CULTURAL COMPETENCY GUIDELINE FOR ONTARIO PUBLIC HEALTH UNITS TO ENGAGE SUCCESSFULLY WITH ABORIGINAL COMMUNITIES

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Indigenous Primary Health Care Council

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Kāhui Tautoko Consulting Ltd hope the findings of this report help further strengthen the relationships between Public Health Units and Aboriginal communities across Ontario.

No reira, ngā mihi māhana ki a koutou.

Tēnā koutou, tēnā koutou, tēnā koutou katoa.

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EXECUTIVE SUMMARY

"In this report, the terms Aboriginal and Indigenous are generally used interchangeably. Indigenous peoples is the term accepted by the United Nations Declaration on the Rights of Indigenous Peoples, and is in increasing usage today. In the Canadian context, there are three Aboriginal groups recognized by the Constitution: First Nations, Inuit and Métis. It is important to note that throughout this report, we recognize and respect each interchangeable term as described by the authors of their statement or commentary"

Purpose

In 2018, the Ministry of Health and Long-Term Care (MOHLTC) enhanced the language of the Ontario Public Health Standards which explicitly calls for governance and boards of health to engage with Indigenous communities and organizations as well as with First Nation, Inuit and Métis communities. Public Health Units (PHU's) play a critical role in tailoring programs and services to meet the needs of local Indigenous communities. Given this context, there is a need for guidance on effective and successful engagement.

In 2017, the Aboriginal Health Access Centres (AHAC) and Aboriginal Community Health Centres (ACHC) Leadership (now known as the Indigenous Primary Health Care Council) working in partnership with the Association of Ontario Health Centers (AOHC) and the Ontario Ministry of Health and Long-Term Care, commissioned Kāhui Tautoko Consulting Ltd (KTCL) to undertake a review to support the development of a cultural competency guideline for Ontario Public Health Units (PHUs) to successfully:

- Develop good protocols and processes for engaging with the Aboriginal community including AHACs and communities;
- Develop strong partnerships for the success of all partners involved in service delivery; and
- Improve stakeholder relations between PHUs and Aboriginal communities

This work aims to raise the cultural safety practice of workers and organizations who are working in and with Aboriginal communities in order to improve processes and outcomes of Public Health work for the benefit of the Aboriginal population.

For this review – cultural safety, effective engagement and collaboration opportunities (between PHUs and AHACs / Aboriginal service providers) have been explored – as each dimension has the intention of resulting in successful collaborative partnerships between Ontario PHUs and Aboriginal service providers (e.g. AHACs) to better serve the Aboriginal population. The findings have clearly demonstrated that culturally safe engagement *can* result in successful collaborations and offer opportunities for effective and pragmatic collaboration between Ontario PHUs and AHACs that deliver primary health care (defined as an integrated model of delivery that includes primary care services and public health programs). Further the literature review research and the engagement sessions with PHUs has provided examples of similar collaborations that have benefitted both the providers and the target populations. The work is important to both PHUs and the Aboriginal community. Persistent health disparities in the Aboriginal community highlight the need for collaborative and culturally appropriate partnerships between PHUs and Indigenous service providers.

Cultural Safety in Public Health

Supporting Indigenous or Aboriginal individuals and communities within health requires trust, compassion, and mutual respect - however in today's day in age, this is still not being achieved consistently. Systemic racism continues to be a major barrier to positive engagement and relationships between health care workers (and organizations) and Indigenous communities. Systemic racism is often referred to as interpersonal or relational racism when people experience some form of discrimination – intentional or unintentional. The expectation is that all health care providers and workers will commit to providing culturally safe care.

What is evident from the review is that there are many definitions of the terms: culture and Aboriginal culture; cultural responsiveness; cultural appropriateness; cultural awareness; cultural sensitivity; cultural competency and cultural safety. Users develop their own definitions in order to apply them in the context they intend to use them. This flexibility and adaptability will and should always remain since culture – and

Aboriginal culture - is a continually evolving and changing concept. Aboriginal culture in itself is therefore about a people who share an indigenous history; who express beliefs and values, actions, customs, language and traditional knowledge often in a common way; but who are different intra-culturally and inter-culturally. Aboriginal peoples belonging to different cultural groups within Aboriginal society, also belong to many other 'cultural' groups such as those related to their age, wisdom and experience (e.g. Elders), those related to their professions (such as Aboriginal Physicians) or those related to their gender (such as Aboriginal women). Overall, Aboriginal culture is dynamic. What makes Aboriginal culture in Canada specifically unique and different to all other cultures that exist in the country – is that Aboriginal culture centres itself on indigeneity (belonging or originating naturally in a land or region). Aboriginal culture has no other equivalents in Canada since no other cultural group in Canada has or continues to experience what the Aboriginal population has experienced through the many manifestations of colonization that have occurred.

Cultural competency and safety refer to:

- ⇒ People development (ability of the practitioner to take knowledge, lessons and experiences about culture learned over time either through their own life and/or through formal learning) and being able to apply them to their practice to improve the health outcomes for the service user or patient.
- ⇒ Organisational development (processes, policies, practices being in place that increase access of services and remove any perceived barriers for the Aboriginal population; that support personnel practicing in a culturally competent way; that ensure community members have a culturally safe experience and that results in improved outcomes).

Effective Engagement with Aboriginal Communities

This report provides a brief overview of the Ontario Government's policy on the relationship with Aboriginal peoples in Ontario. Since PHUs are effectively an extension of government it makes sense that PHUs review and understand this policy position as it provides the 'umbrella' under which engagement activity happens with Aboriginal communities in a manner which is consistent with provincial policy. The Ontario Government has signed protocols with both First Nations and the Mètis Nation of Ontario which focus on strengthening relationships that respect Aboriginal Rights and Title - but also benefit the social, cultural and economic well-being of Aboriginal peoples while protecting and promoting their distinct cultures, identities and heritage. Further the Ontario Government policy and commitments essentially places a responsibility on PHUs to help support the achievement of social, cultural and economic goals of Aboriginal peoples through wellness-oriented approaches. Literature provides a number of pointers for effective engagement and communications with Aboriginal communities.

A certain level of understanding of the historic changes and impacts of colonization should be included as part of any ongoing engagement and capacity building process within health care before engaging with indigenous communities. Evidence confirms that colonization and systemic discrimination has led to adverse, multi-generational health effects, which continues to have a significant impact on the current health status of Aboriginal people. Key concepts to be aware of when engaging with Aboriginal communities also lie in understanding the principle of reciprocity and that engagement is an exchange of information and knowledge. Along with the concept of reciprocity, PHUs need to reflect on how power and privilege and racism and oppression might affect behaviors; decisions and resource allocation within the public health system.

Opportunities for Collaboration and Partnerships: PHUs and Aboriginal Communities

Many of the articles and publications that were reviewed often use 'collaboration' and 'integration' inter-changeably. For the purposes of this report, the term 'collaboration' is favoured. There are some positive lessons about enablers and facilitators for collaboration as well as barriers to such collaboration that the Ontario PHUs and AHACs / Aboriginal service providers can learn from to seek out opportunities. The evidence identifies that public health (PHUs) and primary health care (AHACs) collaboration can and does occur at a variety of levels. One article describes four levels of collaboration: Intra-personal (within the professional field); Inter-personal (between public health and primary care professionals; organizational

(between some organizations); and systemic (across the system at a regional, state or national level for instance).

The report generally identifies the enablers or facilitators of collaboration between the two systems as well as the barriers to collaboration – and there is also evidence of many examples of positive and negative outcomes of such collaboration that are cited in the evidence. The literature also identifies that for several functions in Public Health and Primary Health Care, there can be identifiable responsibilities allocated to each but there are several functions where overlap can occur – mostly in health promotion; health surveillance and disease and injury prevention. Additionally there are several benefits to the population's health by having public health play a greater role in accessing primary care data to better monitor and report on the health of the population, and to identify high risk populations and health conditions. The literature identifies a number of areas where PC and PH have collaborated successfully elsewhere which provide opportunities in Ontario - for example: community education activities and needs assessment.

A high level framework for PHUs to consider when looking at how collaboration with AHACs / Aboriginal service providers might occur – is across three levels - system, organizational and inter-personal.

1. INTRODUCTION

For 35 years, the Association of Ontario Health Centers (AOHC) has continually strived towards a shared commitment to recognizing and confronting barriers to equitable health and wellbeing to achieve its strategic vision for "The best possible health and wellbeing for everyone living in Ontario". AOHC is Ontario's voice and advocates for over 100 community-governed primary health care organizations including the ten Aboriginal Health Access Centres (AHAC) across Ontario.

The Ontario Ministry of Health and Long-Term Care (MOHLTC) is responsible for administering the health care system and providing services across Ontario. In 2018, MOHLTC enhanced the language of the Ontario Public Health Standards which explicitly calls for governance and boards of health to engage with Indigenous communities and organizations as well as with First Nation, Inuit and Métis communities. In February 2018, Ministers of MOHLTC were quoted in saying:

"Historic investments to improve the health and well-being of Indigenous communities have only been possible through respectful partnerships between Ontario and Indigenous partners" – Dr Eric Hoskins Minister of Health and Long-Term Care

"Improving the health, healing and wellness of Indigenous people through culturally appropriate services and programs is an important step on the journey of reconciliation and can only be done by working hand in hand with Indigenous partners"- David Zimmer Minister of Indigenous Relations and Reconciliation

These quotes are further supported by the 2015 Historic Political Accord signed by the Chiefs of Ontario and the Government of Ontario to guide the relationship between First Nations and the province; Ontario's First Nations Action Plan describing the investment to ensure that Indigenous people have access to more culturally appropriate care; and the "Journey Together" paper outlining Ontario's commitment to reconciliation with Indigenous peoples.

Public Health Units (PHU's) play a critical role in tailoring programs and services to meet the needs of local Indigenous communities. Given this context, there is a need for guidance on effective and successful engagement. To that end, the Aboriginal Health Access Centres (AHAC) and Aboriginal Community Health Centres (ACHC) Leadership (now known as the Indigenous Primary Health Care Council) working in partnership with the Association of Ontario Health Centers (AOHC) and the Ontario Ministry of Health and Long-Term Care, commissioned Kāhui Tautoko Consulting Ltd (KTCL) to undertake an independent review to support the development of a cultural competency guideline for Public Health Units to successfully:

- Develop good protocols and processes for engaging with the Aboriginal community including AHACs and communities;
- Develop strong partnerships for the success of all partners involved in service delivery; and
- Improve stakeholder relations between PHUs and Aboriginal communities

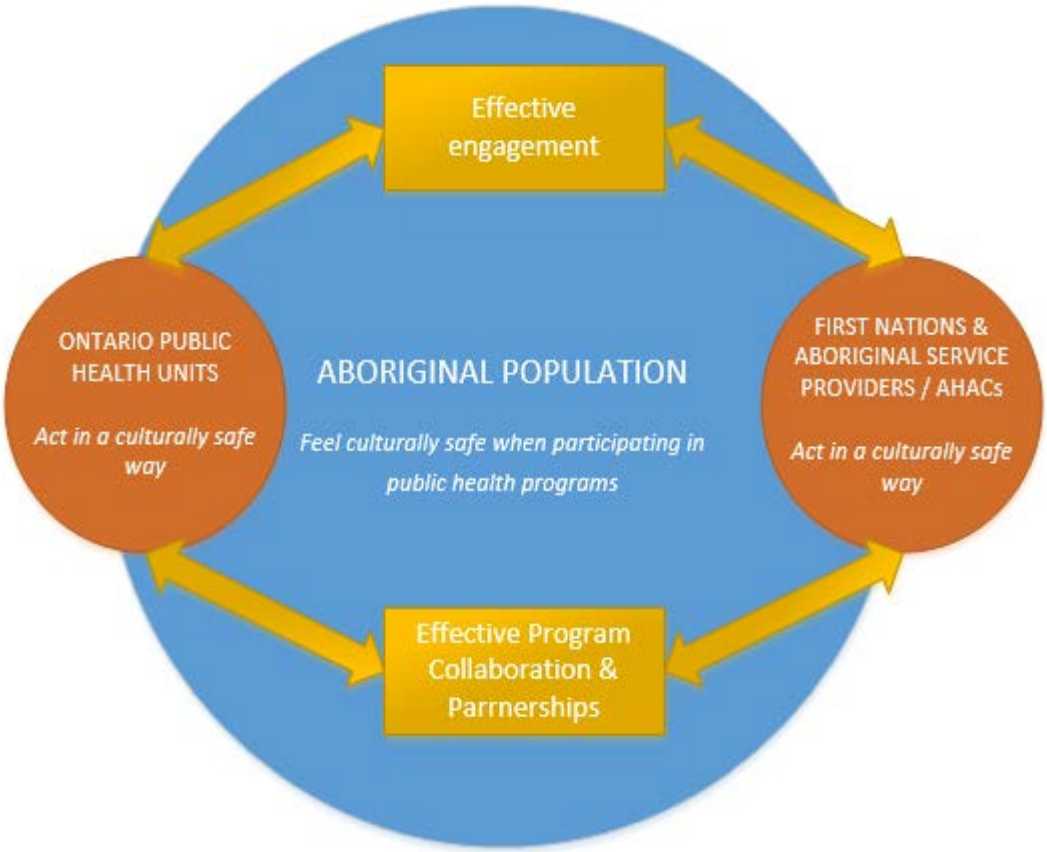
This work aims to raise the cultural safety practice of workers and organizations who are working in and with Aboriginal communities in order to improve processes and outcomes of Public Health work for the benefit of the Aboriginal population.

The work is important to both PHUs and the Aboriginal community. Persistent health disparities in the Aboriginal community highlight the need for collaborative and culturally appropriate partnerships between PHUs and indigenous service providers.

1.1 Defining Scope

There is an expectation that improving the cultural safety of Ontario Public Health Unit workers and organizations (both regionally and nationally) should lead to more effective and culturally appropriate engagement processes with Aboriginal service providers and the Aboriginal population. This improved engagement process should by definition lead to more effective partnership and collaboration between service

providers and with the community - that benefits the health of the Aboriginal population. Furthermore, culturally safe PHU workers should create an environment where the Aboriginal community and service providers feel culturally safe themselves when interacting with PHUs viz:



To be of value to Public Health Units, the review therefore incorporates the following components:

- Defining and exploring cultural safety in a health setting so that it is clear what 'culturally safe PHUs' could and should look like;
- Defining effective engagement processes with the Aboriginal community based on best practices;
- Exploring opportunities for effective Public Health program collaboration and partnership with the Aboriginal community, including Aboriginal service providers such as AHACs who also deliver public health programs (but may also deliver primary care services as well).

Therefore, the report includes researched evidence on cultural safety; Aboriginal engagement; and public health collaboration.

In scoping the review, the writers were cognisant of the need to produce advice that would be of value to Ontario's Public Health Units (PHUs). Investigating successful engagement techniques are not helpful if not done in the context of understanding the reason WHY the engagement is occurring. The work has been commissioned to support PHU workers to engage successfully with Aboriginal service providers and communities in a culturally safe way. In order to achieve this goal there is a need to understand what culturally safe practice means and looks like – but also what the engagement is intended to result in. In this case the writers have assumed that engagement is for the purposes of supporting successful collaborative partnerships with Aboriginal service providers (e.g. AHACs) to better serve the Aboriginal community. It is vital therefore to look at what collaborative partnerships could look like, and where the interface lies between PHUs and AHACs (and other Aboriginal service providers) who also deliver Public Health programs as well as primary care services.

2. METHODOLOGY

2.1 Methodology Scope

The scope of this review was to respond to a request to support the development of a Cultural Competency Guideline for Public Health Units (PHUs) to engage successfully with Aboriginal communities including Aboriginal Health Access Centres (AHACs) and Aboriginal Community Heath Centre (ACHCs). The methods for the development of the PHU Cultural Competency Guideline included the following timelines and activities:

October 2017:

- Initial discussion with key stakeholders overseeing project
- Brief review of current appropriate Aboriginal engagement guidelines

November 2017:

- Literature review of 160 articles to identify similar guidelines and tools that support health teams and government agencies to engage effectively with Aboriginal and Indigenous communities across Canada, USA, Australia and New Zealand. Key words applied included various combinations of: public health; primary care; population health; cultural safety; engagement; consultation; communications; best practices; successful and effective programs; evaluations; indigenous; Aboriginal; First Nation; Torres Strait Islander; Native American; Alaska Native; and Māori – for each country.

February 2018:

- Engagement with three PHU sample sites (Sudbury, Toronto and London) to seek recommendations, ideas and any concerns about current relationships between PHUs and Aboriginal communities and to hear proposed solutions to improving relationships

This project was undertaken in conjunction with the "Moving Forward on Diabetes" review to avoid the duplication of multiple site visits across Ontario and saving on logistical costs.

This report contains the results of the Aboriginal guidelines paper; literature review and engagement with the 3 sample PHU engagement sessions undertaken between October 2017 and February 2018 by KTCL. Aboriginal Health Access Centres (AHAC) and Aboriginal Community Health Centres (ACHC) Leadership (now known as the Indigenous Primary Health Care Council) will make its own decisions as to whether it implements any or all of the recommendations contained in this independent report. KTCL will not release or discuss any information learned from the review process outside of the organization.

2.2 Scope Amendment

From a discussion with MOHLTC in December 2017, it was determined that the scope and timeline expectations of KTCL's contract differentiated from that of MOHLTC's requirements. From the Ministry's perspective, the *Relationship with Indigenous Communities Guideline* requirement was essentially 'how do AHACs want PHUs to engage with them?' and formed a chapter within a broader document due for release by the end of January 2018. From the AOHC's contract with KTCL, the *Engagement Guideline* was to develop a guideline for PHUs to engage with Aboriginal communities; develop 'good protocols and practices for engaging with Aboriginal communities *'including AHAC's'*; developing strong partnerships for successful service delivery; and recommendations for strengthening stakeholder relationships. This being due for submission in March 2018 (this report) after the completion of the PHU and AHAC engagement sessions. While KTCL accommodated this scope and timeline change and submitted an "AHAC engagement chapter" for the MOHLTC *Relationship with Indigenous Communities Guideline* in early January, the engagement process with the AHAC's and the three PHU sample sites (London, Sudbury and Toronto) in February 2018 meant their views were not reflected or validated in the MOHLTC guideline. However their views are expressed in this report. At the time of submitting this report, the MOHLTC guideline was yet to be finalized and published.

