Ministry of Health and Long-Term Care

Relationship with Indigenous Communities Guideline, 2018

Population and Public Health Division,
Ministry of Health and Long-Term Care

Effective: January 1, 2018 or upon date of release

Ontario

TABLE OF CONTENTS

1. Preamble

The Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (Standards) are published by the Minister of Health and Long-Term Care under the authority of section 7 of the *Health Protection and Promotion Act* (HPPA) to specify the mandatory health programs and services provided by boards of health.[1,2] The Standards identify the minimum expectations for public health programs and services. Boards of health are accountable for implementing the Standards including the protocols and guidelines that are referenced in the Standards. Guidelines are program and topic-specific documents which provide direction on how boards of health shall approach specific requirement(s) identified within the Standards.

2. Purpose

This guideline is intended to assist boards of health in implementing the requirements established in the Health Equity Standard and the requirement for boards of health to engage in multi-sectoral collaboration with municipalities, LHIN(s), and other relevant stakeholders in decreasing health inequities. The requirement further specifies that engagement shall include the fostering and the creation of meaningful relationships, starting with engagement through to collaborative partnerships with Indigenous communities and organizations, as well as with First Nations and Indigenous communities striving to reconcile jurisdictional issues. While the *Health Equity Guideline, 2018* (or as current) outlines the approaches to addressing health equity in the assessment, planning, delivery, management and evaluation of all public health programs and services, this guideline provides boards of health with the fundamentals to begin forming meaningful relationships with Indigenous communities that come from a place of trust, mutual respect, understanding, and reciprocity. Content is organized as follows:

- Sections 1 Preamble, 2 Purpose, and 3 References to the Standards provide a brief orientation to this guideline.
- Sections 4 Context, 5 Key Definitions, 6 Introductions to Determinants of Indigenous Health and 7 Governing Bodies provides high-level information about Indigenous communities in Ontario. More detailed information is provided in the Relationship with Indigenous Communities Toolkit.
- Section 8 Roles and Responsibilities identifies the core links between the requirement for engagement with Indigenous Communities and related requirements in the foundational and program standards. It outlines the roles and responsibilities of the Indigenous and Intergovernmental Relations Unit in the Population and Public Health Division (PPHD), Ministry of Health and Long-Term Care (MOHLTC).
- Section 9 Engagement with Indigenous Communities outlines potential approaches that boards of health shall consider when engaging with on and off reserve Indigenous communities and organizations.

- Section 10 Use of Health Information provides high-level information about use of Indigenous health data and the requirement for Indigenous-defined and Indigenous-controlled approaches.

3. Reference to the Standards

This section identifies the standard and requirement to which this guideline relates.

Health Equity Standard

Requirement 3. The board of health shall engage in multi-sectoral collaboration with municipalities, LHINs, and other relevant stakeholders in decreasing health inequities in accordance with the *Health Equity Guideline, 2018* (or as current). Engagement with Indigenous communities and organizations, as well as with First Nation communities striving to reconcile jurisdictional issues, shall include the fostering and creation of meaningful relationships, starting with engagement through to collaborative partnerships, in accordance with the *Relationship with Indigenous Communities Guideline, 2018* (or as current).

4. Context

This section provides a high-level introduction for boards of health to build and/or further develop their relationships with Indigenous communities and organizations in a culturally-safe, culturally-humble and trauma-informed way.

The Indigenous population in Ontario is comprised of the First Nations, Métis, and Inuit groups who may live on and off reserve, in urban, rural and remote areas, each with their own histories, languages, cultures, organizational approaches, and jurisdictional realities that will need to be considered. It must be emphasized that though there are over-arching terms for the original inhabitants of the Americas (e.g. Indigenous, Aboriginal, First Nations, etc.), these populations are unique and distinct ethno-cultural entities.

To respect and acknowledge the diversity across Indigenous populations, the guideline was prepared in partnership with the Chiefs of Ontario (COO), providing the First Nations perspective and the Urban Indigenous Health Table (UIHT), providing an urban Indigenous community perspective. In addition, the new Indigenous Primary Health Care Council (IPHCC) provided the perspective of Aboriginal Health Access Centres (AHACs) and Aboriginal governed Community Health Centres (ACHCs). AHACs and ACHCs are community controlled health care organizations that serve Indigenous communities on and off-reserve, in rural, urban and isolated areas across the province. They are important partners for boards of health when planning and delivering public health programs to Indigenous Peoples.

5. Key Definitions

Boards of health should have a good understanding of key terminology and definitions when engaging with Indigenous individuals or communities. While this section does not provide an exhaustive list, it is important to maintain consistency and to contact the particular Indigenous individual or organization to learn which terms are preferred.[3]

Aboriginal Peoples

"Aboriginal Peoples" is a collective name used for all of the original Peoples of Canada and their descendants. The Canadian Constitution Act of 1982 specifies that the Aboriginal Peoples in Canada consist of three groups: Indians (First Nations), Inuit and Métis.[3]

The term "Indigenous" in increasingly preferred in Canada over the term "Aboriginal". Ontario's current practice is to use the term Indigenous when referring to First Nations, Métis and Inuit Peoples as a group, and to refer to specific communities whenever possible.

Indigenous

"Indigenous" means 'native to the area.[3] It is the preferred collective name for the original people of Canada and their descendants. This includes First Nations (status and non-status), Métis and Inuit.

It is important to remember that each Indigenous nation in the larger category of "Indigenous" has its own unique name for its community (e.g., Cree, Ojibwa, Inuit).

