

MNO BMAADZIIDAA

The Good Life

A collaborative project between Algoma Public Health
and North Shore Tribal Council First Nations



Algoma
PUBLIC HEALTH
Santé publique Algoma



March 31, 2015

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Acknowledgements:

The leadership of Dr. Kim Barker is acknowledged. Her guidance and knowledge was instrumental in the initiation of this project.

The time, accommodation and knowledge of Linda Ogilvie, Public Health Advisor with **Chiefs of Ontario** and Brent Maloughney, MD, MSc, FRCPC provided meaningful direction to the contributors.

Thank you to the North Shore Tribal Council Chiefs, Health Directors and representatives, for their support and participation.

- Serpent River First Nation
- Sagamok Anishnawbek
- Thessalon First Nation
- Atikameksheng Anishnawbek
- Mississauga First Nation
- Garden River First Nation
- Batchewana First Nation

Funding for this project was provided by Ministry of Health and Long-term Care (MOHLTC).

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Overview/History

This collaborative project was initiated by Algoma Public Health (APH) and North Shore Tribal Council (NSTC) to share, communicate and explore the development of a relationship framework agreement that will bring more effective public health services to both organizations.

The need to address gaps in public health for First Nation communities has been well documented that;

- First Nation communities experience substantial disparities in health outcomes compared to the rest of Canadians;
- There is a lack of clarity regarding roles and responsibilities relating to public health service delivery, a lack of data and significant infrastructure gaps.

APH commissioned NSTC, who represents seven First Nations located along the North shore of Lake Huron to support the project. Two First Nations health directors were seconded for a period of 3 months.

The project was funded by the Ministry of Health and Long-term Care (MOHLTC) in November 2014. As part of the secondment agreement the following deliverables were drafted to guide the planning process of the initiative:

- (a) Summary of the activities and outcomes as they relate to the development of culturally competent and safe staff including recommendations for ongoing maintenance of staff competencies in this area.
- (b) Summary of the activities and outcomes as they relate to the face-to-face meetings held between APH, First Nations communities, and other key partners and stakeholders.
- (c) Summary of existing relationship agreements and frameworks that exist between other jurisdictions such as those in the Sioux Lookout, Akwesasne and Curve Lake.
- (d) Recommendations regarding the pros and cons of Section 50 under the Health Protection and Promotion Act for the purposes of public health service delivery.
- (e) Draft Terms of Reference as well as a proposed framework for the development of a formal, tripartite arrangement between NSTC, First Nations and Inuit Health Branch of Health Canada and APH.
- (f) Proposed recommendations for sustainable delivery of services, including the role of FNIHB, MOHLTC and municipalities.

The following key activities supported the project:

- In 2006, at the 32nd annual All Ontario Chiefs Conference, Resolution 06-47 was passed by the Chiefs in Assembly. The resolution supported the development of a Public Health Relationship Framework which would provide opportunities for improved services and information, address service delivery gaps and coordination while recognizing and respecting First Nation culture and traditions. (appendix A)
- In 2011, Chiefs in Assembly passed Resolution 11-26 (appendix B) which supported further work to develop a Public Health System Framework. As a result, the First Nations Public Health Advisory Committee (FNPHAC) was formed with members from First Nations, Ministry of Health and Long-Term Care and Health Canada. FNPHAC advocated for a senior-level decision making table and Resolution 11-38 supported the establishment of a Trilateral First Nations Health Senior Officials Committee (TFNHSOC).
- In November 2013 APH assigned Public Health Nursing time, one day a week, to a First Nation Liaison function. The Public Health Nurse was to achieve two goals;
 - to better understand the needs of First Nations communities with respect to the types of services APH currently provides to the First Nations communities , and
 - participate on key provincial and federal committees, to gain a deeper understanding of service models and governing jurisdictions.
- In 2014, the Union of Ontario Indians coordinated a First Nations Communities and Public Health Units Relationship Event for the First Nations communities and public health units along the Highway 17 corridor between North Bay and Sault Ste. Marie, including Manitoulin Island. The event was supported by TFNHSOC and funded by the Ministry of Health and Long-Term Care and provided the opportunity for strengthening local relationships.
- In 2014, APH submitted a proposal for one-time funding to the Ministry of Health and Long-Term Care for funding to *“better serve First Nation communities within the Algoma Public Health District. Through this initiative, APH will gain cultural competencies that support current APH program and service offering while undertaking relationship building with our First Nation communities”*.

A Name for the Project built on Similar Principles/Vision/Teachings

Naming the Project was an important first step in order to give it life or a meaning. The project team combined the mission, vision, values of APH and the Anishinabe Worldview to come up with a project name. The project was named Mno Bmaadziidaa, The Good Life and the “good life” would be reached by both entities by “Walking together for health”.

It is with great appreciation and honour that the vision, values and teachings of APH and First Nations are shared in this report, so that we continue to help our people walk together for Health.

Algoma Public Health

Mission: Together with our communities, Algoma Public Health is a leader in promoting and protecting health and well-being.

Vision: Together, we create and sustain healthy communities.

Values: Excellence, Respect, Accountability & Transparency and Collaboration

Anishinabe Worldview

We are guided by the Seven Grandfather Teachings:

Respect: To honor all creation. Give respect if you want to be respected.

Humility: To be calm, compassionate. You are equal to others, but you are not better

Bravery: To have a strong heart. Do what is right, even when the consequences are unpleasant

Honesty: To be righteous. Always be honest in word and action with yourself and others

Love: To know peace. Love must be unconditional

Wisdom: To cherish knowledge. Wisdom is given by Creator to be used for the good of people

Truth: Speak the truth. Do not deceive yourself or others.

Public Health vs First Nation Community Health Programs and Services

The project team identified the need to have similar language and a clear understanding of how Public Health and First Nation Community Health operates and what programs/services they deliver. A review of each entity, program and service delivery model was completed and a list of programs and services was provided. The information collected would be useful when APH and First Nations are ready to move forward as each will gain a better understanding of public and community health.

Public Health

“Public health is the science and art of preventing disease, prolonging life and promoting health through organized efforts in society.” John Last, Dictionary of Epidemiology. Public Health focuses on entire communities and has three main approaches which are health promotion, health protection and prevention of disease. These services are delivered by education, skill building, coalition building/community action and policy development.

APH is governed by an autonomous Board of Health and receives provincial and municipal (75-25%) funding to deliver programs and services.

“The Organizational Standards communicate the government’s expectations for governance and administrative practices that are based on generally accepted principles of good governance and management excellence.” – *Ministry of Health and Long-Term Care, Ontario Public Health Standards 2008*

The [Ontario Public Health Standards \(OPHS\)](#) are published as the guidelines for the provision of mandatory health programs and services by the Minister of Health and Long-Term Care, pursuant to Section 7 of the [Health Protection and Promotion Act](#), R.S.O. 1990, c. H.7. The Standards outline the expectations of the Boards of health in the delivery of programs and services. The Foundational Standard ensures that public health programs and services are delivered and informed by population health assessment surveillance and evaluation.