2.3 Limitations of the review

Due to the itinerary limitations, there was only sufficient time for KTCL to engage with the Access and Equity team within Toronto Public Health Unit. The site visit dates also conflicted with the Chiefs of Ontario Health forum also making it difficult for PHU staff availability in Toronto.

3. CULTURALLY SAFE PUBLIC HEALTH CARE

3.1 Why Cultural Safety is Important

3.1.1 Government Priority

The Government of Canada is committed to building a renewed relationship with Indigenous Peoples based on the recognition of rights, respect, cooperation and partnership. To that end, the Government launched a major review and reform of its laws, policies and operational practices to help ensure that the Crown is:

- Meeting its constitutional obligations with respect to Aboriginal and treaty rights
- Adhering to international human rights standards, including the United Nations Declaration on the Rights of Indigenous Peoples
- Supporting the implementation of the Truth and Reconciliation Commission of Canada's Calls to Action (TRC released its report and 94 calls to action to begin repairing the relationship between Canada and Indigenous people)

The Canadian Health Act claims accessibility as one of its five guiding principles. Accessibility involves the ability to appreciate the evolving community and the capacity to respond. Barriers to access are generally in three areas: cultural / language barriers; socio-economic barriers and systemic barriers of accessibility and equity. Many Aboriginal peoples face all three barriers in the Western or mainstream health care system in Canada. Research over the past 20 years has demonstrated that quality of care requires attention to differences in culture: "*The integrated pattern of human behaviour that includes thoughts, communications, actions, custom, beliefs, values and institutions of a … ethnic group*"

Supporting Indigenous or Aboriginal individuals and communities within health requires trust, compassion, and mutual respect - however in today's day in age, this is still not being achieved consistently. Systemic racism continues to be a major barrier to positive engagement and relationships between health care workers (and organizations) and Indigenous communities. Systemic racism is often referred to as interpersonal or relational racism when people experience some form of discrimination – intentional or unintentional. The expectation is that all health care providers and workers will commit to providing culturally safe care.

Cultural differences between patients and providers can lead to: diagnostic errors, harmful drug interactions resulting from simultaneous use of conventional and traditional medicines; inadequate patient adherence to clinical recommendations about prescriptions, care and treatment plans (due to differences in hearing and understanding jargon and instructions) and higher rates of hospital admission. Cultural responsiveness extends beyond language to include a much larger set of professional attitudes, knowledge, behaviours and practices, and organizational policies, standards and performance management mechanisms to ensure responsiveness to the diversity of patients who walk through health services' doors. It is for all of these reasons [and many more of a political and historical nature] that cultural safety for Aboriginal peoples is important and why the work of the Ontario Public Health Units is vital to improve health outcomes for Aboriginal peoples of Ontario.

3.1.2 Improved Clinical Practice and Health Outcomes

There are many international studies which have highlighted less effective health outcomes and clinical practices occurring for people of other non-dominant cultures or minority cultures such as indigenous peoples. Interestingly much has been written about the effects of cultural negligence on people of colour, Hispanic / Latino communities and Black American populations. Not nearly as much research has been done on the effect of cultural negligence on indigenous populations however recommended references include the 'First People Second Class Treatment', 'Our Health Counts' and 'Wise Practices for Indigenous-specific Cultural Safety Training'. The following are a few examples of other studies.

Todd et al (1993) state in the findings of their research entitled 'Ethnicity as a risk factor for inadequate emergency department analgesia' that Hispanic patients with fractures to the humerus, radius, ulna, femoral shaft, tibia, and fibula were less likely to receive emergency department (ED) analgesics (pain relief) than similar non-Hispanic white patients. Results showed that non-Hispanic whites were twice as likely to receive ED pain medication and Hispanics were more likely to receive low-dose, oral or non-narcotic analgesics. After

controlling for several variables including ethnicity, sex, language, and insurance status, Hispanic ethnicity was still the strongest predictor of no analgesic. The research suggest several reasons for this difference including the presence of patient advocates who might influence physicians and the failure on the part of physicians to recognize pain in culturally different patients.

Burns et al (1996) report on study entitled 'Black Women receive less mammography even with similar use of primary care'. Using Medicare claims from ten states, this article examines differences in mammography use between elderly black and white women. The use of mammography seems to increase as primary care visits increase, but black women had lower use rates than white women across all levels of primary care. However, within race, mammography use by black women did not vary greatly.

Research has demonstrated that physicians are more likely to encourage elderly white women to obtain mammograms than elderly black women, highlighting concerns around provider attitudes. Black women have also been shown to have less knowledgeable about mammography than white women, highlighting concerns about patient education.

These are just three examples of cases where cultural difference does not appear to have been taken into account by health practitioners when dealing with peoples of other cultures. This is evidence that health outcomes can be improved when cultural diversity is taken into account during the process of providing health services.

3.1.3 Growing Diverse Populations and Patients

In light of the diversity of the Canadian population, the application of cultural competence in health care relationships holds particular relevance in Canada. Demographic figures gathered by Statistics Canada provide evidence of the non-homogenous nature of the Canadian population and thus reinforce the necessity of a culturally competent health care system. Canada is a country with citizens from various cultural backgrounds. The 1996 census conducted by Statistics Canada identified the ethnic diversity of the Canadian population. Of those reporting only a single ethnic origin, approximately two-thirds of respondents claimed to be of European origin and nearly one-third simply claimed to be of Canadian origin. Of the respondents reporting more than one ethnic origin, the most common origins were Asian, Aboriginal, Caribbean, Arabian and African.

Canada also has a sizeable immigrant population. The total number of immigrants between 1961 and 1996 was 4,971,070. The ethnic composition of the immigrant population has been dynamic over the years. In 1957 the top ten source countries of immigrants were European; whereas, in 1997, eight of the top ten were non-European. Furthermore, in 1999, the top three regions of origin were Asia and Pacific (51%), Europe and the United Kingdom (21%) and Africa and the Middle East (18%).

Another factor, inextricably intertwined with culture is language. One study titled "Language Barriers in Access to Health Care", recognizes that language is not the only cultural barrier in access to health care; however, language is the basis for further understanding. When the client and the health care provider can communicate on a basic level, this provides a foundation for a more positive health care interaction. The importance of language runs deeper than the necessity for health care providers to be able to work in one of Canada's two languages (French or English).

3.1.4 Aboriginal use of Mainstream Services Programs like Public Health

Community strengths enable Aboriginal people to survive and overcome the many challenges that have a current and historical basis. These strengths include individual and group persistence, and a determination to establish a rightful place in society and on the land. For many, the desired changes to health may best occur through healing ways that are based on a holistic approach. This concept integrates the physical, mental, emotional and spiritual aspects of the person. It also hinges on connections between the individual, family, community, kin, relations and all of creation. According to this perspective, a healthy person is balanced and in harmony with the material and spiritual worlds. Mainstream services that provide support in neighbourhoods with high proportions of Aboriginal people benefit from including more Aboriginal people on their staff to help achieve this goal of holism and connection. *"Health care professionals should reflect the diversity of Canadian society and understand the ethnic backgrounds of the populations they serve".*

Mainstream services tend to receive higher usage after outreach activities or after hiring Aboriginal staff. This is an essential step to Aboriginal people moving beyond crises management and reactive health care into prevention. As important are respectful relationship that welcome each participant as a unique human being whose history partially explains current behaviour. For people who are feeling bad, such things as body language, tone of voice, rapidly spoken medical jargon, 'rough' words and being stereotyped each create barriers that people withdraw from. These factors may explain in part why Aboriginal people attend a mainstream program, support, or service once – and then do not return.

Aboriginal people receive health services through a unique combination of federal, provincial, and Aboriginal-run programs and services. For Aboriginal people, ongoing federal/provincial jurisdictional and funding issues have created gaps and inadequacies in health services. Improved access, greater Aboriginal control and involvement, and improved working relationships with the health system are some of the needs that have been recognized.

Use of mainstream services by Aboriginal peoples often demonstrates two phenomena – they are either higher users of services than non-Aboriginals (e.g. emergency rooms being used as first port of call primary care services) or they are lower users of services than non-Aboriginals (e.g. some medications; child health and immunizations). In both cases there is a problem. Low usage does not necessarily mean that there is not a health need. High use does not necessarily mean more of those types of services are needed. In most cases, high use of emergency rooms for instance demonstrates access barriers to primary care (either through cost, distance or appropriateness barriers). Low use may also mean there are access barriers where there shouldn't be. Either way – both situations create health inequalities between Aboriginal and non-Aboriginal peoples. It is essential that these gaps are closed and that government health agencies as the main deliverers of mainstream services, identify where these gaps are, and what strategies they need to employ, to close them.

3.1.5 Aboriginal Health Status Needs Attention

As stated in a variety of health reports, the standard of living for an Aboriginal person living in Canada and Ontario is likely to be 20 percent below the national and provincial averages, based on measures such as income, employment, education attainment and housing adequacy. Indigenous people in Ontario experience lower health status, including shorter life expectancy, higher infant mortality and higher rates of chronic and infectious diseases. The chances are any disease or health condition from diabetes, pneumonia, or HIV/AIDS to injuries caused by a motor vehicle crash – are more likely to happen to an Aboriginal rather than non-Aboriginal. Life expectancy is lower for Status Indians. These facts are certainly not new. They describe a well-known and longstanding inequality in health and social status – an inequality that affects indigenous people in Canada and around the world. Many statistics about the Aboriginal population are grim however there are improvements that have been seen in areas like infant mortality for instance. These huge gains in health are due to the extraordinary resilience and capacities of Aboriginal peoples; cultural and political resurgence: and the success of targeted programs and services and some improvements in social-economic conditions (e.g. housing on reserve, educational attainment).

National surveys have found that chronic conditions such as heart disease, diabetes and arthritis are more common among Aboriginal people. The number of people experiencing these chronic conditions will increase in the coming years, because of population growth and because health and illness patterns are shifting from infections to chronic diseases.

Most of the available health statistics on Aboriginal people relate to those who live on reserve. There is a critical need for accurate, region-specific data about the health problems that Aboriginal people experience, including non-status First Nations, Mètis and Aboriginal people living in the urban areas.

Health Authorities and Public Health Units have a significant role to play in influencing these health inequalities and improving health outcomes for Aboriginal peoples.

3.2 Cultural Safety Definitions

3.2.1 Cultural Definitions in health care – what does it all mean?

There are many definitions and iterations of culture in health care – all with different meanings but many with overlaps. It is important for PHUs to agree on what 'cultural safety' means and the differences, similarities or connections between this term and others used in different contexts. By being clear what it means for the Ontario PHUs then it will be easier to implement transformational processes to work toward culturally safe programming, and measurement against goals will also be easier. Any agency or institution using the term(s) needs to state their own definitions so it is clear to their own readers, users, students or staff – what they mean when they apply the terms. The mostly commonly used terms associated with cultural safety are:

- Cultural responsiveness
- Cultural appropriateness
- Cultural awareness
- Cultural sensitivity
- Cultural safety
- Cultural competency

Often these terms have been used interchangeably for training purposes – when in fact the training content has sometimes been the same or very similar. The following outlines some definitions used within Canada and other countries for the above terms.

3.2.2 Culture

It is important to define what is meant by culture. Definitions of culture are often confused by using terminology such as 'race' and 'ethnicity' but a basic definition of culture reveals a far broader understanding. One definition of culture is:

'The totality of socially transmitted behaviour patterns, arts, beliefs, institutions, and all other products of human work and thought. These patterns, traits, and products considered as the expression of a particular period, class, community, or population and can be expressed in intellectual and artistic activity and in the works produced by the 'culture' or 'culture group'

Culture is essentially a convenient way of describing the ways members of a group understand each other and communicate that understanding. More often than not, the nuances of meaning are generated by behaviour rather than words, and much of the interaction between members is determined by shared values operating at an unconscious or 'take for granted' level. Many groups have their own distinctive culture: the elderly, the poor, professional groups, gangs and the army according to one researcher. Culture is increasingly recognized as a crucial variable in the delivery of health care services. Diagnosis, treatment and program planning and implementation require special skills and sensitivities when the health care practitioner and the patient / community are from different cultures. In terms of Canada, the Canadian Constitutions recognize three groups of Aboriginal people:

FIRST NATIONS

A term that came into common usage in the 1970s to replace the word "Indian" which many people found offensive. Although the term First Nation is widely used, no legal definition exists. Among its uses, the term "First Nations peoples" refers to the Indian people in Canada, both Status and Non-Status. Many Indian people have also adopted the term "First Nation" to replace the word "band" in the name of their community

Status Indian: Are defined as an Indian under the Indian Act and are usually a member of a First Nation or Band. Prior to the mid-1960's, most status Indians lived on-reserve. In recent years, a steady migration to the urban centres has seen almost 50% choosing to live off-reserve, usually in towns near their home reserves or in cities far from them.

Non-Status Indian: An Indian person who is not registered as an Indian under the Indian Act. This may be because his or her ancestors were never registered, or because he or she lost Indian status under former provisions of the Indian Act.

METIS

The Métis peoples originated in the 17th century with the intermarriage of the early waves of European (mainly French and Scottish) men and First Nations women in the western provinces (Smylie, 2009). In the following two centuries the Métis nation birthed a distinct language (Michif) and culture, and occupied a key economic role in the fur trade (Smylie, 2009). The Mètis have a unique culture that draws on their diverse ancestral origins, such as Scottish, French, Ojibway and Cree.

INUIT

An Aboriginal people in northern Canada, who live above the tree line in the Northwest Territories, Northern Quebec and Labrador. The word means "people" in the Inuit language – Inuktitut. The singular of Inuit is Inuk.

There are many diverse groups of Aboriginal people which cannot be assumed to respond in the same ways. Similarly, different generations may respond in a different manner especially as Aboriginal populations have undergone such radical and quick changes over the recent past. There is also little understanding on how vast a number of native cultures there are. In Canada, because of the sixties scoop; residential school and laws banning culture, there has been lots of disruptions that contributes to the diversity of people. This is seen in the desire to get one answer that can apply to every native person. Despite these differences, Aboriginal people still share the basics of respect, honour and equality as well as their value on people and place, despite a loss of specific culture practices.

Cultural Perspectives in Nursing

In 'Critical Cultural Perspectives and Health Care Involving Aboriginal Peoples', some of the research highlighted the complexities inherent in attempting to define culture. Specifically research examined the problems that can arise when culture is defined too narrowly or from a culturalist perspective and the implications of applying narrow definitions of culture in the area of Aboriginal health. To counter these tendencies toward narrow understandings of culture, they propose a 'critical cultural perspective' as one way of broadening nurses' understandings about the complexities of culture and the many facets of culture that require critical consideration. Many articles from the literature review highlighted this finding including references to the following:

...filled with individuals who are deeply committed to their professional work, who are regarded as highly skilled practitioners, who believe themselves to be liberal human beings - and yet they unknowingly, unwittingly contribute to racial inequality.

'Most non-Aboriginal people are still caught up in the stereotypical images they see in the media and overlook emerging Aboriginal modernity, viewing Aboriginal people in cultural terms while Aboriginal people see themselves in cultural and political terms'.

...through singing and dancing all they want...tension arises when aboriginal people express a desire and act as more than just a cultural group, when we want to do more than just sing and dance, when we want to develop institutions of governance...and when we want our institutions to be visible, respected and paid attention to. (Newhouse 2004: 12)

'I find I cannot think of a Native person I have ever looked after that was not a gentle person. I really can't. They are very gentle people.....I think my basic premise, especially with elderly Native people, is that they have a wisdom and a spirituality that many of us, I think, never achieve. They just know things. And I am very respectful of that and...how that is viewed by the other members of their family'.

Some of the authors from the literature review found that these descriptions could be interpreted as romanticizing or exoticizing First Nations culture; the cultural gaze could be interpreted as a colonial gaze. Fascination with Aboriginal elders and spirituality has the potential to reinforce representations of Aboriginal

peoples as exotic. In the health care context, assumptions about Aboriginal peoples as 'dependent on the system' or as incapable become linked to assumptions about Aboriginal patients as dependent on pain medications, or as necessarily struggling with addictions, or as less than capable of caring for themselves, or as irresponsible in relation to their families or children.

Despite the emphasis in health care on culturally sensitive approaches, or perhaps in part because of the ideas underlying such approaches, assumptions about Aboriginal peoples founded on popularized, narrow conceptualizations of 'Aboriginal culture' make it ripe for health care providers to relate to Aboriginal peoples poorly. While at first glance cultural sensitivity seems a laudable approach, it leaves health care providers open to drawing upon stereotypes and generalized assumptions in their practice. Viewing culture from a critical cultural perspective helps to remind us that people enact their culture differently, depending on their situation or context. When we are called on as health professionals to deliver cultural programs, or culturally-sensitive services, we must first give critical consideration to how we are conceptualizing 'culture' - and become better attuned to the blind spots that may affect our perspectives when we are influenced by a narrow view of culture.

Our arguments are intended to draw attention to the problems inherent in adopting the narrow definitions of culture embedded in cultural sensitivity models, and how these narrow understandings can perpetuate stereotypes about particular ethno-cultural groups - in this case Aboriginal peoples. Unlike New Zealand, where nurses are required to learn about cultural safety, the historical roots of present day inequities, and marginalizing practices in health care (Nursing Council of New Zealand), no such formal strategies exist in Canada, the USA, the UK, or Australia.

Unfortunately, in the absence of competing frames of reference, nurses will continue to draw on established theories of culture - underpinned as they are by culturalist discourses - to interpret the presumed health and social needs of Aboriginal peoples.

3.2.3 Cultural Responsiveness

Cultural responsiveness extends beyond language to include a much larger set of professional attitudes, knowledge, behaviours and practices, and organizational policies, standards and performance management mechanisms to ensure responsiveness to the diversity of patients who walk through health services' doors. One of the findings from the research recommend three types of 'enablers' to improve accessibility to health care:

- Enablers for access (e.g. interpreters, bi-lingual staff)
- Enablers for cultural responsiveness (e.g. diverse staff; standards and guidelines for culturally responsive care; ethnic data collection)
- Enablers for comprehensiveness (e.g. community profiles and needs assessments; community engagement and partnerships)

These can be summarized into the following enablers of a responsive health care system:

- Communication and Awareness
- Public policies – external [factors]
- Databases – data, key contacts
- Community engagement
- Policies and Standards
- Community Development and Engagement
- Reflective workforce
- Outreach programs – bi-cultural / bi-lingual advocates
- Training for Service providers: Cultural Competency and Awareness
- Language services – interpreting and translations [of paper-based information]

Cultural responsiveness takes on an organizational focus – it focuses on the ability of the system or institution to be culturally competent. The National Respite Network (US) defined 'cultural responsiveness' in family services. In it, cultural responsiveness is defined as 'being aware of, and capable of functioning in, the context of cultural difference'. It is an essential tool in moving personal and professional interactions beyond racial

assessments to cultural relevancy. Cultural responsiveness can aid in differentiating the limitations in family functioning that may be caused by poverty, the environment, and/or culture from those due to unhealthy family conditions or behaviours. Culturally responsive approaches must include information, activities, and practice opportunities that interweave family centred practice are vital.

