



Sioux Lookout
First Nations
Health Authority

Community Consultation

Public Health Project

October 2014
Sioux Lookout First Nations Health Authority
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Acknowledgements

The Sioux Lookout First Nations Health Authority (SLFNHA) would like to acknowledge Sandy Lake, Muskrat Dam, Nibinamik, Lac Seul and Sachigo Lake for hosting us in their communities. Representatives from each community welcomed our team warmly and ensured our consultation process went smoothly. We would also like to acknowledge Eagle Lake and Wabigoon Lake representatives for giving their time to attend a meeting with us and provide their input. SLFNHA would like to acknowledge Pam Hubbard, a Graphic Facilitator, who has put a significant amount of time into working with our project team both within the communities and with the SLFNHA team and our public health working group. SLFNHA would also like to recognize our partners at the First Nations Inuit Health Branch (FNIHB) Ontario Region and Sioux Lookout, the Ministry of Health and Long Term Care Public Health Planning and Liaison Branch (MOHLTC), the Northwest Local Health Integration Network (LHIN), the Northwestern Health Unit, the Thunder Bay District Health Unit, Matawa First Nations Tribal Council, Keewaytinook Okimakararak (KO) Tribal Council, Eabametoong First Nation, and Webequie First Nation. Our partners have worked hard to provide us with guidance and expertise throughout the process of developing the Public Health Model. I would also like to acknowledge the SLFNHA public health team members for organizing and attending the community visits and meetings with me, including: Janet Gordon, Brent Wesley and Maureen Chabbert. In addition to the project team, Dr. Mary Raukar, a resident in Public Health and Preventive Medicine at the Northern Ontario School of Medicine, was a great resource during community visits. Finally, we would like to acknowledge Health Canada and the Health Services Integration Fund for making this project possible through their three-year funding grant.

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Executive Summary

The Sioux Lookout First Nations Health Authority was mandated by the Chiefs under Resolution 10-06 to develop an integrated regional public health system for the 31 communities in the Sioux Lookout area. In order to develop a model for this regional public health system, we undertook a community consultation process to gain input from community members and health workers. We visited five communities and hosted a round table discussion with two more. We also conducted interviews with community physicians and FNIHB allied health professionals. During the community consultation process we gained input on the strengths and challenges associated with public health in the communities and the key priority health areas. We discussed the hopes and concerns for a new public health system, and various considerations that should be included in the system. Participants in the sessions outlined their vision for a public health system, including the key values and objectives that must be considered. The roles of various partners were also discussed. This report provides a consolidation of the findings from the consultation process and includes a draft copy of the public health model that incorporates the community feedback.

Through the community consultation process we determined that the public health system must be holistic and incorporate traditional knowledge, values, and ways of life. However, it was clear that the definition of “traditional” is very different between each community, thus there must be flexibility in the system. It was also overwhelmingly stated that services for mental health and addictions must be incorporated into the system, even though they are not always viewed as the domain of public health. It was also evident that parenting and support for families should be integral to the system, as having a strong family and supportive upbringing is a determinant of health.

We also found that the system must focus on capacity building, as many health workers felt inadequately trained for their positions. Training in various areas was suggested, including in data collection and analysis to improve their abilities to identify priority areas and plan programs accordingly. Community feedback recommended that the health related programs be located together in one building. Some people felt that it should be within or attached to the clinic since community members visit the clinic anyway and it would facilitate teamwork with the nursing staff. However, others felt that it should be a separate building (although close to the clinic if possible) so that the public health programs were not pulled into acute care situations. Participants in the interviews felt that the public health system should be managed by the health director with governance support from a health board or committee. The role of Chief and Council was seen to be as advisors to set the overall vision and goals. It was recommended that the Tribal Councils play a role in advocacy and technical support, especially around water, sanitation, and housing. SLFNHA’s role was also seen as advocacy and support; however, more specific feedback included assisting with: trainings, technology (i.e. data systems), consistent public health messaging and facilitating collaboration between communities.

Following the community consultation process we invited the First Nations representatives on our Public Health Working Group to a meeting where we incorporated the community feedback into a model for public health. This model has been termed “Approaches to Community Wellbeing” and reflects First Nations values and priorities. Feedback regarding this model is encouraged and can be directed to the Public Health Project Coordinator.