Program/Services:

- Environmental Health Program
- Vaccine Preventable Disease Program
- Parent Child Services Program
- Communicable Disease/Infection Prevention and Control Program
- Sexual Health Program
- Needle Exchange Program
- Chronic Disease Prevention Program
- Prevention of Injury and Substance Misuse

The following programs are offered by APH but are not included in the Ontario Public Health Standards. These programs are not offered by most of Ontario's 36 health units:

- Genetic Counselling Program (Ministry of Health and Long Term Care.
- Canada Prenatal Nutrition Program (Health Canada)
- Infant and Child Development Program (Ministry of Children and Youth Services)
- Preschool Speech and Language Services (Ministry of Children and Youth Services)
- Community Alcohol/Drug Assessment Program (MOHLTC – North East Local Health Integration Network)
- Community Mental Health Support Services Program (MOHLTC – North East Local Health Integration Network)

First Nation Health Care Model

Health Canada works with First Nations to improve health outcomes, provide access to quality health services and support local control of the health system in First Nation communities. The [First Nations and Inuit Health Branch Program Compendium](#) was created to provide effective, sustainable, and culturally appropriate health programs and services that contribute to the reduction of gaps in health status between First Nations and Inuit and other Canadians.

First Nation Health is governed by individual community Chief and Councils and some First Nations have volunteer Health committees who assist with community planning.

First Nations receive federal funding from the Health Canada First Nations & Inuit Health Branch to deliver community based health promotion, disease prevention, primary healthcare (immunization), home and community care services, programs to control communicable diseases and address environmental health issues and non-insured health benefits to supplement those health benefits provided by provinces, and private insurers.

Programs/Services:

Primary Health Care

1. Health Promotion and Disease Prevention
 - a. Healthy Child Development
 - i. Healthy Pregnancy and Early Infancy
 - ii. Early Childhood Development
 - iii. Oral Health
 - b. Mental Wellness
 - i. Mental Health and Suicide Prevention
 - ii. Addictions Prevention and Treatment
 - iii. Indian Residential Schools Resolution Health Support
 - c. Healthy Living
 - i. Chronic Disease Prevention and Management
 - ii. Injury Prevention

2. Public Health Promotion
 - a. Communicable Disease Control and Management
 - i. Vaccine Preventable Diseases
 - ii. Blood Borne Diseases and Sexually Transmitted Infections
 - iii. Respiratory Infections
 - iv. Communicable Disease Emergencies
 - b. Environmental Health
 - i. Environmental Public Health
 - ii. Environmental Health Research
3. Primary Care
 - a. Clinical and Client Care
 - b. Home and Community Care

Supplementary Health Benefits

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

Appendix C – Excerpt from a Summary of the History and Work of the First Nations Public Health Advisory Committee

Environmental Scan

The project team acknowledged that, input from First Nation Health Directors was needed to determine the current state of relationships, and in addition to explore further interest in pursuing a formal working relationship with public health.

On January 22, 2015, the Mno Biimaaziidaa project Team formally presented at the NSTC Chiefs meeting to obtain support for the Project. A motion was passed by the NSTC Chiefs to have their respective communities participate in the project. (Appendix D)

As part of the partnership between NSTC and APH, the following communities would be included in the Environmental Scan:

- Sagamok Anishnawbek
 - *NOTE: Sagamok was included in the Environmental Scan as it is identified in the Jurisdiction of APH. This community presently accesses services with Sudbury District Public Health Unit.*
- Serpent River First Nation
- Mississauga First Nation
- Thessalon First Nation
- Garden River First Nation

Although the Indian Friendship Centre works with NSTC in various programs, their members should be included as citizens of the City of Sault Ste. Marie and also be consulted in the context of understanding the needs of First Nations people.

Batchewana First Nation is included as a NSTC community but was not part of the environmental scan. APH was able to have discussions with Batchewana via their Liaison worker and was provided with some insight as to the relationship with their First Nation.

Michipocoton First Nation is a First Nation in the jurisdiction of APH and a community visit was not completed due to time constraints of the project.

An Environmental Scan was conducted within the First Nation communities, which was to identify current and further options in building capacity and a trusting relationship with APH.

Assessment tools were reviewed and researched to be utilized in this Environmental Scan. The assessment included the following process:

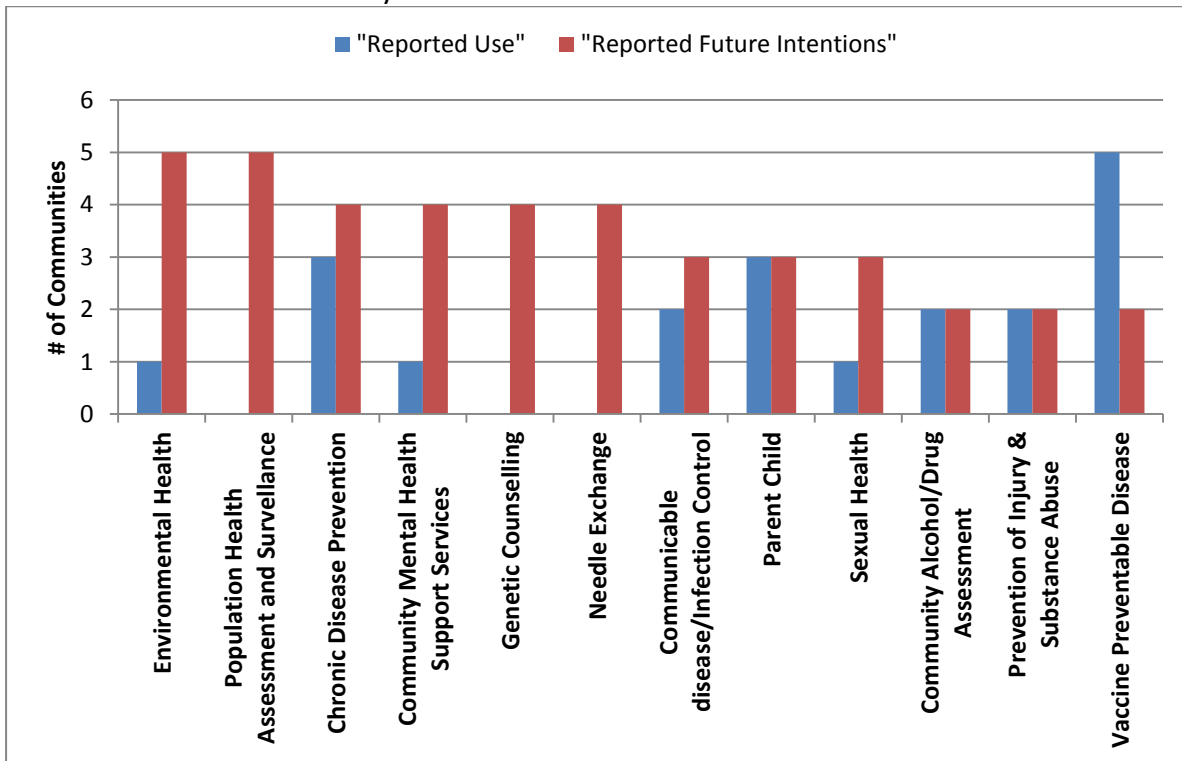
- Community visits were scheduled with Health staff of 5 First Nation communities
- Introduction of the project was presented to the community
- Programs and Services from APH was presented
- Communities were asked the following
 - Are you aware of the Services/Programs of APH
 - Does your community access any of these services
 - Would your community consider building capacity with APHU
 - Would your community consider accessing services from APHU

Key informant Interviews were conducted in each of the First Nation communities of Garden River, Thessalon, Mississauga, Serpent River and Sagamok First Nation. A comprehensive description of the public health programs was not provided to the participants.

