Talking together to improve health
Gi-noondidaa ji mina-maajiishkag noojimoowin

E wichi ayamihitonaniwahk kchi minwashik mino pimatisiwin

Ontario Public Health Unit Survey

June 2018

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Citation

Talking Together to Improve Health Project Team. (2018). *Talking Together to Improve Health: Ontario Public Health Unit Survey.* Sudbury, ON: Locally Driven Collaborative Projects.

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Executive summary

The term "First Nations community" is utilized throughout this report as a respectful alternative phrase for the term reserve. It refers to a community which is officially recognized and administered on land that was set asi under the Indian Act or under a treaty agreement, and which is governed by a band council. The term "Indigenous" refers to all persons of Indigenous ancestry -- First Nations, Métis, and Inuit.

Introduction

Ontario's public health units deliver a broad range of population health programs aimed at improving the health of the community, protecting the health of all, and ensuring everyone has equal opportunities for health. Public health units are required to tailor programs and services to the local context and community needs. Thirty-five (35) public health units operate across Ontario (previously 36), and 21 of them intersect with the boundaries of 133 First Nations communities.

Engagement is strongly encouraged within a number of health-related calls to action within the final report of the Truth and Reconciliation Commission of Canada (TRC). The 2018 Ontario Public Health Standards have enhanced language which explicitly calls for boards of health to engage with Indigenous communities and organizations as well as with First Nation communities. [Ministry of Health and Long-Term Care (MOHLTC), 2018]. Given this context, public health in Ontario has a need for guidance on principles and practices that can promote effective engagement with First Nations communities. However, little formal guidance is currently available to public health, and little is known about the wishes of First Nations communities with respect to engagement and collaboration with local public health units. The scope of the project was Northeastern Ontario with a focus on First Nations communities.

The overall intent of this research project is to answer the following research question:

"What mutually beneficial, respectful and effective principles and practices of engagement between First Nations communities and public health units in Northeastern Ontario can be identified, as an important step in working toward improved opportunities for health for all?"

The first phase of the project involved a literature review. Four themes emerged: **respect, trust, self-determination,** and **commitment**. The literature review findings helped develop and inform the Ontario Public Health Unit Survey. The focus of the survey was to understand the public health units' perspective on current principles and practices of engagement between First Nations communities and public health units, as well as perceived successes and challenges. The next phase of the project involves key informant interviews with health organizations that have existing indigenous health focused strategies. The final phase of the research is called the Gathering and Sharing Learning phase. This phase consists of gathering information via focus groups, sharing

circles and interviews with individuals from five to six First Nations communities from Northeastern Ontario. The information accumulated from this phase will contribute to identifying principles and practices that have been utilized or recommended for developing effective engagement between First Nations communities and public health. All components of the research project will inform and support the development of the final report. Those who are currently or planning to engage with urban Indigenous communities and organizations may also learn from this project's findings.

To ensure that the overall approach to this project is appropriately balanced, an Indigenous Circle comprised of representatives with expertise, experience and Indigenous perspectives from communities within the Northeast was established. The project team includes five public health units (with Public Health Sudbury & Districts as lead agency), the Indigenous Circle, and two Laurentian University academic advisors.

This research project was supported with funding from Public Health Ontario's Locally Driven Collaborative Project (LDCP) stream.

Methodology

The survey tool was developed with the aim to identify current engagement practices as well as perceived successes and challenges within the context of engagement between Ontario's public health units and First Nations communities, from the perspective of the public health unit. The survey component of this research project was approved through several ethics review processes.

In August 2017, a study recruitment package and online survey link was emailed to Medical and Associate Medical Officers of Health representing the then 36 public health units in Ontario. The invitation was for one organizational survey to be completed by each public health unit, on behalf of the organization, utilizing the internal processes that were most suitable to them. A total of 24 public health units responded to the survey. Ten of thse respondents indicated that they do not engage with First Nations communities because their public health unit does not intersect with the boundaries of any First Nations communities.

The project team decided to exclude responses from those 10 public health units in order to focus solely on engagement practices between public health units that intersect with First Nation communities. This exclusion is not intended to suggest that these public health units do not engage with Indigenous Peoples and communities, nor that they would not have an interest in understanding and applying principles and practices of effective engagement with Indigenous Peoples.

Results

The final response rate for this survey was 67% when only those public health units (14/21) who intersect with First Nations communities are considered.

Engagement context

- First Nations community health centres and/or health directors play an important role as a first point of contact within the initial engagement process.
- The impetus for public health units to engage with First Nations communities is often a direct request from a First Nations community for a specific program or service.
- Public health units use engagement approaches that focus on relationship building and are tailored to First Nations community perspectives.
- Of all public health unit programs, vaccine preventable diseases and the prevention and control of infectious diseases were most frequently selected as program areas in which public health units engage with First Nations communities.

Specific public health unit practices

- Only two public health units have First Nations representation on their board of health or a public health unit advisory group.
- Although half of public health units have Indigenous Peoples employed, responses point to opportunistic rather than purposeful employment practices.
- Most public health units (79%) have provided cultural awareness/competency training to staff who engage with First Nations communities.
- Few public health units have policies or guidelines for First Nations community engagement.
- Half of public health units consider First Nations communities in their overall strategic planning and/or in program planning processes.

Factors that contribute to engagement

- There are three main approaches to encourage successful engagement:
  - **Internal supports -** there are a number of public health unit supports that may contribute to the development of an organizational perspective where First Nations communities are viewed as equal partners.
  - **Proactive -** some public health units actively seek opportunities to engage with First Nations communities.
  - **Responsive -** there are instances where public health units described approaches where they provide support to First Nations communities as requested.

- Most engagement practices considered by public health units to be successful or positive had a number of overarching components related to building relationships with First Nations communities.

- Engagement was also perceived to be successful when opportunities for further collaboration were presented.

Challenges to meaningful Engagement

- A number of responses pointed to a lack of clarity with regards to which health organization are most responsible or appropriate to deliver a public health service within a First Nations community.

- Multiple components within the actual planning and/or delivery of public health programming to First Nations communities are perceived to hinder engagement. These include, but are not limited to, staff turnover, financial pressures, and a lack of data on Indigenous health needs.

- Engagement was felt to be less successful when programming discussions did not result in any actual implementation.

Future engagement

- The majority of respondents (79%) did not feel their public health unit had the skills and knowledge to effectively engage with First Nations communities.

- More than 75% of respondents felt more resources would be useful to further support their engagement with First Nations communities. The include additional public health unit funding, additional funding to First Nations communities, human resources, cultural awareness and competency supports, and training supports.

- When asked about plans to follow specific protocols to further guide engagement, most public health units (64%) were uncertain or were waiting for the release of protocols to determine their use.

Discussion

The objective of the Ontario Public Health Unit Survey was to gather and learn about practices and examples of engagement and/or collaboration from the public health unit perspective. Perspectives of First Nations communities are being sought in a separate process involving in-depth interviews.

Based on the survey results, Ontario's public health units have engaged with First Nations communities to varying degrees. All of the public health units reported having had some engagement with First Nations communities in the past five years. In many cases, the engagement is episodic — connecting when circumstances lead to such connection (responding to a request from the First Nation, or engaging around a particular program or issue). In a smaller number of cases, the engagement is part of an ongoing relationship that has been built over time. Public health units spoke of the importance of respecting First Nations community wishes and following the lead and direction of the First Nations communities when there are possibilities for collaboration.

Factors such as complex or unclear jurisdictional responsibilities affected the potential for effective engagement. Since ongoing engagement depends on personal relationships, staff turn-over or changing roles can diminish the potential for engagement. Working together on specific initiatives with valued outcomes was a more beneficial practice than connecting without a clear purpose in mind. However, there had been successes in getting to know each other and understanding diverse roles and approaches to public health. Public health units did express some concerns about not being able to meet First Nations community expectations due to financial and human resource capacity limitations or due to mandate restrictions (outside of a public health unit's scope of practice).

Public health units felt that they had a need for additional training and understanding of First Nations community traditions, protocols and practices including decision-making and approvals.

Principles and wise practices in engagement examples

Four principles were identified in the literature review: **respect, trust, self-determination,** and **commitment**, each with associated wise practices. Given these survey results, it is of interest to ask: to what extent are the principles and practices from the literature review evident in the examples of public health / First Nations community engagement described by public health units?

Respect

Based on the findings from this project's literature review, the first principle of **respect** focuses on the need for non-Indigenous Peoples to understand, acknowledge, and appreciate both the history and current context of Indigenous Peoples.

As noted in the description of engagement practices above, public health units describe the importance for them to communicate, build respectful relationships, and respect the wishes of First Nations communities in any interactions.

Cultural competency training may be one step toward respectful relationship building. The majority of public health units who responded to the survey have provided cultural competency training to their employees, or have made training available through other providers. The nature of the training varies, however, and there would be opportunities to deepen the training from brief guest speakers to multi-day engagement, and to broaden the reach of the training by ensuring that more public health staff (including leadership and board members) complete the training. The majority of respondent public health units said that they still needed to know and understand more. It may also be important to consider extending the scope beyond cultural competencies and shift toward a broader approach of cultural safety and cultural humility.

The Indigenous Circle noted that an important concept to consider as an objective is *cultural humility*, which speaks to the idea of ongoing self-reflection and life-long learning, as opposed to cultural competence, which may suggest an endpoint after which a person considers themselves to have mastered certain content. Furthermore, the specific nature of training should have local relevance and involvement, and should provide an opportunity for people to talk, ask questions, share ideas and build relationships.

Formal land acknowledgment practices are an example in literature of a respectful practice. Three public health units formally acknowledge the traditional owners of the land on which they are gathering at the start of board of health meetings or other health unit events, but others could perhaps consider this as a formal practice. No public health units reporting having a land acknowledgement plaque in their buildings, which could be a respectful practice to consider. Presentations to First Nations councils, in parallel with presentations to municipal councils, is another way of acknowledging and respecting First Nation governing structures.

One public health unit has formal guidance for engaging with First Nations elders and knowledge keepers, which may be another respectful practice that public health units should develop, in consultation with local First Nations. Guidance for staff when working with First Nations

communities on reportable disease follow-up or on health data projects, were other examples of respectful practices, as was the case for public health unit staff on Jordan's Principle.

Trust

Based on the findings from this project's literature review, the principle of **trust** is another principle that was recognized as foundational to the establishment of respectful and mutually empowering long-term relationships (Talking Together to Improve Health Project Team, 2017).

Examples from public health units included having face-to-face meetings and enlisting respected people in communities as a way to begin building relationships based on trust. Respondents in this study expressed that allowing enough time for relationship building was important as it is not possible to establish trusting relationships in one meeting.

Seeking First Nations community input into public health unit planning processes is one example of a practice that has potential to build trust, if perspectives are sought early and respected. These processes work best when it is understood that First Nations have their own capacity and responsibility for health, and may or may not wish for the same kind of collaboration that public health units have in mind.

Self-determination

Based on the findings from this project's literature review, partnerships with Indigenous Peoples have been identified to be more successful if the principle of **self-determination** is considered and understood (Talking Together to Improve Health Project Team, 2017). This can be encouraged by ensuring collaborations are driven by Indigenous communities, providing opportunities to build Indigenous workforce capacity, building on the strengths of the Indigenous communities, and having strong Indigenous representation in the decision-making process.

The notion of self-determination was seen throughout survey responses. Many public health units described engagement approaches that are driven by First Nations community needs. Some emphasized that strategies cannot be developed without First Nations involvement and that self-determination needs to be respected.

Engagement that incorporates the principle of self-determination can mean that collaboration does not result, if it is not needed, wanted or possible at a certain time. Public health units emphasize that, in their experience, respectful relationships can continue even when particular initiatives do not go forward. Being ready and open to other initiatives is part of the trusting relationship that can be established between First Nations communities and public health units.

Commitment

Based on the findings from this project's literature review, the final principle, **commitment**, focuses on the importance of tangible and sustainable action to develop and maintain long-term and effective partnerships (Talking Together to Improve Health Project Team, 2017). Commitment can be signalled through practices that support collaborative learning, shared decision making and mutual responsibility for beneficial outcomes. Flexibility with regards to funding structures and timelines are also required to support a fulsome engagement process. As such, progressive leadership is required to do things differently. Additional supporting practices include purposeful Indigenous

hiring, ongoing reflection, visible community presence, and ensuring that Indigenous communities validate findings and that their perspectives are included.