Indian

As mentioned above, Indian Peoples are First Nation Peoples recognized as Aboriginal in the Canadian Constitution Act of 1982. In addition, three categories apply to Indians in Canada: Status Indians, Non-Status Indians, and Treaty Indians.[3]

The term "Indian" refers to the legal identity of a First Nations person who is registered under the federal Indian Act. The term "Indian" should be used only when referring to a First Nations person with status under the Indian Act, and only within its legal context. Aside from this specific legal context, the term "Indian" in Canada is considered outdated and may be considered offensive due to its complex and often idiosyncratic colonial use in governing identity through this legislation and a myriad of other distinctions (i.e., "treaty" and "non-treaty," etc.).

First Nations

This term generally applies to individuals both with or without Status under the federal Indian Act and therefore should be used carefully in order to avoid confusion. For example, when talking about a program that applies only to Status Indian youth, avoid using the term "First Nation". The term "First Nation" should not be used as a synonym for Aboriginal or Indigenous people because it does not include Inuit or Métis. Some

communities have adopted “First Nation” to replace the term “band”. Despite the widespread use, there is no legal definition for this term in Canada.

There are 133 First Nation communities in Ontario, 127 of which are recognized by the federal Indian Act.

Métis

The Métis are a distinct people with mixed First Nations and European heritage with their own customs and recognizable group identity. Métis representative organizations may have differing criteria for who qualifies as Métis under their particular mandates.

Inuit

Inuit homelands in Canada are found in the far north, including Nunavut, the Northwest Territories, the Yukon, northern Quebec and Labrador. There are no Inuit traditional territories in Ontario. Inuit live in the province in urban centres or other municipalities (with the largest population in the Ottawa area) and may be represented through distinct educational, social service and political organizations.

Urban Indigenous Communities

This term refers primarily to First Nation, Inuit and Métis individuals currently residing in urban areas. According to 2016 Census data, the urban Indigenous population continues to be one of the fastest growing segments of Canadian society.[4]

It is important to note that there are indications that the Census may undercount urban Indigenous populations in some areas of Ontario.[5] They are at risk of non-participation in the Census due to factors such as increased rates of mobility and its associated lack of living at a fixed address, historical distrust of government due to past and present colonial policies and migration between geographical locations.[5]

6. Introduction to Determinants of Indigenous Health

Indigenous People’s experiences with the health care system are greatly influenced by their Indigenous identity. Historically, Indigenous Peoples have been collectivist in their social institutions and processes, specifically the ways in which health is perceived and addressed.[6] Indigenous ideologies embrace a holistic concept of health that reflects physical, emotional, spiritual, and mental dimensions.[6]

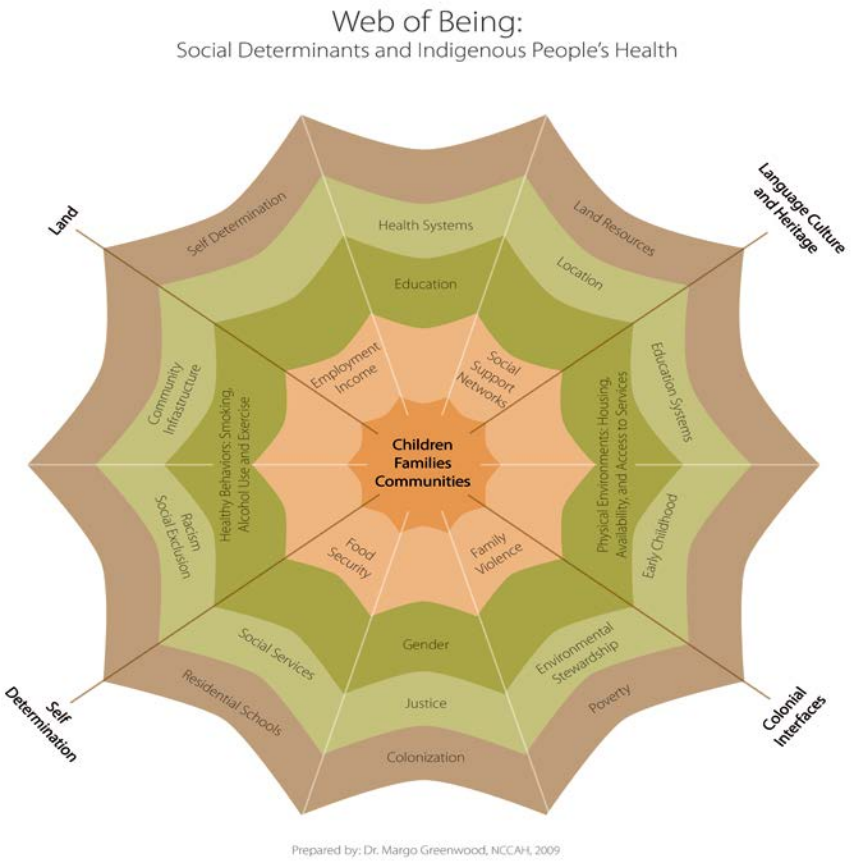
The Web of Being (Figure 1), developed by the National Collaborating Centre on Aboriginal Health, illustrates the determinants of health for Indigenous Peoples and shows how these factors are interconnected to form a strong web that affects people’s health and well-being.[7] Factors such as colonialism, racism and social exclusion have had and continue to have a profound effect on communities, families and individuals’ health that has resulted in intergenerational trauma and are responsible for the social

inequities and resulting health inequities that exist between Indigenous Peoples and the general Ontario population.

Personal, familial and community resilience, restoring and promoting Indigenous identity, keeping cultures and languages alive, and self-governance are among the factors that have had positive impacts on health and well-being of the Indigenous population.