Community Assessment Results

The results of the Community Assessments were compiled by APH and using the answers documented in the visit notes from each community questioned, themes were created for each domain of public health services offered by APH. The results of the community assessment were based on the health directors of the First Nation Communities current and past experience/knowledge of public health programs. The community answers were used to classify current involvement with APH and/or other Public Health Units, and to classify future intentions to partner with APH. Once the current state of community involvement was classified, the state was identified as either “reported use” or “no reported use.” Similarly, future intentions were classified as either “no reported future intentions” or “reported future intentions.” The overall results of the number of communities with “no reported use” of services offered by APH and/or other Public Health Units as well as the number of communities with “reported future intentions” by each public health service domain are outlined in Table 1 and Chart 1.

Chart 1 – Overall Community Assessment Results



Summary of Findings

For the five First Nation communities investigated, the most commonly reported domains of public health services used or accessed were: Vaccine Preventable Disease by all five communities, Parent Child by three communities and Chronic Disease Prevention by three communities. Of the other nine public health domains of service, seven were used or accessed

in one or two communities and three, Population Health Assessment and Surveillance, Genetic Counselling and Needle Exchange, had no reported use in any of the five communities investigated. All public health usage is reported for APH except one community that listed Sudbury and District Health Unit as their provider.

While there are inconsistencies in the access of public health services by First Nation communities in the Algoma District, there is a strong reported desire from the communities for greater involvement with public health. At least two communities reported future intentions to utilize public health services for every domain presented, while two domains, Environmental Health and Population Health Assessment and Surveillance, were unanimously reported as a target for future use and involvement.

Demographics:

Below (Table 1) are the populations of the five sites using Aboriginal Affairs & Northern Development Canada 2014 data and 2014 Census Data.

Table 1 – Population using Aboriginal Affairs and Northern Development Canada

Community	On Reserve	Off Reserve	Total
Serpent River First Nation	371	863	1,234
Mississauga First Nation	390	875	1,265
Thessalon First Nation	105	634	739
Garden River First Nation	1,262	1,514	2,776
Batchewana First Nation	788	1,979	2,767
Sault Ste. Marie Indian Friendship Centre (IFC)			7,000

Total Population served is approximately 15,781 (On Reserve #'s and IFC #'s)

Cross Cultural Training

Cultural Competency training was provided by Maya Chacaby through the Ontario Indigenous Friendship Centre and in collaboration with the Indian Friendship Centre in Sault Ste. Marie. The four hour training was offered March 4, 5, and 6, 2015. 189 of 200 APH staff attended one of the three days to receive this information.

Participants were introduced to key historic markers and the impact to the health outcomes of Indigenous people. Concepts were introduced to facilitate the improvement of relationships through cultural competency. Programs were asked to take a moment at their next team meeting to discuss the first recommendation Maya shared about providing “space” for the Anishinaabek culture. Programs were to ask themselves “Is there someone you know who is from one of our First Nation communities or Urban setting who could provide you with some direction about making this “space?”” Programs were then to reach out to their contacts and ask if they have any information they would be willing to share to assist APH creating this “space.”

Evaluation of the Cultural Competency training was performed by the presenter (Maya Chacaby) and by APH. The workshop was reported as “Very Good” by at least 95% of respondents for the evaluation conducted by the presenter (n = 145) for: meeting workshop objectives, the presentations throughout the workshop, the content overall, the schedule and timing and lastly the preparedness of the group for the workshop (Chart 2). On the evaluation carried out by APH (n = 87) 91% of respondents reported agreeing or strongly agreeing that the training was relevant to their practice (Chart 3).

Chart 2 – Presenter evaluation of 145 responses for Cultural Competency training at APH, rating aspects of the workshop as “Very Good”