Introduction

The Sioux Lookout First Nations Health Authority was mandated by the Chiefs under Resolution 10-06 (see Appendix A) to develop an integrated regional public health system for the 31 communities in the Sioux Lookout area. To date the project has conducted an environmental scan of similar public health systems in Canada, a public health inventory of services and human resources in the area, and a consultation meeting with the health directors. The project team has also conducted five consultation visits with selected communities, a round-table discussion with representatives from Treaty 3 communities, interviews with community physicians, and interviews with Allied Health Professionals employed by FNIHB – Sioux Lookout. The purpose of the consultation process was to gain input from various key stakeholders in the community to identify what makes a public health system unique in the First Nations context. As was pointed out during one interview, the program must be developed for the northern context and a system from the south cannot merely be dropped into the north with minor adjustments. With that in mind, the public health project targeted a range of communities spanning different geographical areas, Tribal Councils, population sizes, access, and readiness. Furthermore, once in each community the public health project team strived to gain perspectives from a variety of sources including nurses, health program staff, health director, health board members, Chief and Council, Elders, school leaders, and others.

Community Selection

Our first step in the community selection process was to contact all of the communities. Participants from the Public Health Conference February 19-21st 2014 were emailed an evaluation form that also asked them to identify if they were interested in participating in the next development process. They were emailed several reminders, and those who did not reply were also faxed a copy of the form. Communities that were unable to attend the conference were contacted by phone. Multiple attempts over three different business days were made to reach them. After being contacted, our first selection criteria was whether they were interested in being part of the consultation process and whether they were committed to providing the time and effort needed to participate. Thirteen communities expressed interest. For a chart outlining the selection process, please see Appendix B.

After identifying interested communities, each community was assessed for the type of access available (i.e. Fly-in versus road access) to ensure we had a variety of accessibility included in our sample. Communities were also assessed for Population. In the Anishinabe Health Plan, when considering Human Resources requirements the following population sizes were considered: 200, 500, 1000 and 2000. In order to be representative of all communities, and to stay in line with The Anishinabe Health Plan categories, we attempted to ensure that one community from each of these population categories was included. In order to stay in line with the percentage of communities that have road access (23%), only one community with road access was chosen. Since two communities with road access were identified in the 1000 population category, and only one in the 200 category, the 1000 population size community will represent the road access component. Since more communities with approximate populations of 500 people were interested in the process, two were chosen from that category.

The health structures of the different communities were considered. Unfortunately, none of the health transfer communities indicated interest, so we were unable to include that in the selection processes. An effort was also made to represent a variety of Tribal Councils.

Choosing the two communities to represent the 500 population category was difficult as they all had similar structures and readiness. In addition, all of them represented Tribal Councils that had not yet been included in our sample, so we could not reduce the sample by considering previously used Tribal Councils. However, to represent multiple Tribal Councils we knew we would not choose two that were from the same one. We selected Fort Severn, due to its unique location up north. In our previously selected communities, south west (Lac Seul), north west (Muskrat Dam, Sandy Lake) and north (Fort Severn) were already represented. Thus, we decided to choose a community that represented those in the north east (Nibinamik). Unfortunately, due to scheduling conflicts, visiting Fort Severn was not possible. As a result, we reviewed the remaining interested communities of that population size and chose the next farthest north community – Sachigo Lake.

After selecting the five sample communities, it was also decided that the Treaty 3 communities of Wabigoon Lake, Wabauskang, and Eagle Lake should be consulted as well due to their unique proximity to Northwestern Health Unit and since they fall under Grand Council Treaty 3 instead of Nishnawbe Aski Nation. However, at the time of the Round Table discussion only representatives from Wabigoon Lake and Eagle Lake were able to attend.

In effort to obtain a more complete picture of current public health-focused issues and activities in the sample communities we interviewed the physicians, environmental health officers, a communicable disease nurse who work within those communities. We also involved Health Directors from the Tribal Councils in the discussions.

Consultation Process

During the community visits, key informants were interviewed regarding public health, strengths and challenges in the current system, reporting structure, data collection, inter-program collaboration, and views on a future model. In each community, a forum was hosted to discuss public health, strengths and challenges in the community, hopes and fears for a new system, the vision for a future system, and the next steps needed to achieve the vision. In two communities, we invited a graphic facilitator to come and lead the discussions and capture the key ideas in images. These images can be found in Appendix D. Following each visit a report was developed on the key findings and given back to the health director and any interested participants. The Health Director was encouraged to share the report as widely as desired and feedback was welcomed if participants felt the report was not accurately reflective of the conversations.

Physicians were asked about the key public health priorities in the community, the role physicians can play in a public health system, and things to consider in developing a public health system. The Communicable Disease nurse and Environmental Health Officers were asked about their views on public health concerns in the community and a future system, as well as job specific questions to better understand the support provided to the community. Tribal Council Health Directors were interviewed in an effort to understand the existing and potential support they could provide within the public health system.