It has also been cited that self-determination is the most important determinant of health among Indigenous People.[6] Self-determination influences all other determinants including education, housing, safety, and health opportunities. Research has shown that community initiatives, cultural pride and the reclamation of traditional approaches to health and healing have helped to improve and promote mental, physical, emotional and spiritual health within Indigenous communities.[8] Raising awareness among health practitioners of Indigenous cultural practices, histories and worldviews particular to the region in which they work are key to bridging gaps of misunderstanding among public health practitioners and the Indigenous People they serve.[7]

Figure 1: The Web of Being: Determinants and Indigenous People's Health



Source: Dr. Margo Greenwood. The web of being. Prince George, BC: National Collaborating Centre for Aboriginal Health (NCCAH); 2009. Used with permission.[7]

7. Governing Bodies

This section provides an overview of some of the governing bodies with which boards of health should become familiar, in order to better prepare themselves to engage with Indigenous communities and organizations from a strengths-based approach. The strengths-based approach implies a conscious effort to build from a community's assets, achievements, and structures that can enable improvements.[9] Although day-to-day business between boards of health or their staff would mainly be conducted with staff in health centres, such as clinical and health services directors and managers, having an understanding of how certain policy decisions are made is vital to ensuring that engagement is done in a meaningful and respectful way.

7.1 First Nations

As described above, the term "First Nation" entered common usage in the 1980s to replace the term "Indian Band/Reserve".

The "Band Council" is a term used for the local governing authority for a First Nation community that is politically recognized by the federal government. Each Band Council is made up of an elected Chief and councillors from the community. Some communities have even replaced the name "Band" with "Elected" (e.g. Six Nations Elected Council). It is important to remember that though these Band Councils are in place, there are also traditional governing bodies that can exist within a First Nations community. Some communities also have their traditional governance leaders as their elected Chief or councillors.

Political Territorial Organizations

In Ontario, the majority of First Nations are affiliated with larger regional groupings known as political territorial organizations (PTO). PTOs are a primary support for advocacy and secretariat services for First Nations. Each PTO has an elected Grand Council Chief and Deputy Grand Chief. In Ontario, there are currently four PTOs including: Nishnawbe-Aski Nation, Grand Council Treaty #3, Anishnabek Nation (Union of Ontario Indians), and the Association of Iroquois and Allied Indians.

Tribal Councils

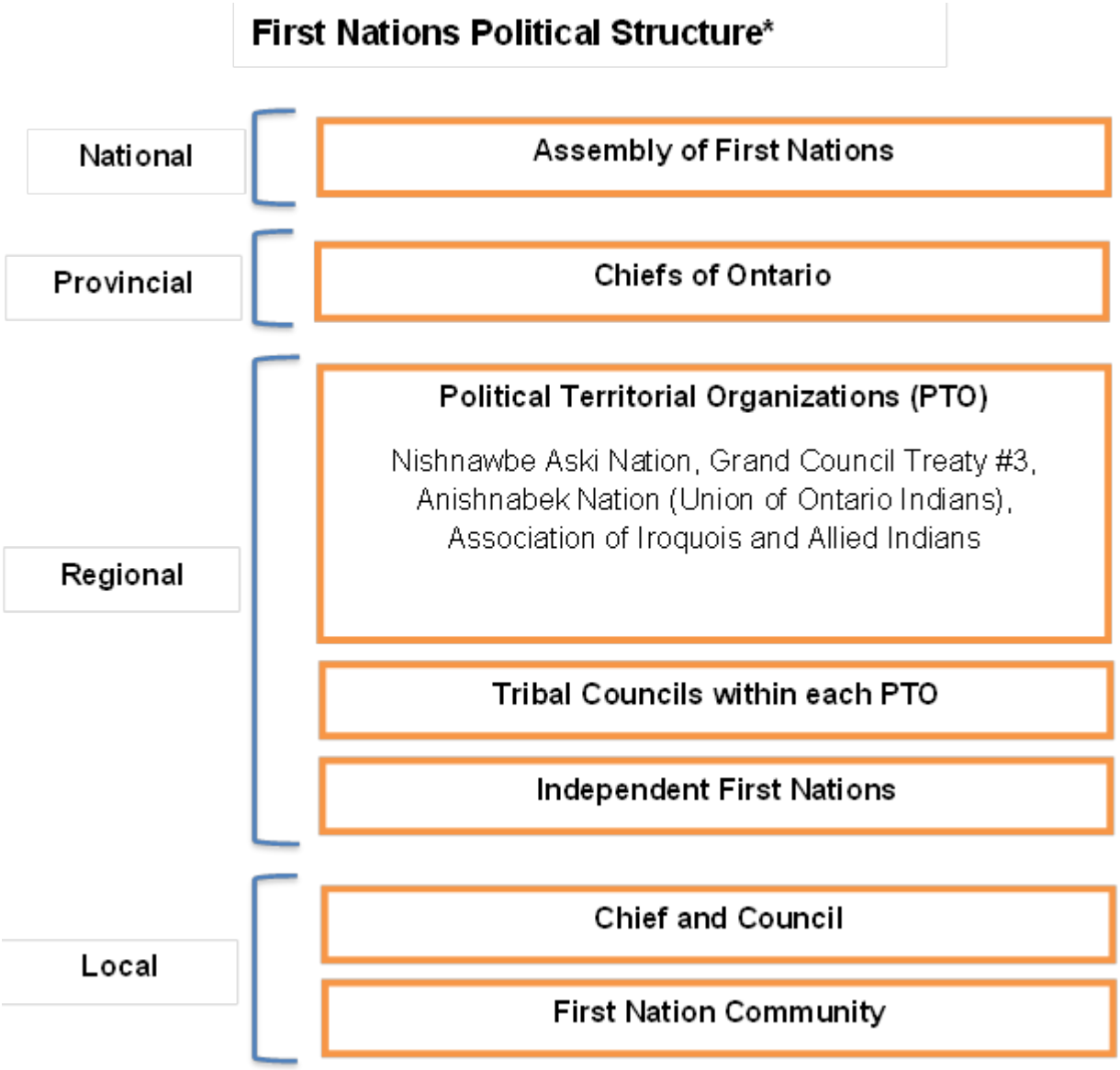
Tribal Councils are organizations that represents the interests of a number of First Nation communities usually with a defined geographic region or based on political, socio-cultural or historical affiliation. Tribal Councils act as a liaison between their member First Nations and various levels of government representing the member communities' political, social, cultural and economic aspirations. The authority that First Nations delegate to their Tribal Council varies and it most often based on resolutions endorsed by the Chiefs and/or councillors who represent their member community and by extension the interests of their band membership. Via this process, most Tribal Councils are mandated to serve as a strong, central voice and advocacy organization for their members. Most Tribal Council organizations provide planning, coordinating and advisory