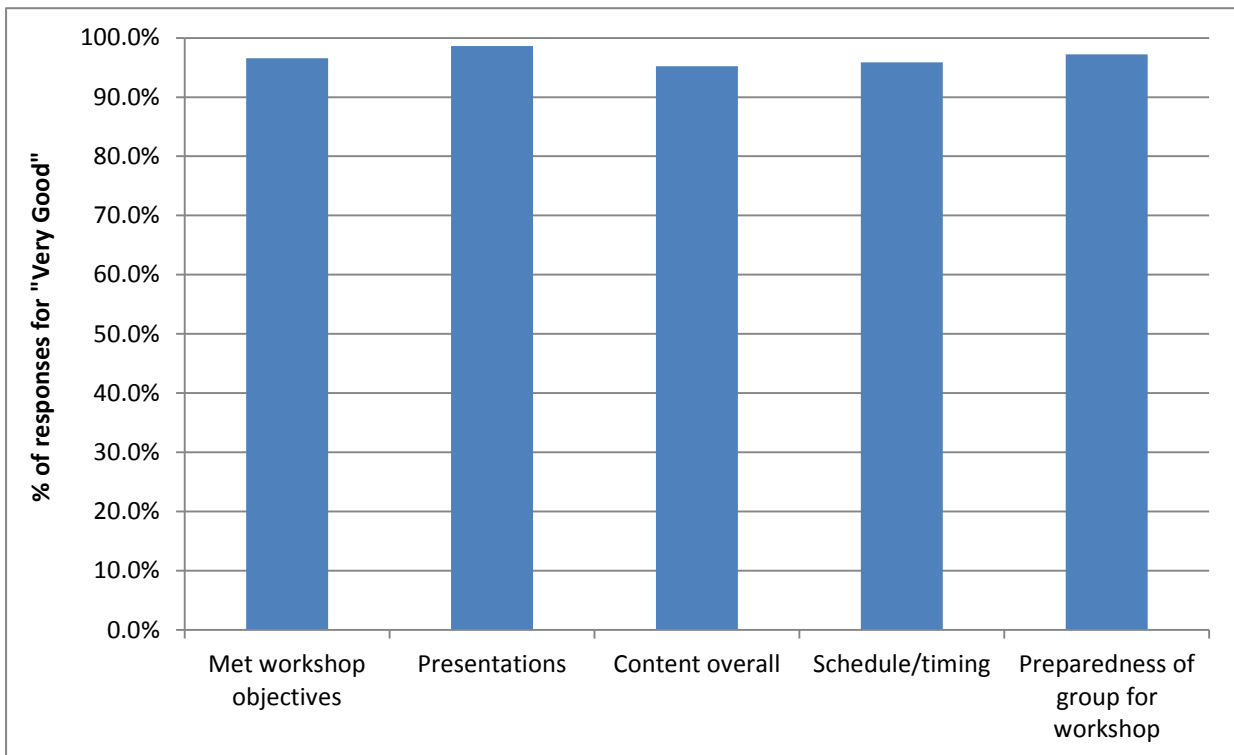
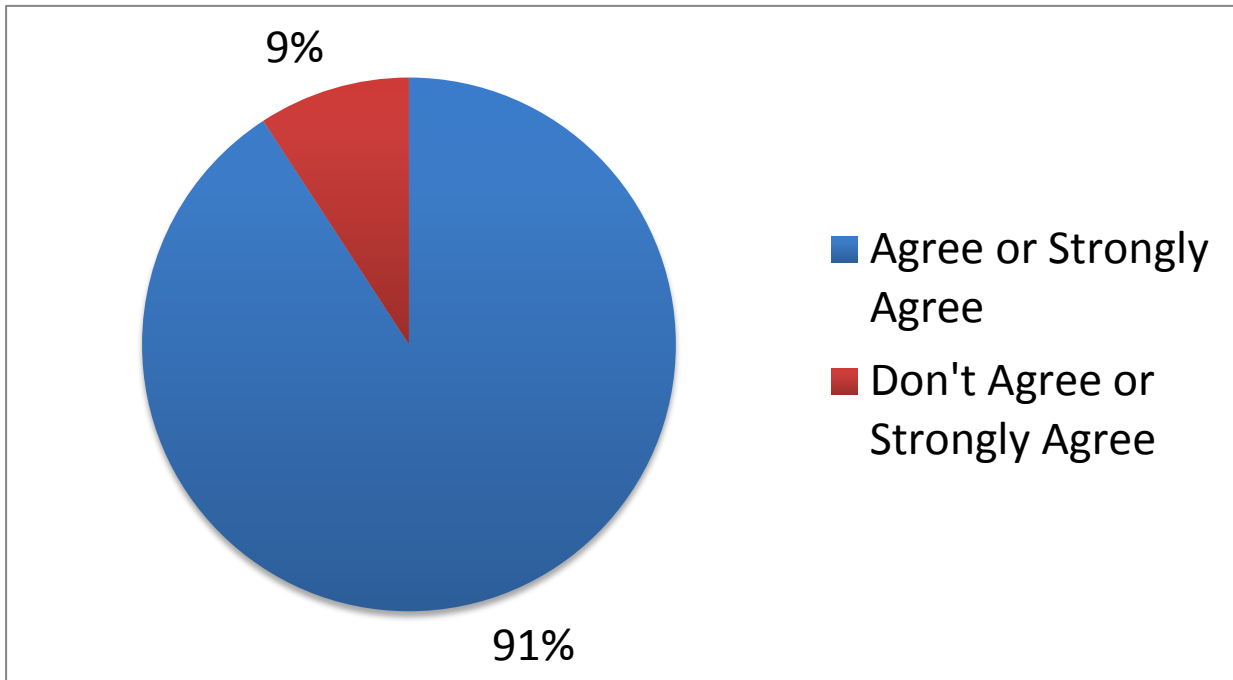


Chart 3 – Distribution of 87 responses from APH evaluation of their cultural competency training about relevancy to practice



Further perceptions about the strengths and weaknesses of the Cultural Competency training were also collected and themed. The most resounding theme, identified by both the presenter’s evaluation (Table 3) and APH’s evaluation (data not shown), was the desire for more sessions of this nature.

Table 3 – Themed responses from evaluation conducted by the presenter of the Cultural Competency workshop

Question asked	Top response themes
What I liked most about the Cultural Competency workshop was:	Presenter’s passion Interactive group activity History Personal stories/reflections Cultural competency discussion
What I liked least about the Cultural Competency workshop was:	Lack of time Not long enough Need more
As a follow up to the Cultural Competency workshop I would like to suggest:	Longer time More access to Elders/leaders Create more of these workshops

Legislation and Legal Framework

The purpose of the Health Protection and Promotion Act is to provide for the organization and delivery of public health programs and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario. A board of health may consider entering into an agreement with the council of a band. Should a board of health agree to undertake this consideration, section 50 of the HPPA outlines the process.

50. (1) A board of health for a health unit and the council of the band on a reserve within the health unit may enter into an agreement in writing under which,

(a) the board agrees to provide health programs and services to the members of the band; and

(b) the council of the band agrees to accept the responsibilities of the council of a municipality within the health unit. R.S.O. 1990, c. H.7, s. 50 (1).

(2) The council of the band that has entered into the agreement has the right to appoint a member of the band to be one of the members of the board of health for the health unit. R.S.O. 1990, c. H.7, s. 50 (2).

(3) The councils of the bands of two or more bands that have entered into agreements under subsection (1) have the right to jointly appoint a person to be one of the members of the board of health for the health unit instead of each appointing a member under subsection (2). R.S.O. 1990, c. H.7, s. 50 (3).

(4) An appointment under this section may be for one, two or three years. R.S.O. 1990, c. H.7, s. 50 (4).

(5) In this section, “band”, “council of the band” and “reserve” have the same meanings as in the Indian Act (Canada). R.S.O. 1990, c. H.7, s. 50 (5).

Further, a legal opinion was received. Krista Yao, Nadjiwon Law Office, provided this legal opinion regarding the advisability of a section 50 Health Promotion and Protection Act (HPPA) Agreement for the purposes of public health service delivery to First Nation communities. As well, a sample memorandum of agreement was also provided (appendix E). Highlights of the work completed indicate that although each First Nation will have to sign an individual relationship agreement, only one FN community can hold a voting seat on the APH Board of Directors. Non-voting seats may also be a consideration. Other considerations include calculation of payment, program and services provision protocols, FNIHB role, FNIHB Medical Health Officer role, Ontario Medical Officers of Health/Board of Health MOH’s role, First Nations schools (if applicable) and First Nations Information Management.

Under a Section 50 agreement a Health Unit would ensure the application and benefit of all components of the OPHS and HPPA are available to all people within its catchment area regardless of place of residence.

Funding Models/Agreements/MOU

Curve Lake First Nation provided the Project Team with a copy of the Agreement that they use to access services from their local Public Health Unit, Peterborough Public Health.

The agreement was reviewed by Krista Yao, lawyer from Nadjiwon Law Office, and suggestions were made to improve the Agreement to meet the needs of First Nations. Highlights of her suggestions include adding an OCAP (Ownership, Control, Access, Possession) provision to cover the use and disclosure of FN specific data, and adding Schedules to specify programs and services and costs.

Algoma Public Health did not undertake legal review within the timeframe of this project. It is suggested that the MOHLTC may consider taking on this review for consideration by all 36 Ontario Health Units.

Communication Plan/Engagement

The Project Team identified the need to ensure that stakeholders were consulted, informed, involved and reported back to in relation to the Project Objectives. Partnership Development and Stakeholder engagement is key to ensuring the success of the Project.