Definition of Public Health

Public health was viewed as the health and well-being of the whole community. It was seen as holistic, including physical, mental, social, and spiritual wellness. As one respondent stated, “Public Health is the vehicle that carries us along the road of health.” It was described as looking after yourself and the health of the community. Public health looks at prevention strategies and early interventions to promote optimal health. Thus, public health is upstream thinking about health before issues arise. Participants felt it was very important that mental health support, spiritual wellness, good environment, and respect for, and protection of, the land were represented in public health. Public health refers to health as influenced by the social determinants of health, and it includes disease management, mental health, environmental health, childhood development, economic development, living conditions, injury prevention, outbreak control, safe food and drinking water, animal bites, physical activity, tobacco-free living, substance use prevention and food security. One main goal of public health systems is to provide a credible source of information and reliable advice.

Strengths in the Community

Culture

Culture is a big part of the communities. There are many community events including: cultural weeks, sweat lodges, smudging, feasts, cook outs, gatherings, festivals, sewing classes, and canoe courses. There are also numerous outdoor activities people take part in and a lot of activities for the youth. The communities also discussed community cohesion and how they all come together to support each other in times of crises.

Teamwork

The different health programs work as a team together to coordinate programs. The health program staff also offer peer support to each other, help each other out and work as a team to share ideas and make sure that no age group or issue falls through the cracks in the system. The staff members have positive attitudes and are dedicated employees that want what is best for the community. The staff share knowledge with each other and community members, and encourage healthy behaviours. The respondents highlighted that the health programs are very involved with the schools, and the schools rely on the health staff to address health education. This partnership means that children are learning about health and nutrition at a young age and receive health messages about healthy eating and physical activity regularly.

Programs

There are a lot of public health programs available in the communities. Respondents discussed a variety of clinic programs that were working well, including: immunizations, well-baby clinics, well-women clinics (including pap smears), flu immunization clinic, prenatal program, dental program, personal support worker home visits, and telemedicine. Water and water testing were also mentioned as positive influences on health in some communities but not others. Potable water is testing takes place

weekly and is conducted by the water plant operator. It is also done quarterly and annually by Environmental Health Officers. The samples are sent to labs and when the results are available the Environmental Health Officers write a letter outlining the findings and attach the results. If there is an issue of concern that needs to be addressed then the letter is faxed, otherwise it is mailed. Food safety checks are done on a regular basis according to the risk level associated with a proprietor. Food safety trainings are provided frequently. Some communities highlighted existence of community-based First Response Teams that respond to community emergencies. Where there was a public health nurse, respondents commented that the position has been held by the same nurse for over a year, which allowed her to develop better relationships with health program staff and school staff. The public health nurse is getting out into the community, thereby expanding the reach of her services. The communities are taking steps to deal with the addiction issues within their respective community and the suboxone program was highlighted as a particular strength in all communities that had one. Participants noted that you can see an immediate impact on the clients in the suboxone program as they are functioning more in the community and taking better care of themselves and their families. Another community said their suboxone program would be starting the following month. One community also mentioned that Mental Health workers are starting to come into the community more often as well.

Most communities have access to an arena, although not all were used to their full potential. In one community the Aboriginal Diabetes Initiative have exercise equipment available to the public to use. Some communities also mentioned little gardens in the community, and there are community teachings about how to cook foods in a more healthy way.

Another strength in some communities was that smoking in public buildings and events is not permitted. It was also highlighted that there are lots of volunteers, although mostly for community events and not necessarily for health related tasks. Programs in some communities were using Facebook to promote events and one community had calendars of program events posted at various buildings around the community. A couple of communities mentioned a partnership with the Northwestern Health Unit for Children's Oral Health Initiative (COHI) and the Food Boxes program.

Challenges to Health

Human Resources

Several challenges human resources related issues arose throughout the discussions. Heavy workloads amongst clinic and program staff were highlighted. Some communities had important positions vacant and have been unable to fill them. This often meant other programs and staff taking on additional roles. Staff commented that they often feel discouraged or frustrated and need more support and debriefing opportunities to prevent burnout. Transient nursing staff also presents a challenge. It was also pointed out that multiple employers complicate things as the doctors are employed by Sioux Lookout Regional Physician Services Inc. (SLRPSI), the nurses are employed by Health Canada, and the program and support staff are employed by the community.

Staff turnover and staff burnout were also mentioned as a challenge. There is a need for more staff, especially in the suboxone program as the staff has been challenged by the rapid expansion of the program. Although the suboxone program is a strength in the community, it also pulls a lot of program workers away from their roles to go and assist with the distribution.

The job responsibilities associated with many of the health programs typically require workers to be available outside of a typical 9-to-5 workday schedule. Overall, there is also a lack of administration support. Another issue related to personnel and staff retention is the lack of training of community level workers. Without more training and supports to which they can consistently refer, it is hard for the community workers to make significant and sustainable contributions to health issues even despite good efforts and intentions.

Scheduling of visiting specialists was also mentioned as a challenge, because unless someone is paying close attention to scheduling, the same eager participants may be seen regularly while others may not be seen at all. Access to diabetes educators and dietitians varied based on the community, with one community commenting that they did not have either service while another community commented that they did not visit frequently enough. .