The three main focal points of program design that can facilitate the development of culturally responsive services are organizational structure, policies, and procedures; the training curricula; and, supervisory and staff roles and responsibilities.

3.2.4 Cultural Appropriateness

Culturally appropriate care was described as being tangible, action oriented, and respectful of diverse cultural practices. It includes the physical structure and environment, how a program or service is delivered and by whom, and it provides choices relative to how each person experiences culture. A culturally competent health worker or organization will have an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural background. They will acknowledge:

- That Ontario has a culturally diverse population (this diversity discourse has contributed to erasure of Indigenous people and the ongoing colonial situation and resultant inequities)
- That a health workers' culture and belief systems influence his or her interactions with patients and accepts this may impact on the worker-patient relationship
- That a positive patient outcome is achieved when a worker and patient have mutual respect and understanding.

3.2.5 Cultural Awareness

The National Aboriginal Health Organisation (NAHO) states in its 'Position Statement on Cultural Competency and Safety' that the dominant discourse is on cultural awareness and cultural sensitivity. These concepts largely focus on increasing the health provider's knowledge of various cultural beliefs or trends. While NAHO supports cultural awareness as an important part of cultural safety, it aims to emphasise that awareness is only a starting point of the learning continuum. Cultural safety is near the end point of this continuum. It is therefore important to note the distinctions between cultural awareness, cultural competence and cultural safety. The provision of culturally safe care involves lifelong learning and continuing competence. Cultural safety is the outcome of culturally competent care. The Indigenous Physicians Association of Canada and Association of Faculties of Medicine of Canada (IPAC-AFMC) state in their draft paper on core cultural competencies for under-graduate medical education that 'cultural safety takes us beyond: Cultural awareness – the acknowledgement of difference; Cultural sensitivity – the recognition of the importance of respecting difference, and Cultural competence – which focuses on the skills, knowledge and attitudes of practitioners. While these three approaches have contributed to IPAC-AFMC's understanding of the need to attend to a patient's culture, there are real limitations and concerned associated with them. A central tenet of cultural safety is that it is the patient who defines what 'safe service' means to them. Cultural safety is different from cultural competence in that the personal reflection space is added to address the attitudinal dimension of learning. Learning about colonization and deep ongoing learning and reflection about how it's currently embedded within individual value systems and organizations is a critical part of working towards culturally safe practice, organizations and systems. If this is not done first – people are likely to distort and romantize Indigenous cultural practices and/or see Indigenous people as the 'problems' – e.g. we must adapt for 'them' rather than we must look at ourselves and our organizations to see how we have been contributing to and normalizing inequity and discrimination.

3.2.6 Cultural Sensitivity

Being culturally sensitive involves having an understanding and appreciation of the consequences of the acts of 'cultural genocide' violations that impacted Canada's indigenous people. With loss of language and externally imposed denial of ancestry came a sense of confusion and loss of self-esteem, which resulted in alcoholism and traditions not being passed down. Despite the length of time Europeans have been here, there is still a lack of understanding about Aboriginal people and their circumstances. They still negatively judge

Aboriginal people based on blanket assumptions and negative stereotypes rather than considering each person's unique circumstances. Indigenous peoples across Canada have and continue to experience intergenerational transmission of historic trauma; unremitting trauma and post-traumatic effects since Europeans reached these lands and unleashed a series of contagions among the Indigenous population. These contagions burned across the entire continent from the southern to northern hemispheres over a four hundred year timeframe, killing up to 90 per cent of the continental Indigenous population and rendering Indigenous people physically, spiritually, emotionally and psychically traumatized by deep and unresolved grief. Furthermore policies were developed that related to intentional elimination of the Indians in order to get land including the Indian Act which still exists today – it is the only race based legislation left in the world and sadly the narratives that were developed to justify these polices are still alive and strong.

One research paper gave an in-depth view of culturally appropriate and sensitive care. Sensitive health care for Aboriginal people is based on relationships that extend from a shared understating of the effects of history and respect for life ways that are different. Culturally- appropriate health care is tangible, action oriented, and is founded on respect for diverse cultural practices. A lack of respectful communication comes across as patronizing and is often based on stereotypes about Aboriginal people. Physical actions can also be intimidating. For example, standing over someone with arms folded, asking questions too quickly, and not waiting for an answer discourages communication. Aboriginal people tend to have a more reflective and deliberate speech pattern then non-Aboriginal people.

Some of the findings from the research note that 'cultural safety within an indigenous context, means the health professional / Administrator / educator – whether indigenous or not – can communicate competently with a patient in that patient's social, political, linguistic, economic and spiritual realm'. Interestingly, a number of articles state that cultural awareness is the beginning step in the learning process (understanding difference) and cultural sensitivity is an intermediate step (self-exploration begins). Cultural safety is the final outcome of the process where a [nurse/medical] practitioner can provide safe care when interacting with patients from other cultures. Cultural safety recognizes the nurse as the bearer of their own culture and attitudes, and that nurses consciously or unconsciously exercise power over patients.

Furthermore, one researcher stated that the difference between cultural safety and cultural competency as "although the differences between cultural competence and cultural safety are probably outweighed by their similarities, they have quite distinct starting points, contexts, and quite different histories. Both are about the relationship between the helper and the person being helped, but culturally safety centres of the experiences of the patient (or client) while cultural competence focuses on the capacity of the health worker to improve health status by integrating culture into the clinical context. The point of the exercise is not just to recognize culture – but to be able to maximize gains from a health intervention where the parties are from different cultures."

3.2.7 Cultural Competency

There is significant literature and published materials on the topic of cultural competency – more than any of the other dimensions mentioned above. Health Canada commissioned and published the report "In Certain Circumstances" Issues in Equity and Responsiveness in Access to Health Care in Canada in 2000. In the section "Introduction to Cultural Competence in Paediatric Health Care' the following is noted (the following is summarized from an abridged version of the original report).

> For years, Canadians have looked with pride to their health care system, as a national symbol of our collective values. There is room for improvement, however, in the provision of Canadian health care. For example, culture can play a significant role in the accessibility of health care and as a result it is essential for health care providers to demonstrate cultural competence. In order to fulfil the principles of the *Canada Health Act* and satisfy the health care requirements of a diverse nation, the meaning and relevance of cultural competence in health care must be addressed.
>
> The *Canada Health Act* is the framework for health care in Canada. This pivotal piece of legislation stresses the importance of access to health care for all citizens. As such, one of

the five principles of the *Canada Health Act* is the principle of accessibility. Within the context of the *Canada Health Act*, this principle refers to financial barriers to health. However, the specific text does not fully embody the true meaning of accessibility to health care for Canadians. Other barriers such as the geographic distribution of the population, a lack of specialized health care providers and a lack of interpreters may also create a barrier to access. Further barriers are often the result of cultural differences that give rise to ineffective communication and misunderstandings. Limited communication often results in limited assessment and thus, limited treatment.

Communication is an essential aspect of health care. In turn, cultural competence is an important aspect of communication. In order to receive appropriate treatment of the highest quality, it is necessary for clients from all cultural backgrounds and linguistic profiles to be able to voice their individual needs, within their specific context, to a health care provider. When information has been successfully communicated by the client and understood by the health care provider, there is greater likelihood that the client will be able to access and receive the necessary care.

Through the literature review, there were a number of other definitions from Canada and internationally that aim to describe "cultural competence".

"Cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system or agency or among professionals that enable effective interactions in a cross-cultural framework.

"Cultural Competency is the ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds and religions in a manner that recognizes, affirms, and values the cultural differences and similarities and the worth of individuals, families, and communities and protects and preserves the dignity of each."

3.3 Summary of Definitions

What is evident from the review is that there are many definitions of the terms:

- Culture and Aboriginal Culture
- Cultural responsiveness
- Cultural appropriateness
- Cultural awareness
- Cultural sensitivity
- Cultural competency
- Cultural safety

In summary, the users of this information will tend to develop their own definitions in order to apply them in the context they intend to use them. This flexibility and adaptability will and should always remain since culture – and Aboriginal culture - is a continually evolving and changing concept. For this reason the meanings are constantly changing and their uses often overlap, duplicate each other and interlink. It is important though, that any definitions do not run the risk of stereotyping any particular 'cultural' group. The research reveals there are many definitions for culture however the most common features of each definition are that:

- Culture defines any group of people with shared behaviours and beliefs, systems of thought
- The group has shared ways of understanding and styles of communication
- Culture includes actions, artefacts, language and knowledge
- People can belong to several 'cultures' at one time – for instance at ethnic culture and a professional workgroup culture
- Expression of culture by 'members' is often different within cultural groups and between cultural groups – there is no 'one size fits all' category

Applying this theory, Aboriginal culture in itself is therefore about a people who share an indigenous history; who express beliefs and values, actions, customs, language and traditional knowledge often in a common way; but who are different intra-culturally and inter-culturally. Aboriginal peoples belonging to different cultural groups within Aboriginal society, also belong to many other 'cultural' groups such as those related to their age,

wisdom and experience (e.g. Elders), those related to their professions (such as Aboriginal Physicians) or those related to their gender (such as Aboriginal women). Overall, Aboriginal culture is dynamic.

What makes Aboriginal culture in Canada specifically unique and different to all other cultures that exist in the country – is that Aboriginal culture centres itself on indigeneity. As the acknowledged indigenous culture – Aboriginal culture has no other equivalents in Canada. No other cultural group in Canada has experienced what the Aboriginal culture has experienced through the many manifestations of colonization that have occurred.

3.3.1 Defining the Domains of a PHU Cultural Safety Approach

This report has looked at a wide variety of definitions for each of the most commonly used terms within the cultural safety spectrum. What is evident is that there are multiple definitions for cultural safety used in Canada and abroad – and that the term is often interchangeably used with other terms like awareness, sensitivity, responsiveness, appropriateness and competency. It is acknowledged that all First Nations and Aboriginal communities will have their own definitions of 'cultural safety' and the variety of terms discussed in this report. The intent is NOT to interfere with sovereignty over those Aboriginal-owned definitions. The evidence shows that there are similarities in definitions of the main terms that used and in what context they should be used. This can be summarized as follows:

Cultural Responsiveness

Findings on cultural responsiveness discuss this topic with reference to a combination of people attributes and organizational or institutional attributes. Key definitions refer to improving professional attitudes, knowledge, behaviours (the 'people' component) and practices, strategies, plan, policies and procedures, standards and performance management / remuneration mechanisms (the 'institutional' component) in order for the 'whole' to be responsive. Cultural responsiveness is not alone concerned with improving the competency of the practitioner but also improving the system in which the practitioner operates.

Cultural Appropriateness

Some define 'cultural appropriateness' similarly to cultural responsiveness, referring also to a combination of people attributes (behaviours, attitudes) and institutional attributes (policies, structures, programs and services) to describe this domain. However 'appropriateness' refers more to "matching" the people and the systems to the cultures and communication styles of the clients or stakeholders. It has an underpinning feature of having to be 'fit for purpose' or 'suitable' for the purposes intended. Unlike responsiveness, which aims to prepare a system to be ready for anything – appropriateness on the other hand is more specific in that it requires behaviours, systems and policies to be specifically tailored for the target group(s) concerned. This is where the slight differentiation between 'responsiveness' and 'appropriateness' appears to exist.

Cultural Awareness

There is wide variations in the definitions of cultural awareness and more often than not, it is discussed in the context of cultural sensitivity and cultural safety as well. In fact, the Indigenous Physicians Association of Canada place cultural awareness on the lower end of a continuum of learning. All agree that cultural awareness is the first step in the continuum toward achieving cultural competency. Evidence cites cultural awareness as 'the acknowledgment of difference'. It is about the learner understanding their own culture, and learning about another culture's practices, customs, beliefs and traditions – and then respecting the differences.

Cultural Sensitivity

Cultural sensitivity is about understanding and appreciating the consequences of European contact on Aboriginal people (e.g. loss of language) and understanding the effects of history. There is an intrinsic requirement to learn about the consequences and impacts of this history – not just to see what happened – but understand what the outcomes (negative and positive) have been and exist today. Cultural sensitivity is defined as 'recognising the importance of respecting difference. Cultural sensitivity allows the learner to understand why the cultural differences are, the way they are, historically and in today's context.

Cultural Safety

A great deal has been written and implemented around the domain of cultural safety. The term centres on the experience of the patient, and whether they feel 'culturally safe' before, during or after having received services. It focuses on practitioners being aware that they bring their own culture 'to the table' and that it is

important to allow the patient to contribute their culture to the intervention or relationship. Unsafe practice is defined as a situation where the patient may feel disempowered or diminished by the interaction with a health practitioner. Cultural safety learning would include a study of experiences of patients (either positive or negative) and with patient satisfaction and quality improvement. Studies in this area would encourage changes in practice by institutions and practitioners in order to better the patient experience next time and beyond.

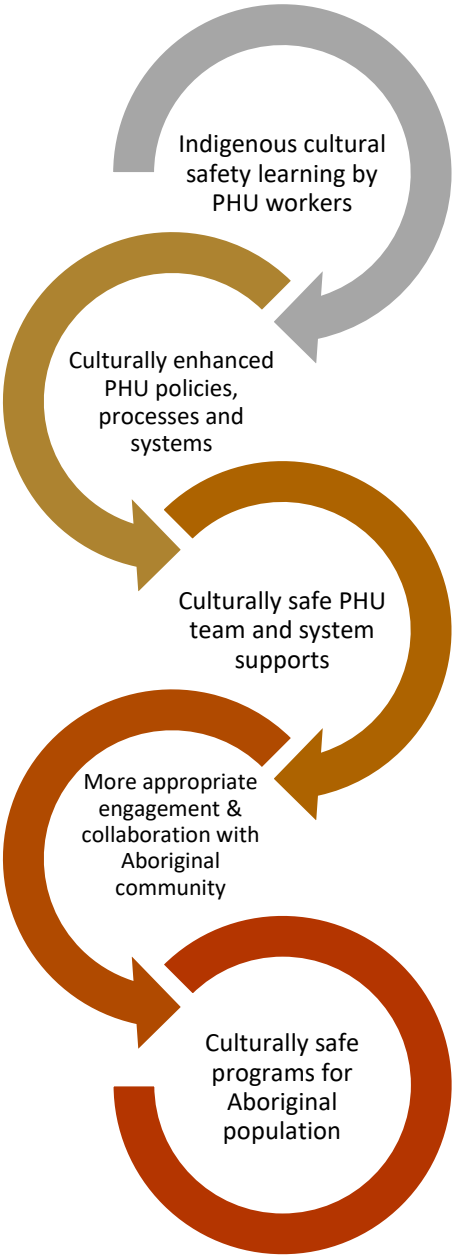
Cultural Competency

Cultural competency is defined in many ways – the common feature of almost all definitions is however, that competency recognizes that people and/or systems are able to apply their knowledge about culture to changing or improving practices in way that influences health and wellbeing outcomes. The connection to improving health outcomes is the strongest theme of 'cultural competency' in health care circles. Competency is not just about 'being aware' or 'being sensitive' to other cultures, and how those cultures have developed to the place where they are today. Competency is about using that knowledge to positively influence and even fundamentally change, the way a person or organisation operates in order to improve outcomes. Since this is true – there is an inherent element of 'measurement' in cultural competency. Sometimes cultural competency is referred to solely in terms of improving the personal skills, knowledge and behaviours of individual practitioners involved in service delivery – such as Cultural Competency within the Nursing profession.

When cultural competency refers solely to 'people development' the definition centres on the ability of the practitioner to take knowledge, lessons and experiences about culture learned over time (either through they own life and/or through formal learning) and being able to apply them to their practice to improve the health outcomes for the service user or patient. Competency assumes a level of proficiency since competency is usually measured either through formal standards, Job Description criteria; accreditation and registration processes; or remuneration policies. When competency refers to institutions or organisations, it refers to processes, policies, practices being in place that remove barriers for clients; that support personnel practicing in a culturally competent way; that ensure patients have a culturally safe experience and that results in improved outcomes. Again there is a measurable element to organizational cultural competency.

Summary

These various definitions seeks only to propose a clear way of defining the subtle differences between each domain, in order to inform the development of a PHU Cultural Safety Framework and approach. The following model suggests a way forward to visually show how PHUs can work towards providing culturally safe programming for and with the Aboriginal population:


Indigenous cultural safety learning by PHU workers
Culturally enhanced PHU policies, processes and systems
Culturally safe PHU team and system supports
More appropriate engagement & collaboration with Aboriginal community
Culturally safe programs for Aboriginal population

4. EFFECTIVE ENGAGEMENT WITH ABORIGINAL COMMUNITIES

4.1 Ontario Government Position on Relationship with Aboriginal peoples

The following describes a brief overview of the Ontario Government's policy on the relationship with Aboriginal peoples in Ontario[1]. Since Public Health Units are effectively an extension of government it makes sense that PHUs review and understand this policy position as it provides the 'umbrella' under which engagement activity happens with Aboriginal communities in a manner which is consistent with provincial policy.