services, while others may also deliver programs and services depending on specific agreements made with government.

Chiefs of Ontario

The Chiefs of Ontario (COO) is a political forum and secretariat for collective decision-making, action and advocacy for 133 First Nations communities located within the boundaries of the province of Ontario. It is important to note within these distinctions that some First Nations and First Nation organizations do not consider the COO as their political representatives with the provincial or federal government.

Guided by the Chiefs in Assembly, COO upholds self-determination efforts of the Anishinabek, Mushkegowuk, Onkwehonwe and Lenape Peoples in protecting and exercising their inherent and Treaty rights.



*This figure is intended to provide a visual representation of the relationships only. It is not intended to depict a hierarchical/organizational structure and may not apply to some First Nation communities as they work with governments directly.

Federal and Provincial Responsibilities for Indigenous Health

Both the provincial and federal governments provide health services to Indigenous People in Ontario, including First Nations.

Ontario offers provincial services to residents of Ontario, including Indigenous Peoples living in Ontario (regardless of whether they live on- or off-reserve), on a basis that does not discriminate. This includes the application of Jordan's Principle, a child-first principle meant to prevent First Nations children from being denied essential services or experiencing delays in receiving them, due to jurisdictional disputes.

This aligns with the *Child, Youth and Family Services Act, 2017*, which includes an acknowledgement in the preamble by the Government of Ontario that, "where a First Nations, Inuk or Métis child is otherwise eligible to receive services under the CYFSA, an inter-jurisdictional or intra-jurisdictional dispute should not prevent the timely provision of that service, in accordance with Jordan's Principle."[10]

It also aligns with a key element of the Canadian Human Rights Tribunal (CHRT)'s definition of Jordan's Principle put forth in 2016, i.e. where a government service is available to all other children, and a jurisdictional dispute arises between Canada and a province/territory, or between departments in the same government regarding services to a First Nations child, the government department of first contact pays for the service and can seek reimbursement from the other government/department after the child has received the service.

Subsequent CHRT rulings since 2016 have expanded the scope of Jordan's Principle for the federal government beyond the development of a formal jurisdictional dispute resolution mechanism to address gaps in government services and ensure substantive equality in the provision of services to the child.

For many on-reserve First Nations communities in Ontario, federal and First Nation community health services (e.g. First Nations nursing stations or community health centres in rural or remote communities) are the first point of care, although serious illness, emergencies and long-term care will typically move patients into the provincial system. Federally funded services may include environmental public health services(such as public health inspections and monitoring drinking water quality), community programs including mental health and addictions, early childhood development, chronic disease prevention and management. It is important to note that the services that each First Nation community receives differs between regions and local First Nations. Off-reserve, Métis and urban Indigenous populations are served by provincial health systems, as are First Nations people living on-reserve that are closer to urban centres and/or requiring complex care.

Health services on-reserve are typically provided by the community's health centre, offering a range of primary care and health promotion programs and services to community members and is overseen by the Health Director. When starting to build a relationship with an on-reserve community, the Health Director will be an important partner.

7.2 Urban Indigenous Communities

Ontario is home to the largest population of Indigenous people in Canada with 374,395 Indigenous people living in the province.[4] Ontario's urban Indigenous population continues to increase, mirroring the national trend. Approximately 85.5% of Indigenous people live off-reserve in Ontario, while 79.7% live off-reserve across Canada. In 2016, Ontario had the largest Métis population in Canada at 120,585, up 64.3% from 2006 and accounting for one-fifth of the total Métis population. In Ontario, approximately 40.9% of the Indigenous population is under the age of 24. This demographic context sets out the environment within which the urban Indigenous organizations operate. While the urban Indigenous organizations in Ontario are consistently adapting to the changing environment of community needs, increasing growth and demand places complex challenges and pressures on service delivery and infrastructure required to meet the needs of urban Indigenous communities.[11]

Métis Nation of Ontario

The Métis Nation of Ontario (MNO) was established in 1993 and is the recognized provincial Métis-specific self-governance structure in Ontario representing the collective interests of twenty-nine chartered local Métis Community Councils in nine regional communities across the province. The MNO delivers centrally-coordinated, client-driven, family-centred and wholistic community-based programs and services to Métis people and the broader Indigenous community in Ontario. The MNO delivers these comprehensive wraparound services through seven branches, utilizing a culturally-distinct approach designed to meet the specific needs and realities of Métis people.