Communication and Engagement

Communication was another reoccurring theme among respondents. Although some staff and/or communities felt that they communicated well together, others said it was a particular challenge. Communication is difficult because the programs are spread out in different locations. There is also a disconnect between the nursing station staff and the community program staff and they have difficulty working together and they are not always aware of each other's roles. In regards to clients, language adds to the communication challenge as medical terminology can be difficult to translate and comprehend.

Lack of engagement and participation from the community members was another challenge. Part of the problem is that the community members do not seem to understand all of the programs or what is offered, so they are not sure where to go for health information. Furthermore, people lack interest in health, and they are sometimes tired of hearing the same messages over and over. Encouraging people to attend clinic and programs, and ensuring they actually come, requires a lot of extra time and effort for staff to provide reminder calls or reschedule appointments. However, community members might have trouble attending clinic or events if they do not have childcare or a means of transportation. It was also mentioned that there can be a perception that talking about issues is actually promoting them, which makes talking about certain things (i.e. suicide or sexual education) difficult. Finally, there are not enough land-based activities incorporated into programming, which would likely encourage people to attend.

Funding

Chronic underfunding, including funding cuts, was expressed as challenges in all communities. It is difficult to improve health status without adequate and sustained funding levels that can be utilized to provide programs and services responsive to community needs. Since funding is based on reserve population the allocated funding they get for each program is sometimes too small to hire staff or run individual programs, thus, they must get creative and combine resources to address unmet needs. Funding cuts specific to diabetes programming was especially concerning given the burden of the illness within the communities. There is also a lack of funding for equipment and resources. Furthermore, there is not enough space to do everything, especially activities and workshops. However, it was noted that in some cases a perceived lack of resources might actually be a lack of information about what

resources are available and how they can be accessed. Maintenance and repair of federal buildings is also challenging since it can take time to go through the necessary channels, even if there might be someone within the community who could quickly fix the problem.

Priority Areas

Most of the focus in the communities is on treatment of acute issues. Many of the treatments, however, are only “Band-Aid solutions” without more effort going into prevention. With the prenatal clinic, for example, it is difficult to have enough time to provide health promotion and preventive services because the focus is on ensuring high risk pregnancies survive. Postpartum women are also often lost to follow-up. There is a need to address the rates of teen pregnancy, with increased education on condom use and encouragement of postponing starting a family until after they finish school and have a job. Infant nutrition is a big concern as well. There is interest among women in the communities to breastfeed, but there are inadequate resources and supports for them so they often quit shortly after the baby is born. In addition to breastfeeding, complementary feeding is not being done properly.

The three main environmental concerns highlighted were water, waste/sewage, and housing. Most communities noted boil water advisories in the community, or a lack of trust in the water supply. It was also noted that the sewage system is not ideal and in the winter the freezing of pipes leads to unusable toilets. A more proactive approach to address housing condition issues is desired, including building standards as well as teachings relating to taking care of houses. There is also no real authority to enforce regulations; for example, if the water quality or food safety practices are poor at an establishment Environmental Health Officers and Health Directors do not have the authority to close it. Furthermore, the dusty roads make it hard to do outdoor activities, and therefore it is difficult to practice the healthy lifestyles people learn about. Concern was also expressed that there is not a lot of information about the diseases that may be carried by wildlife and what might be transmitted through meat. Finally, preventing injuries in the community is essential. Specific concerns include fire safety, lifejacket use, seatbelt use, and helmet use on ATVs.

It was mentioned that there is a huge need to stabilize the addictions issues in the communities and it was posited that tackling public health issues would be difficult until that happens. Participants highlighted a gap in alcohol and drug treatment for youth, especially in the 16-18 year age range, since the demand for acute treatment exceeds capacity. It was also discussed that, in general, it is hard to maintain sobriety when recovering addicts return to the community where they re-encounter triggers. Smoking is another public health issue in the communities.

Illiteracy and unemployment rates present a significant challenge to the community, and there is a significant need for more employment opportunities for youth. People’s self-esteem and wellbeing are negatively impacted by lack of education and employment opportunities. Social exclusion, bullying, and discrimination were also mentioned as issues of concern

In relation to existing services, respondents mentioned there is often a lack of information in the community about existing programs. Specific examples noted were misunderstandings regarding the suboxone program, and lack of education around sexually transmitted infection (STI) testing. It was also expressed that there is a need for more culturally appropriate assessment tools that can be used by health service providers. Furthermore, although there used to be physiotherapy and exercise classes to

help manage arthritis and back pain, now patients are usually simply prescribed medications. Where a public health office exists, it lacks technical infrastructure such as their own fax machine, printer, glucometer, etc., which means accessing these resources takes time away from client care. Although many communities expressed working with schools as a strength, it was also noted that it can be challenging depending on the Principal's priorities.