The Ontario Government is building stronger relationships with the Aboriginal people in Ontario and working with them create a better quality of life and new economic opportunities. Policy affirms that the Government is forging stronger relationships with Aboriginal communities, working with them to improve social and economic conditions and working to resolve land claims. Only recently (February 2018), Ministers of MOHLTC were quoted in saying:

"Historic investments to improve the health and well-being of Indigenous communities have only been possible through respectful partnerships between Ontario and Indigenous partners" – Dr Eric Hoskins Minister of Health and Long-Term Care

"Improving the health, healing and wellness of Indigenous people through culturally appropriate services and programs is an important step on the journey of reconciliation and can only be done by working hand in hand with Indigenous partners"- David Zimmer Minister of Indigenous Relations and Reconciliation

Further examples of the way that this is occurring are:

- Political Accord between First Nations and the Government of Ontario (August 2015): A historic Political Accord created a formal bilateral relationship framed by the recognition of the treaty relationship. The Accord confirms that Ontario First Nations and the Ontario Government wish to move forward together in a spirit of respectful co-existence and with a view to revitalizing the treaty relationship. Further the Accord recognizes that First Nations exist as self-governing Indigenous Nations and Peoples with their own governments, cultures, languages, traditions, customs and territories while the Ontario provincial Crown's jurisdiction and legal obligations are determined by the Canadian constitutional framework, which includes the common law and treaties entered into between First Nations and the Crown. The Accord confirms that the First Nations and Ontario recognize the importance of strong First Nations governments in achieving a better quality of life for First Nations and creating a better future for First Nations children and youth. Both parties agreed to work together to identify and address common priorities and issues
- Annual Premier's Meeting: Every year, the Premier and the Minister of Aboriginal Affairs hold a meeting with Aboriginal leaders. It sends a strong signal that Aboriginal people have an important relationship with Ontario; the government and Aboriginal leaders are working to improve things of concern, including education, social and economic matters.
- Aboriginal Affairs Working Group: This is a national group that includes provincial and territorial ministers of Aboriginal Affairs and leaders of the five national Aboriginal organizations. The group works together to improve conditions for First Nations, Inuit and Métis people, including on issues such as education and skills training; improving economic development opportunities; taking action to end violence against Aboriginal women and girls.
- In 2008, the Ontario government and the Métis Nation of Ontario signed a framework agreement that charts a course for a strengthened relationship. The two groups agreed to

[1] https://www.ontario.ca/page/aboriginal-peoples-relationships

work closely to improve the well-being of Métis children, families, and communities while protecting and promoting the distinct culture, identity and heritage of Métis people.

Consultation guidelines also exist for Ministries on Consultation with Aboriginal Peoples Related to Aboriginal and Treaty Rights. The overall goal of consultation is to provide protection to Aboriginal and treaty rights while furthering the goals of reconciliation between Aboriginal peoples and the Crown.

4.2 Engagement vs Consultation

It is vitally important that Ontario PHUs understand the difference between 'consultation' and 'engagement' when working with First Nations and Aboriginal communities and to be cautious when using terminology. The answers lie in the rapidly evolving area of the law called Aboriginal Consultation and Accommodation, and specifically at a legal principle called *the duty to consult* and who owes the duty to consult - the project proponent or the government? Since PHUs are essentially arms of the government as an extension of the provincial Ministry of Health and Long Term Care in Ontario – there is an impact on the actions of PHUs.

> *The duty to consult first emerged in the Delgamuukw and Gis'DaWay decision coming out of the Supreme Court of Canada in December of 1997. With this duty obliging the government to consult with Aboriginal Peoples when projects infringe on the rights and title of the Aboriginal Peoples, these issues were then considered and questions about whether the duty to consult could be delegated by government to the corporations whose business was resulting in the infringement, i.e. forestry or power developments.*

A commonly used term *stakeholder* is also not conducive for First Nations - as they have constitutionally protected rights and are accustomed to dealing with Canada provinces and territories on a Nation-to-Nation (or Government-to-Government) basis. First Nations are not stakeholders in their own traditional lands – they have roles in governing, protecting and stewarding the territories for their members and future generations.

Through the literature review, experience has shown that engagement with Aboriginal groups early in the planning and design phases of any project can benefit all concerned. Conversely there have been instances where failure to participate in a process of early engagement with Aboriginal people has led to avoidable project delays and increased costs to participants. Early engagement is about starting the conversations early – well before the projects requires First Nations' support or permission to proceed within their community. In the very early days it means two-way conversation which is open, honest and forthright. It is important to understand it takes time to build assurances, bridge cultural differences and to gain trust. This doesn't happen with one conversation – it happens over many conversations.

Toronto's first indigenous 2016-2021 health strategy "A reclamation of Well Being: Visioning a Thriving and Healthy Urban Indigenous Community" reflects an example of effective planning from the outset. According to the 'Timeline of Indigenous Health Planning in Toronto" incorporated within the document, the evolution of the strategy was not an overnight process – with conversations dating back to 2008. Toronto Public Health (TPH) Access and Equity team validated the effectiveness of this planning process.

Building positive, respectful and trusting relationships with Aboriginal Peoples also boosts government and public support. As well, it results in a better project design, increases funder confidence and provides regulators with a higher comfort level related to project approval. All these aspects support the certainty that both health agencies and Aboriginal communities are seeking. Those entities that have engaged in a respectful manner and have secured the support of local Aboriginal Peoples are more likely to gain support and can expect benefits for their commitment and efforts. Reaching a decision to move forward requires keeping an open mind, carefully listening to the community, and having a commitment to explore what can and cannot be done. Organizations must be patient, respectful, honest and trustworthy in their discussions, meetings and negotiations with Aboriginal communities.

Successful Aboriginal community engagement incorporates Aboriginal goals of respecting land and resources, and conducting activities in economically, socially and environmentally responsible ways to

ensure long term sustainability. There is no project partner that is more powerful than the support and interest of local Aboriginal leaders and communities.

The work of Public Health Units may not necessarily affect or infringe on Aboriginal rights and title during their usual course of business – but for matters involving Environmental Health; land and infrastructure; natural resources such as water sources and rivers (often impacted by sanitation and other environmental activities within the public health domain) there may be implications. It is always worth considering the issue even if a PHU might think it irrelevant. If the public health program is not considered to impact on Aboriginal Rights and Title – then in the majority of situations the PHU would be 'engaging' to enhance program funding, design, delivery and evaluation for the benefit of the Aboriginal population – and not meeting the government's *duty to consult* in law.

4.3 Engagement with the Aboriginal 'community'

4.3.1 Understanding the Aboriginal Community

For the purposes of this review – the AOHC and Ontario PHUs are interested in improving their engagement with Aboriginal communities and including Aboriginal service providers such as AHACs. First Nations and Aboriginal communities are dynamic and sometimes complex. Like many communities they may include a myriad of formal and informal structures that are impacted by health systems:

- Formal: *and often including service / program delivery*
  - First Nations Chiefs and Councils and their attached departments or teams who plan and provide services for their community members (health; education; social assistance; economic development; land management etc.)
  - Independent Health provider entities (local, regional, provincial)
  - Mètis Associations with Boards and personnel
  - Inuit organizations with Boards and personnel
  - Aboriginal NGOs, businesses (e.g. gas bars, stores, restaurants) and corporations (e.g. Fisheries, Forestry)
  - Schools and Day care centres
- Informal:
  - Elders Groups / Councils
  - Youth Groups
  - Women's Groups
  - Specific program groups (e.g. Support and resilience groups)
  - Advocacy and support groups – disability, LGBTQ, etc.
  - Parent groups
  - General public (service users)

Within these groups and structures there will also be another layer of diversity – not all Elders are the same and each will have unique needs and perspectives. Not all Chief and Council members are the same – and again the Councillors will have different needs and perspectives.

When thinking about engagement with First Nation and Aboriginal communities it is important to identify the different formal and informal groups that the PHU may wish to engage with - and the reason for wanting to reach out to that specific group. Determine key leaders and contact people and their contact details. The rule of thumb is that when wanting to do public engagement in a community, seeking permission from Chief and Council or organizational leadership is not only a courtesy but it shows respect.

Most of the information on these formal and informal structures is often available online through the community's own website(s) and this provides a good start to familiarize with the community. This work could result in a mini-profile of each community that a PHU can keep as a future resource (with contact names and email / phone details) that can be continually updated and used by others in the team.

Due diligence research and learning about the community healthcare providers they are visiting is recommended – this may include Chief and Council, Leadership or authority (including matriarchal leadership), Territory or reserves, and the Laws of the Lands. Providers should take opportunities to learn

from clients of diverse cultures, but do their own research and education as well, as it is not the client's responsibility to teach service providers about their culture.

Once this preliminary scan has been done, the PHU can then plan a process by connecting with one of the identified health leaders in the community and validate the engagement participant groups and individuals.

4.3.2 Principles of Effective and Authentic Engagement

Start from a place of wanting to build a relationship: Literature on engagement with First Nations communities confirms that there is no standard formula for building a good relationship but the common characteristics are trust, goodwill, respect, commitment and transparency. Trust was identified as something not often existent in relationships in the current, mainstream (western) system with Aboriginal people. Indigenous families and communities may be reluctant to work with any non-Indigenous service provider out of fear that they may experience re-traumatization or threatening environments where they were mistreated in the past.

PHUs need to enter the relationship expecting that this will be the first of many times of coming together to do work over the long term. Generally community members find it hard to invest time and effort into people who plan to just visit once to take information – and not to invest in a relationship where there will always be an expectation of meeting again and continuously working together.

From the perspectives of PHUs - it should be remembered that a PHU worker is, at the time of engagement – the face of the organization they represent. Aboriginal communities will expect a relationship at both a personal and organizational level. PHU workers may move on to other roles – but Aboriginal community members are forever attached to their lands and communities. PHU workers who plan on leaving their roles should be proactive in sustaining the PHU-Nation / Aboriginal relationship by handing over the relationship appropriately to their replacement worker. Disappearing to a new job and not making sure someone has been connected in to maintain the trust relationship – can be viewed as disrespectful and signals that the original relationship between the PHU and the Aboriginal group was not authentic.

Be Authentic: A key to authentic engagement relies on mutual recognition and respect that recognizes the importance of indigenous knowledge and expertise[2] and translation of Indigenous (and academic) knowledges into action - that results in health improvements. In other words – PHUs should not assume they have all the answers and should be ready and willing to listen to alternative ideas and perspectives.

Expect Diversity: It should be presumed that every community is different and that relationships will take time. It is important to tailor services and programs to fit individual families' needs and preferences to ensure that services are meaningful. This can mean emphasizing family choice, being flexible in the type of approach and providing options for program delivery rather than assuming the same approach will work for all families.

No pre-conceived ideas: Additionally, pre-conceived ideas or plans are not encouraged, until it is actually heard from the community itself. According to Indigenous Training guidelines, many First Nation people do not want to hear about what you know, what other communities are doing or associations you may have with other First Nations.

4.4 Communication

4.4.1 Lines of ongoing communication are critical

A key finding from one of the literature review studies on twenty-nine signed agreements between First Nations and various partner organizations[18], identified that effective lines of communication was seen as a common characteristic in developing a good working relationship between First Nations and non-Indigenous partners. This includes awareness, understanding, respect and trust as products of good relationships where there is open and honest dialogue. Specifically for Indigenous families, it is important

[2] University of Manitoba 2013; Building Relations with First Nations Handbook

that organizations prepare strategies and resources for facilitating effective communication, and ensure the family understands all relevant documentation (e.g. program and service plans).

4.4.2 Principles of Effective Communication

Be alert to signs and signals: There are a wide variety of communication styles to be aware of when working with First Nations and Aboriginal clients. Health workers should not make any assumptions about literacy levels; or that silence means agreement (i.e. they didn't ask any questions so they must be okay"). The Aboriginal Cultural Practices guideline for Health Professionals outlines some tips for effective communication[3]:

- In some First Nations cultures it is disrespectful to look into a person's eyes. An Aboriginal client who avoids looking into your eyes may be showing you respect – not that they are not interested in what you are saying;
- An Aboriginal client who uses a soft voice may also be signalling respect;
- Sometimes an Aboriginal client will respond to your question with what seems a long-winded story. Be patient: the reply may contain both the information you want and also an indication of their feelings. If you cut the client off you may be perceived as not caring and you will not hear the most relevant pieces of information that you need. Listen carefully and patiently without interruption (or clock-watching);
- Assess the level of understanding when communicating health information and determine the best method of sharing information to client and family (verbal, written, visual);
- For many Aboriginal cultures, silence is not awkward – it is a part of communicating. Do not feel the need to fill gaps in conversation with small talk. Allow pauses to occur, patients might pick up and continue talking long after you think the conversation has ended.

Don't use inappropriate colloquialisms: Using particular colloquialisms is seen as thoughtless, offensive and disrespectful to indigenous communities, particularly those with an 'Indian' reference for example *Indian giver, Indian Time* or *too many Chiefs, not enough Indians*[19]. The evidence supports the use of references that First Nations and Aboriginal people are calling themselves – such as 'native' or 'Indigenous'.

Try not to use acronyms and technical jargon: Overuse of acronyms or technical terms, particularly within the health system can tend to lose the attention of indigenous listeners - ultimately resulting in some people not wanting to or not understanding what advice or information is being provided. For instance trying to promote good health for diabetes prevention should not be explained in Diabetes Mellitus and HbA1c terms - but more simplistic ways for lay people to understand.

Meet and Greet: Always introduce yourself and explain your role and service to the client and family – allow time for them to introduce themselves and their role in the family. Aboriginal people often prefer face to face communication; take time to communicate plans and services in person – be patient in allowing them to respond and ask questions. Identify with the client any need for an interpreter and ensure that clients are offered the chance to include an interpreter when required.

Providing written information: Provide preliminary information or one-pager fact sheets about your program or project to help inform the discussion before it happens OR to use as a tool to walk through during the engagement. Take time to walk people through the information so they truly understand it and have chance to ask questions. Remember they might retain the paperwork and hand it on to other family members – so you want them to communicate key messages accurately by investing time in their understanding.

4.5 Acknowledgement of Traditional Territory

At the beginning of any interaction or meeting with a First Nations community, acknowledgement to the territory is essential as a sign of respect. This recognition affirms the nature of a First Nation's connection to their land or traditional territories and shows respect.

[3] Vancouver Coastal Health (2017) Aboriginal Cultural Practices Guideline for Health Professionals

The CAUT Guide to Acknowledging Traditional Territories specifically states that this shows recognition of and respect for Aboriginal peoples both in the past and the present. Recognition and respect are essential elements for establishing healthy, reciprocal relations. An example of one of the guidelines is a territory acknowledgement for Sudbury, Ontario could be said '*We would like to begin by acknowledging that we are in Robinson-Huron Treaty Territory and the land on which we gather is the traditional territory of the Atikameksheng Anishnaabe people*'. It is also noted in the guide that acknowledging the territory is only the *beginning* of cultivating strong relationships with First Nation peoples of Canada.

4.6 Appreciating the impact of history and colonization on a community

A certain level of understanding of the historic changes and impacts of colonization should be included as part of any engagement and capacity building process within health care before engaging with indigenous communities. This includes gaining prior knowledge of the sixties scoop, residential schools and other government attempts at forcibly assimilating indigenous children and families into western culture. One non-Native study noted that health care professionals who work with First Nations people should understand that it is equally important to understand how they have been affected by social policy due to the oppressive laws that have been imposed upon them.

A number of studies have highlighted the alarming health impacts (and all aspects of Aboriginal ways of living) caused by colonization where Aboriginal communities have been forced to move away from their traditional practices into a mainstream Western society. The historical abuse and drastic lifestyle changes seen in First Nations, Inuit and Mètis populations from pre-contact times to the current environment have contributed significantly to increased rates amongst a number of health diseases and associated complications and a cycle of intergenerational trauma in many Indigenous communities.

Effective collaboration between indigenous communities and non-indigenous organizations to improve services for indigenous communities is critically dependent upon an awareness of the historical relations between Indigenous and non-Indigenous people in Canada. It is important for providers to understand this context when engaging with Indigenous families and communities. Given the historical context of Indigenous communities, and the preferred holistic approach to understanding and responding to health issues, a strength-based approach that involves the whole community is critical when working with Indigenous peoples. It is deemed that people who work with Aboriginal peoples at any time will find it difficult to practice cultural safety if they do not understand Aboriginal issues from their historical context.

4.7 Culturally-safe Approaches to engagement

Some examples of research suggests that attention to cultural competence at a health organization can reduce health disparities. When someone defines a person's culture based solely on their language, colour of skin and social status, it can actually be singling them out in a way that reflects racial prejudice.

In a particular study, investigating culturally safe and unsafe healthcare for indigenous people in Canada suggests that having a *culturally safe practice* can only happen in an environment where healthcare professionals are aware of and sensitive to their clients' social, political, linguistic, economic and spiritual realties. Typically health service providers are not immersed or face the same barriers as First Nation clients. Acknowledging that this reality exists and that the difficulties indigenous people face is a result of inequality (and not the personal fault of people), is the first step to ensuring cultural safety. This acute awareness is needed when engaging Aboriginal communities so that un-informed judgments are not made.

Flexibility with time is a key driver for good engagement with Aboriginal communities. One indigenous training program reinforced the message of not being confined to a timeline when undertaking First Nation community visits – to avoid being accused of 'flying in and flying out' with no true intent of building a relationship. It was noted that more respect and better receptiveness would be achieved if approaches are not dictated by a small window of available time and that care, interest and willingness to listen would be better received. This includes confining people to dates and agendas – a more respectful strategy is to ask which dates would work best for their community and then letting the meeting take its own direction. Organizations seeking to work with Indigenous communities or agencies should begin to build relationships, developing them slowly in order to build a foundation of trust and invest in the relationship over the long term.

Allowing *silent periods* to occur when meeting with First Nations is identified a normal custom to allow people to 'be in the moment' and to reflect. The urge to fill silent moments in time by speaking or pushing the agenda along, should be avoided.

Overdressing is another action that often can send wrong messages. It can be construed as emphasizing power positions (e.g. funders, legislators) and demeaning local community members who may not have the resources to dress in the same way. Aiming for smart casual (to show respect) but not corporate style attire – can make an Aboriginal audience feel much more comfortable and help create an equal power-sharing relationship.

4.8 Key concepts to be aware of in the Engagement Process

4.8.1 Recognizing different worldviews of health and well-being

Indigenous worldviews are based on traditional culture and knowledge. Being immersed in and part of community culture is crucial to the well-being of Indigenous people. Holistic wellbeing in terms of health care is defined as an approach to life and not simply symptoms or diseases. The World Health Organization describes one of its health principles as 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. Working to understand the worldviews of diverse individuals and cultures is important for building relationships.