A process for communicating project activities, expectations, deliverables and outcomes for the duration of this project was established which included development of briefing notes, power point presentation, weekly program updates, presentations to NSTC Chiefs, NSTC Health Directors, and APH Senior Managers.

The Public Health Project Team presented to the Trilateral First Nations Health Senior Officials Committee, Public Health Working Group February 23, 2015.

Recommendations

First Nation communities responded positively to building a relationship with Public Health, the next steps are necessary to continue with the momentum of integrating public health, as per the Ontario Public Health Standards (OPHS), within in First Nation communities.

Provincial/Federal Recommendations

1. Request Health Canada meet with First Nations to begin discussions related to the impacts specific to funding and service, before First Nations enter into Section 50 Agreements with Boards of Health/Public Health Units.
2. Identify the authority of the Medical Officer of Health in the First Nation Communities.

Local Recommendations

1. Obtain APH Board approval to continue its dialogue and relationship building with First Nations.
2. Continue to have conversations with all First Nations communities in the Algoma district to further the preliminary work of this project.
3. Create an environment where each entity, First Nations and APH, can continue to discuss and explore opportunities to partner in absence of formal agreements until such time as more formal agreements are considered.
4. Engage First Nations outside of the NSTC communities who are in the catchment area of APH to determine their interest in integrating public health in their communities.
5. Further explore the current working relationships such as; the purchase of service agreement between APH and Garden River First Nation.
6. Review outcomes of the community assessment with First Nations in relation to the full scope of the OPHS and the interest in exploring programs and services that was expressed by each First Nation.

Limitations

Limitations	Explanation	Outcome
Project timelines	The length of time to complete the project was limited (3 months).	Some deliverables were not met. A more comprehensive approach is needed to achieve the unmet deliverables and recommendations.
Assessment tool	The inability to access existing assessment tools	An assessment tool was adapted for use during the project
Jurisdictions	This project did not include all of the First Nation communities within the APH's jurisdiction.	Although two communities and the Indian Friendship Centre were not included in the project, APH has had these conversations through the Liaison staff member. The conversations involved similar conclusions as the data collected and presented as a result of the project.
Leadership Changes at APH	During the project there was a change in leadership.	Support to continue the work of establishing a relationship framework between APH and First Nations and Urban Indigenous people will depend on the support of the Medical Officer of Health of Algoma and the Board of Health.
Assessment design	There was not a comprehensive list or description of the public health programs, Board of Health outcomes, societal outcomes or foundational standards provided in the assessment. A key question was not asked: "if the participants of the assessment intend to engage with "all" or the "full scope" of public health programs and services(OPHS and HPPA).	The First Nation community health directors who participated in the assessment have varying backgrounds and experience that was not taken into account prior to conducting the assessment. The project is identifying "what" is needed and the recommendations will include the "how." This will include promoting a deeper understanding of public health and First Nation communities. Next steps should include if there is interest from First Nation Communities accessing "all" public health services as per the HPPA and the OPHS.

This entire project between APH and the NSTC was premised on the basis of advancing the process of collaboration and relationship building between the two entities. Relationships are all about creating healing, hopeful, honest, culturally sensitive and trusting relationships as we work together

We acknowledged the need to not only establishing trust but trustworthiness amongst both parties. This project, however brief in nature, provided us with an understanding that making First Nations and APH responsible to define clear tasks and discuss processes was paramount to advancing our mutual goals and desires for helping the target populations that we want to serve. To that end, we believe this project accomplished that we look forward to sharing our collaborative approaches in moving ahead.

Appendix A – Chiefs of Ontario, Resolution 06-47

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CHIEFS OF ONTARIO

32nd Annual All Ontario Chiefs Conference
June 27-29, 2006
Kitchenuhmaykoosib Inninuwug

FIRST NATIONS and PUBLIC HEALTH (reference Section 5 – Public Health)

RESOLUTION 06/47
Page 1 of 2

WHEREAS public health planning and pandemic preparedness continue to be a priority for First Nation communities in Ontario;

MOVED BY:

Grand Chief Denise Stonefish,
Proxy, Hiawatha First Nation

WHEREAS the Assembly of First Nations has begun development of a National Public Health Framework to assist in "defining a *First Nation public health system*", including jurisdictional clarity; health information and surveillance; appropriate resourcing; enabling legislation; and comprehensive community programming;

SECONDED BY:

Grand Chief Stan Beardy,
Proxy, Kashechewan

WHEREAS First Nations in Ontario have participated in and completed a regional environmental scan on Public Health issues, supporting the need for a First Nation Public Health Framework, but also calling for a "made-in-Ontario" approach;

CARRIED

Opposed: 1
Bob Bruyere, Proxy,
Wawakapewin First Nation

WHEREAS Health Canada has announced the discontinuation of First Nation and Inuit Health Information System funding post March 2007;

Certified Copy of a Resolution adopted
on June 28, 2006.

WHEREAS the Province of Ontario has begun development of an Immunization Information System, proposed to include First Nation members;

Angus Toulouse,
Ontario Regional Chief

THEREFORE BE IT RESOLVED that we, the Chiefs in Assembly, direct the establishment of a Public Health Advisory Committee, as well as a Knowledge Management Advisory Group (both to be overseen by the Health Coordination Unit and OCCOH), with a specific mandate to follow up on the issues raised within the preliminary findings of the First Nation Public Health Environmental Scan, and provide regular progress reports and updates to the Chiefs in Assembly:

1. Specifically, the *Public Health Advisory Committee* will deal with issues involving governance and jurisdiction, resourcing, and the completion of a Public Health Framework for First Nations in Ontario;
2. The *Knowledge Management Advisory Group* will provide technical and policy direction related to health information and surveillance, future First Nation information management systems, and the utilization of telehealth technologies in Ontario;

FURTHER BE IT RESOLVED that we mandate the Chiefs of Ontario (COO) Office to pursue funding to assist in carrying out public health planning work, including the recruitment of a Public Health Specialist to act as an Advisor to COO and all First Nations in Ontario;

FINALLY BE IT RESOLVED that, while tripartite processes may be required where the Province of Ontario is to participate, any involvement of First Nations is conditional on the recognition and non-derogation of the special fiduciary relationship between First Nations and Canada, and any resulting health information or management systems shall remain under the control of First Nations and their membership.