In terms of formal relationships that may reflect commitment, only two public health units who responded to the survey had First Nation representation on their board of health, and of those, only one did so through positions reserved for First Nation representation. In a similar vein, two public health units had an Indigenous Advisory Committee (in place or in process). Half of the public health units had written agreements, such as memoranda of understanding for particular programs and services. Three public health units had Indigenous engagement as a priority in their strategic plan, board motion or other formal process.

With respect to staffing and staff roles, another aspect of commitment to long-term relationships, staff and management positions at some public health units explicitly incorporate Indigenous engagement as part of their roles. Some public health units have staff who self-identify as Indigenous. Some public health units were looking to enhance their recruitment strategies to increase the number of Indigenous staff.

The incorporation of strategic plan priorities with respect to Indigenous partnership and collaboration to improve the health of the population, when done with ongoing engagement, is a way of ensuring commitment to working together and contributing to meaningful improvements, both in ways of working together and in health outcomes.

Next Steps

The survey findings in this report are one piece of a larger exploration and represent only the perspectives of Ontario public health units that responded to the survey.

It is apparent from these survey responses from public health units that engagement with First Nations communities is important and valued. The examples provided illustrate the possibilities and the variety of ways that such engagement can happen and can be supported. However, the majority of public health units do not feel that they have sufficient knowledge and skills to effectively engage.

Few public health units identify high-level direction related to engagement in governance, policy or strategic domains, and the need for direction and support through mandates at the provincial level is noted. Some public health units have staff who self-identify as Indigenous, but this is by no means considered sufficient or representative of the local Indigenous population. It becomes clear that there is more to be done to prepare public health units for effective engagement with Indigenous communities.

From a public health perspective, as identified in the survey and further described in this report, resources to support greater and additional engagement are needed. The types of resources needed include financial resources for both public health units and First Nations, human resources, cultural awareness information and training, and travel funding, among other supports. Policy and governance supports were also cited as resource needs.

Elements of the engagement principles and practices identified in the literature review can be seen in actual public health unit examples. Despite some examples, many principles are not widespread or well-established in practice at this time, and there is opportunity for the principles to be more fully

evident in public health practice. Public health units expressed wishes to move forward in being good partners and collaborators when collaboration is desired, and in working respectfully alongside First Nations communities to improve health. A strong mandate from the province to public health units, and direction from the provincial public health level were mentioned by some public health units as a basis for further development of their approaches to Indigenous engagement, along with ongoing input and direction from First Nations communities.

Findings from the literature review and this report will be utilized in future phases of the broader research project (see Introduction). As a whole, this cumulative data gathering process will be taken together to represent a full picture of the guidance for public health on principles and practices that can promote effective engagement with First Nations communities.

Strengths and limitations

Strengths

There were several strengths of the survey portion of the project. In particular, Indigenous Circle members informed the design of the public health unit survey and the report, bringing a community informed approach and a culturally-oriented perspective to the work.

This is the first survey of Ontario public health units on engagement practices and perspectives with First Nations communities, and as such provides valuable new information. The timing of this project aligns with other initiatives and momentum that is supporting and encouraging beneficial, respectful and effective engagement between Ontario's public health units and First Nations communities.

Limitations

The survey responses from 10 public health units were excluded from analysis because they do not intersect with First Nations communities. As such, the project team recognizes that First Nations and Indigenous Peoples live in and outside of First Nations communities across Ontario, and that effective engagement with Indigenous Peoples and communities is important for all public health units.

In terms of the sample, the 67% (14/21) response rate was lower than anticipated. In particular, there are 21 public health units that intersect with First Nations communities, and seven of them did not respond to the survey.

Survey responses are limited to public health unit perspectives on and perceptions of engagement. Due to the nature of the survey method, it was not possible to probe or gather additional depth about public health unit practices. The next phase of this research will seek perspectives from First Nations communities.

Introduction

The term "First Nations community" is utilized throughout this report as a respectful alternative phrase for the term reserve. It refers to a community which is officially recognized and administered on land that was set aside under the Indian Act or under a treaty agreement, and which is governed by a band council. The term "Indigenous" refers to all persons of Indigenous ancestry -- First Nations, Métis, and Inuit.

Ontario's public health units deliver a broad range of population health programs aimed at improving the health o the community, protecting the health of all, and ensuring everyone has equal opportunities for health. Public health units are required to tailor programs and services to the local context and community needs. Thirty-five (35) public health units (previously 36) operate across Ontario, and 21 of them intersect with the boundaries of 133 First Nations communities.

The project

Engagement is strongly encouraged within a number of health-related calls to action within the final report of the Truth and Reconciliation Commission of Canada (TRC). The 2018 Ontario Public Health Standards have enhanced language which explicitly calls for boards of health to engage with Indigenous communities and organizations as well as with First Nation communities. (MOHLTC, 2018). Provincially, these calls for enhanced engagement have been signaled by First Nations, government ministries, and public health units.

Given this context, public health in Ontario has a need for guidance on principles and practices that can promote effective engagement with First Nations communities. However, little formal guidance is currently available to public health, and little is known about the wishes of First Nations communities with respect to engagement and collaboration with local public health units. There is interest and value in understanding how best to engage, and developing ways of engaging that are effective for all. There is also a need to better understand current capacity, learn from past successes, elicit the wishes and preferences of First Nations communities with respect to engagement with public health, and develop processes for stronger engagement.

The overall intent of this research project is to answer the following research question:

"What mutually beneficial, respectful and effective principles and practices of engagement between First Nations communities and public health units in Northeastern Ontario can be identified, as an important step in working toward improved opportunities for health for all?"

The focus of this project is Northeastern Ontario, as a way of maintaining a manageable scope within limited timelines. As another limitation of scope, the focus of this project is on First Nations communities that intersect with public health units, despite the fact that First Nations and Indigenous

Peoples live in and outside of First Nation communities across Ontario. The learnings from interactions between First Nations communities and public health units in the Northeast may be relevant for understanding possibilities across the province, although specific principles and practices may be expressed differently depending on the context and physical location. The multiple phases of the research project are described briefly below.

Phase 1 - literature review

The first phase of the project involved a review of both grey and academic literature that explored strategies, approaches, and principles of engagement and collaboration between Indigenous Peoples, and public sector agencies in the north, and agencies in North America, New Zealand, and Australia (Talking Together to Improve Health Project Team, 2017). The intent of the literature search was to identify relevant sources broadly and in a global context, and for this reason, the term Indigenous, native, First Nation and Aboriginal were used in relation to this literature review.

Based on the literature review findings, four themes emerged: **respect, trust, self-determination,** and **commitment**. Within each principle, a number of wise practices were also identified. These wise practices are viewed as specific actions that can contribute to more successful partnerships.

The first principle of **respect** focuses on the need for non-Indigenous Peoples to understand, acknowledge, and appreciate both the history and current context of Indigenous Peoples. The literature outlined a number of cultural competency practices that can be seen as a pre-cursor to any engagement activities. Practices that honour the diversity of the unique Indigenous cultures are also recommended. Formal acknowledgment practices, such as workplace signs that identify the traditional owners of the land, further foster this principle.

Trust is another principle that was recognized as foundational to the establishment of respectful and mutually empowering long-term relationsips. As many historical and ongoing events have led to considerable distrust by many Indigenous Peoples, for any successful engagement to occur, trust must be a central consideration. Early engagement, working with respected Indigenous members, inclusivity of Indigenous members, aiming for balanced representation of age groups and genders, and appropriate and ongoing communication are all likely to build trust.

Partnerships with Indigenous Peoples have been identified to be more successful if the principle of **self-determination** is considered and understood. This can be encouraged by ensuring collaborations are driven by Indigenous communities, providing opportunities to build Indigenous workforce capacity, building on the strengths of the Indigenous communities, and having strong Indigenous representation in the decision-making process.

The final principle is **commitment**, which focuses on the importantce of tangible and sustainable action to develop and maintain long-term and effective partnerships. Practices that support co-learning and power sharing can foster mutual responsibility. Flexibility with regards to funding structures and timelines are also required to support a fulsome engagement process. As such, progressive leadership is required to do things differently. Additional supporting practices include purposeful Indigenous hiring, ongoing reflection, visible community presence, and ensuring that Indigenous communities validate the findings and that their perspectives are included.

In all, these four principles and their associated practices present a synthesis of findings that have been utilized, suggested, or recommended when public-sector agencies engage with Indigenous communities. This literature review is an important foundational step that provides supportive context and informs the next phases of this project.

Phase 2 - Public Health Unit Survey

The literature review findings helped develop and inform the present component of the research: the Ontario Public Health Unit Survey. The focus of the survey was to understand the public health units' perspective on current principles and practices of engagement between First Nations communities and public health units, as well as perceived successes, challenges and lessons learned.

Phase 3 - Key informant interviews with health organizations

The next phase of the project involves engagement with key informants from organizations that have existing Indigenous health focused strategies. This phase of the research will enhance the findings from previous phases and contribute to the development of methods and future opportunities for positive partnerships between First Nations communities and public health units.

Phase 4 - Gathering and sharing learning

The final phase of the research is about gathering and sharing learning. This phase consists of gathering information in the form of focus groups, sharing circles and interviews with individuals from five or six First Nations communities from Northeastern Ontario. The information accumulated from this phase will contribute to identifying principles and practices that have been utilized or recommended for developing effective engagement between First Nations communities and public health. All components of the research project will inform and support the development of the final report. Those who are currently or planning to engage with urban Indigenous communities and organizations may also learn from this project's findings.

Project team

The project team includes five public health units (with Public Health Sudbury & Districts as lead agency), the Indigenous Circle, and two Laurentian University academic advisors.To ensure that the overall approach to this project is appropriately balanced, an Indigenous Circle comprised of representatives with expertise, experience and Indigenous perspectives from communities within the northeast was established. Their role was to provide community context and a culturally-appropriate lens to the planning and implementation of the project. The Indigenous Circle members supported the development of the research methodologies, data collection tools, and interpretation of the literature review and survey results.

Background

The term "First Nations community" is utilized throughout this report as a respectful alternative phrase for the term reserve. It refers to a community which is officially recognized and administered on land that was set aside under the Indian Act or under a treaty agreement, and which is governed by a band council. The term "Indigenous" refers to all persons of Indigenous ancestry -- First Nations, Métis, and Inuit.

Both Ontario public health units and First Nations communities offer a broad range of public health services and population health programs.

First Nations health services

In Ontario, there are 133 First Nations communities (Chiefs of Ontario, 2017) and just over one third (35%) of First Nations Peoples with registered status reside within a First Nation community (Statistics Canada, 2016).

Historically, Indigenous Peoples maintained their health through well-established traditional systems of care. Often these systems incorporated traditional wellness approaches. Many First Nations communities have health services including community health care, offering a range of primary care, preventive and health promoting programs and services to members who reside in the community as well as those who live off reserve. These services are funded through several funders at different levels of government and create a complex system of health services and accountability for First Nations communities (North East LHIN Aboriginal Health Care Reconciliation Action Plan, 2016).

Most health services provided within a First Nations community are supported by the First Nations and Inuit Health Branch, Departement of Indigenous Services (NCCAH, 2011). See Appendix A for an overview of these federally funded health services. First Nations communities can either control the delivery of these services through transfer payments, have services directly delivered by FNIHB staff, or for smaller First Nations communities, these programming responsibilities are transferred to regional First Nation health authorities.

Provincially, various ministries fund a number of health services for Indigenous Peoples regarless of their place of residence. Some services are funded within the Aboriginal Healing and Wellness Strategy, Ontario's First Nations Health Care Plan, as well as a number of other programs offered though Ontario's Health Insurance Plan. However, access to these services may be limited by a number of challenges such as geography, socio-economic status, jurisdictional ambiguities, language or culture barriers (NCCAH, 2015). This variety of authorities and service delivery mechanisms creates fragmentation and likely results in in reduced opportunities for health for First Nations communities.

Ontario Public Health

In Ontario, there are 35 public health units (previously 36) responsible for the delivery of mandatory health programs and services (Appendix B) as outlined within the Ontario Public Health Standards (OPHS; MOHLTC, 2018). Public health programs are delivered to diverse large and small populations, in both urban and rural settings. Population health approaches are utilized with the ultimate goal to improve and protect the health and well-being of the population of Ontario and reduce health inequities (MOHLTC, 2018). Every public health unit is governed by a board of health as required within the Health Protection and Promotion Act. The board's composition varies across the province but may consist of municipally elected representatives, provincially appointed members, and citizen/public members.