A person's worldview develops through day-today interactions with family and community and includes a set of values, goals, knowledge, beliefs and culturally appropriate ways of behaving. While there are different variations of Indigenous worldviews, some evidence outlines some of the common, shared principles of First Nation, Inuit and Mètis worldviews: Knowledge is universal; there are many different perspectives that are shaped by an individual's experiences; everything is alive and the relationship between people and the spiritual world is important. While each Indigenous group has their own traditions and teachings, the Anishnaabe, Cree and Mi'kmaq believe that following the Seven Grandfather teachings is important for maintaining the health and wellness of each person and the community. Medicine Wheel and holistic frameworks are commonly used for unique ways of knowing and understanding within a cultural context. This being a common approach globally with indigenous or aboriginal communities. The ancient Medicine Wheel has been used by Aboriginal peoples for thousands of years throughout North America and specifically the Cree Medicine Wheel teachings have been around for centuries. It would be necessary for non-Native workers to understand the spiritually holistic worldview of Aboriginal peoples if they want to work effectively with First Nations peoples and communities.

The general literature on family engagement emphasizes the importance of considering family members as the experts on their own family. It is important to focus on empowering clients by recognizing that people will always have valuable expertise about what does or does not work. Some First Nations may wish to be directly involved in all or some stages of planning which provides greater opportunities to address cultural issues, economic priorities and environmental values.

4.8.2 Reciprocity in relationships with Aboriginal Communities

Reciprocity is identified as the practice of exchanging things with others for mutual benefit, especially privileges granted by one country or organization to another and is an underlying principle in Aboriginal society. Some of literature provided evidence that reciprocity is expressed through exchange and trade of food and tools, through social and family relationships, spiritual and totemic principles, and the political climate of Aboriginal society. Central to reciprocity for Aboriginal society is timelessness, spirit exists both now and before. Creation is both a historical and current event, and the law is for both now and always. In short the interconnectedness of all things. Historically reciprocity has both unified Aboriginal society and been a source of political, legal and cultural animosity and mystification within colonial settings.

Economic reciprocity involves a relationship with the land, other groups, and ecological resources. Indigenous peoples often have a land and food management system involving the controlled use of natural resources. Groups lived in a reciprocal arrangement with the land. Trade of weapons, tools, medicine and food was also used to demonstrate reciprocity within the Aboriginal economy, these items were exchanged for other items required. One researcher noted that groups that were abundant in certain resources such

as commonly found berries or fish were at a distinct advantage when it came time to trade for meat and in effect were performing risk management in the case of drought.

Social reciprocity involved social obligations toward others within the group and to other groups. In Aboriginal society each person has an identity, a standing and a sense of belonging. Within the society relatedness is a key concept and this relatedness allows each person to know how to act and behave toward each other person in the group. Within this system all have a sense of personal and group (kin) identity which protects and balances psychological, emotional, and physical survival in society. This kinship reciprocity extends to widows, orphans and even outsiders and ensures social equilibrium.

Spiritual reciprocity involved a stewardship of the land, with those most connected to the land being the best stewards of the lands. Most anthropologists acknowledge that the Aboriginal culture is built on a deep spirituality, where a unifying concept of the world is lived in encompassing the person, place, language, stories, art and music. Humans are parts of systems that are part of the balance, part of universal reciprocity. Elders assume the role of dispute resolution, teaching, advising on marriage partners, and assume responsibility for sacred objects, spiritual matters and rituals.

Political reciprocity involved elements of tradition and respect. Aboriginal people saw themselves as stewards of the land not unlike other indigenous communities. Historically issues are epistemological, methodological, and systemic. Even when co-management policies are developed and implemented, the Indigenous intellectual property is often either marginalized or appropriated. Because of the long history of outside agencies trying to assert power over tribal authority and tribal resources, tribal agencies are often reluctant to collaborate. The tribe, like the state, has to deal with the vagaries of the political climate at any given time. Historically this situation has caused the relationship between the tribe and the state, as well as that of the tribe and federal agencies, to run hot and cold over time.

Ontario PHUs in building relationships with Aboriginal communities must realize they will be viewed as a reciprocal partner in the relationship – and that there will always be an 'exchange' of some sort whether tangible or intangible.

4.8.3 Power and Privilege

It is important to recognize the type of power that surrounds our privilege (whether or not we *feel* powerful) in society. The privileged group as the power to act and define reality; determine what is normal and correct and institutionalize and systematize discrimination. Ways that the privileged culture uses power may include:

- Structures and Organizations:
    - Decision making: unfair distribution of capacity to make and enforce decisions
    - Resources: provision of unequal access to money, education, information and opportunity
- Cultural Values:
    - Standards: Parameters for appropriate behavior are set such that they reflect and give privilege to the norms and values of the dominant culture
- Ideology:
    - Naming reality: Involves defining 'reality' by naming 'the problem'; the 'solution; the 'institution' incorrectly or too narrowly. Have a set of beliefs with a bias.

Power is identified as being about the possibility of deciding on resource allocation while privilege is about reaping the benefits. Power is involved in deciding that universal health care is 'too expensive' or will 'limit my choices' – while privilege is reflected in the fact that being born white gives one a far greater chance of survival than most people in the world. Power involves defining the parameters of the discussion while privilege is about not needing to know that the parameters have been set.

4.8.4 Racism and Oppression

The concepts of power, privilege, race and equity are linked. Power and privilege influence the degree of access to resources which may not be equitably allocated to all. There are different types of racism – some conscious and some unconscious. All types of racism can impact a person's ability to obtain health services thereby impacting their health status. Racism is the belief that race accounts for differences in human

character and ability - and that a particular race is more superior to others. Oppression is a system of domination of one group over another. Systemic or institutional racism is a form of racism that may be introduced consciously or unconsciously through policies and procedures that are based on the values of the dominant society and adversely affect those who are not.

4.8.5 Effective Engagement Example in Ontario

Through engagement with the Toronto Public Health (TPH) Access and Equity team, and upon accessing the published Toronto's first indigenous 2016-2021 health strategy "A reclamation of Well Being: Visioning a Thriving and Healthy Urban Indigenous Community", this journey (to date) provides a model of effective engagement. Contents within the document highlight the process for planning, and establishing the Toronto Indigenous Health Advisory Circle (TIHAC) – which includes AHAC.

Historically TPH (Access and Equity Team) had been working with different indigenous groups across several areas within the organization. Having over 1,800 employees across many programs in TPH, it can be envisaged that many partnerships and engagements with Indigenous groups would have been overwhelming and hefty, for both TPH and the indigenous communities they engaged with.

With the establishment of the TIHAC, this ultimately provided an effective forum for Indigenous experts and community leaders to provide recommendations to the health sector (specifically to TPH and Toronto Central LHIN) on improving health outcomes for Indigenous people in Toronto. One TPH member noted that "It is a demonstrated commitment that makes a huge difference to how TIHAC and TPH work together…….being led by community is the key – it's a full partnership model".

4.9 Effective Engagement Summary

The Ontario Government has signed protocols with both First Nations and the Mètis Nation of Ontario which focus on strengthening relationships that respect Aboriginal Rights and Title - but also benefit the social, cultural and economic well-being of Aboriginal peoples while protecting and promoting their distinct cultures, identities and heritage. The work of Public Health Units may not necessarily affect or infringe on Aboriginal rights and title during their usual course of business – but for matters involving Environmental Health; land and infrastructure; natural resources such as water sources and rivers (often impacted by sanitation and other environmental activities within the public health domain) there may be implications. Further the Ontario Government policy and commitments essentially places a responsibility on PHUs to help support the achievement of social, cultural and economic goals of Aboriginal peoples through wellness-oriented approaches.

The review provides a number of pointers for effective engagement including:

- ⇒ Researching and understanding communities (and keeping relevant information on-hand for others to utilize in their planning and relationship development)
- ⇒ Beginning conversations as a stepping stone toward building sustainable relationships through nurturing trusting, transparent and respectful relationships underpinned by goodwill and commitment
- ⇒ Being authentic which relies on mutual recognition and respect that recognizes the importance of indigenous knowledge and expertise and translation of Indigenous (and academic) knowledges into action - that results in health improvements. In other words – PHUs should not assume they have all the answers and should be ready and willing to listen to alternative ideas and perspectives.
- ⇒ Expecting diversity - that every community is different and that relationships will take time. It is important to tailor services and programs to fit individual families' needs and preferences to ensure that services are meaningful.
- ⇒ Not having pre-conceived ideas until it is actually heard from the community itself
- ⇒ Being flexible with time
- ⇒ Not overdressing
- ⇒ Recognizing differences in worldviews of health and well-being: being prepared to learn and listen to a different perspective. Having an open mind and being curious to understand

Effective communications with Aboriginal communities also requires particular skills to be alert to signs and signals in body language and conversation. In some First Nations cultures it is disrespectful to look into a person's eyes. An Aboriginal client who avoids looking into your eyes may be showing you respect – not that they are not interested in what you are saying. For many Aboriginal cultures, silence is not awkward – it is a part of communicating. PHU staff should not feel the need to fill gaps in conversation with small talk. Not using colloquialisms, jargon, acronyms and technical language is another key to messaging and communications. Acknowledgement to the traditional territory is an essential sign of respect. This recognition affirms the nature of a First Nation's connection to their land or traditional territories and demonstrates this respect.

A certain level of understanding of the historic changes and impacts of colonization should be included as part of any engagement and capacity building process within health care before engaging with indigenous communities. This includes gaining prior knowledge and undertaking extensive self-learning to appreciate the impacts of government policies on health status today. Evidence confirms that colonization and systemic discrimination has led to adverse, multi-generational health effects, which continues to have a significant impact on the current health status of Aboriginal people.

Key concepts to be aware of when engaging with Aboriginal communities also lie in understanding the principle of reciprocity and that engagement is an exchange of information and knowledge. Reciprocity is identified as the practice of exchanging things with others for mutual benefit, especially privileges granted by one country or organization to another and is an underlying principle in Aboriginal society. Ontario PHUs in building relationships with Aboriginal communities must realize they will be viewed as a reciprocal partner in the relationship – and that there will always be an 'exchange' of some sort whether tangible or intangible.

There is much evidence that shows it is important to recognize the type of power that surrounds our privilege (whether or not we *feel* powerful) in society. The privileged group as the power to act and define reality; determine what is normal and correct and institutionalize and systematize discrimination. Ways that the privileged culture uses power may include decision-making and resource allocation for instance. Power is identified as being about the possibility of deciding on resource allocation while privilege is about reaping the benefits. The concepts of power, privilege, race and equity are linked. Power and privilege influence the degree of access to resources which may not be equitably allocated to all. There are different types of racism – some conscious and some unconscious and all types of racism can impact a person's ability to obtain health services thereby impacting their health status. Systemic or institutional racism is a form of racism that may be introduced consciously or unconsciously through policies and procedures that are based on the values of the dominant society and adversely affect those who are not. It is for this reason that PHUs should review their policies and procedures to assess signs of power, privilege, racism and oppression and that the dominant culture is not benefitting unfairly.

5. PUBLIC HEALTH COLLABORATION AND PARTNERSHIP

5.1 Public Health and its importance for Aboriginal communities

Public health has been defined as '*the combination of sciences, skills, and beliefs that is directed to the maintenance and improvement of the health of all the people through collective or social actions. The programs, services, and institutions involved emphasize the prevention of disease and the health needs of the population as a whole*'[4]. According to the Public Health Agency of Canada, the definition of public health is "*…an organized activity of society to promote, protect and improve, and when necessary restore, the health of individuals, specified groups, or the entire population. It is a combination of sciences, skills and values that function through collective societal activities and involves programs, services and institutions aimed at protecting and improving the health of all people*'. There are varying definitions of the mission of public health. However, the most current and widely accepted mission definition is: *'Promote physical and mental health, and prevent disease, injury, and disability.'* Public health services may go unnoticed within a community because they are often (but not always) preventive versus reactive. Public health services play a key role in assuring the health and well-being of Aboriginal communities.

5.2 Relationship with Primary Care

Primary care refers to *first-contact care*, in which the majority of health problems are treated. It is the foundation of any health care system, and nations with strong primary care seem to have better health than those without. Primary care has been described as: *'the level of a health services system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and coordinates or integrates care, regardless of where the care is delivered and who provides it. It is the means by which the two main goals of a health services system, optimization and equity of health status, are approached*[5].

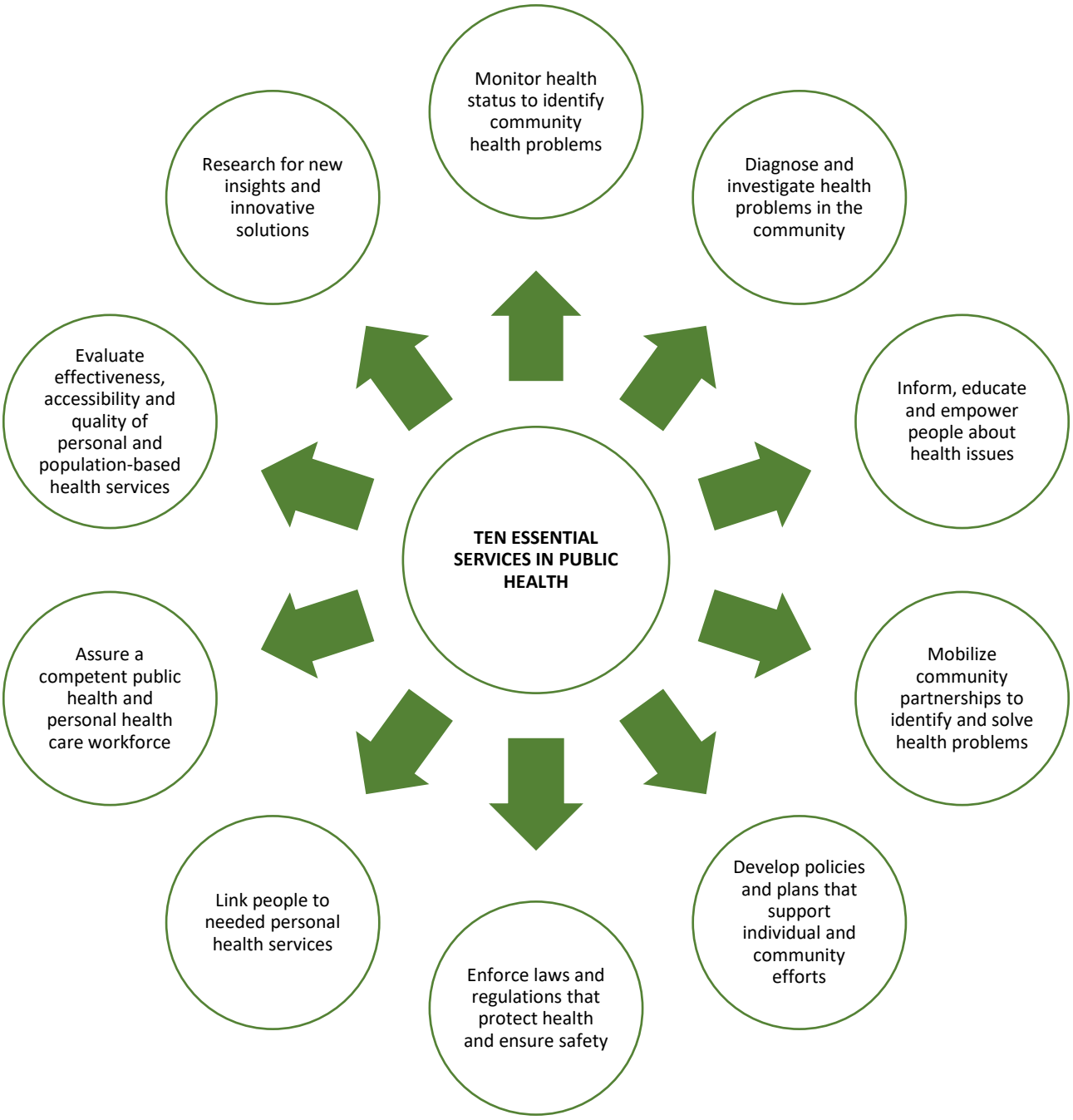
Perhaps the most widely accepted definition of primary healthcare is that provided in the World Health Organization (WHO) Alma Ata Declaration: *… essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development … It is the first level of contact of the individual, the family and the community with the national health system … and constitutes the first element of a continuing health care process.* WHO's definition of primary healthcare incorporated coverage of basic health services such as education on methods of preventing and controlling health problems; promotion of proper nutrition; sanitation; maternal and child health; vaccination, prevention and control of endemic disease; appropriate treatment of common disease and injuries; and provision of essential drugs.

Primary Health Care is a broader concept. In addition to primary care services, it includes health promotion and disease prevention, and also population-level public health functions. It is on this basis that the relationship between Public Health Units and Primary Care becomes vitally important since *Primary Health Care* incorporates several traditional public health functions. Additionally – most AHACs deliver primary health care (a combination of public health and primary care services).

[4] Last J.M. (1995) *A Dictionary of Epidemiology* (3rd Ed.) Toronto: Oxford University Press

[5] Johns Hopkins Bloomberg School of Public Health. http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-primary-care-policy-center/definitions.html

Ten Essential Services used in Public Health[6]



[6] http://iom.edu/Reports/1988/The-Future-of-Public-Health.aspx; http://www.health.gov/phfunctions/public.htm

5.3 Aboriginal Population Health

Health Canada states that improving the health of any given population is referred to as ***population health***. Population health helps to determine the many factors, such as chronic disease, that influence the health of a population, identify the various reasons why some populations are healthier than others, and use that information to develop and implement policies and actions aimed at improving the health and well-being of those populations experiencing health challenges.

The health of a population is influenced by key physical, social, economic and cultural factors, known as **determinants of health.** These determinants include the following:

- Income and social status
- Social support networks
- Education and literacy
- Employment and working conditions
- Social environments
- Physical environments
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment
- Health services
- Gender
- Culture

Population Health is a vitally important function for the Ontario PHUs especially when it comes to surveillance of the state of the health of the Aboriginal population – and the impact of the social determinants of health on this population. Working together with the Aboriginal population is essential for PHUs to accurately interpret data on the state of their health and to fully understand the social determinants and their specific impact on Aboriginal communities.

5.4 Relationship of Public Health to AHACs

According to Health Canada Public health is distinguished from other components of the health system by two underlying characteristics:

1. A focus on the health of **populations** as a whole instead of individuals.
2. A focus on the **promotion of health and the prevention** (and control) **of diseases and injuries**, rather than treatment of diseases.

