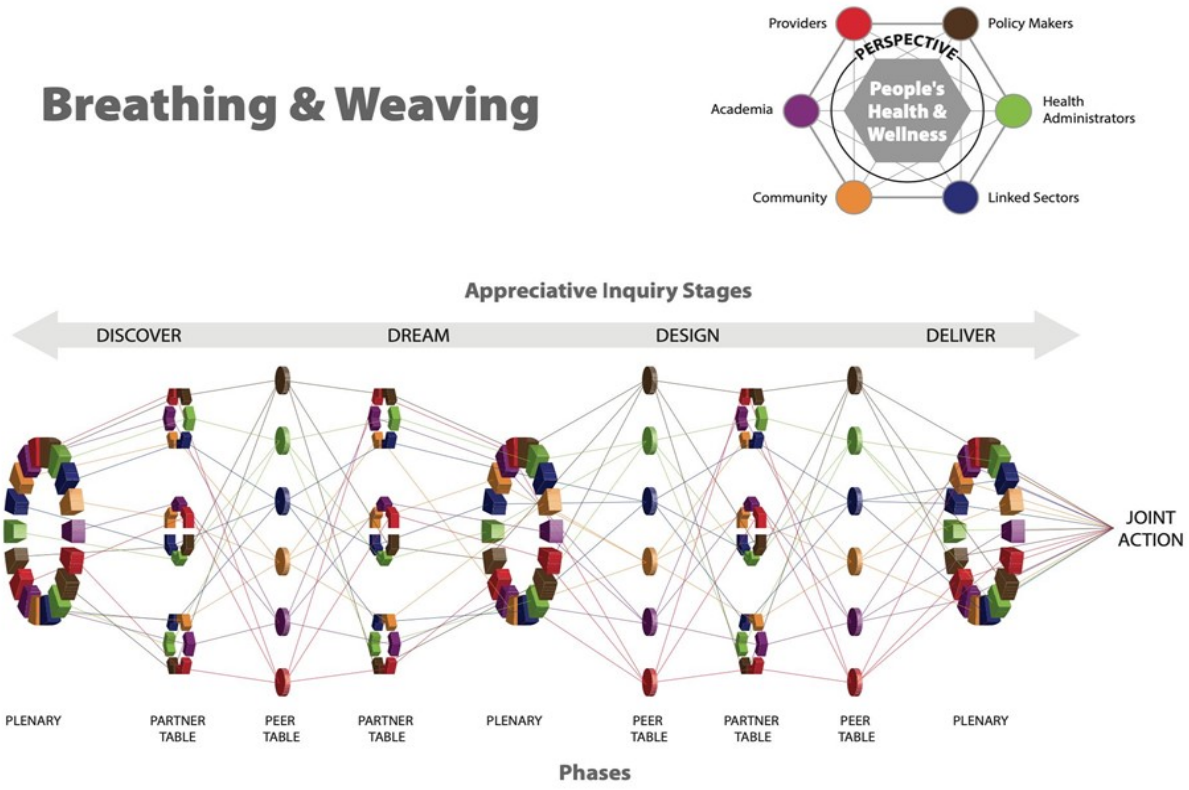
By making traditional First Nations protocols foundational to the event in this manner, we ensured rural and First Nations attendees would be supported in sharing their experiences. Moreover, the ongoing orientation to listening and learning created the context of engagement and provided an opportunity for non-Indigenous partners to become grounded in Indigenous cultural learning, supported respectful relationships between Indigenous and non-Indigenous health care partners and continuously oriented the diverse perspectives of participants to the generously shared wisdom of First Nations Elders and Cultural Knowledge Holders.

Appreciative Inquiry and 'Breathing and Weaving'

The rounds of dialogue between the various perspectives of the Partnership Pentagram Plus were organized in line with the principles of Appreciative Inquiry and the concept of 'Breathing and Weaving' [Figure 1]. While more traditional planning tools tend to focus on gaps and problems that ultimately contribute to negative perspectives at the end of the planning process, Appreciative Inquiry is strength-based and guides focus with positive intention through four stages to describe "the best of what is", to dream "what might be", to design "what should be", and to deliver "what will be" (Bushe 2011). As a result, attendees leave the planning session acknowledging that there is positive work to build on and often with a set of concrete collaborative actions that result from the process. 'Breathing and Weaving' is a model of consultation developed by FNHA and the RCCbc which utilises the Appreciative Inquiry framework and allows for group consultation and peer discussion. The resultant strength of 'Breathing and Weaving' is that by validating ideas through peer group discussion and sharing

within larger mixed-partner groups, the process can move through all four phases of Appreciative Inquiry ('Discover', 'Dream', 'Design', and 'Deliver') towards a 'joint action' which recognises that, in order to effect a desired change, each peer group can only take responsibility for actions that are within their collective control.