Record Keeping

Immunization record keeping is a challenge since some clients may get some immunizations within the community and some during visits outside of the community. Health Canada monitors immunizations, but it is not analyzed and the communities do not receive any feedback on how they are doing compared to others or a standard. In all forms of program reporting, the numbers do not seem to be compared to a standard, so it is difficult for health staff to assess their own performance. Without feedback they are missing valuable information that would help them improve their services. It was also noted that surveillance data that is collected is not shared with all necessary staff, which impedes the development of responsive programming. Thus, collaboration needs to take place between data collectors, frontline workers, and decision makers.

Supervision

The Nurse in Charge (and other nurses) report directly to Health Canada. Agency nurses report to their agency who in turn reports to FNIHB. The Telemedicine Coordinator reports to KO Telemedicine, however in all but one community they received in-community support and supervision from the Health Director. The Home and Community Care (HCC) workers report to the Home Care Case Manager, who then reports to FNIHB and the Health Director. HCC is under the parameters, or "essential elements", determined by FNIHB, but in most communities it is directed by the Health Director. In one community, Home and Community Care is under the supervision of the Tribal Council. All of the other programs report to the Health Director. The Health Director, in turn, reports to Chief and Council every one to three months on the progress and needs of the programs. This reporting structure depended on the community, however, if there was a Health Board then the Health Director reported to them regularly and only to Chief and Council for specific issues. In one community, some of their programs fall under the health director, while others fall under the social programs director. Both National Native Alcohol and Drug Abuse Program (NNADAP) and Mental Health report to the Social Programs Director.

In a future public health system, most people said that the current system should be maintained – with programs reporting to the health director. Although, respondents mentioned concerns that the exact responsibilities of the health director are unclear and that information is not always passed on to the staff from the health director, which leaves staff unsure of what resources and services are available to them.

In a future public health system there should be more opportunities for program staff to voice concerns, share information and ideas with other programs, and share experiences with other communities/organizations. It was suggested that there should be more face to face reporting and weekly meetings to share ideas and discuss work successes and concerns. In one community program staff currently submit activity forecast calendars at the beginning of the month and an actual activity

calendar/report at the end of the month, which may be a strategy that would work for other communities as well.

Data Collection

Programs keep track of information relating to the number of clients, ages, gender, family information, incidents, appointments, referrals, activities, education sessions, and workshops. Currently the data collected is mostly used for the nurses and program staff to know their clients and keep track of their progress. Furthermore, for the telemedicine education sessions they conduct evaluations to help identify priority areas. The nurses keep track of immunizations and reportable diseases. It was felt that immunization and health data should not just go to SLFNHA and FNIHB but should also be reported to the community (band, health authority and community members).

The information is recorded in monthly reports that are submitted to the Health Director and then generally compiled and submitted as annual reports to the funders. For those programs that do not report to the Health Director, it was still felt that the Health Director should at least be aware of the clinic and program information even if it is not formally reported to them. It was noted that for some programs, the reports did not influence program priorities due to the set funding agreement and requirements. One respondent mentioned that the same funding formula has been used for programs for years, and it needs to be revisited. Some respondents were not sure what the data was used for, and others said that there was no formal feedback on their reports. Respondents said since the data is not analysed they do not know how they are doing in relation to targets, which also makes it hard to set goals in the first place.

Although some respondents were satisfied with the type of information already gathered, others had suggestions of other data necessary. In general it was suggested that more of the “right” data needs to be collected, and receive feedback from their reports on how they performed (i.e. in an outbreak). Specific information desired included: closer follow-up on prenatal care (vitamins taken, anemia, diabetes rates in pregnancies, teen pregnancies), vaccination rates, IV drug use, and diabetes rates and associated complications, prevalence of diseases, and the ages people are diagnosed with different illnesses. It was also mentioned that the sexual health program can be problematic and staff need to understand the reasons why clients are hesitant to ask for the free condoms. They would like to see this information kept over the years in order to observe trends. In the future, respondents felt that the data collected could be used to show the needs for more resources from outside, to identify health topics that need to be covered in school, to develop health education (formal and informal), to evaluate programs, and to plan programming. The information gathered should be reported to Chief and Council, funding agencies, and back to the community. Support and direction relating to data analysis would be needed to do this efficiently.