Twenty-one (21) public health units intersect with 133 First Nation communities. Appendix C (Figure 2, 3, and 4, Table 1) outlines the geographic dispersion of both public health units and First Nations communities across Ontario. In the northeast, there are five public health units and 40 First Nations communities with various structures and ways of working to fulfil various public health functions.

Methodology

The term "First Nations community" is utilized throughout this report as a respectful alternative phrase for the term reserve. It refers to a community which is officially recognized and administered on land that was set aside under the Indian Act or under a treaty agreement, and which is governed by a band council. The term "Indigenous" refers to all persons of Indigenous ancestry -- First Nations, Métis, and Inuit.

Research ethics

The Ontario Public Health Unit Survey component of this research project was approved through a delegated review from Laurentian University's Research Ethics Board and an expedited review from the Public Health Sudbury & Districts' Research Ethics Review Committee. Internal ethics approval processes were also attained by Grey Bruce Health Unit, Algoma Public Health, North Bay Parry Sound Public Health Unit and Porcupine Public Health.

Recruitment

In August 2017, a study recruitment package was emailed by Dr. Penny Sutcliffe (project lead) to all Medical and Associate Medical Officers of Health (MOH) which represent Ontario's 36 public health units. This package included an online survey link as well as an electronic copy of the survey, consent, general study information, and instructions for completing the survey. Of note, there are currently 35 public health units across Ontario as two have amalgamated after the administration of this survey.

Public health units were initially provided four weeks to complete the survey. Reminders were sent via email at mid-point and a few days before the deadline. An extension of four weeks was then provided in response to feedback that survey completion timelines coincided with staffing vacation and other workload pressures. An additional two surveys were also accepted past this deadline.

Every MOH was asked to coordinate their public health unit's response utilizing the process that were most suitable to them. This methodology was chosen in recognition of the diverse organizational structures of public health units across Ontario. Consent to participate was organizational in that MOH provided consent on behalf of their organization as a whole. As such, every public health unit could only submit one survey and there were no incentives (financial or other) to participate.

Survey tool

The project team developed the survey tool with the aim to identify current engagement practices as well as perceived successes and challenges within the context of engagement between Ontario's public health units and First Nations communities, from the perspective of the public health units themselves. The content of the survey was informed from the literature review, which was previously completed as part of this project. This was done in order to continue to align this research sub-component to those of the broader research project.

The survey consisted of 55 items that were divided into five sections: background, specific public health unit practices, successes and challenges, future planning, and follow-up. Survey questions included a range of response options including single, multi-select, and open-ended. Most items additionally provided open-text fields to describe or add responses. See Appendix D for a copy of the survey questions.

Data analysis

Survey data was exported from SurveyMonkey® into two formats. The first was a master Microsoft Excel spreadsheet with raw data. Access to this document was limited to select project team members and utilized to verify that data matched SurveyMonkey® auto-generated reports and to cross-reference specific public health unit responses. The research officer also followed-up with the public health unit contact name provided within the survey when responses needed to be clarified.

The second format was an auto-generated report which provides an overview of survey results by question with frequencies, percentages, and listings of qualitative answers. All data within open-text fields were thematically analyzed and reported as such.

The draft of this report was reviewed by project team members which includes Indigenous Circle members. This served to further augment and enrich some discussion points and attain feedback on the report as a whole.a

Sample

A total of 24 public health units responded to the survey. In Ontario, there are 36 public health units, therefore, the initial response rate was 67%.

The 24 responses included 10 responses from public health units who do not intersect with First Nations boundaries. The project team decided to exclude these 10 responses in order to focus solely on engagement practices between public health units and First Nations communities. The final response rate for this survey was 67% (14/21) when only those public health units who intersect with First Nations communities are considered within the denominator. See Figure 1 below.

This exclusion is not intended to suggest that these public health units do not engage with Indigenous Peoples and communities, nor that they would not have an interest in understanding and applying principles and practices of effective engagement with Indigenous Peoples.

It was noted in the project team discussion that Indigenous Peoples live throughout Ontario, and that all public health units are likely providing services to Indigenous Peoples in some capacity. Although the focus of this survey is specific to public health units that intersect with First Nations communities, the survey findings should be of interest to all Ontario public health unit.

All 14 respondents indicated that they have engaged with First Nations communities in the past five years and have done so for more than three years. The majority (64%) estimate that they engage with First Nations communities about once a month or more. The number of First Nations communities which intersect with public health units ranges from 1 to 41, with a median of 2.

Strengths and limitations

The term "First Nations community" is utilized throughout this report as a respectful alternative phrase for the term reserve. It refers to a community which is officially recognized and administered on land that was set aside under the Indian Act or under a treaty agreement, and which is governed by a band council. The term "Indigenous" refers to all persons of Indigenous ancestry -- First Nations, Métis, and Inuit.

The overall intent of this research project is to answer the following research question:

"What mutually beneficial, respectful and effective principles and practices of engagement between First Nations communities and public health units in Northeastern Ontario can be identified, as an important step in working toward improved opportunities for health for all?"

The survey results reported in this document are one component of the full research project, and must be understood to reflect only the perspectives of responding public health units.

Strengths

There were a number of strengths of the survey portion of the project. In particular, Indigenous Circle members informed the design of the public health unit survey and the report, bringing a community informed approach and a culturally-oriented perspective to the work.

This is the first survey of Ontario's public health units on engagement practices and perspectives with First Nations communities, and as such provides valuable new information. The timing of this project aligns with other initiatives and momentum that is supporting and encouraging beneficial, respectful and effective engagement between Ontario's public health units and First Nations and urban Indigenous communities.

Because of the multi-phase design of the study, First Nations communities will have the opportunity to share perspectives on engagement with public health more generally. This is an overall project strength in that this cumulative data gathering process will be taken together to represent a full picture of the guidance for public health on principles and practices that can promote effective engagement with First Nations communities.

Limitations

Survey responses are limited to public health unit perspectives on and perceptions of engagement. The next phase of this research will seek perspectives from a small sample of First Nations communities. Due to the nature of the survey method, it was not possible to probe or gather additional depth about public health unit practices. In particular, survey responses do not reflect the duration, quality, or depth of engagement practices. It is possible that public health units over-represented their level of engagement, as the survey did not identify the degree to which a public health unit and a First Nations community engaged in an actual program or service.

A limitation of scope relates to the fact that this report focuses solely on public health units that intersect with First Nations communities. The survey responses from 10 public health units were excluded from analysis because they do not intersect with First Nations communities and therefore are out of this project's scope. As well, the project team recognizes that First Nations and Indigenous Peoples live in and outside of First Nations communities across Ontario. As such, survey responses does not reflect engagement with persons from First Nations communities who are accessing public health services outside of a First Nations community.

Although all Ontario Medical Officers of Health were the recipients of the survey participation invitation, there was no expectation for consistency as to which public health unit staff or department completed the survey, which may have contributed to variability in the perspectives represented in the survey results.

Results

The term "First Nations community" is utilized throughout this report as a respectful alternative phrase for the term reserve. It refers to a community which is officially recognized and administered on land that was set aside under the Indian Act or under a treaty agreement, and which is governed by a band council. The term "Indigenous" refers to all persons of Indigenous ancestry -- First Nations, Métis, and Inuit.

Engagement context

All public health units (14) who indicated that they intersect with First Nations communities were asked to report on a number of components that frame their context for engagement.

Key points:

- First Nations community health centres and/or health directors play an important role as a first point of contact within the initial engagement process.
- The impetus for public health units to engage with First Nations communities is often a direct request from a First Nations community for a specific program or service.
- All public health units share information or resources as part of their engagement.
- Public health units use engagement approaches that focus on relationship building and are tailored to First Nations community perspectives.
- The nature of engagement activities mainly focused on relationship building and the provision of a public health unit service without a purchase of service agreement.
- Of all public health unit programs, vaccine preventable diseases and the prevention and control of infectious diseases were most frequently selected as program areas in which public health units engage with First Nations communities.
- Clinic type services were most often cited as more conducive to engage with First Nations communities.
- Through engagement, most public health health units felt that they were able fulfill the service request or need of a First Nations community.

Initial engagement process

Public health unit responses indicate that First Nations community health centres and/or health directors play an important role as a first point of contact within the initial engagement. A majority (79%) of respondents identified that either their public health unit was approached by or that they approached First Nations community health centres and/or health directors as a means to initiate engagement activities. Seven respondents noted that they approached a First Nations community through community members while seven public health units also identified that another organization facilitated initial engagement. Few noted the involvement of the provincial government or the First Nations and Inuit Health Branch (Health Canada) in the initial engagement process (Appendix E – Figure 3).

Prompt for engagement

Public health units were also asked to describe what prompted their engagement with First Nations communities. Most of the respondents (71%) indicated that their engagement was prompted by a desire to establish partnerships to effectively respond to First Nations identified needs or requests. Many described that to respond to these requests, they extended available public health programs and services to First Nations communities. The programming areas where this occurred include: emergency preparedness, health promotion, dental services, environmental health, and control of infectious diseases.

Additional prompts for engagement include: overall intent to improve health opportunities for First Nations communities, development of written service agreements, joint health services planning, and responding to identified funding opportunities. Three public health units noted that their public health unit received enhanced internal direction to engage with First Nations communities (i.e., strategic plan, board of health, senior management).

Nature of engagement

Public health units were also asked to identify the nature of their engagement activities with First Nations communities (Appendix F – Table 2). All respondents identified that they share information or resources with First Nations communities as part of their engagement. Getting to know each other/relationship building as well as the provision of a public health unit service without a purchase of service agreement were identified by most public health unit respondents (12/14). Services provided without a formal service agreement were predominantly clinical type services, and very rarely, health promotion-related services. Three public health unit respondents indicated having a formal purchase of services agreement in place to provide service to a First Nations community.

Few respondents (4/14) noted that they are in the process of developing formal agreements, such as memoranda of understanding, inter-agency agreements, or other unspecified types of agreement. These agreements were related to vaccine provision, data sharing, animal bite investigation, Healthy Babies Healthy Children, and a nutrition-related program.

Engagement approach

Thirteen respondents described how their public health unit approaches engagement with First Nations communities. Two main themes emerged: engaging based on community needs and relationship building.

Many public health unit respondents (10/13) identified engagement approaches that are driven by First Nations community needs. The words "need" and "request" were used frequently to describe engagement approaches. Approaches to better understanding a First Nations community perspective included visiting the communities, responding to public health service or program requests, and engaging in dialogue to know more about each other. This includes learning more about the community's health, and determining possible collaboration opportunities. Some respondents also emphasized that strategies cannot be developed without First Nations involvement and that self-determination needs to be respected.

Over half of responses (9/13) identified relationship building as a pivotal engagement approach. Working with and/or reaching out to people who work within the First Nations communities, community leaders and members was noted. Some specifically made mention of First Nations health centre front line staff and directors as well as building on pre-existing relationship that public health unit staff had with the community. Approaches also included inviting these same First Nations professionals to participate on committees, working together to jointly develop resources and plan events, and ensuring public health unit presence in the First Nations community (i.e., health fairs).

Public health programming areas

The [Ontario Public Health Standards (OPHS) and Protocols](the "Standards") establish the minimum requirements for fundamental public health programs and services to be delivered by Ontario's 36 boards of health, which includes 16 specific program areas. Within a multi-select question format, public health units were asked to identify all of the program areas in which they have engaged with First Nations communities.

Results demonstrate that public health units engage in relation to all program areas. Eleven of the 16 Standards were selected by over 50% of respondents (Appendix G – Table 3). Vaccine preventable diseases (93%) and the prevention and control of infectious diseases (86%) were most frequently selected as programming areas where public health units engage with First Nations communities.

Public health units were also asked to describe program areas they felt were more conducive to engaging with First Nations communities. Topics most often noted were grouped within the following categories: vaccine preventable diseases (4/11), oral health (3/11), sexual health (2/11) influenza clinics (2/11), communicable and infectious diseases (2/11) and diabetes prevention (2/11). Other areas that were noted include: seniors falls prevention, pandemic planning, environmental health (safe water, vector borne diseases, emergency preparedness), early years, Healthy Babies Healthy Children, and broad support on statistical data and resources. It should be noted, however, that each of these were only each identified by one public health unit. As such, there is great variability in perspectives on which program areas are most conducive to engagement. Some public health units indicated that programming choices depend on the needs identified and brought forth by the First Nation communities to public health units. Two comments suggested that programming

topics are more conducive to engagement when they are within the scope of the Ontario Public Health Standards.