MNO Secretariat is mandated as the elected MNO governance structure to develop and implement policies, programs and services for the Métis people of Ontario that address specific goals outlined in the MNO's Statement of Prime Purpose including the following objectives:

- To provide care and support necessary to meet the fundamental needs of the citizens of the Métis Nation.
- To promote the improved health and wellness of Métis children, youth, families and the whole Métis community.
- To be the authority and source for Métis culture and traditions in Ontario, which differ in some ways from the Métis of the Prairies.
- To advance recognition and respect of Métis rights and the Métis as a Nation and a distinct people.

Ontario Federation of Indigenous Friendship Centres

The Ontario Federation of Indigenous Friendship Centres (OFIFC) is a provincial Indigenous organization representing the collective interests of 28 member Friendship Centres located in towns and cities throughout Ontario. The OFIFC administers over 20 wholistic, culture-based programs and initiatives which are delivered by local Friendship Centres in areas such as justice, children and youth, health, mental health and

addictions, family support, healing and wellness, education, and employment and training with direct cultural supports.

The vision of the Friendship Centre Movement is to improve the quality of life for Indigenous people living in an urban environment, by supporting self-determined activities that encourage equal access to, and participation in, Canadian society and that respects Indigenous cultural distinctiveness. The Friendship Centres represent the most significant off-reserve Indigenous service infrastructure in Ontario and are dedicated to achieving greater participation of all urban Indigenous Peoples in all facets of society, inclusive of First Nation – Status/Non-Status, Métis, Inuit and all other people who identify as Indigenous to Turtle Island. Friendship Centres respond to the needs of tens of thousands of community members requiring culture-based services every day.

Ontario Native Women's Association

The Ontario Native Women's Association (ONWA) is a not-for-profit organization that was established in 1971 to empower and support Indigenous women and their families throughout the province of Ontario. ONWA's vision is to be a unified voice for equity, equality and justice for Indigenous women through cultural restoration within and across Nations. The mandate of ONWA is to empower and support all Indigenous women and their families through research, advocacy, policy development and programs that focus on local, regional and provincial activities.

ONWA's membership consists of fifty-two (52) local membership organizations that provide Indigenous women the support, capacity building opportunities, and visibility they need to further enhance their lives. Membership provides opportunity for Indigenous women within Ontario to influence both national and provincial policies and legislation as it relates to their lives. The ONWA Board of Directors consists of sixteen members, including four Directors, one of which is a Youth Director, from each of their four regions. ONWA has a Grandmother's Council, comprised of one Grandmother from each region. ONWA's head office is located at Fort William First Nation and has nine satellite offices located across the province that provide proven, culturally sensitive, wholistic services through its numerous programs in order to meet the needs of Indigenous women and their families. ONWA has an established Research and Policy Department that focuses on influencing legislative change to address the systemic barriers that Indigenous women face.

ONWA is committed to delivering culturally enriched programs and services to Indigenous women and their families regardless of their status or locality that strengthen communities and guarantees the preservation of Indigenous culture, identity, art, language and heritage. Ending violence against Indigenous women and their families and ensuring equal access to justice, education, health services, environmental stewardship and economic development, sits at the cornerstone of the organization. ONWA insists on social and cultural wellbeing for all Indigenous women and their families, so that all women, regardless of Indigenous heritage may live their best life.

7.3 Aboriginal Health Access Centres (AHACs) & Aboriginal Community Health Centres (ACHCs)

Unique in Canada and made in Ontario, AHACs/ACHCs are community-governed, community-led, Indigenous informed, primary health care organizations. They provide a comprehensive array of culturally safe health and social services to Indigenous Peoples across the province. These services include: primary care, traditional healing, mental health and wellness, addictions, cultural programs, health promotion programs, community development initiatives and social support services. From clinical care to integrated chronic disease prevention and management, family-focused maternal/child health care, addictions counselling, traditional healing, mental health care, youth empowerment and other programs, AHACs/ACHCs continue to serve as a key entry point to overall family and community health and development.

Opportunities to work with AHACs and ACHCs

Many boards of health already work with AHACs/ACHCs, and these relationships have developed since AHACs began in 1995 and the Indigenous governed Community Health Centres, like Anishnawbe Health Toronto a decade later. They have now been operating for over two decades so the opportunities for health units and AHACs/ACHCs to collaborate have often presented themselves in the regular course of business. AHACs/ACHCs deliver both western and Indigenous informed public health programming as well as primary health care, alongside traditional approaches to wellness.

AHACs/ACHCs operate from the Indigenous Model of Wholistic Health and Wellbeing focused on comprehensive, continuity of care from promotion to rehabilitation throughout the life stages. In addition to primary care services (i.e. physician and Nurse Practitioner type of services), it includes health promotion and disease prevention, and also population-level public health functions.[12] Additionally – most AHACs/ACHCs deliver primary health care (a combination of public health and primary care services). Engaging with AHACs/ACHCs should begin from the premise that AHACs/ACHCs already deliver many culturally relevant and safe, public health programs and so will be looking for collaborative, respectful and equal partnership opportunities with boards of health.

There are a number of activities where boards of health and AHACs/ACHCs can collaborate. Examples include:

- Community activities: community engagement, community development and multi-sectoral involvements;
- Joint health promotion, health education and prevention initiatives;
- Health services: including chronic disease management including screening; immunization and emergency response preparedness. Includes using outreach services to reach specific populations and facilitating linkages among health care providers and services;

- Information systems: developing and managing information systems; sharing information and collecting population data for analysis;
- Evidence-based practice: developing and implementing best practice guidelines;
- Needs assessments: especially performance of community and health needs assessments and program planning;
- Quality assurance and evaluation: mainly around provider and program performance measurement;
- Teamwork and management: joint team meetings focusing on client concerns and practice governance;
- Professional education: health professionals academic programming and various staff training activities;
- Advisory and steering functions: participating on Advisory Boards and committees; and
- Social marketing and communication: especially informing the public on specific health issues.