Inter-program Collaboration

The health director discussed inter-program collaboration and mentioned how some programs form a cluster under Health Canada guidelines and work well together. They try to collaborate and share information so the client intake process is minimized. The Early Childhood Development programs work together closely. In one community, the ECD programs also worked closely with the ADI worker. The personal support worker and home support worker work together and with the Home Care Case Manager mostly. NNADAP, Mental Health and the Suboxone program work closely together. The CHR

supports a variety of activities, and works with almost all of the programs (Mental Health, NNADAP, ADI, and ECD). Brighter Futures works with the ADI and HBHC programs. Where the services exist, Brighter Futures partnered with the Youth Council, Right to Play, and Teach Patrol Program. NNADAP, Mental Health, Dental Hygienists, CHRs, DOT, Brighter Futures, and the ECD worker partner with the school to do classroom visits for presentations, demonstrations, and health checks (i.e. lice checks).

The nurse in charge works with the nurses and public health nurses, and meets with the Health Director to discuss issues. The nurses also work with Telemedicine when the physician needs blood work or vitals done. The public health nurses work with the CHR, the Early Childhood Development centre, Aboriginal Diabetes Initiative, and the child growth study. The public health nurses said that they are at the beginning or early stages of communicating with the various programs and they wish the process would go faster because they still do not know what exactly all of the programs do. The nursing staff in general do not know what is going on with the other programs and do not refer their patients to community programs. If nurses and program staff are able to communicate between each other better, then they can better serve the community by identifying needs and setting clients up with the right service.

In the future, Telemedicine suggested that it could work with the suboxone program by providing information sessions there as a way to reach a large audience at once. A couple of people responded that they would like to work more closely with the Environmental Health Officer when he/she visits, and one mentioned the possibility of trying to work more with lands and resources department.

Respondents felt that they need to find more ways to work together since a lot of what needs to be done cannot be accomplished alone. In order to meet the needs of the community, they need to liaise with other programs, however, it can be challenging to create partnerships and work together with high staff turnover. Overall, respondents felt that they should have all staff working together more and include other departments in order to improve programs and services and gain a more holistic approach. Other respondents suggested regular meetings to share information, keep everyone informed, and learn from each other. In addition to these meetings happening within the community, it would also be beneficial to link between similar programs in other communities to learn from each other and identify best practices. It was also mentioned that communication of information to the community must also be improved, so that they understand the programs better.

Role of Physicians

The current role of physicians in public health is primarily to ensure that the nurses were carrying out immunizations. Other contributions to public health include assisting with harm reduction strategies and the suboxone program. Furthermore, sexual health (i.e. pre-pregnancy care, pregnancy and STI testing and treatment), HIV and Hepatitis C screening, and cancer screening were mentioned by physicians. Also, physicians conduct health promotion consultations with their patients as much as possible. The physicians in Sandy Lake also highlighted their community outreach initiatives (i.e. radio shows) to help spread health promotion messages. In a future public health system, physicians felt, in addition to continuing their current public health aspects, their primary role could be to advocate for public health programming and refer their patients to appropriate services. Furthermore, they felt they could work in partnership with the public health system and act as a resource or support.

Hopes for a New System

The participants hope that the new public health system will bring in more resources, such as more up-to-date educational materials, more support staff, and planning for new facilities. With a new public health system the communities could benefit from having more up-to-date and reliable information. The participants hope that there will be better use of technology, including using websites, Facebook groups, and twitter, to spread public health messaging (especially around mental health). These means of communication could be used as a way of sharing information, connecting to other people and being a place to make things happen.

They also hope that there will be more professionals coming into the community and staying longer, such as dentists, doctors, and specialists. Participants hope that the public health system will be managed well and will deliver programs and services based on community priorities/needs. Ideally, these workers would be hired from within the community to create jobs and provide more opportunities in the community. They hope it will include team building, staff debriefings, and staff meetings to keep the workers informed and updated on information. They hoped all workers would have more training (especially for young people) and thus, be more qualified. They also hope it will promote capacity building within the community. In addition, young people within the community would look to the future and have career goals.

The participants felt that having an integrated public health system could help others understand what public health is, identify common goals, and support consistent messaging that is relevant to the community. They also hope that support from a regional structure will help the community-level public health nurse to identify needs and goals and help coordinate more resources to assist in a more targeted approach to health issues. They hope that the public health system would help the community have nice safe clean houses, safe drinking water, and safe and affordable healthy foods.

People will change their lifestyles (i.e. personal hygiene), and there will be less alcoholism and drug abuse in the community. There will be role models for healthy lifestyles in the community, such as Chief and Council, parents, grandparents, teachers and elders. Individuals will be connected to religion or spirituality (if that helps them). Overall, they see the system as providing a better life for future generations. Finally, they hope that it will lead to a healthier community overall that is focused on “well-being.”

Concerns for a New System

The participants are concerned about where the funding will come from for this program, whether there will be enough, and whether it will mean cuts to existing services. They also wonder how the existing funding and management structure and how health services are currently perceived might change. Participants worry about how a new structure will impact the current, informal system. They wonder about how a system will change how existing services are delivered since they are used to doing things a certain way and many of the programs are already delivering programs well. They also wonder whether a new system will move them further away from their traditional practices and customs as people come into the community and tell them how to do things.