Positive engagement outcomes

Within a multi-select question format, respondents were asked to list positive outcomes that resulted from engaging with First Nations communities (Appendix H - Table 4). While all response options were selected by at least one public health unit, the majority (93%; 13/14) identified that a service need for the First Nations community was met, while just over half (64%; 9/14) identified that engagement resulted in First Nations committee participation and half (7/14) noted that engagement met a service need for the public health unit.

Specific public health unit practices

All public health units (14) who indicated that they intersect with First Nations communities were asked to identify current practices that guide their engagement work with First Nation communities. The list of practices that were included in the survey were informed by findings from a review of the literature on practices of engagement with First Nations communities[1]. Please see Table 6 (Appendix F) for all results related to these public health unit practices.

Key points:

- Only two public health units have First Nations representation on their board of health or a public health unit advisory group.
- Although half of public health units have Indigenous Peoples employed, responses point to opportunistic rather than purposeful employment practices.
- Most public health units (79%) have provided cultural awareness/competency training to staff who engage with First Nations communities.
- Few public health units have policy or guideline level practices for First Nations community engagement.
- Half of public health units consider First Nations communities in their overall strategic planning and/or in program planning processes.
- Most common approaches to providing public health unit updates to First Nations communities was done through: invitation to events, email updates, frontline staff meetings, and community engagement sessions.

Governance level practices

First Nation representation on board of health

Few (2/14) public health units who engage with First Nations communities indicated that they have a First Nations representative on their board of health. One respondent indicated that each First Nation

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[1] Please refer to the Review of Literature report.

that intersects with their public health unit is represented on their board of health, while the other noted that this representation is coincidental by public appointment.

First Nation community representation on a public health unit advisory group

Few (2/14) public health units have First Nations community representation on an advisory group or Indigenous advisory committee. One of these respondents is currently in the process of finalizing membership recruitment for such a committee.

Formal written agreements

Seven public health units have formal written agreements in place between themselves and First Nations communities, with memoranda of understanding being the most common. Included in these agreements were topics such as needle exchange, nutrition, physical activity, dental screening, vaccines, animal bite investigations, joint program planning as well as a tripartite agreement letter between two public health units aligned with the same First Nation.

Informal or unwritten agreements for engagement

Half (7/14) of public health unit respondents have informal or unwritten agreements with First Nations communities. The focus of these agreements related to: rabies control (2), vaccine preventable and communicable diseases (2), water and food safety (1), tobacco (1), children's oral health (1), beach sampling (1), health fairs (1), school dental programs (1), data collection (1), and committee work (1).

Organizational commitment statements

Three public health units indicated that they have a board motion or formal statement outlining a commitment by the public health unit to engage with First Nations communities. The focus of these statements includes: recognition of Indigenous Peoples within the strategic plan, naming First Nations as part of a public health unit's mandate, and a board motion supporting the development of an Indigenous engagement strategy.

Other governance practices

Some public health units also carry out the following practices: territorial acknowledgement when the board of health Chair and/or Medical Officer of Health are in attendance and holding yearly meetings between the public health unit board and each First Nations community. One public health unit is currently pursuing a board-to-board meeting to connect First Nations governance and public health unit governance.

Staffing Level practices

Indigenous employees

Half of respondents (7/14) have Indigenous Peoples employed in their public health unit. Many responses point to opportunistic rather than purposeful employment practices. One public health unit stated that "these are staff that have been hired based on skills and that during their employment, have self-identified as being Indigenous. There may be additional staff that are from Indigenous ancestry that we are not aware of…". It was also noted that having Indigenous employees on staff fluctuates based on people leaving and joining the organization. One respondent stated, "It is a goal

of the organization to employ Indigenous Peoples, however Indigenous applicants are few and far underrepresent our population. [We] continue to pursue ways to increase applicants."

Lead staff – Indigenous engagement

Half of respondents (7/14) reported having a lead who works across teams or service users to support engagement in First Nations communities. Leads include a public health nurse, a health promoter, or a member of the health equity team. Three public health units indicated having a manager who provides leadership, guidance, and/or support for engaging with First Nations communities.

Cultural awareness/competency training

Cultural awareness/competency training was provided in most (11/14) public health units who engage with First Nations communities. Some public health units provided this training to all staff, while others provided this to some but not all of their staff. Examples of training programs provided include: Ontario Indigenous Cultural Safety Training, Indigenous Cultural Competency (delivered by the Ontario Federation of Friendship Centres), and Local Health Integration Network sponsored programming. One public health unit outlined that staff are informed of and encouraged to participate in cultural competency training programs in the community. Another public health unit reported being early in the development stage of cultural competency training.

Other processes for cultural competency development include staff being trained as a part of their orientation, staff conference guest speakers, a community of practice, staff attending an all-day cultural awareness training session, and the opportunity to participate in a lunch-and-learn session with an Elder. One public health unit described the following: "We incorporate Indigenous traditions and rituals into all of our public events. This has included drumming at our open houses, smudging in our new building, prayers by Elders, [and] an opening statement that acknowledges the territory".

Policy or guideline level practices

In general, few public health units have policies or guideline level practices that may support engagement with First Nations communities. Only one public health unit identified having policies or guidelines for working with Elders, two have policies or guidelines for engaging with First Nations communities, and three have a policy requiring territorial acknowledgement at significant organizational events. One public health unit additionally described that whenever they present to municipal councils, they also offer to present to their First Nations councils.

Programming level practices

Half of public health units who engage with First Nations communities (7/14) indicated that their public health unit explicitly considers the needs of First Nations communities in their strategic planning. Within these plans, some described expanding their service reach to be inclusive of First Nations communities, Indigenous Peoples as a priority population/health equity focus, and Indigenous engagement as a strategic direction and priority for their public health unit.

Similarly, seven public health units indicated that they explicitly consider First Nations communities in program planning. Programs such as dental, early years, health equity, health-care provider outreach, speech therapy, and vaccine delivery considered First Nations communities in their planning process. The word "priority" appeared six times in qualitative answers related to

programming level practices. These broadly referred either to Indigenous engagement or First Nations communities as being prioritized within their planning processes.

Environmental level practices

None of the 14 public health unit respondents have signage or plaques acknowledging the traditional territory of the First Nations community on which their public health unit office is located. When asked if their public health units display Indigenous artwork, five public ealth units indicated that artwork is displayed within public areas, most often in reception/lobby areas, meeting rooms, board rooms, and on branding materials.

Communications level practices

Five public health units noted that they use Indigenous language in resources and publications. This is mainly limited to resources that are requested or utilized by Indigenous clients. Four respondents utilize Indigenous representation or symbols in marketing materials. Its use was noted within annual reports and campaign materials depending on the resource or event.

Seven public health units indicated that they collaborate with First Nations communities to develop culturally appropriate program resources or other promotional materials. Specific program topics include: sacred and commercial tobacco, asthma curriculum, breastfeeding promotion, mental health brochures, diabetes prevention, falls prevention, children's oral health, and selecting aboriginal children's book bundles.

Five public health units responded that they provide internal updates to staff across programs and divisions on First Nations community engagement. For the most part, these updates are provided as needed to all public health unit staff and/or managers.

Eleven public health units reported that they communicate with First Nations communities to provide updates on public health activities. Within a multi-select question format, most common communication approaches included: invitations to events (82%, 9/11), email updates (55%, 6/11), frontline staff meetings (55%, 6/11), and community engagement sessions (45%, 5/11). Public health units (5) described additional approaches which includes: presentation to Chief and council, presentation to First Nations organization board members, direct letters to community leaders, briefing notes, advertising and promotion, health fairs, telephone calls, in-person meetings, and a local newspaper column by the Medical Officer of Health.

Factors that contribute to engagement

All public health units (14) who indicated that they have engaged with First Nation communities were asked to reflect on their practices and activities perceived to positively contribute to engagement.

Key points:

- There are 3 main approaches perceived to encourage successful engagement:

  o Internal supports: there are a number of public health unit supports that may contribute towards an organizational perspective where First Nations communities are viewed as equal partners.

  o Proactive: some public health units actively seek opportunities to engage with First Nations communities.

  o Responsive: there are instances where public health units described approaches where they provide support to First Nations communities as requested

- Most engagement practices considered by public health units to be successful or positive had a number of overarching components related to building relationships with First Nations communities. These include but are not limited to:

  o Some type of involvement with First Nations community representatives such as health directors, health sector staff, Tribal Councils, and community members.

  o Optimizing and building from existing relationships.

  o Engaging through face-to-face meetings.

- Engagement was also perceived to be successful when opportunities for further collaboration were presented.

Public health unit supports

Thirteen respondents provided answers that describe what their public health unit does or has done to support and encourage successful engagement with First Nations communities. These were grouped into three themes: internal supports, proactive practices, and reactive practices.

The first focuses on internal public health unit supports. Responses included the development of an organizational perspective where First Nations communities are viewed as equal partners and those living within are part of the public health mandate. Respecting Indigenous views and culture, being interested to learn and ask questions about First Nations communities, and ensuring culturally appropriate services were also identified as encouraged practices. Public health units noted that they provide Indigenous-focused competency/awareness training opportunities and staff time to engage. This includes the time and budget necessary to travel to remote areas. One public health unit noted that they have assigned staff to support Indigenous engagement while another provides opportunities for Indigenous public health unit staff to be involved in engagement work. Senior leadership who encourage First Nations engagement was noted as an important support.

The second theme relates to proactive practices where public health units felt that they supported engagement by actively seeking such opportunities. Examples included providing First Nations communities with information on public health unit programs and services, discussing culturally appropriate public health initiatives with First Nations leaders, advocating for First Nations membership on committees, and promoting local First Nations cultural events (with permission from the First Nations community). Some identified that relationship building was supported when they joined Indigenous health-focused committees as a means to further network. Developing links with First Nations health service providers who deliver similar programming as public health units was also noted as a proactive measure.

Alternately, three public health units described reactive support approaches. These were described as instances where First Nations communities approached the public health units with specific requests and public health units worked to fulfill them. Request examples were linked to service provision, joint advocacy efforts, as well as general information and resources.

Engagement activities

Thirteen of the public health units who indicated that they have engaged with First Nations communities in the past few years also shared and described examples of engagement practices that they would consider to be successful or positive. The overarching theme of these activities focused on components believed to support the process of building a relationship with First Nations communities.

Many examples incorporated some type of involvement with First Nations community representatives/leaders, which included health directors, health sector staff, Tribal Councils, and community members. Reference to the words 'staff' and 'workers' was noted 17 times throughout the responses and also included mention of relationships, key contacts, linkages, involvement, connecting, partnership and working together. One example illustrated the role of a First Nations health director to identify key community members for the public health unit to connect with. Another public health unit worked with First Nations staff to recruit families for a program and also make appropriate referrals.

In parallel, a few described instances where the public health unit found it helpful to optimize and build from existing relationships. One respondent described that joining an existing Indigenous health focused strategy helped their public health unit "…build relationships alongside those who have already done so". Relationships were also supported through simultaneous participation from both First Nations communities and public health units on advisory and planning committees, steering committees, working groups, and networks related to programming and the delivery of provincial priorities, public health programs and local initiatives.

Methods of engagement included foremost face-to-face meetings for initiating activities, identifying areas of interest, planning, reaching agreements and developing common goals for positive outcomes. One public health unit explained that some of their staff who stayed in local First Nations community homes in turn gained a better understanding about that same community. Some respondents described being part of forums which facilitated open dialogue to determine areas of mutual interest and greater understanding of roles. Engagement was further identified through the involvement of youth to support, advocate and enhance local initiatives for collective action and

community health. As such, providing public health unit staff time to build the relationship to better understand the community and attain the required permission, approvals and/or protocols to provide the service in the communities was also noted.

Through staff collaboration with First Nations communities, public health units identified two main positive outcomes. The first outcome was the serendipitous transfer of cultural and community knowledge between internal public health unit staff. The second outcomes was that staff who participate in Indigenous engagement have gained enhanced cultural appreciation and understanding from that experience. Shared material, financial, and human resources for programs and initiatives were further identified as a positive practice between First Nations communities and public health units.

Lastly, many public health units perceived engagement to be successful when opportunities for further collaboration were presented. One respondent explained that "this connection was felt to be successful as the First Nations community representative expressed interest in furthering the relationship on a sustainable collaborative basis". This was similarly noted as an unexpected positive outcome as a result of engagement for one public health unit as they "…did not expect to have requests to expand our original service level agreements." Some of these opportunities arose from initial discussions to develop or update service level agreement which led to additional agreements.