These principles allow public health to work in a complementary way with the rest of the health system. One of the most important components of public health is its reliance on multi-sectoral partnerships. Multi-sectoral partnerships are necessary because everyone has a role to play in public health activities and programs. This may include a new mother concerned about her baby's hearing, an organization advocating for reductions in childhood obesity, or a business group looking to develop healthy policies in the workplace.) Improved health and social outcomes are possible with better coordination and collaboration between public health and primary care. The framework described by Rowan et al (2004) in their report is useful for identifying the basic characteristics of Public Health (delivered by Ontario's PHUs) and Primary Health Care (that is delivered by most AHACs) in order to clarify opportunities for collaboration and integration:

Basic Characteristics of Public Health (PHUs) and Primary Health Care (AHACs)

CHARACTERISTIC	PUBLIC HEALTH (delivered by PHUs)	PRIMARY HEALTH CARE (delivered by most AHACs)
Definitions	The combination of science, skills and beliefs that is directed to the maintenance and improvement of the health of all of the people through collective or social actions. The programs, services and institutions involved emphasize the prevention of disease and the health needs of the population as a whole	Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community, through their full participation and at a cost that the community and country can afford to maintain at every stage if their development….it is the first level of contact of the individual, the family and the community with national health systems…and constitutes the first element of a continuing health care process
Primary Mission	Health of the community or population	Health of the individual and family members
Essential Functions	• Population health assessment • Health surveillance • Health promotion • Disease and injury prevention • Health protection • Disaster response	• Diagnosis and treatment of medical conditions including counselling, pharmacotherapy and minor surgical procedures • Health promotion and preventive care • Maternal and child care including obstetrics • Emergency care • Rehabilitative care • Palliative Care • Patient advocacy • Participation in community health programs • Education and health advocacy
Attributes / Principles	• Public good • Determinants of health • Equity, diversity and social justice • Partnership • Public participation • Interdisciplinary approaches • Science-based • Efficient cost-effective • Continual improvement • Sustainability	To provide all Canadians, wherever they live, with access to an appropriate health care provider, 24 hours a day, 7 days a week
Personnel	• Public health nurses • Public health physicians • Laboratory personnel • Infection control practitioners and hospital epidemiologists	• Family physicians or General Practitioners • Nurses • Nurse Practitioners • Mental Health workers

CHARACTERISTIC	PUBLIC HEALTH (delivered by PHUs)	PRIMARY HEALTH CARE (delivered by most AHACs)
	• Infectious disease specialists • Epidemiologists • Other public health workers (inspectors. Dental hygienists, health promotion specialists)	• Pharmacists • Laboratory technicians • Other allied (physiotherapists, dieticians)
Skills	• Epidemiology and health services investigation / research • Designing, launching and maintaining public health programs and interventions • Report and policy writing • Administration • Communication with professionals • Committee services work	• Investigation and management of clinical problems • Consultation and communication • Small-group leadership skills • Practice management • Medical audit
Evaluation / Research emphasis on Effectiveness and Efficiency of Services	• Evaluate structure, process and outcome of services • Based primarily on epidemiology and demographic data and on economic concepts • Focus on disease causes, means of disease prevention; processes and outcomes of health care	• Audit of clinical work and practice organization • Based partly on subjective views of staff and patients • Focus on management of common health problems and on structure and processes of primary health care delivery

The table below further identifies features and responsibilities of primary care and public health and is adapted from the National Public Health Partnership. The model outlines three main categories, including those that are:

(1) primarily the responsibility of public health (i.e. Ontario PHUs)
(2) a joint function of public health and primary care (i.e. most AHACs) and
(3) primarily the responsibility of primary care (i.e. most physician practices).

The second category includes health surveillance, health promotion and prevention of disease and injury, the areas in which public health and primary care are more closely linked and have the greatest potential for integration.

FEATURES	PRIMARILY THE RESPONSIBILITY OF PUBLIC HEALTH		JOINT FUNCTION OF PUBLIC HEALTH AND PRIMARY CARE		PRIMARILY THE RESPONSIBILITY OF PRIMARY CARE	
FUNCTIONS	Population Health Assessment	Health Protection	Health Surveillance	Health Promotion	Disease and injury prevention	Disease management
Sample interven-tions	• Health needs assessment • System report card	• Facility Inspections • Water treatment monitoring	• Health surveys • Disease registries • Communicable disease reporting	• Intersectoral community partnerships to solve health problems	• Immunizations • Investigation and outbreak control • Encouraging and supporting	• Treatment and acute care • Management of complications • Rehabilitation

FEATURES	PRIMARILY THE RESPONSIBILITY OF PUBLIC HEALTH		JOINT FUNCTION OF PUBLIC HEALTH AND PRIMARY CARE		PRIMARILY THE RESPONSIBILITY OF PRIMARY CARE	
FUNCTIONS	**Population Health Assessment**	**Health Protection**	**Health Surveillance**	**Health Promotion**	**Disease and injury prevention**	**Disease management**
		• Air quality monitoring • Regulatory enforcement	• Ongoing analysis of data • Report to practitioners • Report to public health • Disaster response	• Advocacy for public health policies (education, housing, income) • Improving personal skills • Creating physical and social environments to support health (e.g. tobacco control, bike paths)	healthy behaviors (eating, not smoking) • Chronic disease prevention (e.g. cancer screening)	• Maintenance and follow up • Self-management • Continuity of care
Intervention objectives	Identify population health needs and report on health status	Identify and ameliorate health and safety risks	Identify trends or emerging problems; activate screening and protection protocols	Prevent movement to at-risk groups	Prevent movement to established disease or hospitalization	Prevent / delay progression to complications and prevent hospital admissions; continuity of care
Main target groups	General population	General population	General population; at-risk groups and individuals	General population; at risk groups and individuals	General population; at-risk groups and individuals	Individuals with established disease

One study that was reviewed identified that Canada has been a leader in developing models of integrated health systems that combine individualized approaches to influence personal health behavior and community approaches to influence the health of the population. Historically, public health and primary care have shared a common goal: a healthy population. In characterizing the relationship among primary care, family physicians and the public health system during the SARS crisis, it was suggested that there were 'weak links between public health and the personal health services system, including primary care, institutions, and home care' (Public Health Agency of Canada).

Following a meeting on future strategic directions for primary healthcare, the World Health Organization (WHO) reported that a new approach to integrating systems was needed: strengthening public health functions in primary healthcare settings. This approach could improve local public health surveillance and reinforce disease prevention and health promotion. To facilitate an intersectoral approach between primary care and public health, the WHO report suggests some interesting and useful ideas:

- Give more prominence to the public health functions within primary care.

- Use leaders to promote intersectoral collaboration.
- Use evidence to demonstrate that important health and social outcomes can be achieved only through intersectoral collaboration.
- Involve intersectoral stakeholders in agreeing on health goals and priorities.
- Build the mechanisms for collaboration at every level, from national to local.
- Integrate health into definitions and processes of wider community development.
- Develop appropriate attitudes towards collaboration and power-sharing.
- Develop influencing skills among primary care professionals and managers at the local level.

In the United States, the fields of primary care and public health in the United States have for the last century generally functioned independently of each other. This was not optimal; the health challenges required improved efforts to work together in an integrated fashion to address the root causes of illness and prevent additional cases of disease, and to make the default choice a healthy one. Effective support of healthy behaviors required coordination of the work of clinicians, particularly primary care clinicians, with public health agencies, schools, businesses, and community groups to better utilize community resources. In such an integrated system, primary care and public health worked together to support individuals, families, patients and their caregivers, and to improve the health of individuals and populations.

In 2012, the Institute of Medicine (IOM) released the report, 'Primary Care and Public Health: Exploring Integration to Improve Population Health' in which the Committee on Integrating Primary Care and Public Health reviewed promising models of primary care and public health integration, often with shared accountability for improved community and population health outcomes. From their review of numerous examples, the IOM committee developed a set of principles that they deemed essential for successful integration of primary care and public health:

1. a shared goal of population health improvement;
2. community engagement in defining and addressing population health needs;
3. aligned leadership;
4. sustainability, including shared infrastructure; and
5. sharing and collaborative use of data and analysis.

The IOM report noted that integration can start with any of these principles and that starting is more important than waiting until all are in place. Porterfield et al also identified in a separate literature review and environmental scan a number of interventions that linked primary care and community organizations for delivery of preventive services in such areas as tobacco cessation and obesity prevention. One such visible effort, as described in an editorial by Linde-Feucht and Coulouris, is the Healthy Weight Collaborative, a quality-improvement project to prevent and treat obesity among children and families. This effort draws on the assets of multiple sectors and highlights the importance of bringing together primary care and public health to effect meaningful change.

5.5 Opportunities for Collaboration between PHUs and Aboriginal Service Providers

The information above has already signalled strategic areas where PHUs and AHACs / Aboriginal service providers could collaborate.

A report entitled "A Scoping Literature Review of Collaboration between Primary Care and Public Health" identified three determinants for collaboration including: Systemic determinants (outside the organization) in the environment where the collaboration takes place; Organizational determinants (conditions within the organization); and Interactional determinants (interpersonal interactions between team members). The figure below proposed a number of activities where public health and primary care collaborated. Brief descriptions of these types of collaborative activities are as follows:

- Community activities: community engagement, community development and multi-sectoral involvements;

- Joint PH-PC health promotion, health education and prevention initiatives;
- Health services: including chronic disease management including screening; immunization and emergency response preparedness. This 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: specially 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;
- Social marketing and communication: especially informing the public on specific health issues

5.5.1 Collaboration for the Health of Specific Populations

Providing for specific populations who are vulnerable including those who are difficult to reach, older persons living alone and young children with risk factors, was explored. These groups were noted to present challenges to both primary care providers as well as public health agencies. One example that was reviewed was an initiative for at-risk children that included primary care providers, public health agencies and mental health services. It included training for primary care providers in assessment of social and emotional development of child-patients; provision of a public health care coordinator to whom primary care providers could refer children who screened positive (who would then link children to appropriate specialized services) and providing feedback to primary care providers on status and outcomes for those patients. This particular example was so successful that it recruited 39 practices serving 41,000 children.

5.5.2 Examples of Public Health Collaboration

According to research on how best to integrate public health services within primary care is a concern in many countries. Ten models were identified that varied in their level of implementation. For example, the United Kingdom's Public Health in Primary Care Trusts was the only model found that focused on national-level implementation imposed from top levels of government down to providers. Five models were introduced at the community level. There were three models at the patient–provider level that were more narrowly focused on the relationship between a public health department and primary care providers. Notably, five models were developed in Canada, a finding that may reflect the growing national interest in developing this capacity.

Activities in Public Health (PH) and Primary Care (PC) Collaborations

Through the literature review, models differed in their stage of development and focus. Some were at the planning stage in which policies or directives were newly created by a group or committee, with plans for implementation in the near future. Some models were in early stages of implementation, while others were more fully implemented and had also been evaluated. Most models focused on the general integration of public health functions in primary care, usually integrating chronic disease prevention within primary care settings. Only one model considered infection control.

Models such as the Family Health Teams in Ontario or Primary Care Networks in Alberta deserve careful consideration. They involve multidisciplinary or inter-professional team practices including public health and primary care providers; capitated, salaried or blended models of remuneration for family physicians; a funding system or incentives program for health surveillance, health promotion and prevention of disease and injury; a rostered patient population; and a frontline information technology system to collect health promotion and disease prevention data continuously and systematically, as well as the capacity to detect and report new and emerging diseases.

Many of the integration examples and studies that were reviewed as part of the project, converged around a specific health issue that was identified as a community area of concern. Most often these issues were identified by local health leaders and practitioners and supported by data and at times the key health concerns were identified in community health assessments. However the focus of the concerns almost always fell into one of three categories: Chronic disease; Prevention and health promotion and Health of specific populations (e.g. seniors).

5.5.3 Collaboration for Chronic Disease & Injury Prevention

Often public health agencies and medical practices discovered that their actions alone were not sufficient to effectively mitigate the impact of chronic diseases on population health. A particular example which aimed to address a state-wide increase in the prevalence of diabetes, included multiple agencies across multiple jurisdictions to create innovative partnerships to strengthen diabetes prevention, detection and treatment. It included medical practices, public health, home care providers, diabetes support groups, businesses and community groups in order to strengthen community resources, support health professionals with care guidelines, enhance knowledge of the disease among all health professionals, raise community awareness and facilitate data collection and use. The result from this improved population health outcomes and improved the reach and prevalence of community awareness events and health professional education.

The Canadian Society has placed increasing emphasis on disease and injury prevention, as seen in recent federal reports[7]. For example, one paper recommended a larger investment in prevention and health promotion activities within the healthcare system. The report calls for the integration of prevention and promotion initiatives as a central focus of primary care, targeted initially on reducing tobacco use and obesity and increasing physical activity in Canada. It also calls for a National Immunization Strategy.

There is also growing recognition in Canada that prevention should focus more on chronic diseases. One study recommended the development of a National Chronic Disease Prevention Strategy that should incorporate public education efforts, mass media programs and policy development. Such a strategy could be implemented through various public health settings, including primary care, and could address the needs of priority groups (e.g., Aboriginal peoples).

5.5.4 Collaboration for Prevention and Health Promotion

It was noted in a few studies that prevention and health promotion play a significant role in improving population health, but the impact of these activities depended on the ability to reach as much of the target population as possible in a meaningful way. The review further identified that both primary care and public health have critical roles in prevention and health promotion and are positioned to carry out these roles with different sets of resources and relationships with the community. It was identified that by linking primary care, public health and the community – coordinated, cooperative approaches to prevention and health promotion could expand the reach and effectiveness of their efforts. In the examples that were reviewed, often a public health professional would seek participation of primary care providers in a particular public health campaign. This sought to utilize the primary care provider's relationships with individuals to complement the population-level initiatives (e.g. public health training primary care providers to deliver evidence-based behavioural interventions for tobacco control, and then referring patients to quit-lines operated by the public health agency).

Through the research, health promotion is defined as "the enabling of people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and realize their aspirations, to satisfy needs and to change or cope with the environment". "Health promotion contributes to and shades into disease prevention" through healthy public policies, community interventions and public participation.

Health promotion has been viewed historically as an important domain for physicians. It is reported that health promotion is practiced by governments, non-governmental organizations and primary care service

[7] Commission on the Future of Health Care in Canada 2002; Government of Canada 2003

providers in a fragmented and poorly integrated fashion. No health goals have been set nationally for health promotion.

One study identified that if primary care and public health professionals have integrated roles in health promotion, then they both need access to timely information concerning regional and community health concerns. They also need to be made aware of current trends in evidence-based health promotion activities. Effective and efficient methods of team-based interventions are required whereby physicians, public health nurses and other health professionals involved in primary care delivery have an identified and manageable role to play in health promotion. They also need to be adequately compensated for this role.

5.5.5 Collaboration for health surveillance

The responsibility for health surveillance is one of the most important functions of public health according to the Institute of Medicine Primary Care and Public Health. The National Advisory Committee on SARS and Public Health defines health surveillance as "the tracking and forecasting of any health event or health determinant through the continuous collection of high-quality data, the integration, analysis and interpretation of those data into surveillance products (for example reports, advisories, alerts, and warnings), and the dissemination of those surveillance products to those who need to know". The report suggests that surveillance data can come from at least four types of sources including surveys, administrative reports, special-purpose data and clinical records.

According to Health Canada, the link between public health and primary care is most obviously found in clinical data, which are critical for surveillance purposes. First-contact providers are the first to see new and emerging diseases, acting as "sentinels" for the public health system. However, at the present time Canada does not have an integrated surveillance system that allows timely information to be reported upward through the public health hierarchy from local primary care providers to national and global networks. Furthermore, for family physicians to fulfill their public health role in surveillance during an infectious disease outbreak, they require "protocols, protective equipment and prompt information".

Timely detection depends on rapid communication from frontline healthcare providers to public health officials. Priority has been placed on the development and implementation of electronic health records (EHRs), which will help to remedy the communication gap. Furthermore, the Network for Health Surveillance in Canada lists several activities, such as the development of priority information systems, to support an integrated public health and primary care system. It also plans to help develop the skills needed to undertake health surveillance and to interpret surveillance data.

5.5.6 Collaboration for Disease Prevention

The need for collaboration for disease prevention was a reoccurring theme throughout the literature review. A particular disease prevention study by Health Canada highlighted an example where prevention can be found in tobacco control and cessation. Public health professionals work with various partners and institutions ranging from policymakers to the public to make cigarettes less accessible by regulation (taxation, restriction of advertisements and minimal legal age for purchasing) and health promotion (educational and social marketing targeted at encouraging youth not to smoke). Health care professionals actively engage in counselling and providing pharmaceutical supports to help high-risk individuals quit smoking.

Another example of working together was the preparation for and management of the H1N1 pandemic. Public health was responsible for developing pandemic preparedness protocols and guidelines on federal, provincial, territorial and local levels prior to the emergence of the H1N1 influenza virus. Throughout the pandemic, public health carried out active surveillance of H1N1 activity, coordinated H1N1 vaccine clinics and assessment centers, and communicated current information to health care professionals. Health care professionals also had an integral part in pandemic preparedness and management by regularly reviewing H1N1 updates and protocols, providing clinical expertise to guide and inform pandemic management policies, and delivering health care services to the public. This ability for public health to work in tandem with the other parts of the health system is vital to a well-functioning system, which is ultimately essential to both individual and population health.

The US Centers for Disease Control (CDC) continues to work at the intersection of public health and health care, through its work with the Internal Revenue Service to develop guidance for charitable hospitals in their implementing and reporting on the new community health needs assessment and ongoing community benefit requirements, through pilot projects linking electronic laboratory and medical records with public health, through identification of winnable battles (e.g., decreasing health care–associated infections), and through its engagement in the Million Hearts initiative, a DHHS effort to prevent one million heart attacks and strokes during the next five years. CDC also has long-standing relationships to support integration of public health into health professional education, particularly in medical education, through cooperative agreements with such academic organizations as the Association of American Medical Colleges, the Association for Prevention Teaching and Research, and the Association of Schools of Public Health. Integrative efforts are incentivized by CDC through the CDC Community Transformation Grants.

Public health authorities and primary care providers in Canada may be more open to cooperation than in the past. The SARS crisis revealed how difficult it would be for public health and primary care professionals to respond separately when the next pandemic strikes. Both primary care reform and public health renewal are priorities in strengthening Canada's health system. In all jurisdictions, stakeholders have been engaged in widespread debate about the future of primary care services delivery, and substantive changes are underway. New priorities and new approaches to resourcing primary care have the attention of service providers.