Participants also mentioned a fear of the unknown or change in general, including that people’s jobs might change and/or they do not want to take the extra time necessary that shifting roles takes and that

prevention takes. Participants felt that in general, change is always a cause for concern and requires them to go out of their comfort zone.

They also wonder if the staff hired (i.e. AMOH, MOH) will have awareness of isolated First Nations communities and their unique needs. We discussed that, in general, SLFNHA hires people with previous work experience with First Nations and will ensure that staff are prepared to work with the communities. The participants expressed concern about people outside of the community accessing information about the community because they do not want to be singled out for certain health issues. They feel that the balance between primary/acute care and public health might be difficult to achieve. They also worry that this discussion may be raising people's hopes for nothing or that it may not address their priorities.

Public Health Vision

General Vision

The vision for a public health system is one that promotes wellbeing and includes factors affecting the whole communities. Chief and Council will recognize health as a priority and both the Council and the community will fully support the public health system. The system will be well-funded and funding will be flexible in order to address the most pertinent issues in the community. There will be sufficient resources and infrastructure to provide necessary public health services to a high standard of care. Furthermore, there will be strong infrastructure within the community (i.e. housing, clean water, paved roads, all season roads, etc.) to assist in keeping the community healthy. The system will encourage collaboration between sectors, and everyone will be working towards the same goal. It will be a proactive system that prevents health concerns before they become crises. The health system will include trained, dedicated, motivated and knowledgeable staff with proper health and human resources policies to support them.

The new system will assist in lifting the barriers that exist between traditional medicine and western medicine to find an agreeable balance. The Public Health system must be holistic and focus on mental, physical, spiritual, and social wellbeing. In terms of mental health, the system will promote positive people who feel good about themselves, know who they are, and can speak their language. In regards to physical health, the system will focus on healthy eating and teaching people how to cook and eat properly, and how to lose weight in a healthy way. They will learn to understand and listen to their own bodies and take care of it. People will decide for themselves that they want a better life and choose to quit unhealthy habits and start healthy lifestyles. Furthermore, the system will promote the importance of physical activity in traditional ways (i.e. snowshoeing, walking, etc) and incorporate land-based activities to reconnect the community members with the land. They envision a future where the youth feel connected to spirituality, community, and culture, which will be accomplished by building a bridge between the youth and the Elders, so traditions can be passed on. Furthermore, they want the youth to have a sense of responsibility and stay in school.

The system includes keeping track of the health of the community with a reliable data system and using the information to plan and improve services. There will be a regional support system to assist in the use of this data as well as to streamline reporting. The program will be evaluated on a regular basis to assess how we are doing and update programming. The system will provide easier access to accurate

health information and will spread awareness of illnesses and healthy lifestyles. It will focus on prevention, including dog control, keeping the community clean, preventing the spread of disease, and reducing harm (i.e. substance abuse and injuries). The system would include traditional healers and medicines, and encourage passing on traditional knowledge from generation to generation.

Values and Principles

The system must be grounded in traditional values and teachings (medicine wheel, grandfather teachings, Christian values) and their native language. The health system will respect their independence, and be a self-sustaining self-governed system within the community. It will promote strong leadership. The value of community is also important, including that the Public Health System needs to focus on community directed initiatives, community networking, and building the capacity of community members. Respect will also be integral to the system, including respect for people, animals, and nature. For example, valuing and respecting employees and incorporating support services for employees to promote positive mental health and avoid burnout) will be important. There will also be a connection to spirituality. The principle of accessibility, both in terms of access to services and information, and access to the necessary supplies to live a healthy life (i.e. affordable healthy foods) is essential. The system will be inclusive, so everyone feels that they have an opportunity to succeed. Last, but not least, the basic public health standards will be upheld to ensure the best quality of care for the community.

Objectives

Overall, the objective of the system will be to heal people holistically. Healthy eating and availability of fresh and affordable produce will be a priority within a public health system. Specific health priorities include dental health, hypertension, diabetes, prenatal/postnatal care, injury prevention, environmental and poison prevention, immunizations, nutrition, contraception, dialysis, speciality care, parenting, drug addictions, housing, and safety. Increasing outreach services will also be a priority within the system. There will be a focus on the younger generation within the system, but Elders will also be a priority. There will be a Meals on Wheels program available and there will be a helpline for their needs (especially Elder abuse). Some communities also expressed the desire for a retirement home. There will be bylaws that are specific to health within the communities (according to each individual community). Finally, within the system there will be a focus on communication and teamwork to improve the quality of services.

In addition to these priorities, participants highlighted several specific objectives they hope the public health system will achieve.