8. Roles and Responsibilities

The Public Health Accountability Framework in the Standards articulates the scope of the accountability relationship between boards of health and the ministry and establishes expectations for boards of health in the domains of Delivery of Programs and Services; Fiduciary Requirements; Good Governance and Management Practices; and Public Health Practice. The Organizational Requirements specify those requirements where reporting and/or monitoring are required by boards of health to demonstrate accountability to the ministry. The *Health Equity Guideline, 2018* (or as current) highlights those Organizational Requirements where boards of health shall consider embedding health equity principles and approaches to support the effective functioning of boards of health in addressing health equity and implementing the requirements of the Health Equity Standard.

Boards of health are required to engage in public health practice that results in decreased health inequities such that everyone has equal opportunities for optimal health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances.

When working with Indigenous communities and organizations, application of the Standards and their supporting protocols shall be conducted with the approaches outlined in this guideline. The strategies for implementation will vary from board to board and will depend on how an Indigenous community or organization wishes to be engaged. To ensure the best possible outcome, boards of health should use the expertise and experience of Indigenous communities and organizations to drive the process.

Indigenous and Intergovernmental Relations Unit, PPHD, MOHLTC

The Indigenous and Intergovernmental Relations Unit works with Indigenous partners to enhance planning, assessing and delivery of public health programs and services to

reflect community needs. The team can help facilitate engagements between boards of health and Indigenous communities.

9. Engagement with Indigenous Communities and Organizations

This section provides insight into a number of key principles and approaches that may be helpful to boards of health in forming partnerships and collaborating with Indigenous communities and organizations.

The effectiveness of the Standards will be determined by its success in engaging and supporting Indigenous communities and organizations. To be effective, public health models of care and promotion need to be shaped differently towards and with Indigenous Peoples and organizations. Directly engaging with Indigenous communities and organizations as experienced health, social and cultural community hubs, will provide critical information, partnerships and networks, and community resources in the development of culturally-appropriate processes to support health promotion and disease prevention. With Indigenous input and guidance, boards of health can create opportunities to adapt, enhance, and build culturally-appropriate services in geographic public health units, which Indigenous people are more likely to use, resulting in better health outcomes.

The Indigenous partners strongly recommend that boards of health and their employees familiarize themselves with the milestone policy document – New Directions: Aboriginal Health Policy for Ontario. The Aboriginal Health Policy was developed collaboratively between the Ministry of Health and Long-Term Care and First Nations and Indigenous organizations in 1994. It is a broad direction guideline for Indigenous involvement in planning, design, implementation, and evaluation of programs and services directed at Indigenous communities.

9.1 Guiding Relationship Principles

Across Ontario, many examples of effective engagement between boards of health and Indigenous communities exist. Engagement is defined as a process of involvement through a respectful relationship. Indigenous Engagement is a sustained process where trust is built by ensuring Indigenous people have the opportunity to actively participate in decision making from the earliest phase.[13] The approach to Indigenous engagement will differ across the province and within communities, depending on local culture and demographics, proposed initiatives, and existing relationships. When practically applying the Standards to Indigenous communities, approaches shall recognize and support the following principles:

1. **Relationship Building:**
   Strengthen existing and emerging relationships with Indigenous communities, on a foundation of trust and recognition of the rights of First Nations, Métis and Inuit

Peoples. Always invite and include Indigenous organizations at the outset of any new initiative.

2. **Recognition, Respect and Mutuality:**
   Acknowledge the diversity of histories, cultures, language, needs, priorities and protocols among and within First Nation, Métis, and Inuit Indigenous communities. Recognize, support and respect the unique capacity, needs and realities of the Indigenous organizations and their elected governance structures at the local, regional and provincial levels. The relationship should be based on mutuality, which is understood as mutual recognition, mutual respect, sharing and mutual responsibility.
3. **Self-Determination:**
   Self-determination acknowledges the inherent rights of Indigenous People to freely determine their own pathways and to make decisions about all aspects of their communities and livelihoods.[13] To support this principle in the context of this guideline, community-based Indigenous organizations need to be provided with the opportunity to lead or influence relevant decision-making processes that will impact Indigenous people and communities, and facilitate greater opportunities for Indigenous control over health.
4. **Timely Communication and Knowledge Exchange:**
   Processes shall promote meaningful engagement and knowledge exchange based on an open, reciprocal dialogue with Indigenous organizations, recognizing that mutually acceptable outcomes are contingent on clear, open and transparent communications at every stage of the process.
5. **Coordination:**
   Boards of health shall collaboratively work with Indigenous organizations and non-Indigenous stakeholders to determine appropriate processes of consultation, engagement and co-development to avoid duplications and maximize integration with other health care policy and program initiatives.

9.2 Types of Relationship Models

The above guiding relationship principles are helpful suggestions to inform all consultation activities and related processes with Indigenous organizations. These principles will assist to develop communication, engagement, and co-development processes that support relationship building and result in improved outcomes. However, due to historical relationships and community contexts, Indigenous communities and organizations may not be willing to engage immediately with boards of health and their employees, and these processes may take time and require flexibility from boards of health. This guideline provides engagement options that take a phased approach accounting for the different stages boards of health and Indigenous communities may be at in building their relationship.

Communication

Open and respectful communication styles are at the forefront of successful communication strategies. In order to foster trust, face-to-face dialogue is suggested as an effective approach. This may take the form of community visits, meet and greet sessions, informal interactions and meetings.