Appendix B – Chiefs of Ontario, Resolution 11-26

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CHIEFS OF ONTARIO

37TH ALL ONTARIO CHIEFS CONFERENCE
June 14-15-16, 2011
Toronto, Ontario

RESOLUTION 11/26

SUBJECT: FIRST NATIONS AND PUBLIC HEALTH

MOVER: Chief R. Donald Maracle, Mohawks of the Bay of Quinte

SECONDER: Chief Keith Knott, Curve Lake First Nation

DECISION: CARRIED
1 Opposed: Ava Hill, Proxy, Six Nations of the Grand River Territory

WHEREAS:

1. Through an intensive survey and engagement process, including 100 First Nation community responses, the need for improved Public Health Service Delivery was confirmed as a continuing priority for First Nations in Ontario.
2. The First Nations Public Health Advisory Committee, through All Ontario Chiefs Conference Resolution 06-47, has been working diligently to establish a Public Health Framework for participating First Nations in Ontario, and a significant early investment has been made.
3. Stage one of the Framework Development Plan has been completed, but significant work remains to be finalized.
4. Health Canada has announced the creation of the new Health Services Integration Fund, replacing the Aboriginal Health Transition Fund.
5. The Ontario Ministry of Health and Long Term Care and Health Canada have committed to the establishment of a Trilateral First Nations Health Senior Officials Committee, which will support the work being done by the First Nations Public Health Working Group. The Trilateral First Nations Health Senior Officials Committee must respect the fact that there are also First Nations processes that will work directly with the Ministry of Health and Long Term Care.
6. Recognition will be given to regional public health initiatives, to be respected by the Health Coordination Unit and the Ontario Chiefs Committee on Health.

THEREFORE BE IT RESOLVED that we, the Chiefs in Assembly:

1. Mandate participation in a tripartite health process in the context of this Resolution, as long as this process respects the Honour of the Crown in Right of Canada, in respect of First Nations.
2. Direct that the work of the First Nations Public Health Working Group/First Nations Public Health Advisory Committee continue to be overseen by the Health Coordination Unit and Ontario Chiefs Committee on Health, with a specific mandate to work towards the development of a First Nations Public Health System Framework for participating First Nations, and to provide regular progress reports to the Chiefs in Assembly.
3. Mandate the Chiefs of Ontario to pursue funding through the Health Services Integration Fund to assist in carrying out this public health work for participating First Nations.
4. Declare this Resolution is without prejudice to Grand Council Treaty #3 health initiatives.

Certified Copy of a Resolution dated June 16, 2011.



Angus Toulouse, Ontario Regional Chief



Appendix C – Excerpt from *A Summary of the History and Work of the First Nations Public Health Advisory Committee*

Excerpt from *A Summary of the History and Work of the First Nations Public Health Advisory Committee*

Comparison of Ontario and Federal First Nations' Public Health Program Descriptions

As previously described, the *Health Protection and Promotion Act*¹ provides the legislative framework for public health in Ontario. This includes establishing the minimum standards for public health programs and services to be provided by the 36 public health units within their geographic catchment areas. The Ontario Public Health Standards (OPHS) were published in 2008 updating the previous 1997 version. Key features include the following:

- The OPHS “outline the expectations for boards of health², which are responsible for providing public health programs and services that contribute to the physical, mental, and emotional health and well-being of all Ontarians”
- The OPHS “incorporate and address the determinants of health throughout and include a broad range of population-based activities designed to promote the health of the population and reduce health inequities by working with community partners”
- “The primary focus of public health is the health and well-being of the whole population through the promotion and protection of health and the prevention of illness.”
- The OPHS “allows for flexibility in local public health programming by emphasizing the importance of population health assessment and surveillance to inform program planning and service delivery... boards of health shall continuously tailor their programs and services to address needs that are influenced by differences in the context of their local communities.

The OPHS include a Foundational Standard and a series of five program standards. Many of the standards are accompanied by more detailed protocols, as well as guidance documents.

¹ Boards of health and/or Medical Officers of Health are also named in 57 other pieces of Ontario legislation or associated regulations.

² The ‘board of health’ is the governance body for a public health unit. A variety of permutations exist across the province, which as of 2008 included: 22 autonomous boards that operate separately from the administrative structure of their municipalities; 4 autonomous boards that are integrated into municipal structures; 4 boards that are councils of single tier municipalities; and, 6 boards that are councils of regional municipalities.

Table 1: Ontario Public Health Standards: Foundational and Program Standards, 2008.

Standard	Components
Foundational Standard	Population health assessment Surveillance Research and knowledge exchange Program evaluation
Chronic Diseases and Injuries	Chronic disease prevention Prevention of injury and substance misuse
Family Health	Reproductive health Child health (includes CINOT/dental program; and, Healthy Babies, Healthy Children)
Infectious Diseases	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
Environmental Health	Food safety Safe water Health hazard prevention and management
Emergency Preparedness	Public health emergency preparedness

For First Nations, Health Canada's First Nations and Inuit Health Branch (FNIHB) describes a series of public health-related programs within their *Program Compendium*,¹² which form the basis of grant funding and/or direct service delivery to First Nations communities. The *Compendium* describes five areas of programming (see Table 2).

Table 2: FNIHB Program Compendium, 2007.

Program	Components
Community Programs	Children and youth Mental health and addictions Chronic disease and injury prevention
Health Protection and Public Health	Communicable disease control Environmental health and research
Primary Care	
Supplementary Health Benefits	
Health Governance and Infrastructure Support	

Table 3 outlines the considerable differences in context between the two documents. This has direct impact on the structure, style and level of detail of the two documents, as well as implications for comparing their content.

Table 3: Comparison of System Contexts for the Ontario Public Health Standards and FNIHB Program Compendium

Characteristic	Ontario Public Health Standards	FNIHB Program Compendium
Empowerment	Explicitly linked to HPPA	Reflect Health Canada policy
Focus	Specifically on public health	A continuum of promotion, prevention, screening/early detection, treatment and rehabilitation.
Funding	75% provincial; 25% municipal	Federal
Local Governance	Local Board of Health – majority of members are typically municipal representatives	Chief and Council
Apply to...	Define expectations for catchment area of a public health unit (i.e., multiple communities); coordination and technical/scientific expertise supported at provincial level	Focus is on individual FN communities. Some technical/professional capacity provided by regional FNIH office.
Comprehensiveness	Fulfill core public health system functions Detailed set of standards and programs	Core functions not all explicitly addressed. Collection of selective set of programs. Higher level descriptions.
Discretion	Minimum standards; all mandatory; tailoring to local needs; may provide additional services	Only health protection programs are mandatory; other programs may not be universal
Local Staffing	Stable funding. Full-time, multi-disciplinary professional workforce. Smaller health units may have limited graduate level trained personnel (e.g., MOH, epidemiologist)	Within FN communities, funding grant cycle impairs hiring of permanent staff. Mandatory programs have 5-year funding cycles. Funding cycle, program-specific funding, and small community sizes impair hiring of full-time professional staff

A high level comparison of the two documents finds that two OPHS program standards are not addressed in the Compendium:

- Foundational Standard: this includes requirements for population health assessment, surveillance, research and knowledge exchange, and program evaluation.

- Emergency Preparedness: this includes requirements for preparing for, responding to, and recovering from public health emergencies.

The OPHS' Foundational Standard reflects the importance of these cross-cutting activities to support decision making regarding priorities, planning, implementation and evaluation of public health interventions. The COO consultation with communities indicated that "little is being done in terms of gathering regular data for planning and evaluation purposes". These tasks are not a small undertaking and the reality is that even smaller health units (i.e., those serving less than ~125,000 people) are likely to struggle to fulfill these requirements on their own. This is why access to data sources and the establishment of information systems is pursued on a system-wide basis. Emergency Preparedness is similarly an issue that extends beyond the capacity of individual communities.