Figure 1: Process of Breathing and Weaving



For the retreat, a panel of speakers opened the event by explaining the concept of visioning and planning in the context of health system transformation to the audience of approximately 250 participants. The event space was arranged with round tables to support dialogue and interaction amongst attendees during the plenary sessions, and break-out rooms were designated for 'peer' tables or 'partner' tables. Based on the Partnership Pentagram plus model, peer tables included attendees from the same sector on the pentagram, while partner tables were mixed with at least one representative from each peer group/sector. Similar to the act of breathing, members of peer groups joined partner groups (breathing out) and shared their perspective before returning to their peer groups (breathing in) with their learnings. Partner groups, meanwhile, followed the principles of weaving, with different perspectives being woven together and synergies identified at the table.

The peer tables and partner tables then alternated with timed discussions lasting approximately one hour each, with groups capped at 15 people to provide the opportunity for more fulsome engagement and for everyone to participate in the dialogue. At the beginning of the event, more time was given to partner tables to support the weaving of perspectives and identification of synergies, while more time was held for peer tables towards the end of the event as they considered commitments to action. Each group was led by a speaking facilitator and a writing facilitator following Appreciative Inquiry discussion exercises. In this way, key discussion points were captured and consolidated for sharing with the group at large, and key themes were pulled for sharing at the end of the event. Space was also held throughout the day for a 'big share', in which a facilitator would moderate a panel of representatives from differing peer groups to share reflections from table discussions, and the event culminated with a 'big share' and with individuals and peers committing to action.

Outcomes: Relationships & Long-term Commitments to Change

In the first instance, this event demonstrated that it is possible to design a large-scale event based on the Partnership Pentagram Plus which brings together a variety of stakeholders to plan for socially accountable health system change and provide feedback on provincial health system initiatives in a way that meaningfully addresses issues of rural and First Nations inclusion. More than that, however, it demonstrated the power of PP+ and Breathing & Weaving in the formation of relationships across organizations and long-term commitments to change. For example, the following commitments were made:

- By BC MoH (policy perspective) to continue work with FNHA (health administration perspective) on supporting First Nations engagement in the PCN development process through the provision of funding for First Nations community members to actively engage with the PCN development process to their desired extent.
- By BC MoH, in collaboration with FNHA, to create funding mechanisms for Indigenous health care providers that were identified as being critical recommendations through the Truth and Reconciliation Commission of Canada (2015) and the United Nations Declarations on the Rights of Indigenous Peoples (2011).
- Individuals bringing perspectives from academia, health administration, and providers to collaboration on issues around appropriate selection of rural-interested medical students and residents, and to work together to refine admissions selection processes for medical school based on current evidence.

The event was also foundational for several ongoing collaborative projects to effect long-term change in the health care system. One particularly notable example is the Real-Time Virtual Support (RTVS) program, which provides access to live video support for rural emergency, intensivists, pediatricians, and maternity/newborn providers from specialists located elsewhere in the province. This Partnership Table lives on as a learning community leading the Virtual Health and Wellness Collaborative for Rural and First Nations BC. Moreover, as a result of the strong relationships and trust that were formed through this collaboration, it was possible to expedite and facilitate rollout of the program in the early stages of the Covid-19 pandemic. Indeed, the

program was stood up within a matter of weeks and allowed both, patients and providers, to have immediate access to virtual services in a time of uncertainty and fear in the face of an overburdened health system and has since been integrated into the provincial health system, linking rural communities, transport systems, and regional programs, and assisting providers in rural communities who may otherwise be isolated and unsupported.

Conclusion

Ultimately, the success of the 2019 Provincial Health Care Partners' Planning Retreat has truly been seen in the ongoing relationships built both during the planning process and the integrated program itself, providing the foundation for ongoing relationship-based planning and collaboration. Work continues among partners in a collaborative manner that values connection and co-creation and does not shy away from open and honest dialogue that is necessary to maintain these relationships. The inclusion of rural and First Nations voices as partners brings diverse perspectives into dialogue with each other simultaneously and is already creating new paths forward for health system planning in British Columbia.

None of these outcomes would have been possible had the Partnership Pentagram Plus (PP+) partners not been provided space and opportunity to come together for meaningful dialogue and planning. This process was enabled and empowered by the foundational commitments and process: first, the commitment to honouring Indigenous ways of knowing and being and co-creating the event with Indigenous partners, and second, the commitment to Appreciative Inquiry and Breathing and Weaving in implementation. Together, these mutually reinforcing commitments allowed for the strengthening and validation of a multiplicity of ideas and perspectives from Discovery to Delivery.

Building on the success of this consultation among provincial leaders, there was recognition of the scope for the expansion and refinement of the Breathing and Weaving model, particularly in terms of vertical integration of perspectives from the meso and micro levels. With that in mind, it served as the basis for the 2020 BC Rural and First Nations Health and Wellness Summit, which hosted over 950 people virtually in 57 community tables across British Columbia with a greater emphasis on community inclusion by bringing provincial leaders into direct connection with rural community perspectives**.** Looking to the future, the model will also be employed to structure the pre-conference sessions and produce the conference declaration when RCCbc co-hosts the 2022 Towards Unity for Health Conference (TUFH 2022) in Vancouver, bringing together an inter-professional, international, and multi-level audience with the express intention of linking 'rhetoric to action' and 'the village to the globe'.

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