In addition to communication styles, being upfront and honest about expectations, intentions, resources, or any limitations are key to building trust. This can be done by providing ongoing project updates, sharing results, and reporting back to the Indigenous community in the form of emails, phone calls, mail outs and routine meetings. Doing this demonstrates commitment to the partnership and can show the community that their responses were heard and used.[13]

Past issues, conflicting perspectives, or limited capacities and resources may lead Indigenous communities and organizations to decline the offer to develop deeper engagement, in which case regular communication is a viable alternative to maintaining and developing a positive relationship with the Indigenous community.

9.2.1 Relationship Models with First Nation Communities

Strengthening relationships between Indigenous communities and boards of health

Strengthening local relationships between Indigenous communities and boards of health enhances public health programs and services leading to improved health outcomes. There are many ways this may be achieved including:

- Providing cultural competency training to assist public health staff gain more knowledge about the customs and traditions of the Indigenous communities in their catchment area. This provides a means for health units and Indigenous communities to engage in dialogue to better understand each parties' respective needs and expectations in relation to public health.
- Initiating public health dialogue sessions with First Nation communities and the board(s) of health staff can build relationships and provide opportunities to discuss public health priorities.
- Inviting First Nations, Inuit and Métis health services providers to training and/or workshops, sharing relevant public health information, and sharing information on regional public health data.

Shared delivery of public health services

Sharing of resources and/or program infrastructure at the federal, provincial and/or local level can increase access to public health services for Indigenous communities. In First Nation communities' on-reserve, health services are funded by the provincial and federal government (see above: Federal and Provincial Responsibilities for Indigenous Health). The community's Health Director can provide information regarding federal health services and through collaboration, an integrated program may be developed.

Promising practices include:

- Exploring partnerships with the federal government and First Nation communities to develop models of integrating federal and provincial public health programs (e.g. to improve access to oral health services in Northern communities).
- Exploring ways to partner with a First Nations organization to address urgent public health priorities (e.g. dog population management in remote areas to promote safer communities).

Informal agreements and/or memorandums of understanding (MOUs)

Once a relationship has been established, an informal agreement and/or an MOU may be negotiated between Indigenous communities and board(s) of health to outline a process for delivering public health services more effectively to communities in a region.

Promising practices include:

- Collaborating with a First Nations organization on a relationship framework agreement to enhance public health services to Indigenous communities and the board of health. The framework may include an environmental scan of current services and cultural competency training for public health unit staff.
- Collaborating with a First Nations community on an MOU for delivery of specific public health programs and services by the board(s) of health to the community.

Formal agreements

A formal agreement regarding public health services and delivery may be negotiated between First Nations communities and boards of health. This includes exploration of establishing a Section 50 Agreement (under s.50 of the *Health Protection and Promotion Act*) which enables First Nations communities to enter into formal agreements with boards of health whereby:[2]

- The board agrees to provide health programs and services to members of the First Nation community;
- The First Nation Council agrees to accept the responsibilities of a municipality within the health unit; and
- The First Nation Council may appoint a member of the community to sit on the board of health.

The Section 50 Agreement can take many forms, ranging from an agreement for a specific service(s) to an agreement for all public health services. The type of agreement negotiated will depend on the needs of the First Nation community.

Integrated public health service models

The development and implementation of federally and provincially integrated public health service delivery models for First Nations communities is a longer term approach to resolving jurisdictional issues, enhancing partnerships and improving access to public health services. This process needs to be designed and led by an Indigenous-governed organization as the programs and services would be delivered by First Nations and requires a commitment from all partners including board(s) of health, MOHLTC, the

federal government, and First Nation leadership. This approach requires strong community ownership and engagement, and a plan that is endorsed by First Nations leadership, as appropriate.

Further information on potential integrated public health service models are provided in the Relationship with Indigenous Communities Toolkit.

9.2.2 Relationship Models with Urban Indigenous Individuals, Organizations & Communities

Informal arrangement

As a relationship with urban Indigenous organizations develops, it is likely that agreements and engagements will evolve without clear terms, objectives or responsibilities. Informal arrangements with Indigenous organizations are not defined by timelines, outcomes, or resource sharing but rely on reciprocal respect. As an early relationship stage, informal arrangements allow for mutual trust and goal-sharing, resulting in opportunities to formalize the relationship further on.

Promising practices include:

- Identifying an appropriate process based on the scope and impact of the proposed relationship, action and outcomes.
- Attending Indigenous organization and community events and inviting Indigenous organizations and community members to public health events.
- Organizing meet-and-greet sessions for both boards of health and Indigenous organizations to learn about organizational mandates and services.

Referral relationship

Urban Indigenous organizations may be primary points of referral for urban Indigenous community members. Referring to community-based Indigenous organizations ensures that Indigenous individuals and families are provided the option of culturally-based approaches recognizing the significance and impact of the social determinants of health.

Promising practices include:

- Understanding of the local Indigenous programs and services offered and relationship development with staff.
- Continuous open communication on organizational operations and the local Indigenous community.
- Ideally formalized referral process between organizations.
- Understanding diversity of service providers and organizations within urban Indigenous communities.

Collaboration

Urban Indigenous organizations shall be included in the development of initiatives that will affect their communities, as they will help guide the process for appropriate engagement and development.

This may also involve a specific Indigenous engagement process where, on behalf of the board of health, Indigenous organizations may be responsible for coordinating and facilitating engagement with Indigenous community members and representatives.

Promising practices include:

- Inviting Indigenous organizations to participate in public health initiatives from the beginning and being clear about community priorities.
- Being flexible on participation, timelines, resources, and capacity limitations.
- Inviting Indigenous organizations to participate to provide perspectives to local planning boards and committees.