Overall, in comparison to the OPHS, the *Compendium's* program descriptions are different, less well defined, and have a number of gaps. The OPHS are more comprehensive, more detailed and in some areas more inclusive. Notable gaps in the FNIHB basket of programs were found in the areas of public health emergency planning, as well as surveillance and epidemiology, which include the collection and assessment of health data to inform decision making and outbreak response.

National and International Comparison of Indigenous Public Health Models

Models of public health service delivery and organization for indigenous peoples were sought from a range of jurisdictions including the US, Norway, New Zealand, and Australia, as well as approaches taken in Ontario and other provinces. This work was undertaken with the purpose of examining what approaches to better service delivery and coordination were in place elsewhere that could provide useful information to First Nations in Ontario.

Ontario

Several existing models provide direct and indirect information regarding public health models. An example of a local agreement exists between the Curve Lake First Nation and the Peterborough public health unit. As per the provision in the HPPA, the health unit provides services to the community in return for per capita allocation cost equivalent of the municipal share of service costs (i.e., 25%). The First Nation also appoints a representative to the unit's board of health. Another public health example is the Ontario Health Plan for an Influenza Pandemic (OHPiP), which illustrates a tripartite agreement on a province-wide basis that fostered collaboration in advance on scientific, technical and response issues while attempting to minimize impact of jurisdictional/political barriers. Activated during H1N1, it resulted in Tamiflu from the provincial stockpile to be sent to Nishnawbe Aski Nation communities in the spring of 2009 while mass hospitalizations were occurring in Northern Manitoba communities. Potentially, this type of model could be applied to other public health issues such as diabetes, mental health, and heart disease.

Additional agreements have been established for providing clinical healthcare services for northern communities including the Weeneebayko/James Bay Agreement and the Sioux

Lookout Four Party Agreement. While neither explicitly cover public health services, both illustrate the need to consider patterns of existing healthcare services, particularly from southern Ontario teaching centres, as well as the extent, if any, of existing health unit involvement, in the development of potential public health models.

Other Provinces

In British Columbia (BC), a high-level tripartite First Nations Health Plan was established in 2007. It is positioned as an enabling document setting out a series of founding principles, committing the parties to working collaboratively over a ten year period to develop coordinated approaches to the provision of health services. The overall goal is to reduce inequities, improve coordination and to “acknowledge and respect established and evolving jurisdictional and fiduciary relationships and responsibilities.” The agreement does not explicitly address public health. Also in BC, the Tsawwassen First Nation treaty came into effect in 2009 and is the first urban treaty in the history of the province. Under the Act, the Tsawwassen Government may make laws respect to health services including public health provided by a Tsawwassen institution on Tsawwassen lands.

In Alberta, provincial public health legislation contains provisions for designated authority to provincial medical officers of health to and within First Nations or to appropriately qualified physicians serving First Nations. Alberta was also the site of the establishment of a First Nations EpiCentre. It was an attempt to address concerns by First Nations leaders on the issues of health information and research and was modeled on comparable centres in the US. The Alberta EpiCentre has faced governance and funding issues and ceased operations. Nevertheless, the EpiCentre model does represent one type of approach to address the need for evidence, data and comparators to be able to understand and track trends in disease and health determinants within and across First Nations, beyond what can be undertaken at the individual First Nation level.

The James Bay Agreement (1975) covers a large geographic area on the eastern side of James Bay and northeastern Quebec. Control over health services, including public health, for James Bay coast communities was largely transferred from the province to the Cree Regional Health Board. This Board exercises the powers and authorities of a formal regional board in the area of public health as part of the provincial public health system, and thereby under Quebec’s public health legislation.

In Saskatchewan, public health services are delivered through regional health authorities with limited provincial involvement in public health delivery to First Nations. The Northern InterTribal Health Authority serves 33 First Nations communities and includes a ‘public health unit’ which was initially focussed on surveillance and health protection, but is gradually expanding to other public health functions (e.g., health promotion). The Northern Saskatchewan Population Health Unit provides more specialized public health functions for the three most northern health authorities in Saskatchewan. Because the population base is geographically defined, the unit serves a diverse population comprised of 40% First Nations “ on-reserve, 20% First Nations off-reserve, 24% Métis, and 16% non-Aboriginal. All the medical

health officers within the province, whether employed by regional health authorities, Saskatchewan Health, First Nations, or the Federal government have authorities recognized under provincial public health legislation. The provincial Patient Care Commissioner tabled a report in 2009 to Saskatchewan Health recommending health organizations to develop partnerships with Aboriginal organizations and patients to improve the health of First Nations and Métis peoples.

United States

The governmental context for public health overall, and the provision of health services through the US Indian Health Service (IHS), are fundamentally different from the situation in Canada. First, the absence of a universal healthcare system in the US places greater pressure for direct service delivery through the IHS. Second, with statutory authority, there is greater certainty of the federal role. Third, being part of the same Department of Health and Human Services, the IHS is able to partner directly at the federal level with the Centers for Disease Control and Prevention (CDC), as well as the Environmental Protection Agency. Fourth, the presence of the US Public Health Service provides IHS with public health expertise and cross-appointments from CDC.

There are 12 tribal epidemiology centres (TEC) located across the US, although some IHS regions do not have a TEC. These centres have a wide ranging mandate related to both disease epidemiology and analysis, investigating diseases of concern, and responding to public health emergencies. Most of the centers are operated under contract by tribal health authorities which link with IHS regional offices. The intent of the tribal epi-centres is to improve the availability of health-related data and its analysis. However, there are a number of challenges including accessing state level data; privacy and legal roadblocks to sharing data; and, sharing of data between tribal epi-centres. Tribal authorities in several states have pursued data sharing agreements particularly regarding immunization data. A challenge for tribal authorities is the absence of county level public health capacity to engage with since in the US, many states have a large number of quite small county-based public health departments. This is a major limitation to pursuing local agreements.

A novel approach in Alaska is the Alaska Tribal Health Compact where a group of 39 tribal health organizations linked by an agreement on common goals and objectives operates a comprehensive healthcare system blending state medicare, Medicaid and IHS funding. Basic dental, immunization and disease prevention programming are included. The motivation is that better economies of scale and greater specialization would be available if planning was coordinated and pooled on a multi-community basis. The concern is that the system has resulted in Aboriginal leaders assuming ownership of problems, budgetary shortfalls and service rationing that was previously the responsibility of the state and the IHS.

New Zealand

The New Zealand context differs considerably from Ontario. The indigenous population is three and a half times larger and located in an area a tenth of the size of Ontario. Furthermore, the complexities of the division of powers between a federal and provincial government also do not exist. Overall, there are national level Maori Health Strategies and Health Action Plans. Each of the 21 District Health Boards is required by law to develop its own Maori Health Plan. The Boards are also required to develop region specific plans to address health disparities. There is increasing collaboration and cooperation between the Boards and Maori communities and service providers with formal agreements being established. A national directive establishes the requirements for Crown-Maori agreements. All agreements are reviewed by the Justice Department and the main Maori national organization. Any agreements not following the directive must obtain Cabinet approval to proceed.