Challenges to meaningful engagement

All public health units (14) who indicated that they have engaged with First Nation communities provided responses on the challenges they face in developing meaningful engagement with First Nations communities. The challenges can be grouped into one main themes related to program planning and service delivery.

It is important to note that results from this section only provides perceived engagement challenges from a public health unit perspective, which must be taken at face value. A balance of perspectives from First Nations communities will be acquired at a later phase of this project.

Key points:
- A number of responses pointed to a lack of clarity with regards to which health organization is most responsible or appropriate to deliver a public health service within a First Nations community.
- Multiple components within the actual planning and/or delivery of public health programming to First Nations communities are perceived to hinder engagement. These include but not limited to: staff turnover, financial pressures, and a lack of data on Indigenous health.
- Engagement was felt to be less successful when programming discussions did not result in any actual implementation.

Program planning and delivery

A number of public health units expressed challenges on how to best work within the Ontario public health system to meaningfully engage First Nations communities. A number of responses pointed to a lack of clarity with regards to which health organization is most responsible or appropriate to deliver a public health service within a First Nations community.

By way of background, public health services for First Nations communities is a federal mandate of the First Nations and Inuit Health Branch (FNIHB) of Health Canada. For their part, Ontario public public health units are funded jointly by local and provincial governments. These funds are to be utilized for the delivery provincially legislated public health programs and services to all Ontarians ([Ontario Public Health Standards, Ontario Ministry of Health and Long-Term Care](#)).

Public health units described financial pressures related to providing public health services to First Nations communities. This includes the consideration of incurred costs such as staffing capacity, training, travel time, and mileage. One public health unit described increased program delivery requirements from the ministry without new funding dollars for its implementation. In other words, finances are stretched within a number of contexts.

The presence of multiple public health units in proximity to a given First Nations community introduces a challenge, as public health units are uncertain as to who should deliver the services. One respondent expressed concerns that they "do not want to infringe on relationship building" with a First Nations community whose boundaries intersects with a different public health unit.

Enforcement of public health legislation was noted to pose challenges. Although specific examples were not provided, one response made note that investigations can occur which involve both First Nations communities and non-First Nations communities. These responses pointed to a lack of clarity of roles in relation to such instances.

One public health unit outlined that environmental health programming (i.e. rabies and food handling) as an area of challenge. This was described as instances when a First Nation community makes a service request directly to a public health unit for a service that is within the funded responsibilities of FNIHB to provide. In parallel, a respondent described an instance where a First Nations community wanted to deliver a public health program component but was not permitted to do so, due to ministry requirements. This situation created a challenge not only for the public health unit that had to deliver this component but also the First Nations community that wanted more involvement.

Challenges relating to changes in First Nations leadership as well as staff turnover both within First Nations health centres and public health units was perceived to slow relationship building and impact program delivery. A number of public health units lacked clarity with regards to the steps involved regarding First Nations approval and decision-making processes.

A few public health units felt engagement was less successful when programming discussions with First Nations did not result in any actual implementation within that same community. One public health unit described efforts to set up a First Nations networking committee that was met by an eventual lack of interest and/or resources. Data on Indigenous health was also identified as lacking, thereby making it difficult to develop and deliver evidence-based programming.

Future engagement

All public health units (14) who indicated that they have engaged with First Nation communities were asked about their perceived skills and knowledge to engage as well as their future plans for engagement.

Key points:

- The majority of respondents (79%) did not feel their public health unit had the skills and knowledge to effectively engage with First Nations communities.
- More than 75% of respondents felt the following resources would be useful to further support their engagement with First Nations communities: additional funding to their public health unit, funding to First Nations communities, human resources, cultural awareness and competency supports, and training supports.
- When asked about plans to follow specific protocols to further guide engagement, most public health units (64%) were uncertain or were waiting for the release of protocols to determine their use.
- With regards to public health unit plans to further engage with First Nations communities, responses were mixed where some planned to continue or build from their current engagement work (5), were unsure of their next steps (5), plan to provide staff with cultural competency/safety training (3), along with a few additional single responses.

Skills and knowledge

Only three public health units felt that they have the appropriate skills and knowledge to engage with First Nations communities. When asked to describe what has been helpful to support engagement, two of these same respondents referred to the provision of staff training on cultural safety. Public health unit staff familiarity with surrounding First Nations communities, dedicated staff working on Indigenous engagement and updates to the Ontario Public Health Standards were also noted as helpful supports to engagement.

Alternatively, those (11/14) who did not feel that their public health unit had the skills and knowledge to effectively engage were asked about what they are missing. The word 'training' appeared 21 times throughout responses with an emphasis around specific topics relating to cultural competency, awareness, safety, and/or sensitivity. Respondents also made comments with regards to a general need to learn more on how to engage effectively with First Nations communities.

Additional learning needs included: traditional healing methods, Indigenous protocols (i.e. land acknowledgement and Elder honorarium), First Nations governance and structures, and Truth and Reconciliation Commission of Canada recommendations. Last, opportunities to share knowledge between public health units was noted as a potentially helpful avenue for further learning.

Additional resources to engage

Within a multi-select answer question, 13 public health units identified resources they felt would be useful to further support their engagement with First Nations communities (Table 6). All of them

noted that additional funding to their public health unit would be useful while over 75% of respondents also selected human resources, cultural awareness and competency supports, funding to First Nations communities, and training supports. Four public health units provided additional responses within an open text field which included supports related to governance and policy practices, staff who are from the First Nations communities, and a need to know more on the First Nations community's vision for public health with a focus on relationship building.

Table 6 - *Resources to further support engagement*

	%	*n/N*
Programming dollars to public health units	100	13/13
Human resources	92	12/13
Cultural awareness and competency supports	85	11/13
Programming dollars to First Nations communities	77	10/13
Training supports	77	10/13
Supplies and materials	46	6/13
Programming space	23	3/13

Note: All items were measured on a check-all-that-apply format. Percentages in table represent respondents who checked off that item

Preparation for effective engagement

Respondents were asked to describe how their unit has prepared themselves to engage with First Nations communities. This is within the context of the 2018 Ontario Public Health Standards which outlines a new requirement for public health units to engage with Indigenous organizations and communities.

Responses (13) were grouped into three themes: staffing, training, and planning. Some respondents provided more than one answer. Four public health units identified that they have designated staff (management and/or front-line staff) to work on Indigenous engagement. Seven responses are linked to processes that may inform public health unit engagement with First Nations communities. This includes strategic and operational planning, developing an Indigenous engagement strategy, collecting Indigenous health data, learning from other public health unit engagement processes, and proactively connecting with First Nations communities and organizations which represent them. Six respondents identified that they have already provided or in the process of planning to provide staff training on topics such as cultural safety, sensitivity, and competency in support of its preparation for Indigenous engagement.

Plans for further engagement

Respondents were asked in an open ended question how their public health unit was planning to further engage with First Nation communities in order to meet the requirements within the [Ontario Public Health Standards](). Some respondents provided more than one answer. Five public health unit responses pointed to continuing or building from their current work with First Nations communities. Alternatively, five public health units were unsure of their next steps. This was generally explained by a need to attain further information to inform their engagement plans. Examples of this information includes ministry guideline and requirement documents, outcomes from this project, as well as public health units specific plans around strategic planning and the development of an Indigenous engagement strategy. Three public health units were planning cultural competency/safety training. Additional single responses included dedicated staff to work with First Nations and a review of the Truth and Reconciliation Commission report.

Specific protocols to guide engagement

Respondents were asked in an open-ended question if their public health unit planned to follow any specific protocols to further guide engagement with First Nations communities. Most public health units (9/13) were uncertain if they will use specific protocols or were waiting for the release of protocols to determine their use. Two respondents stated that they were currently in the planning process, one stated that cultural competency protocols were important going forward, and one stated that they would use a protocol built on respect and collaboration.

Discussion

The term "First Nations community" is utilized throughout this report as a respectful alternative phrase for the term reserve. It refers to a community which is officially recognized and administered on land that was set aside under the Indian Act or under a treaty agreement, and which is governed by a band council. The term "Indigenous" refers to all persons of Indigenous ancestry -- First Nations, Métis, and Inuit.

The objective of this survey of Ontario public health units was to gather and learn about practices and examples of engagement and/or collaboration from the public health unit perspective. Perspectives of First Nations communities are being sought in a separate process involving in-depth interviews, focus groups and sharing circles. Discussion points below are based from the responses of public health units (14) who indicated that they intersect with First Nations communities.

Nature of engagement

All 14 public health units reported having had some engagement with First Nations communities in the past five years. Those interactions tend to be frequent, once a month or more often, and are initiated both by the First Nation and by the public health unit (or by other partners). First Nation Health Centre directors are an important point of contact for public health units.

There were many contexts and reasons for the engagement: sharing information; getting to know each other; providing service; and sharing training, supports, or research/data. Some of the engagement examples were specific to particular public health programs. Among the most common were vaccine preventable diseases, Healthy Babies, Healthy Children, communicable disease prevention, needle exchange and harm reduction, dental health, Healthy Kids Community Challenge, programs in schools, and health promotion/chronic disease prevention.

According to the public health units that responded to the survey, their engagement practices rely on frequent communication and relationships built over time. Public health units spoke of the importance of respecting First Nations community wishes and following the lead and direction of the First Nations communities when there are possibilities for collaboration.

Based on the survey results, Ontario public health units have engaged with First Nations communities to varying degrees. In many cases, the engagement is episodic—connecting when circumstances lead to such connection (responding to a request from the First Nation, or engaging around a particular program or issue). In a smaller number of cases, the engagement is part of an ongoing relationship that has been built over time.

External environments and internal variables were described as influencing engagement. Factors such as complex or unclear jurisdictional responsibilities were felt to affect the potential for effective engagement. Because much ongoing engagement depends on personal relationships, staff turn-over or changing roles can diminish the potential for engagement. Working together on specific initiatives with valued outcomes was a more beneficial practice than connecting without a clear purpose in mind. However, there had been successes in getting to know each other and understanding diverse

roles and approaches to public health. It may be that the important factor is being clear from the start about what the goal of interacting is and what the expectations should be. Public health units did express some concerns about not being able to meet First Nations community expectations due to financial and human resource capacity limitations or due to mandate restrictions (outside of a public health unit's scope of practice). Public health units felt that they had a need for additional training and understanding of First Nations community traditions, protocols and practices including decision-making and approvals.

Principles and wise practices in engagement examples

Part of this project involved completing a literature review focused on identifying key principles and practices of engagement between Indigenous communities and public health. The literature review involved both grey and academic literature that explored strategies, approaches, and principles of engagement and collaboration between Indigenous Peoples and public-sector agencies in North America, New Zealand, and Australia. Four principles were identified in the review: **respect, trust, self-determination,** and **commitment**, each with associated wise practices. These principles are recommended as exemplifying the underlying philosophy and approach needed to engage successfully and work in meaningful ways with First Nations communities. The wise practices are viewed as specific actions that can contribute to more successful partnerships with First Nations communities.

Given these survey results, it is of interest to ask: to what extent are the principles and practices from the literature review evident in the examples of public health / First Nations community engagement described by public health units?

Respect

Based on the findings from this project's literature review, the first principle of **respect** focuses on the need for non-Indigenous Peoples to understand, acknowledge, and appreciate both the history and current context of Indigenous Peoples (Talking Together to Improve Health Project Team, 2017).

As noted in the description of engagement practices above, public health units describe the importance for them to communicate, build respectful relationships, and respect the wishes of First Nations communities in any interactions.

Cultural competency training may be one step toward respectful relationship. The majority of public health units who responded to the survey have provided cultural competency training to their employees, or have made training available through other providers. The nature of the training varies, however, and there would be opportunities to deepen the training from brief guest speakers to multi-day engagement, and to broaden the reach of the training by ensuring that more public health staff (including leadership and board members) complete the training. The majority of respondent public health units said that they still needed to know and understand more. It may also be important to consider extending the scope beyond cultural competencies and shift toward a broader approach of cultural safety.