5.5.7 Leadership for Collaboration

It was identified that it was not always public health-led ventures that initiated collaboration and partnerships with primary care providers. Several primary care practices who themselves created an outreach program were seen as successful. An example of this included a neighbour-hood approach to reduce lead poisoning rates among children. They employed a team of outreach workers led by a nurse-coordinator from the primary care health center to conduct blood tests, conduct environmental surveys and report results to the clinic and the public health agency for follow-up and intervention. This resulted in significant decreases in lead poisoning in the area. In a few cases a neutral convener brought together public health professionals and primary care providers such as a community or non-profit group or academic organization, to create a coalition to address a specific issue. Often partners will form a committee and appoint coordinating capacity to ensure the partnership maintains momentum as well as to ensure communication between all of the stakeholders occurs.

5.5.8 Collaborating around Data

A key opportunity for integrating primary care and public health is sharing data. Both sectors generate data that can be leveraged by the other to support their respective functions more effectively. Primary care can generate data to create population-based data useful to public health in coordinating surveillance or community assessments. Public health assessment data can in turn be tailored to provide valuable information on concerns or risks in a community served by particular primary care practices while allowing practitioners to assess their clinical performance. Several factors hinder data-sharing however – incompatible data systems; lack of trained workforce to develop and implement data-sharing opportunities and varying uses of measurement. One example that was studied had created a data-hub to capture data from various sources and standardize them for re-use.

5.6 Summary of Collaborations and Partnerships

The evidence identifies that many other researchers and health systems have sought to address the desire to increase collaboration between primary care (PC) and public health (PH). Many of the articles and publications that were reviewed often use 'collaboration' and 'integration' inter-changeably. For the purposes of this report, the term 'collaboration' is favoured. There are some positive lessons about enablers and facilitators for collaboration as well as barriers to such collaboration that the Ontario PHUs and AHACs / Aboriginal service providers can learn from to seek out opportunities.

Levels of Collaboration: The evidence identifies that public health and primary care collaboration can and does occur at a variety of levels. One article describes four levels of collaboration:

- Intra-personal (within the professional field)
- Inter-personal (between public health and primary care professionals
- Organizational (between some organizations)
- Systemic (across the system at a regional, state or national level for instance)

Additionally some also support a systemic and organizational level but refer to an 'interactional' level of collaboration between individual practitioners. This would appear to be a simpler model to work with.

Enablers, Barriers and Outcomes of Collaboration: Identifying the enablers or facilitators of collaboration between primary care and public health as well as the barriers to collaboration had conflicting results with many examples of positive and negative outcomes of PC and PH collaboration.

Overlap in PC and PH Responsibilities offers opportunities: For several functions in PC and PH, there can be identifiable responsibilities allocated to PC as well as to PH – but there are several functions where overlap can occur – for instance maintaining disease registries (i.e. at EMR level and at population level) and screening. These linkages between functions and responsibilities is further supported by other researchers who identified that most of the overlap and opportunities occurs in health promotion; health surveillance and disease and injury prevention. Additionally there are several benefits to the population's health by having PH play a greater role in accessing primary care data to better monitor and report on the health of the population, and to identify high risk populations and health conditions.

Areas of activity where PHUs and AHACs / Aboriginal Service Providers could collaborate successfully: A number of areas where PC and PH have collaborated successfully elsewhere which provide opportunities in Ontario include:

- Community education activities
- Professional education
- Social marketing and communication
- Quality assurance and evaluation
- Teamwork
- Needs assessment and planning
- Health promotion and education
- Prevention
- Information systems

Furthermore there are specific examples and case studies where this has occurred at an institutional level such as bringing in PH staff to practice sites; establishing one stop shop centres where both provide programs together; establishing free clinics; conducting community needs assessments; mounting health education campaigns and using clinical data to support decision-making, targeting of resources and patient follow-up.

Strong Examples of Collaboration

Many of the examples and case studies that were reviewed identify successful collaborations in different areas:

- PC and PH collaboration around chronic disease and injury prevention (e.g. for diabetes patients)
- PC and PH collaboration around prevention and health promotion (e.g. public health campaigns related to tobacco control)
- PC and PH collaboration around the health of specific populations (e.g. young children with specific risk factors)
- PC and PH collaboration around health surveillance (e.g. SARS, H1N1)
- PC and PH collaboration around data (e.g. public health assessments)

The evidence highlights that leadership for collaboration is essential – and that it can come from either sector. The model below proposes a high level framework for PHUs to consider when looking at how collaboration with AHACs / Aboriginal service providers might occur identifying across three levels (system, organizational and inter-personal) what may be possible; what enablers are needed; what barriers need to be addressed and avoided; and what potential outcomes might arise from successful collaboration.

A PROPOSED FRAMEWORK FOR STRENGTHENING ONTARIO PUBLIC HEALTH COLLABORATION WITH ABORIGINAL SERVICE PROVIDERS (incl. AHACs)

LEVEL	FACILITATORS / ENABLERS (success factors)	BARRIERS TO PLAN TO AVOID /PREVENT	TYPES OF OUTCOMES POSSIBLE IF EFFECTIVE	EXAMPLES OF COLLABORATION
System **PH regional level (*Epidemiologists, planners, researchers, investors, consultants, strategy & policy leads*)**	• Government involvement / system support & policy: Support of Ontario Government (policy) & direction; Doctors of Ontario; AOHC; academic support; alignment of provincial system with local priority setting; willingness to allocate and re-distribute resources • Funding/resources: Government investments in AHACs; technical, informational support to teams; funds for project / admin support; sustainable funding for collaborative programs; ability to look at alternative funding models; funded education for professionals • Education and Training: providing professional & cultural safety education system-wide; re-tool education programs in PHUs to bridge gaps	• Health Policy: Provincial priorities take precedence over local priorities; rapid & constant change created by national initiatives; policy overload • Funding Barriers: Lack of extended stable funding for collaborative projects; HR funding barriers; inequities between PH program investments • Power and control issues: Separate entrenched bureaucracies; power of hospital care over community care; fear of loss of autonomy; physicians have greater power than PH nurse roles • Information and infrastructure: Lack of data infrastructure (EMRs); lack of surveillance systems; lack of pop'n health need information; challenges with data sharing	• Economic & community development • Improved use of culturally appropriate education materials across system • Resource sharing more efficient • Collaboration fills service gaps & efficiencies through elimination of duplication of services and improved communication • Increased access to care • Improved health service delivery process to communities • Improvement in population health and public health approaches (e.g. increase in prevention efforts)	• Advocacy for changes to laws and regulations that create barriers to achieve of health goals • Influence health system policy to reflect better practice at community level (e.g. funding models; quality standards) • Address outbreaks and crisis health issues together (e.g. SARS) • Target high risk populations (e.g. Aboriginal health; refugee/migrants; social determinants of health)
Organizational **Organizations in an identified geographic location (*AHACs, PHUs, community organizations, First Nations & Aboriginal community groups*)**	• Support of organizational leaders / management / accountability: PHU Program Leaders, community leaders, First Nations & Aboriginal leaders and AHACs (e.g. steering committees) • Geographic proximity: Clear identification of area and each other's services in those areas • Shared protocols: Data collection & sharing agreements; evidence-based toolkits (e.g. Falls Prevention toolkits), decision support tools, clinical support tools available for all underpinned by clear principles	• Lack of common agenda: Lack of common vision; competing agendas; physician workload issues; lack of joint planning • Lack of knowledge and skills: knowledge on laws / regulations; deficiencies in skills and capacities of providers; dysfunctional committees lacking leadership; poor use of HR capacity; caps in communication • Resource limitations: limited human, time, financial & space resources; staff feel unsupported; community mobilization takes longer than expected	• Improved health outcomes for Aboriginal patients and communities through better targeting of programs and resources • Increased self-care and preventative health care by patients; Improved immunization rates • Stronger working relationships between organizations in same areas • Better use of data at practice and population level to inform decision-making at all levels (harmonized)	• Using population-based data to inform decision-making at clinical level and organizational level (e.g. targeting more health promotion & education for key health issues) – mounting joint campaigns around key health issues in the population e.g. diabetes • Conducting community needs assessments • Engage in cross-sector training • Free clinics or targeted clinics
Interactional / interpersonal **AHAC / Aboriginal workforce & local PHU workforce (*e.g. PH Nurses, Educators, Promoters, Nurses, Physicians, NPs, planners, EHOs*)**	• Role Clarity: spend time to clarify & define roles; • Shared Purpose, philosophy and professional identity: early successes develop trust; cultural sensitivity & core values; collaborate to resolve problems • Developing & maintaining good relationships: Maximize existing positive relationships; develop teamwork; nurture relationships • Effective communication & decision-making strategies: promote understanding of each other's roles; value regular meetings; attend to processes up-front; consensus building; listening to team members	• Attitudes and Beliefs: stereotyping roles of partners; lack of trust; resistance to change; interpersonal conflict; devaluing roles • Relationship Challenges: poor rapport between collaborators; Communication issues and inadequate understanding of each other's roles	• Educational improvements for staff of all partners • Greater autonomy and decision-making by professionals • Greater awareness of each other's role and how best to use each other's skills • Health professional development & retention • Better use of roles (NPs, RNs, PHNs etc.) for patients • Development of new skills • Better use of settings where services delivered (e.g. co-location)	• Bring new PH personnel to AHAC sites • Establish one-stop shop centres • Coordinate services at different sites • Establish free clinics • Establish referral networks • Identify high risk shared patients to provide greater support to • Improved use of specialized skills held by PC and PH workforce (e.g. HIV AIDs, Hepatitis, harm reduction, LGBTQ, youth / women-specific)

6. PUBLIC HEALTH UNIT INTERVIEWS

KTCL undertook site visits and engagement interviews with three Public Health Unit (PHU) sites across Ontario (Sudbury, Toronto and London), primarily with staff members from the Health Equity teams, to seek recommendations, ideas and any concerns about current relationships between PHUs and Aboriginal communities and to hear proposed solutions to improving relationships. The results from these engagement interviews have been analyzed and categorized into four themes: What works well; Opportunities; Links with AHACs; and Specific roles.

There are 36 Public Health Units across Ontario, and therefore the sample views are only reflective of three departments within three PHU sites across Ontario.

6.1 What works well

Various relationships currently exist with Indigenous communities, across the three PHU sample sites and departments. Regular connections and relationships with Indigenous communities and service providers have been built over time some with those of whom sit at the same tables; through previous and current collaborative funding initiatives; cultural competency training and coming together for a unified health planning program. One noting that "we value each other's input into planning".

There are formal agreements in place for specific collaborative programs or initiatives such as Dental; Smoking Cessation; Poverty Reduction; Children's Health but these appear to be opportunistic as opposed to consistent. Each PHU site was able to provide an example of current collaborative initiatives between the PHU and Indigenous service providers who work with Indigenous communities. It was identified that Community led or community driven programs have provided the most positive results according to all three sites. One noting "We need Indigenous people to be guiding us". A specific Dental Clinic initiative that was directed and driven by the community, allowed the PHU to gather feedback from Indigenous communities on indicators of success. Another specific example of how relationships were working well included one group who are currently investing in a research project. The project is underpinned by First Nations engagement principles and while in its infancy, this has pathed the way for a successful collaboration. As described earlier in the report, collaborations that have mutual benefits and that are formed upon trust and respect appear to have the best results.

The establishment and guidance of Indigenous Advisory groups (or bodies) was seen as being highly beneficial towards achieving mutual and positive health outcomes for Indigenous peoples. The creation of the Toronto Indigenous Health Advisory Circle (TIHAC) was described as a successful model of how a community led advocacy and advisory group were able to include a wide representation (including youth and elders) that have the expertise to inform health priority planning. The wide representation of TIHAC was critical particularly with having a diverse urban indigenous population in Toronto. Another example provided is the Poverty Reduction initiative that is supported by an Indigenous Advisory Group and a Francophone Advisory Group where AHAC's were invited to be involved. Contradictory to this however there are currently sub-regional integration tables in place however PHUs noted that they are yet to see outcomes from this group in relation to Indigenous Health priorities.

6.2 Opportunities

All PHU's interviewed are guided by some form of strategy, strategic document or mandate. There was general consensus across all three sites that they welcome Indigenous input into the development of their Strategic documents wherever possible. A comment was made that PHUs will consult AHACs on their Strategic Plan and vice versa. Additionally, it was noted that the embedding of Indigenous Outcomes into Annual planning and reporting would ensure Indigenous relationships and programs are continually incorporated into service provision initiatives.

One particular strategic objective was that of placing focus on supporting PHU staff through capacity development. It was seen that effective relationships and partnerships with AHAC's and indigenous communities required competent and culturally safe PHU staff. This included various competency domains to address such things as Indigenous Public Health training; Stand wise practices; support with hiring

Indigenous staff and ICS. Experiential learning was also raised as a key opportunity for building capacity. This included being involved in Indigenous exhibits; Cultural Fairs; Pow Wow or Cultural dances – "I would like to see the number of Indigenous events which bring awareness to the forefront of peoples promoted more strongly and regularly across the year". Ultimately the AHAC's and CHCs have played a critical role in cultural competency of PHUs and building knowledge and capacity. One commenting "bringing their (AHAC) expertise is a huge opportunity". While this appears to be a strength of AHAC, PHUs also believe there is an opportunity to build further on this to become more systematic, consistent and ongoing. To add further context, there is an Ontario version of the BC San'yas online cultural safety 8 hour training program and while one comment referred to this being a long day, they are always eager to learn wherever they can. "Staff development in general is an area we can really work on together – shared learnings on child health for instance". PHUs want to be seen as effective allies and supporting First Nations to build capacity for Public Health. An additional comments was made that "AHACs are very knowledgeable and supportive in terms of providing or facilitating cultural training solutions to PHU staff. They do this well".

It was also identified that there is room for a shared learnings program, where each party could do secondments with each other. This has the potential for PHU staff to learn more from AHACs and AHACs to learn about the inside of PHUs.

A local level reconciliation plan that looks at taking what has worked and aligned to the Health equity guideline and Trust & Reconciliation calls to action was discussed. Initial thoughts for implementing such a plan would require the support of Indigenous communities and health service providers to help raise awareness and improve education (and a shift in education for PHU staff), increase workforce development, building governance relationships and ensuring there are effective accountability measures. While this discussion is in its infancy, it was acknowledged that this will need to have the commitment of PHU leadership and strategies to ensure that behavioural and knowledge shifts in PHU staff are being monitored. One interviewee noting that "Actions speak louder than words, where it is not just about the learning, we have to change".

Although one PHU site estimated that they have over 30 varied programs across different departments that involved various involvement and engagement with Indigenous communities, there was no "one size fits all" in terms of consistent relationship and engagement approaches. "We have differing relationships depending on what is on the table". Typically, these programs have no formal documentation to identify the relationship and communication process unless it is entered into a specific collaborative contract. All sites affirmed that they want to connect more with AHACs, CHCs and Indigenous communities (including community health centres, health stations and Governance) that are underpinned by strong relationships and engagement principles.

Capturing Indigenous data to inform health planning was seen as the biggest impediment according to one PHU. However it was also seen as a critical and valuable opportunity for each party to work together. It is understood (by PHUs) that AHACs have EMRs that capture good administrative performance data and it was acknowledged that they are their own custodians of this data. However there is uncertainty of whether there is overlap with data that PHUs collect with one interviewee commenting that "it would be good to see how we could streamline this". The "We Ask Because We Care" data gathering campaign that collects infant data has worked well according to one site and has resulted in better targeted care. It is proposed that a similar campaign and approach be implemented for Indigenous data information to be collected so that PHUs can better plan for targeted health needs for Indigenous communities. The literature review also highlighted that there is a critical need for accurate, region-specific data about the health problems that Aboriginal people experience, including non-status First Nations, Mètis and Aboriginal people living in the urban areas.

6.3 Links with AHACs

Aboriginal Health Access Centers (AHACs) and Aboriginal governed, Community Health Centres (ACHCs) are Aboriginal community-led, primary health care organizations. They are service delivery organizations who are important partners for Ontario's Public Health Units (PHUs) when planning and delivering Public Health programs to the Aboriginal population. In fact, it is critical to ensure a strong relationship exists between PHUs and AHACs/ACHCs to avoid overlap and duplication in program design and delivery, and

confusion for Aboriginal community members. The interviews with PHUs agree with this interdependent relationship statement however there appears to be inconsistencies across the region.

Many PHU staff already work with AHACs/ACHCs and these relationships have developed since AHACs began in 1995. One PHU noted that typically relationships between PHU's and AHACs / CHCs are largely opportunistic rather than systematic and sometimes overlaps occur, however it was further noted that not everything that PHU does is relevant to AHACs and CHCs and each has quite different roles where PHU has different mandates. One site had worked closely with an AHAC Executive Director around entry to communities on things like tobacco, dental, health kids challenges and this support to engage with the First Nations community has worked well. For diabetes funding PHUs had worked with the Executive Directors from AHACs and Health Directors from First Nations communities to plan prevention in the catchment area and to implement funding for them to implement services in their communities. Another noted that "very often we come together on similar committees and connect that way and come to know each other". One interviewee stating that "AHACs are not big on everyone's radar, so it will not look the same everywhere". Aboriginal Health Access Centers (AHACs) and Aboriginal governed, Community Health Centres (ACHCs) as well as Friendship Centres were identified as key service providers that help support the relationship and engagement processes with Indigenous communities. The Wulaawsuwiikaan Healing Lodge was also specifically identified as a unique Ontario offering to the Indigenous communities on their healing journey of which one PHU has worked closely with. Therefore while there is sporadic engagement, this has often presented itself in the regular course of business and there is no real consistent approach according to one site.

Jurisdictional ambiguity was seen as a challenge between First Nations and PHUs provincial and federal mandates. For instance, the PHUs follow the Ontario Public Health standards where they work in areas of Environmental Health (water, food safety etc.) which isn't in the mandate of AHACs but does have some overlap with First Nations who are federally funded to do some of this work. The literature review also identified that for Aboriginal people, ongoing federal/provincial jurisdictional and funding issues have created gaps and inadequacies in health services.

One PHU commented that they have good connections with AHACs and that it is more of a challenge for them connecting with individual First Nations communities. Further noting that "We continue to work on that and it is strengthening all the time". We recognize and respect AHAC knowledge and they respect ours – we have mutual aims. "Trust and Relationship building is key".