Australia

Australia is the closest to Canada in terms of the division of responsibilities between levels of government for healthcare and public health. The federal government has pursued agreements since 2004 with the perspective of 'shared obligation'. Early implementation was problematic with highly paternalistic language. While the language has been tempered over time, the basic premise of shared responsibility has been maintained. Tripartite agreements between federal, state and Aboriginal health councils have been pursued to improve access to services and achieve greater equity of health and wellbeing for Aboriginal peoples.

Summary

In reviewing the approaches taken elsewhere to address healthcare and public health services for indigenous populations, the approaches have been tailored to the local context regarding the indigenous community and broader systems of public health and healthcare. There is no single approach that will work or can be easily transferred to First Nations across all of Ontario. In addition, the experience elsewhere indicates that the needs of smaller more remote communities (regardless of country studied), are more likely to benefit from more collective approaches to service planning and delivery than solely relying upon what can be directly provided within the community. In general terms, the more complex the service, the more likely that a joint approach can help provide this service – this is most clear in the way in which Alaska and the U.S. Tribal areas organize more specialized supports such as epidemiology, immunization and emergency planning – with hub centers responsible for providing technical support to multiple communities.

Appendix D – North Shore Tribal Council, Resolution January 22, 2015

North Shore Tribal Council – Board of Directors Meeting Minutes Batchewana First Nation, SSM, ON – January 22, 2015

Present:

Harvey Bell, Batchewana First Nation	Chief Isadore Day, Serpent River First Nation
Peter Jones, Garden River First Nation	Elaine Johnston, Serpent River First Nation
Craig Sayers, Garden River First Nation	Chief Paul Eshkakogan, Sagamok Anishnawbek
Chief Alfred Bisailon, Thessalon First Nation	Nelson Toulouse, Sagamok Anishnawbek
Mary Ann Giguere, Thessalon First Nation	Chief Steven Miller, Atikameksheng Anishnawbek
Chief Reginald Niganobe, Mississauga First Nation	Harvey Petahtegoose, Atikameksheng Anishnawbek

NSTC Staff:

Nelson Toulouse, Vice Chair
Angus Toulouse, CEO
Allan Moffatt, Comptroller
Natalie Chiblow, ASETS
Elizabeth Richer, Niigaaniin
Marnie Yourchuk, Education
Louisa Chiblow, Technical Services

Other:

Aboriginal Insurance Service -Bill Montour
Algoma Public Health Unit
Nogdawindamin - Kerry Francis
International Union of Operating Engineers - Brian Peltier

Niigaaniin – Heather Pelky, Minobimaadizidaa Coordinator/Facilitator
Niigaaniin – Christina Agawa, Addictions Services Clinical Coordinator

Regrets:

Chairman, Chief Lyle Sayers
Chief Dean Sayers, Batchewana First Nation
Ty Cada, Mississauga First Nation
Patricia Abitong, Administration, NSTC
Annie Austin, ASETS

Recording Secretary, Sandra Owl

Presentation by the Algoma Public Health Unit

The Maamawesying North Shore Community Health Services Health Director provided some opening comments and an introduction to the Mno Bmaadziiwin Project presentation.

The Algoma Public Health Unit (APH) applied for one-time funding from Long Term Care to carry out the Mno Bmaadziwin project. It is a collaborative project initiated by Maamawesying North Shore Community Health Services and Algoma Public Health Unit to share, communicate and develop a relationship framework agreement that will bring more effective Public Health services to both organizations.

The purpose of the project Mno Bmaadziwin is to secure funding to better serve First Nation communities within the APH District. The funding would allow APH to collaborate with our communities to ensure our program and service offerings are aligned to meet the needs of our First Nation communities. The APH will gain cultural competencies while building a relationship and the project would support a process on how service/partnerships will be delivered.

Sagamok Anishnawbek and Atikameksheng Anishnawbek are in different Public Health districts than the other five First Nations to the west. Sudbury/Manitoulin is being approached to share in this collaboration project.

Elder Emma Meawasige suggested that the project name could be more inviting and appropriate by changing the tense to, "**Mno Bmaadzidaa**" which translates to "**Let us have a life of Wellness**"

It was agreed to by the fluent speakers, at which time Acting / Chair, Nelson Toulouse asked respectfully if the project name could be changed. Consensus of the presenters was favourable.

2015-01-05

That *Mamaweswen* NSTC Board of Directors hereby approve its participation in the Mno Bmaadzidaa projects' relationship framework between the Algoma Public Health Unit and member First Nations communities

Moved by: Chief Reginald Nigonobe

Seconded by: Elaine Johnston

CARRIED

Appendix E – Sample Memorandum of Agreement

SAMPLE
MEMORANDUM OF AGREEMENT

Made pursuant to s.50 of the *Health Protection and Promotion Act*, R.S.O. 1990, Chapter H. 7

BETWEEN

____ FIRST NATION
(HEREINAFTER REFERRED TO AS “THE FIRST NATION”)

- AND –

ALGOMA PUBLIC HEALTH

WHEREAS the ____ First Nation is a “band” and its Chief and Council a “council of the band” as referred to in the *Health Protection and Promotion Act* (HPPA);

AND WHEREAS Algoma Public Health is the Board of Health for the Algoma Public Health Unit, as set out in the HPPA;

AND WHEREAS s. 50 of the HPPA states that a board of health for a health unit and the council of the band may enter into an agreement in writing under which, the board agrees to provide health programs and services to the members of the band; and the council of the band agrees to accept responsibilities of the council of a municipality within the health unit;

THE PARTIES HERETO AGREE AS FOLLOWS:

1. Algoma Public Health will make available to the First Nation, the programs and services offered by Algoma Public Health as detailed in Schedule 1.
2. The First Nation will pay Algoma Public Health for the services according to the formula detailed in Schedule 2.
3. This agreement will be in effect until it is superseded or replaced by a subsequent agreement or until it is terminated by either party by giving twelve (12) months written notice. If the end of the notice period falls in the middle of a fiscal year, the payment for the year will be adjusted on a *pro rata* basis and any overpayment given to Algoma Public Health will be refunded forthwith to the First Nation.
4. One representative shall be permitted to attend all meetings of the Algoma Public Health board, and together with the other First Nation representatives will agree on the appointment of one of their number that will sit as a board member and exercise one vote.

5. Algoma Public Health shall provide the First Nation with all notices, information, reports and other documentation, whether in digital or paper format, as provided to the municipalities in the Algoma public health unit.
6. Algoma Public Health will not create, use or disclose any aggregate report that identifies the First Nation, or all First Nations within the area, without prior written consent of the First Nation, as evidenced by the written authorization of the First Nation Health Director.
7. All the terms and conditions of the Schedules are incorporated into this agreement.
8. *[If there are any pre-existing agreements between the parties, they should consider terminating the agreements and wrapping it up in this one.]*

In witness whereof the parties hereto have executed this Agreement as of the ____ day of _____, 20____.