The Indigenous Circle noted that an important concept to consider as an objective is *cultural humility*, which speaks to the idea of ongoing self-reflection and life-long learning, as opposed to

cultural competence, which may suggest an endpoint after which a person considers themselves to have mastered certain content. Furthermore, the specific nature of training should have local relevance and involvement, and should provide an opportunity for people to talk, ask questions, share ideas and build relationships. There was concern among the Indigenous Circle that some training approaches may contribute to a sense that injustices happened in the past and are not ongoing as contemporary realities. Although the idea of learning and sharing was valued by the Indigenous Circle as well as the public health units, it is important to be selective about who provides the training and what the key messages are, so that the training contributes to understanding and is a basis for reconciliation.

Practices that honour the diversity of the unique Indigenous cultures also emerged from literature and can be found to some extent in survey responses. One example of incorporating unique Indigenous cultural expression is through artwork displayed in public health unit buildings. With reference to cultural competency training, discussed earlier, although cultural competency training of some description is fairly widespread in the survey, it is not certain that the specific content of the training reflects the cultural contexts of local First Nations communities. Furthermore, it is not known whether the training was provided by local Indigenous Peoples and knowledge keepers. One way to honour the diversity of local culture is to ensure translation of resource documents and communications in the local Indigenous language.

Formal land acknowledgment practices are an example described in the literature of a respectful practice. Three public health units start with land acknowledgement at board of health meetings or other public health unit events, but others could perhaps consider this as a formal practice. No public health units reporting having a land acknowledgement plaque in their buildings, which could be a respectful practice to consider. Presentations to First Nations councils, in parallel with presentations to municipal councils, is another way of acknowledging and respecting First Nation governing structures. Physical environment features in public health unit buildings, such as having a round board table or naming meeting rooms after bodies of water for example, may express respect for Indigenous ways of working and seeing the world.

One public health unit provides formal guidance for engaging with First Nations elders and knowledge keepers, which may be another respectful practice that public health units should develop, in consultation with local First Nations. Guidance for staff when working with First Nations communities on reportable disease follow up or on health data projects were other examples of respectful practices by two public health units, as was guidance for public health unit staff on Jordan's Principle. Jordan's Principle is a child first principle to prevent First Nations children from being denied or experiencing delays in accessing essential services and supports that are available to all other children.

Trust

Based on the findings from this project's literature review, **trust** is another principle that was recognized as foudnational for the establishment of respectful and mutually empowering long-term relationships (Talking Together to Improve Health Project Team, 2017). As many historical and ongoing events have led to considerable distrust by many Indigenous Peoples, for any successful engagement to occur, trust must be a central consideration. Early engagement, working with respected Indigenous members, inclusivity of Indigenous members and balance in terms of age and genders, and appropriate and ongoing communication are all likely to build trust.

Examples from public health units included having face-to-face meetings and enlisting respected people in communities as a way to begin building relationships based on trust. Respondents in this study expressed that allowing enough time for relationship building was important as it is not possible to establish trusting relationships in one meeting.

Seeking First Nations community input into public health unit planning processes is one example of a practice that has potential to build trust, if perspectives are sought early and respected. These processes work best when it is also understood that First Nations have their own capacity and responsibility for health, and may or may not wish for the same kind of collaboration that public health units have in mind.

Self-determination

Based on the findings from this project's literature review, partnerships with Indigenous Peoples have been identified to be more successful if the principle of **self-determination** is considered and understood (Talking Together to Improve Health Project Team, 2017). This can be encouraged by ensuring collaborations are driven by Indigenous communities, providing opportunities to build Indigenous workforce capacity, building on the strengths of the Indigenous communities, and having strong Indigenous representation in the decision-making process.

The notion of self-determination was a seen throughout survey responses. Many public health units described engagement approaches that are driven by First Nations community needs. Some emphasized that strategies cannot be developed without First Nations involvement and that self-determination needs to be respected. Most engagement practices perceived to be successful incorporated some type of involvement with First Nations community representatives/leaders. Public health units provided examples of reactive approaches in that First Nations communities approached the public health units with specific requests and public health units worked to fulfill them.

Conversely, public health units emphasize that, in their experience, respectful relationships can continue even when particular initiatives do not go forward. There were examples cited in the survey in which First Nations communities decided not to collaborate with public health units or other partners on certain projects. Public health units report that this has sometimes happened when capacity issues prevent anyone from the First Nations community from participating or attending meetings, or when the proposed project did not meet the identified needs of the First Nations community. Engagement that incorporates the principle of self-determination can mean that collaboration does not result, if it is not needed, wanted or possible at a certain time. Being ready

and open to other initiatives is part of the trusting relationship that can be established between First Nations communities and public health units.

There are other examples in which engagement did not happen, or did not happen in a timely fashion, because it was not clear who to connect with on a certain topic. This may have resulted because the public health unit was not familiar with the First Nation governance and decision-making structures and processes, something that could be remedied with increased investment in training and relationship-building. Again, having ongoing relationships that transcend, or are not limited to, particular initiatives, may help to support engagement when needed on a specific issue or project.

Commitment

Based on the findings from this project's literature review, the final principle, **commitment,** focuses on the importance of tangible and sustainable action to develop and maintain long-term and effective partnerships (Talking Together to Improve Health Project Team, 2017). Commitment can be signalled through practices that support collaborative learning, shared decision making and mutual responsibility for beneficial outcomes. Flexibility with regards to funding structures and timelines are also required to support a fulsome engagement process. As such, progressive leadership is required to do things differently. Additional supporting practices include purposeful Indigenous hiring, ongoing reflection, visible community presence, and ensuring that Indigenous communities validate findings and that their perspectives are included.

In terms of formal relationships that may reflect commitment, only two public health units who responded to the survey had First Nation representation on their board of health, and of those, only one did so through positions reserved for First Nation representation. In a similar vein, two public health units had an Indigenous Advisory Committee (in place or in process). Half of the public health units had written agreements, such as memoranda of understanding for particular programs and services (or Section 50 agreements[2] for one public health unit). Three public health units had Indigenous engagement as a priority in their strategic plan, board motion or other formal process. For half these public health units, there are unwritten or informal agreements about specific collaborative efforts. All of these examples may speak to ways to demonstrate and operationalize commitment to ongoing engagement.

With respect to staffing and staff roles, another aspect of commitment to long-term relationships, staff and management positions at some public health units explicitly incorporate Indigenous engagement as part of their roles. Some public health units have staff who self-identify as Indigenous. Some public health units were looking to enhance their recruitment strategies to increase the number of Indigenous staff.

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[2] Section 50 of Ontario's Health Protection and Promotion Act R.S.O. 1990 (HPPA) provides for agreements to be made between the council of an on-reserve band and health unit, such that the health unit provides health programs within the scope of the OPHS (MOHLTC, 2016) and the council of the band would accept the responsibilities of a municipal council within the health unit.

The incorporation of strategic plan priorities with respect to Indigenous partnership and collaboration to improve the health of the population, when done with ongoing engagement, is a way of ensuring commitment to working together and contributing to meaningful improvements, both in ways of working together and in health outcomes. This approach was mentioned by four respondents, with others describing this as an emerging direction. Seeking input and guidance from First Nations communities as part of their program planning, implementation and evaluation is also a alphabetize way of demonstrating and ensuring commitment over the longer-term delivery of health programs and services. Policies, tools, checklists and other formal guidance about the importance of engaging First Nations communities in these planning processes may be helpful as a tangible reminder of these commitments.

Next steps

The term "First Nations community" is utilized throughout this report as a respectful alternative phrase for the term reserve. It refers to a community which is officially recognized and administered on land that was set aside under the Indian Act or under a treaty agreement, and which is governed by a band council. The term "Indigenous" refers to all persons of Indigenous ancestry -- First Nations, Métis, and Inuit.

The survey findings in this report are one piece of a larger exploration and represent only the perspectives of Ontario public health units that responded to the survey. As previously noted, interviews are currently being conducted to gather examples and commentary from the perspectives of First Nations communities and of organizations aligned with public health that have a history of engagement with Indigenous communities. The intent is ultimately to bring all perspectives and learnings together (from First Nations communities, community health organizations, public health, and literature) to identify engagement examples, principles, and wise practices, with a view to providing guidance for moving forward to improve community health.

It is apparent from these survey responses from public health units that engagement with First Nations communities is important and valued. The examples provided illustrate the possibilities and the variety of ways that such engagement can happen and can be supported. However, the majority of public health units do not feel that they have sufficient knowledge and skills to effectively engage. Few public health units identify high-level direction related to engagement in governance, policy or strategic domains, and the need for direction and support through mandates at the provincial level is noted. Some public health units have staff who self-identify as Indigenous, but this is by no means considered sufficient or representative of the local population. It becomes clear that there is more to be done to prepare public health units for effective engagement with Indigenous communities.

From the public health unit perspective, as explored in the survey described in this report, resources to support more and better engagement are needed. The types of resources needed include financial resources for both public health units and First Nations, human resources, cultural awareness information and training, and travel funding, among other supports. Policy and governance supports were also cited as resource needs.

Elements of the engagement principles and practices identified in the literature review can be seen in actual public health unit examples. Despite some examples, many principles are not widespread or well-established in practice at this time, and there is opportunity for the principles to be more fully evident in public health practice. Public health units expressed wishes to move forward in being good partners and collaborators when collaboration is desired, and in working respectfully alongside First Nations communities to improve health. A strong mandate from the province to public health units, and direction from the provincial public health level were mentioned by some public health units as a basis for further development of their approaches to Indigenous engagement, along with ongoing input and direction from First Nations communities.

Findings from the literature review and this report will be utilized in future phases of the broader research project. As a whole, this cumulative data gathering process will be taken together to represent a full picture of the guidance for public health on principles and practices that can promote effective engagement with First Nations communities.

References

1. Algoma Public Health. (2015). *MNO BMAADZIIDAA the Good Life*. Sault Ste. Marie, Ontario. Retrieved from http://www.algomapublichealth.com/media/2181/first-nations-report_mno-bmaadziidaa-july-8-2015.pdf

2. Chiefs of Ontario (2017) *Directory of First Nations.* Retrieved from http://www.chiefs-of-ontario.org/interactive-map/

3. Health Protection and Promotion Act R.S.O. 1990. c.H.7 (HPPA) Part VI Health Units and Boards of Health. s. 48. Retrieved from https://www.ontario.ca/laws/statute/90h07#BK57

4. Ministry of Health and Long-Term Care (2018) *Protecting and Promoting the Health of Ontarians. Ontario Public Health Standard: Requirements for Programs, Services and Accountability.* Queen's Printer for Ontario. Retrieved from http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/

5. Ministry of Health and Long-Term Care. *Ontario Public Health Standards 2008*. Revised March 2017. Queen's Printer for Ontario. Retrieved from http://health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/ophs_2008.pdf

6. Ministry of Health and Long Term Care Health Analytics Branch's "Ontario First Nations Data Tables for Public Health HAB(2009-03-31)xls" file.

7. National Collaboration Centre for Aboriginal Health. (2011). *The Aboriginal Health Legislation and Policy Framework in Canada*. Prince George, British Columbia. Retrieved from http://www.arnbccommunitiesofpractice.ca/ahnn/wp-content/uploads/2015/03/Health-Legislation-Policy-eng.pdf

8. National Collaborating Centre for Aboriginal Health. (2015). *Social Determinants*. Prince George, British Columbia. Retrieved from http://www.nccah-ccnsa.ca/28/Social_Determinants.nccah

9. North East Local Health Integration Network. (2016). *North East LHIN Aboriginal Health Care Reconciliation Action Plan*. Northeast Local Health Integration Network.

10. Ministry of Health and Long-Term Care. Public Health Division. Initial Report on Public Health. August 2009. Public Health Ontario's 2014/15 "Ontario Health Unit Profiles" Retrieved from http://rnao.ca/sites/rnao-ca/files/PMWG_Initial_Report_2009.pdf

11. Talking Together to Improve Health Project Team. (2017). *Talking Together to Improve Health: Litterature Review*. Sudbury, ON: Locally Driven Collaborative Projects.

12. Truth and Reconciliation Commission of Canada. (2015). *Truth and Reconciliation Commission of Canada: Calls to Action*. Winnipeg, Manitoba: Truth and Reconciliation Commission of Canada.