Sometimes we collaborate and bid on things together like contracts for evaluation and will involve each other. There is currently a PHU equity project (including all 36 PHUs) that includes all AHACs, and this forum has been guided by First Nations Health Directors to ensure the PHU follows principles and practices of engagement with First Nations communities. This resulting in an effective foundation for the implementation of the project.

6.4 Specific roles

One PHU site stressed the importance of getting to know the local Indigenous communities and the structures within those communities. Indigenous governance was seen as very important, further noting that it is a sign of respect and a sign of acknowledgement to ensure PHU's understand who plays which roles within Indigenous environments.

The establishment of a Manager of Equity role and Manager of Indigenous Engagement role within the Sudbury PHU, was seen as a unique structure. The Manager of Equity role was created to focus on equity across all areas of Public Health, specifically noting "in order for us to be serious about addressing inequities, we have someone focused on this with a mandate to influence all parts of our work". These roles enable SPHU to focus in on priorities and not spread themselves too thin further commenting that "we can make more impact if we focus in on priority issues and gaps. The Manager of Indigenous Engagement role really looks at jurisdictional issues and evolved from a part time role into a full time role. Both of these roles have a key role to play in building capacity across the whole of the organization. These two roles are also supported by the recent inclusion of a Manager of Mental Health. This role recognizes the importance of behaviour change where First Nations and Indigenous communities are being affect by

how people feel mentally and any trauma or other factors impacting on the health of the population. This unique infrastructural team was described as “we are seen now as walking our talk and under the TRC, we see this as demonstrating our commitment”.

6.5 Summary of Public Health Interviews

Various relationships currently exist with Indigenous communities, across the three PHU sample sites and departments. All agreed that it is critical to ensure a strong relationship exists between PHUs and AHACs/ACHCs to avoid overlap and duplication in program design and delivery, and confusion for Aboriginal community members. Additionally, there was general consensus across all three PHU sites that they welcome Indigenous input into the development of key strategies and program planning design.

Collaborative programming was typically identified as the opportunity for PHUs and AHACs to engage. Some collaborative programs have formal agreements in place however it appears these are more opportunistic rather than a consistent approach. The interviews revealed that the most effective collaborative ventures are those that are Community led or community driven programs that have mutual benefits formed upon trust and respect.

A common theme across all three PHU sites was that of AHACs ability to deliver effective cultural training. Ultimately the AHAC’s and ACHCs have played a critical role in cultural competency of PHUs and building knowledge and capacity. While this appears to be a strength of AHACs and ACHCs, PHUs also believe there is an opportunity to build further on this to become more systematic, consistent and ongoing.

Capturing Indigenous data to inform health planning was seen as the biggest impediment but also seen as a critical and valuable opportunity for each party to work together better. There is a strong desire and critical need for accurate, region-specific data about the health problems that Aboriginal people experience, including non-status First Nations, Mètis and Aboriginal people living in the urban areas.

The establishment and guidance of Indigenous Advisory groups (or bodies) was also seen as being highly beneficial towards achieving mutual and positive health outcomes for Indigenous peoples.

7. CONCLUSIONS AND FINDINGS

7.1 Objectives

This report is aimed at supporting the development a culturally appropriate guideline for Ontario Public Health Units to successfully develop good protocols and processes for engaging with the Aboriginal community including AHACs and communities; develop strong partnerships for the success of all partners involved in service delivery; and to improve stakeholder relations between PHUs and Aboriginal communities. This work aims to raise the cultural safety of workers who are working in and with Aboriginal communities in order to improve processes and outcomes of Public Health work for the benefit of the Aboriginal population.

For this review – cultural safety, effective engagement and collaboration opportunities (between PHUs and AHACs / Aboriginal service providers) have been explored – as each dimension has the intention of resulting in successful collaborative partnerships between Ontario PHUs and Aboriginal service providers (e.g. AHACs) to better serve the Aboriginal population. The research has clearly demonstrated that culturally safe engagement CAN result in successful collaborations and offer opportunities for effective and pragmatic collaboration between Ontario PHUs and AHACs that deliver primary health care (Primary care & Public Health) services. Further the research has provided examples of similar collaborations that have benefitted both the providers and the target populations. The work is important to both PHUs and the Aboriginal community. Persistent health disparities in the Aboriginal community highlight the need for collaborative and culturally appropriate partnerships between PHUs and indigenous service providers.

7.2 Cultural Safety in Public Health

Supporting Indigenous or Aboriginal individuals and communities within health requires trust, compassion, and mutual respect - however in today's day in age, this is still not being achieved consistently. Systemic racism continues to be a major barrier to positive engagement and relationships between health care workers (and organizations) and Indigenous communities. Systemic racism is often referred to as interpersonal or relational racism when people experience some form of discrimination – intentional or unintentional. The expectation is that all health care providers and workers will commit to providing culturally safe care.

What is evident from the literature review is that there are many definitions of the terms: culture and Aboriginal culture; cultural responsiveness; cultural appropriateness; cultural awareness; cultural sensitivity; cultural competency and cultural safety. Users of the terms research and develop their own definitions in order to apply them in the context they intend to use them. This flexibility and adaptability will and should always remain since culture – and Aboriginal culture - is a continually evolving and changing concept. Aboriginal culture in itself is therefore about a people who share an indigenous history; who express beliefs and values, actions, customs, language and traditional knowledge often in a common way; but who are different intra-culturally and inter-culturally. Aboriginal peoples belonging to different cultural groups within Aboriginal society, also belong to many other 'cultural' groups such as those related to their age, wisdom and experience (e.g. Elders), those related to their professions (such as Aboriginal Physicians) or those related to their gender (such as Aboriginal women). Overall, Aboriginal culture is dynamic.

What makes Aboriginal culture in Canada specifically unique and different to all other cultures that exist in the country – is that Aboriginal culture centres itself on indigeneity (belonging or originating naturally in a land or region). Aboriginal culture has no other equivalents in Canada since no other cultural group in Canada has or continues to experience what the Aboriginal population has experienced through the many manifestations of colonization that have occurred.

Cultural competency and safety refer to:

⇒ People development (ability of the practitioner to take knowledge, lessons and experiences about culture learned over time either through their own life and/or through formal learning) and being able to apply them to their practice to improve the health outcomes for the service user or patient.

⇒ Organisational development (processes, policies, practices being in place that increase access of services and remove any perceived barriers for the Aboriginal population; that support personnel practicing in a culturally competent way; that ensure community members have a culturally safe experience and that results in improved outcomes).

7.3 Effective Engagement with Aboriginal Communities

This section of the report begins with a brief overview of the Ontario Government's policy on the relationship with Aboriginal peoples in Ontario. Since Public Health Units are effectively an extension of government it makes sense that PHUs review and understand this policy position as it provides the 'umbrella' under which engagement activity happens with Aboriginal communities in a manner which is consistent with provincial policy. The Ontario Government has signed protocols with both First Nations and the Mètis Nation of Ontario which focus on strengthening relationships that respect Aboriginal Rights and Title - but also benefit the social, cultural and economic well-being of Aboriginal peoples while protecting and promoting their distinct cultures, identities and heritage. Further the Ontario Government policy and commitments essentially places a responsibility on PHUs to help support the achievement of social, cultural and economic goals of Aboriginal peoples through wellness-oriented approaches.

The report provides a number of pointers for effective engagement including:

⇒ Researching and understanding communities (and keeping relevant information on-hand for others to utilize in their planning and relationship development)
⇒ Beginning conversations as a stepping stone toward building sustainable relationships through nurturing trusting, transparent and respectful relationships underpinned by goodwill and commitment
⇒ Being authentic which relies on mutual recognition and respect that recognizes the importance of indigenous knowledge and expertise[8] and translation of Indigenous (and academic) knowledges into action - that results in health improvements. In other words – PHUs should not assume they have all the answers and should be ready and willing to listen to alternative ideas and perspectives.
⇒ Expecting diversity - that every community is different and that relationships will take time. It is important to tailor services and programs to fit individual families' needs and preferences to ensure that services are meaningful.
⇒ Not having pre-conceived ideas until it is actually heard from the community itself
⇒ Being flexible with time
⇒ Not overdressing
⇒ Recognizing differences in worldviews of health and well-being: being prepared to learn and listen to a different perspective. Having an open mind and being curious to understand

Effective communications with Aboriginal communities also requires particular skills to be alert to signs and signals in body language and conversation. Not using colloquialisms, jargon, acronyms and technical language is another key to messaging and communications. Acknowledgement to the traditional territory is an essential sign of respect.

A certain level of understanding of the historic changes and impacts of colonization should be included as part of any engagement and capacity building process within health care before engaging with indigenous communities. Evidence confirms that colonization and systemic discrimination has led to adverse, multi-generational health effects, which continues to have a significant impact on the current health status of Aboriginal people.

Key concepts to be aware of when engaging with Aboriginal communities also lie in understanding the principle of reciprocity and that engagement is an exchange of information and knowledge. Along with the concept of reciprocity, PHUs need to reflect on how power and privilege and racism and oppression might affect behaviors; decisions and resource allocation within the public health system. Systemic or

[8] University of Manitoba 2013; Building Relations with First Nations Handbook

institutional racism is a form of racism that may be introduced consciously or unconsciously through policies and procedures that are based on the values of the dominant society and adversely affect those who are not. It is for this reason that PHUs should review their policies and procedures to assess signs of power, privilege, racism and oppression and that the dominant culture is not benefitting unfairly.

7.4 Opportunities for Collaboration and Partnerships: PHUs and Aboriginal Communities

Many of the articles and publications that were reviewed often use 'collaboration' and 'integration' inter-changeably. For the purposes of this report, the term 'collaboration' is favoured. There are some positive lessons about enablers and facilitators for collaboration as well as barriers to such collaboration that the Ontario PHUs and AHACs / Aboriginal service providers can learn from to seek out opportunities. The evidence identifies that public health (PHUs) and primary health care (AHACs) collaboration can and does occur at a variety of levels. One article describes four levels of collaboration:

- Intra-personal (within the professional field)
- Inter-personal (between public health and primary care professionals
- Organizational (between some organizations)
- Systemic (across the system at a regional, state or national level for instance)

Authors generally identify the enablers or facilitators of collaboration between the two systems as well as the barriers to collaboration – and there is also evidence of many examples of positive and negative outcomes of such collaboration that are cited in the evidence. The report also identifies that for several functions in Public Health and Primary Health Care, there can be identifiable responsibilities allocated to each but there are several functions where overlap can occur – for instance maintaining disease registries (i.e. at EMR level and at population level) and screening. These linkages between functions and responsibilities is further supported by other researchers who identified that most of the overlap and opportunities occurs in health promotion; health surveillance and disease and injury prevention. Additionally there are several benefits to the population's health by having PH play a greater role in accessing primary care data to better monitor and report on the health of the population, and to identify high risk populations and health conditions.

The report identifies a number of areas where PC and PH have collaborated successfully elsewhere which provide opportunities in Ontario - for example: community education activities; professional education; social marketing and communication; quality assurance and evaluation; teamwork; needs assessment and planning; health promotion and education; prevention and information systems. A high level framework for PHUs to consider when looking at how collaboration with AHACs / Aboriginal service providers might occur – is across three levels - system, organizational and inter-personal.

APPENDIX ONE – Building an Aboriginal Community Mini Profile

This checklist should be used to familiarize yourself prior to engagement with Aboriginal communities. It will result in the development of an Aboriginal Community mini profile for PHU to use and share as a future resource with others in the team.

ABORIGINAL COMMUNITY MINI PROFILE		
Community Name		
Key Contact Name		
Phone		
Email		
Address		
Community Engagement Questions	✓	**N/A**
What is the Governance structure of the community? (Chief and Council, Leaders, Matriarchal Leadership)		
What departments fall within the leadership team (health; education; social assistance; economic development; land management; etc.)		
What is the history and culture of the community (Territory or reserve; Laws of the land etc.)		
Who is best to contact to seek authority for engagement with the community?		
What is the structure of the Health Centre or Health Station?		
Who are the independent health provider entities associated with the community? (local, regional, provincial) – Who currently visits the community in terms of health services?		
Who are the Métis Associations with Boards and personnel?		
Who are the Inuit organizations with Boards and personnel?		
Who are the Aboriginal NGO's businesses (e.g. gas bars; stores; restaurants) and corporations (e.g. Fisheries, Forestry)?		
What are the local Schools and day care centres?		
Does the community have advisory groups or councils? (Elders etc.)		
Are there specific groups to help inform health planning / programs (e.g. Youth groups; Women's groups; LGBTQ groups; advocacy groups; parent groups etc.)		
SEEK PERMISSION FROM CHIEF AND COUNCIL (OR AUTHORIZED ORGANIZATIONAL LEADERS) TO ENGAGE		

APPENDIX TWO – PHU Self-Assessment Checklist

This Self-Assessment Checklist is an '*at a glance*' report for making a quick assessment of the organization's Culturally Competency levels. PHU's can tick or colour code the box of the relevant column that applies to show a baseline and progress over time: (NB: ADD other key result requirements as desired – this is an example to use as a basis)

MAIN REQUIREMENTS	NOT IN PLACE	IN PROGRESS	COMPLETED / IN PLACE NOW	NOT APPLICABLE	DON'T KNOW
LEADERSHIP					
1. Aboriginal participation at Leadership level					
2. Aboriginal health impacts considered in leadership papers					
3. All leadership have taken cultural competency training					
4. Aboriginal health integrated in PHU planning framework					
5. Aboriginal HR strategy in place (Aboriginal involvement in recruitment and induction)					
6. Cultural Responsive training for all staff in place					
7. % of Aboriginal recruits per year					
8. Staff survey reflects changes in practice due to cultural competency training					
9. Communication strategies on cultural competency training in place					
10. Regular communication with Aboriginal communities					
11. Data collection and reporting systems include ethnicity requirements for Aboriginal communities					
12. Regular information on Aboriginal health status goes to communities					
13. Quality Management System and Plans include Aboriginal measures and reports					
14. Risk Management System includes Aboriginal risk indicators and reports					
15. Annual evaluation of high-use services on the effectiveness for Aboriginal users					
16. Indigenous Cultural Safety Frameworks integrated into reporting and monitoring systems					
17. Community consultation on research priorities for Aboriginal communities					
18. All research considers the impact on Aboriginal people					
19. All Aboriginal research is in partnership with Aboriginal people					
20. Funds allocated for Aboriginal health services					
21. Annual increase of funds/investments in Aboriginal health					
22. New investments made in Aboriginal health inequalities					
23. Increase number of services contracted to Aboriginal communities					
24. Aboriginal people involved in priority setting and decision-making on service investments					
25. Policies on Aboriginal involvement in decision-making in place					
26. Strategic goals of Cultural Safety reflected in all policies					
27. Cultural perspectives documented in needs assessment, care planning, treatment and discharge planning processes					
28. Aboriginal models of care promoted in services					

MAIN REQUIREMENTS	NOT IN PLACE	IN PROGRESS	COMPLETED / IN PLACE NOW	NOT APPLICABLE	DON'T KNOW
29. Aboriginal youth given priority in mental health/addiction services					
30. Aboriginal health promoters in place					
31. Annual community needs assessment and community profile completed for high-need Aboriginal communities					
32. PHU mini profiles and database for Aboriginal communities and health service providers in their coverage area is created and maintained					
33. Schedule of Aboriginal communities ranked by deprivation and socioeconomic status is maintained					
34. High level of reported satisfaction with Partnership Accord Representatives from Aboriginal communities					
35. Urban Aboriginal health strategy completed and in progress					
36. Well-developed relationship with AHACs/ACHCs					
37. Effective engagement principles developed					
38. Demographic provide of Métis and Inuit people in the region is developed and maintained					
39. Specific needs of Métis and Inuit people are described and met within services					
40. Number of Aboriginal placements /interns per year					
41. Number of collaborations on developing cultural competent and responsive curriculum					
42. 3 articles annually on Aboriginal health service delivery in the public arena					
43. Promotion of Aboriginal Events					
TOTALS					

Enter Totals **Number Percentage**

No. not in place / not started

No. in progress

No. completed / in place

No. not applicable

TOTAL OUT OF 43 **43** **100%**

TARGETS (e.g.)

NOW (2018)	Overall 35 – 40% compliance
By 30/6/2019	Overall 40 – 50% compliance
By 30/6/2020	Overall 50 – 60% compliance
By 30/6/2021	Overall 60 – 75% compliance
By 30/6/2022	Overall 75 – 95% compliance

APPENDIX THREE – Principles of Effective Engagement

APPENDIX FOUR – References and Resources for Engaging with First Nations and Aboriginal Communities

Resources for Engaging with First Nations and Aboriginal Communities

- Developing Effective Working Relationships with Aboriginal Communities: *Canadian Association of Petroleum Producers*
- Consulting with First Nations: *Province of BC*
- Community Futures British Columbia Aboriginal Engagement Toolkit: *Community Futures*
- Early Aboriginal Engagement: A guide for Proponents of Major Resource Projects: *Government of Canada*
- Health Professionals Working with First Nations, Mètis and Inuit Consensus Guideline: *Journal of Obstetrics and Gynaecology Canada*
- A Cultural Competence Guide for Primary Health Care Professionals in Nova Scotia (2005): *Nova Scotia Department of Health*
- Improving the Health of Diverse Populations: Assessing Health Communication Strategies for Diverse Populations. *Institute of Medicine, 2002*
- Asset Mapping: Locating the Gifts in your community: Empowering communities through Access to Information and Training: *Deblois H, Evans. A, 2003*
- Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care: *Family Medicine 1996; 28:291-297*

Aboriginally-Authored Resources Available:

- www.purichpublishing.com Books written about Aboriginal consultation and related topics
- www.icscollaborative.com Online cultural competency training
- www.fourdirectionsteachings.com/main.html Video provides information about indigenous knowledge and philosophy from give diverse First Nations
- www.afn.ca/index.php/en Source of information on Canadian First Nations
- www.cbc.ca/news/politics/never-too-late-to-engage-Aboriginal-groups-says-Doug-eyford A paper by Doug Eyford
- www.newrelationshiptrust.ca/downloads/consultation-and-accommodation-report.pdf Best Practices for Consultation and Accommodation
- www.aandc.ca/firstnationsprofiles provides a brief profile on all First Nations in Canada
- www.ankn.uaf.edu (2001) - Guidelines for Respecting Cultural Knowledge