Formal partnership

Collaborative processes often result in the development of a formal mechanism to oversee and manage the processes, in some cases, over a multi-year period; they are guided by a formal agreement. This is often accompanied by a detailed work plan which lays out key activities and deliverables that will be undertaken to support the process. This approach promotes accountability and transparency and supports mutually agreeable outcomes that have a greater likelihood of success.

Protocol agreements, MOU, Letters of Understanding or Intent, and other types of written agreements can define the terms of a working relationship between board(s) of health and urban Indigenous organizations. Written agreements help to define the roles, responsibilities, and ways each service provider, agency, or organization is expected to interact with one another. They are useful for conveying expectations for organizational and cultural protocols that should be observed by signatories.

Promising practices include:

- Establishing a formal agreement that outlines key activities, deliverables, and expectations to promote collaborative decision making.
- Continuous engagement throughout the process – the identification of the problem, development, design, implementation, and evaluation.

Relationship with the Métis Nation of Ontario (MNO)

The Métis Nation is currently under-identified and under-represented in health research. With Métis representing approximately one third of Ontario's total Indigenous population, engagement is necessary to influence and implement policies that reflect Métis voices and address Métis challenges – policies that are not only authored under the guise of an Indigenous framework; but rather, a Métis specific framework.[14]

Communication: All requests for engagement are to be communicated to MNO's Chief Operating Officer who, as the direct point of contact for the engagement process, will delegate the request accordingly. With over 200 MNO staff and multiple office locations, the most fruitful engagements will occur under the guidance of the Chief Operating Officer who will efficiently pinpoint the most suitable staff, program, location and participants for engagement.

10. Use of Health Information

The landscape of health information involving Indigenous communities is changing rapidly; there is a strong movement towards Indigenous-defined and Indigenous-controlled approaches. Conducting research on Indigenous health issues is complex and requires special knowledge and training in the areas of Indigenous health, participatory research methodology and research ethics.

There are several initiatives underway supporting Indigenous communities in gaining a better understanding of the health of their communities, and the impacts of public health programs and services. These initiatives are led by Indigenous communities, and may include the engagement and support of their local board(s) of health and other information based organizations. Examples include the development of population health data collection system as well as individual disease-specific information and knowledge-exchange opportunities.

One source of First Nations health information is the First Nations Regional Health Survey (RHS). This is a First Nations-governed, national health survey in Canada that collects information about on reserve and northern First Nations communities based on both Western and traditional understandings of health and well-being. The National RHS Phase 2 was initiated in 2008 and completed in the fall of 2010, which included ten participating regions in Canada, including Ontario.[15] It is also being adapted by some First Nations as the basis for population health assessments in their communities.

In the past, Indigenous Peoples had often not been consulted about what information should be collected, who should gather that information, who should maintain it, and who should have access to it. The information gathered may or may not have been relevant to the questions, priorities and concerns of Indigenous Peoples. Because data gathering has frequently been imposed by outside authorities, it has met with resistance in many quarters.[16]

The principles of Ownership, Control, Access and Possession (OCAP) emerged in response to First Nations' concerns about the negative aspects of externally driven research. OCAP applies to all research, data or information initiatives that involve First Nations. It is also used by other Indigenous communities but is not intended to limit or prevent the development of population health data and research.

OCAP is self-determination applied to research and defined as:

Ownership: Refers to the relationship of a First Nations community to its cultural knowledge/data/information. The principle states that a community or group owns information collectively in the same way that an individual owns their personal information.

Control: The aspirations and rights of First Nations to maintain and regain control of all aspects of their lives and institutions include research, information and data. The principle of control asserts that First Nations Peoples, their communities and

representative bodies are within their rights in seeking to control all aspects of research and information management processes which impact them. First Nations control of research can include all stages of a particular research project – from conception to completion.

Access: First Nations people must have access to information and data about themselves and their communities, regardless of where it is currently held. The principle also refers to the right of First Nations communities and organizations to manage and make decisions regarding access to their collective information. This may be achieved, in practice, through standardized, formal protocols.

Possession: While ownership identifies the relationship between a people and their data in principle, possession or stewardship is more literal. Although not a condition of ownership, possession (of data) is a mechanism by which ownership can be asserted and protected. When data owned by one party is in the possession of another, there is a risk of breach or misuse.[17]

For in-depth context and guidelines on health information involving First Nations and Indigenous communities, please see the following resources:

- First Nations Information Governance Centre – www.fnigc.ca
- Canadian Institutes of Health Research; Natural Sciences and Engineering Research Council of Canada; Social Sciences and Humanities Research Council of Canada. Tri-council policy statement (TCPS): ethical conduct for research involving humans. Ottawa, ON: Her Majesty the Queen in Right of Canada; 2014. Chapter 9, Research involving First Nations, Inuit and Metis peoples of Canada. Available from: http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/chapter9-chapitre9 /
- First Nations Centre. Health information, research and planning: an information resource for First Nations health planners. Ottawa, ON: National Aboriginal Health Organization; 2009.First Nations Centre. Ownership, control, access, and possession (OCAP) or self-determination applied to research: a critical analysis of contemporary First Nations research and some options for First Nations communities. Ottawa, ON: National Aboriginal Health Organization; 2005.

Afterword

The *Relationship with Indigenous Communities Guideline, 2018* (or as current) provides a brief overview of Indigenous communities and organizations in Ontario and potential approaches for engagement, with the understanding there is no “one size fits all” approach. The guideline is intended to be evergreen and will be updated, as needed. More information and resources are provided in the Relationship with Indigenous Communities Toolkit.

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