13. Statistics Canada (2016). Distribution of the First Nations population with registered Indican staty by residence on or off reserve. Retrieved from http://www12.statcan.gc.ca/census-recensement/2016/as-sa/fogs-spg/desc/Facts-desc-ap-pa.cfm?LANG=Eng&GK=PR&GC=35&TOPIC=9&#fd1_2

Appendix A: Overview of federally funded First Nations community health services

Primary Health Care

1. Health Promotion and Disease Prevention
    a) Healthy Child Development: Healthy Pregnancy and Early Infancy, Early Childhood Development, Oral Health
    b) Mental Wellness: Mental Health and Suicide Prevention, Addictions Prevention and Treatment, Residential Schools Resolution Health Support
    c) Healthy Living: Chronic Disease Prevention and Management, Injury Prevention

2. Public Health Promotion
    a) Communicable Disease Control and Management: Vaccine Preventable Diseases, Blood Borne Diseases and Sexually Transmitted Infections, Respiratory Infections, Communicable Disease Emergencies, Environmental Health, Environmental Public Health, Environmental Health Research

3. Primary Care
    a) Clinical and Client Care, Home and Community Care

Supplementary Health Benefits
    a) Non-Insured Health Benefits

Health Infrastructure Support

1. Health System Capacity
    a) Health and Planning and Quality Management
    b) Health Human Resources
    c) Health Facilities

2. Health System Transformation
    a) Systems Integration
    b) E-Health Infrastructure
    c) Nursing Innovation

Source: Algoma Public Health, p. 7-8. 2015

Appendix B: Ontario Public Health Mandatory Programs and Services

Standard	Components
Foundational Standards	Population health assessment Health equity Effective public health practice Emergency management
Program Standards	Chronic disease prevention and well-being Food safety Healthy environments Healthy growth and development Immunization Infectious and communicable diseases Prevention and control Safe water School health Substance use and injury prevention

Source: MOHLTC, 2018

Appendix C: Maps - First Nations reserves and Ontario public health units

Figure 2: *Map of Board of Health service areas and First Nations reserves*

Notes:
It is important to acknowledge that, since before colonization in Ontario, First Nations have inhabited traditional territories that are not adequately represented by current provincial maps.

Counts of First Nations are based on the Chiefs of Ontario's current Directory of First Nations (http://www.chiefs-of-ontario.org/first-nations/directory/), Public Health Ontario's 2014/15 "Ontario Health Unit Profiles" and MOHLTC Health Analytics Branch's "Ontario Frist Nations Data Tables for Public Health HAB (2009-03-31).xls" file. Any omissions or discrepancies are unintentional on the part of Public Health Sudbury & Districts.

Board of Health service areas (14) that do not intersect with First Nations reserve lands

Board of Health service areas (21) that intersect with First Nations reserve lands

Prepared by Public Health Sudbury & Districts, March 2018.
Source: Statistics Canada 2007 Health Region boundary file; Statistics Canada 2016 Census Subdivision Cartographic boundary file lcsd000b16a_e.zip.

Figure 3: *Northern Ontario - Distribution of First Nations reserves and Ontario public health units*

Figure 4: *Southern Ontario - Distribution of First Nations reserves and Ontario public health units*

Notes:
It is important to acknowledge that, since before colonization in Ontario, First Nations have inhabited traditional territories that are not adequately represented by current provincial maps.

The presence of First Nations are based on the Chiefs of Ontario's current Directory of First Nations (http://www.chiefs-of-ontario.org/first-nations/directory/), Public Health Ontario's 2014/15 "Ontario Health Unit Profiles" and MOHLTC Health Analytics Branch's "Ontario Frist Nations Data Tables for Public Health HAB (2009-03-31).xls" file.

First Nation reserve lands shown on this map represent the approximate location (not the extent of land) based on geospatial files available from Statistics Canada for the 2016 census. Some First Nations listed in the Chiefs of Ontario's Directory of First Nations may have lands that are not be included in this dataset. Any omissions or errors are unintentional on the part of Public Health Sudbury & Districts.
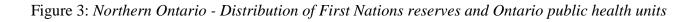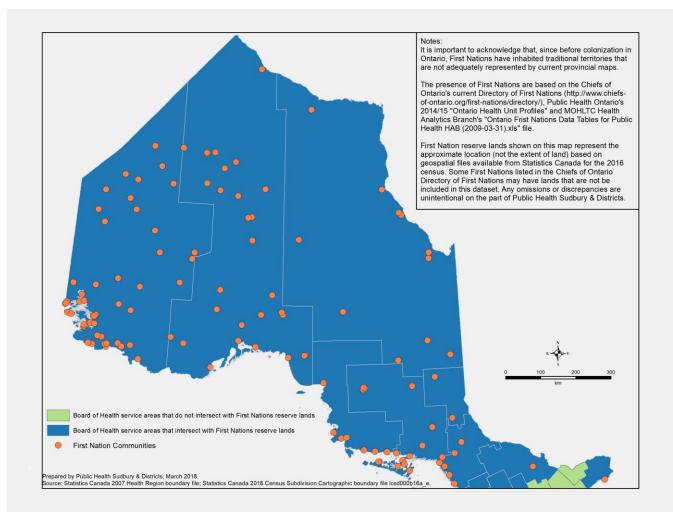
Board of Health service areas that do not intersect with First Nations reserve lands

Board of Health service areas that intersect with First Nations reserve lands

First Nation Communities

0   100   200   300
km

Prepared by Public Health Sudbury & Districts, March 2018.
Source: Statistics Canada 2007 Health Region boundary file; Statistics Canada 2016 Census Subdivision Cartographic boundary file lcsd000b16a_e.
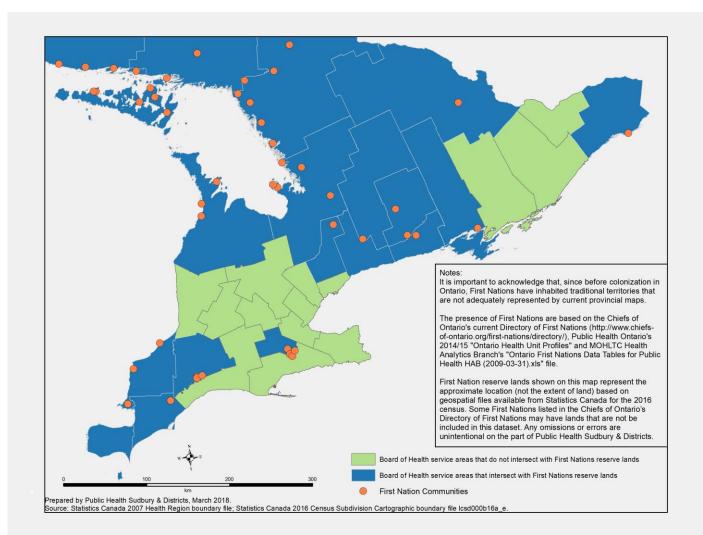
Table 1: *First Nations communities that intersect with Northeastern Ontario public health units*

First Nations communities	Public health unit
Missanabie Cree First Nation*	Algoma Public Health
Batchewana First Nation	
Michipicoten First Nation	
Garden River First Nation	
Mississauga First Nation	
Sagamok Anishnawbek First Nation**	
Serpent River First Nation	
Thessalon First Nation	
Dokis First Nation	North Bay & Parry Sound District Health Unit
Nippising First Nation	
Henvey Inlet First Nation	
Magnetawan First Nation	
Wasauksing First Nation (Parry Island)	
Shawanaga First Nation	
Temagami First Nation (on Bear Island) First Nation	Timiskaming District Health Unit
Timiskaming First Nation	

*Also intersects with Porcupine Health Unit
**Also intersects with Public Health Sudbury & Districts

First Nations communities	Public health unit
Attawapiskat First Nation	Porcupine Health Unit
Fort Albany First Nation	
Kashechewan First Nation	
Moose Cree First Nation	
Peawanuck (Weenusk) First Nation	
Wahgoshig First Nation	
Beaverhouse First Nation***	
Taykwa Tagamou Nation (New Post) First Nation	
Matachewan First Nation****	
Flying Post First Nation	
Constance Lake First Nation	
Chapleau Cree First Nation	Public Health Sudbury & Districts
Atikameksheng Anishnawbek First Nation	
Wikwemikong First Nation	
Sheshegwaning First Nation	
Whitefish River First Nation	
Zhiibaahaasing (Cockburn Island) First Nation	
Sheguiandah First Nation	
M'Chigeeng First Nation	
Wahnapitae First Nation	
Mattagami First Nation	
Brunswick House First Nation	
Chapleau Ojibway First Nation	
Aundek Omni Kaning (Sucker Creek) First Nation	

***Also intersects with Timiskaming District Health Unit
****Also intersects with Timiskaming District Health Units

Appendix D: Ontario public health unit survey

SECTION A: BACKGROUND QUESTIONS

1. Name of your health unit: (drop down menu with all of the Public health unit names)

2. How many First Nations communities are located within your health unit catchment? (open text)

3. In the past five years, has your public health unit engaged with First Nations communities in any way?
   - Yes
   - No (Skip to Q 25)

4. In the past five years, how many First Nations communities have you engaged with? (open text)

5. Overall, can you estimate how frequently your health unit engages with First Nations communities?
   - Very frequently (about once per week)
   - Frequently (about once per month)
   - Occasionally (about once every 3 months)
   - Rarely (about once every 6 months)
   - Very rarely (about once per year)

6. What prompted this engagement with First Nations communities? (e.g. alignment with Strategic Plan, board of health or senior management direction, requests from community, a wish to increase opportunities for health, etc.) (open text)

Ontario public health unit survey (continued)

7. In general, how were most of these engagement activities initiated? (select all that apply)
   - The health unit approached the First Nation community through Tribal Council or elected leadership
   - The health unit approached the First Nation community through the health center/health director
   - The health unit approached the First Nation community through other community members
   - Tribal Council or elected leadership from the First Nation community approached the health unit
   - The health center/health director from the First Nation community approached the health unit
   - Community members from the First Nation community approached the health unit
   - Another organization facilitated initial engagement between the health unit and the First Nation community
   - Provincial government facilitated initial engagement between the health unit and the First Nation community
   - First Nations and Inuit Health Branch (Health Canada) facilitated initial engagement between the health unit and the First Nation community
   - Other (please describe): _____

8. In general, how long has your health unit been engaging with First Nations communities?
   - less than 1 year
   - between 1-3 years
   - more than 3 years

9. What was the nature of the engagement activities between your health unit and First Nations communities? Please select all that apply:
   - Providing a health unit service through a purchase of services agreement – please describe type of service
   - Providing a health unit service without a purchase of services agreement – Please describe type of service (ex: immunization, vaccine ordering and inventory)
   - Conducting research or evaluation
   - Sharing information or resources
   - Getting to know each other/relationship building
   - Training supports
   - Data reports/population health assessment
   - Developing a Section 50 agreement
   - Developing another formal agreement (please describe)
   - Board-level communications
   - Joint public health service planning
   - Other: (open text)

Ontario public health unit survey (continued)

10. Please select all the Ontario Public Health Standards program areas which you have engaged with First Nations communities. Please select all that apply:
    - Chronic disease prevention
    - Prevention of injury and substance misuse
    - Reproductive health
    - Child health
    - Oral/dental health
    - Public health emergency preparedness
    - Food safety
    - Safe water
    - Health hazard prevention and management
    - Infectious diseases prevention and control
    - Rabies prevention and control
    - Sexual health, sexually transmitted infections, and blood-borne infections
    - Tuberculosis prevention and control
    - Vaccine preventable diseases
    - Foundational Standard
    - Healthy Babies, Healthy Children
    - Other: (open text)

If applicable, please name the specific program topic area related to your selections above (i.e. tobacco use prevention, physical activity promotion, cancer prevention…) (open text)

SECTION B: SPECIFIC HEALTH UNIT PRACTICES

11. In general, please describe how your health unit approaches engagement with First Nations communities? (open text)

12. Does your health unit have any of the following governance level practices in place – that can support engagement with First Nations communities?

    A) First Nations representation on your board of health
    - □ Yes (If yes, please describe below)
    - □ No

    B) First Nation community representation on a health unit advisory group or a health unit Indigenous advisory group
    - □ Yes (If yes, please describe below)
    - □ No

C) Formal written agreements (*memorandum of agreement, section 50 agreements*) for engagement with First Nations communities
- □ Yes (If yes, please describe below)
- □ No

D) Informal or unwritten agreements for engagement with First Nations communities
- □ Yes (If yes, please describe below)
- □ No

E) A board motion or other formal statement which outlines the organization's commitment to engage with First Nations communities
- □ Yes (If yes, please describe below)
- □ No

F) Other governance level practices – please describe

13. Does your health unit have any of the following <u>staffing level practices</u> in place – that can support engagement with First Nations communities

A) Indigenous Peoples employed in a variety of roles within your health unit
- □ Yes (If yes, please describe below)
- □ No

B) A lead staff member (or team) who works across teams and service users to support engagemenet with First Nations communities
- □ Yes (If yes, please describe below)
- □ No

C) Provide Indigenous cultural awareness/competency training
- □ Yes (If yes, please describe below)
- □ No

D) Other staffing level practices – please describe

Ontario public health unit survey (continued)

14. Does your health unit have any of the following <u>policy or guideline level practices</u> in place – that can support engagement with First Nations communities

A) Policies or guidelines for working with First Nation Elders from First Nations communities
- □ Yes (If yes, please describe below)
- □ No

B) Policies or guidelines for engaging with First Nations communities
- □ Yes (If yes, please describe below)
- □ No

C) Policies for traditional territorial acknowledgement at significant organizational events
- □ Yes (If yes, please describe below)
- □ No

D) Other policy or guideline level practices – please describe

15. Does your health unit have any of the following <u>programming level practice</u> in place – that can support engagement with First Nations communities?

A) Explicitly considers the needs of First Nations communities in overall health unit strategic planning.
- □ Yes (If yes, please describe below)
- □ No

B) Explicit consideration of First Nations communities in program planning, including in program planning tools, documents, etc.
- □ Yes (If yes, please describe below)
- □ No

C) Other program level practices – please describe

Ontario public health unit survey (continued)

16. Does your health unit have any of the following <u>environment level practices</u> in place – that can support engagement with First Nations communities?

   A) Signage or plaques acknowledging the traditional territory of the First Nation(s) community (ies) in which your health unit office(s) is located
   - □ Yes (If yes, please describe below)
   - □ No

   B) Display Indigenous artwork and/or posters within public areas of your agency
   - □ Yes (If yes, please describe below)
   - □ No

   C) Other environment level practices – please describe

17. Does your health unit have any of the following <u>communications level practice</u> in place – that can support engagement with First Nations communities?

   A) Include the use of Indigenous language in resources/publications
   - □ Yes (If yes, please describe below)
   - □ No

   B) Ensure Indigenous representation or symbols in marketing material
   - □ Yes (If yes, please describe below)
   - □ No

   C) Work with First Nations communities to develop culturally appropriate program resources or other promotional materials
   - □ Yes (If yes, please describe below)
   - □ No

   D) Provides internal updates to staff on First Nation community engagement activities across programs and divisions
   - □ Yes (If yes, please describe below)
   - □ No

Ontario public health unit survey (continued)

E) If applicable, please identify the key communication activities your health unit undertakes with First Nations communities to provide updates on public health activities. Check all that apply:

- newsletters
- radio interviews
- public service announcements
- front-line staff meetings
- invitations to events
- presentations to Chief and Council members
- presentations to First Nations organization board members
- e-mail updates
- direct letters to First Nations leaders
- briefing notes
- press releases
- website content
- community engagement sessions
- survey implementation
- advertising and promotion
- media involvement
- other (please describe)

F) Other communications level practices – please describe

18. Are there any program areas where it has been more challenging for your health unit to engage with First Nations communities? Please describe why you feel this way.

SECTION C: SUCCESSES AND CHALLENGES

The following questions seek to know more about engagement practices or activities that your health unit would describe as being <u>successful or have worked well</u>.

In this context, success is defined by your health unit's perspective and level of engagement. For example, if you are in the preliminary stages of engagement with First Nations communities, a successful engagement may involve initial meetings or introductions; an organization that has a more established relationship with a community may reference more fulsome activities.

19. Please describe examples of past or current engagement practices or activiites between your health unit and First Nations communities that you would consider to be successful or positive. Please identify why you feel they were successful.

20. Are there any program areas where it has been more conducive for your health unit to engage with First Nations communities? Please describe why you feel this way.

21. Please describe what your health unit has done or does to support and encourage successful engagement with First Nations communities.

22. Please list any positive outcomes that have resulted from engaging with First Nations communities. Please check all that apply
    - met a service need for the First Nation community
    - met a service need for the PUBLIC HEALTH UNIT
    - relationship agreement developed
    - board of health participation
    - signed letters of support by First Nations communities
    - data sharing agreement
    - mentoring supports
    - service agreement developed
    - First Nation education materials developed
    - First Nation committee participation
    - joint research involvement
    - joint program or service planning
    - other (please describe)

23. Please describe any unexpected positive outcomes as a result of engaging with First Nations communities. (open text)

24. Alternatively, please describe any challenges your health unit has faced or faces in engaging with First Nations communities? (open text)

GENERAL QUESTIONS

(Only for those who responded NO to Q3 only)

25. Can you describe the reasons for which your health unit is not engaging with First Nations communities? (select all that apply)

- Our health unit catchment area does not align with any First Nations community
- We have tried to engage with First Nations communities in the past but we have not been successful at doing so
- We have been directed not to engage with First Nations communities
- The jurisdictional issues have prevented us from engaging with First Nations communities
- We are limited by resource constraints (financial or human) in being able to effectively engage with First Nations communities aligned within our catchment area
- It has not been a strategic priority of our organization/we lack clear direction from our board or senior leadership with respect to First Nations engagement
- We do not have sufficient knowledge, protocols or principles to assist us in engagement of this nature
- We have not been invited by our First Nations or Indigenous communities to work with them
- Other (open text)

SECTION D: FUTURE PLANNING

25. Do you feel that your health unit has the appropriate skills and knowledge to effectively engage with First Nations communities?

a. Yes
Please describe what has been helpful to support this engagement: (open text)

b. No
Please describe what skills and knowledge you think are missing to effectively engage: (open text)

26. Please describe resources you think would be useful to further support your health unit's engagement with First Nations communities? Please select all that apply.
    - human resources
    - public health programming dollars to health units
    - public health programming dollars to First Nations communities
    - supplies and materials
    - travel dollars
    - programming space
    - training supports
    - cultural awareness and competency supports
    - other (please describe)

27. The Ontario Standards for Public Health Programs and Services Consultation Document outlines requirements for engaging with Indigenous organizations and communities.
    a. In what ways has your health unit prepared itself to effectively engage with First Nations communities?
    b. How is your health unit planning to further engage with First Nations communities in order to meet the requirements in the new standards?
    c. Will your health unit follow any specific protocols in order to guide engagement with First Nations communities?

28. Do you have any other comments to add about your experiences as a public health unit engaging with First Nations communities? (open text)

SECTION E: FOLLOW-UP (ALL RESPONDENTS)

29. Do you consent to your health unit being contacted for follow-up should there be a need for further clarification or exploration of ideas entered in this survey?
    - Yes

Name of Contact:_____
Position:_____
Phone:_____
E-mail:_____
    - No

30. Would you like an electronic copy of your health unit's responses?
    - Yes (A copy of your health unit responses will be emailed to your Medical Officer of Health.)
    - No

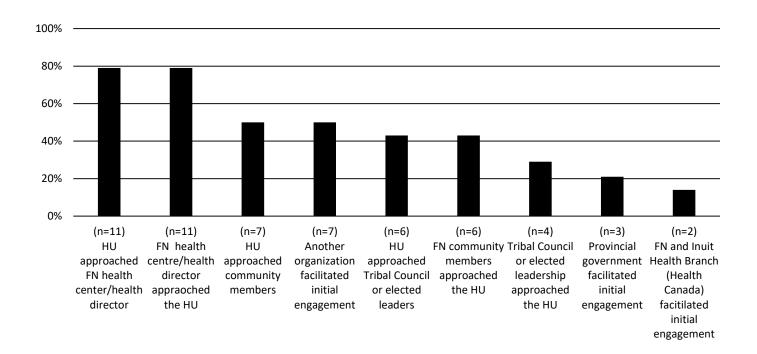# Appendix E: How were most of these engagement activities initiated?

Figure 3: *How were most of these engagement activities initiated? (Select iall that apply; N=14)*

Appendix F: Nature of engagement activities between health units and First Nation communities

Table 2: *Nature of engagement activities between health units and First Nations communities*

	%	n/N
Sharing information or resources	100	14/14
Providing a health unit service without a purchase of services agreement	86	12/14
Getting to know each other/relationship building	86	12/14
Training supports	57	8/14
Developing another formal agreement	29	4/14
Conducting research or evaluation	29	4/14
Data reports/population health assessment	29	4/14
Providing a health unit service through a purchase of services agreement	21	3/14
Board-level communications	14	2/14
Joint public health service planning	14	2/14
Developing a Section 50* agreement	7	1/14

Note: All items were measured on a check-all-that-apply format. Percentages in table represent respondents who checked off that item.

* Section 50 of Ontario's Health Protection and Promotion Act R.S.O. 1990 (HPPA) provides for agreements to be made between the council of an on-reserve band and health unit, such that the health unit provides health programs within the scope of the OPHS (MOHLTC, 2016) and the council of the band would accept the responsibilities of a municipal council within the health unit.

Appendix G: Ontario Public Health Standard program areas which you have engaged with First Nations communities

Table 3: *Please select all the Ontario Public Health Standard program areas which you have engaged with First Nations communities.*

Response Option	%	n/N
Vaccine preventable diseases	93	13/14
Infectious diseases prevention and control	86	12/14
Prevention of injury and substance misuse	79	11/14
Child health	79	11/14
Healthy Babies Healthy Children	71	10/14
Chronic diseases prevention	71	10/14
Oral/dental health	71	10/14
Reproductive health	57	8/14
Rabies prevention and control	57	8/14
Safe water	57	8/14
Sexual health, sexually transmitted infections and blood-borne infections	57	8/14
Public health emergency preparedness	43	6/14
Health hazard prevention and management	36	5/14
Food safety	36	5/14
Tuberculosis prevention and control	36	5/14
Foundational standard	21	3/14

Note: All items were measured on a check-all-that-apply format. Percentages in table represent respondents who checked off that item.

Appendix H: Positive outcomes that have resulted from engaging with First Nations communities

Table 4: *Please list any positive outcomes that have resulted from engaging with First Nations communities. (Check all that apply)*

Response Option	%	n/N
Met a service need for the First Nations community	93	13/14
First Nations committee participation	64	9/14
Met a service need for the health unit	50	7/14
First Nations education materials developed	43	6/14
Service agreement developed	36	5/14
Joint program or service planning	36	5/14
Mentoring supports	36	5/14
Relationship agreement developed	29	4/14
Joint research involvement	21	3/14
Board of health participation	14	2/14
Data sharing agreement	7	1/14
Signed letters of support by First Nations communities	7	1/14

Note: All items were measured on a check-all-that-apply format. Percentages in table represent respondents who checked off that item.

Appendix I: Does your health unit have any of the following practices in place

Table 6: *Does your health unit have any of the following practices in place – that can support engagement with First Nations communities?*

Response Option	% (Yes)	n/N
Governance level practices		
First Nations community representation on health unit board of health	14	2/14
First Nations community representation on a health unit advisory group or a health unit Indigenous advisory group	14	2/14
Formal or written agreements for engagement with First Nations communities	50	7/14
Informal or unwritten agreements for engagement with First Nations communities	50	7/14
A board motion or other formal statement which outlines the health unit's commitment to engage with First Nations communities	23	3/14
Staffing level practices		
Indigenous Peoples employed in a variety of roles within the health unit	50	7/14
A lead staff member (or team) who works across teams and service users to support engagement with First Nations communities	50	7/14
Provides Indigenous cultural awareness/competency training	79	11/14

Table 5 (continued)

Does your health unit have any of the following practices in place – that can support engagement with First Nations communities?

	% (Yes)	n/N
Policy or guideline level practices		
Policies or guidelines for working with Elders from First Nations communities	7	1/14
Policies or guidelines for engaging with First Nations communities	14	2/14
Policies for traditional territorial acknowledgement at significant organizational events	21	3/14
Planning level practices		
Explicitly considers the needs of First Nations communities in overall public health unit strategic planning	50	7/14
Explicit consideration of First Nations communities in program planning	43	6/14
Environment level practices		
Signage or plaques acknowledging the traditional territory of the First Nations community(ies) in which health unit office(s) is located	0	0/14
Display Indigenous artwork and/or posters within public areas of HU	38	5/13
Communications level practices		
Use of Indigenous language in resources/publications	56	5/9
Ensure Indigenous representation or symbols in marketing material	29	4/14
Work with First Nations communities to develop culturally appropriate program resources or other promotional materials	50	7/14
Provide internal updates to staff on First Nations community engagement activities across programs and divisions	38	5/13