1. Increased awareness of health issues and health education in general.
2. Improved parenting skills within the community and strong family structures. This included the goal to increase male attendance at parenting courses. They also wanted to see more male support and bonding in parenting within the community. Participants highlighted parenting as their main objective because it has the potential to influence other priority areas, including: increasing breastfeeding, lowering teen pregnancy rates, increasing safe sex practices and family planning. Strong parenting and home-lives also has the potential to lower drug use and improve mental health.

3. Decreased prevalence of chronic illnesses (specifically lower diabetes and cancer rates), including increased access to screening to catch illnesses earlier. This also includes increased access to cancer screening and increased support available to patients as they undergo screening procedures. In conjunction with this objective, they would like to see increased attendance for clinic checkups for both men and women.
4. More youth graduating from post-secondary school and being employed in the community. They would also like to see a high school in the communities and include trade skills programs.
5. More people to return to traditional practices and to have more traditional foods available. Participants especially highlighted that they want to see this change in the young people, so that more of them hunt. With a return to traditional practices, it is also hoped that there would be increased access to traditional healers and medicines in the community
6. Fewer dogs in the community and more will be kept on leashes.
7. Fewer vaccine-preventable diseases.
8. Reduced respiratory illnesses. In order to reduce respiratory illnesses, the goal is to reduce dust by having better roads.
9. Fewer mental health issues, no unresolved grief and less substance abuse. People in the community have positive outlets and activities to participate in, feel empowered, and have positive self-esteem.
10. More trained staff in the community
11. Increased social interaction and community participation.

Services

It was highlighted that a “one size fits all” model might have rules and procedures that will not apply to their community, so the model must be community specific. The services need to be more flexible so that they can respond to the needs of the community. Programs need to focus more on public health and ensure that they do not overlap with each other. The services need to be holistic and incorporate the four aspects of the medicine wheel. Science and intuition do not need to be separate, and the system should strive for a balance that incorporates traditional practices and medicines. There needs to be a focus on traditional knowledge and programs need to incorporate land-based activities. To effectively incorporate land-based activities, a multi-person lodge that can be used for retreats, counselling, parenting courses, etc. was suggested. Furthermore, there needs to be a minimum standard for services that the community staff needs to uphold so clients can be confident in the services they receive and there is a degree of consistency between communities.

Public Health education will also need to be a significant part of the system, especially targeting schools since they do not have health resources. The public health system should make use of telehealth services by providing diabetes counselling and public health services through telehealth. In designing the public health system, and specifically health promotion messaging, it is important to look at the activities that community members take part in (i.e. fishing, hunting) and address how to make those activities safer. For example, fire safety and Wilderness First Aid courses would be beneficial for the northern communities. The financial capabilities of the community should be considered and health messaging should be modified appropriately. It is imperative that a regional data collection system should be developed with regional statistics and graphics available for communities to refer to in order to identify priorities.

It was mentioned that focus needs to be on the basics, including basic/personal hygiene, which needs to be taught more often and reinforced within the community. Mental health services were identified as a

particular priority because it is difficult to cope with other concerns if you are not mentally well. Respondents said that clients find it hard to talk about their issues because it re-victimizes them as they retell their trauma. Drug addiction, is a symptom of something deeper and the underlying issues need to be addressed. It was also highlighted that services for youth or elders could be provided through a telephone help line. Debriefing and support services are needed for the staff, since they deal with difficult issues within their roles.

The system needs to focus on chronic illnesses, especially diabetes, to promote healthy lifestyles (including diet and exercise), especially amongst young families. Furthermore community kitchens and a chronic disease program should be developed. There should be a school snack and nutrition program to ensure children are eating each day, and are receiving healthy options. It was also noted that the diabetes program should target younger audiences. Education on pharmacology is also needed, as many patients do not understand how their drugs work.

The prenatal program will be able to shift from task-based to a more positive and preventive focus. Men also need to be more involved in reproductive health. Non-insured benefits do not pay for a companion to accompany adult women for labour, so the men lose connection with the birth of their children. Parenting programs and supports need to be considered in the new model, and male participation in the programs should be encouraged.

More environmental health programming and water safety messaging would be beneficial. Access to anger management programs, Elder Care, and visiting services (i.e. foot care and diabetes care) should be increased. The need for access to professional services – especially physiotherapy - and practical resources was also stated. The Dental Hygienist should conduct school visits more often. More counselling and prevention around sexual abuse and child abuse should also be included in the system. In the new system, it was suggested that HBHC program should conduct home visits. More education, awareness and testing for STIs should also be incorporated. More translation services are also required, especially for visits outside of the community. Interest in various databases was also expressed including database for medicines, for public health information, and for band lists and ages. It was also mentioned that it would be nice to have more information and interaction with the Northwestern Health Unit.

All programs interviewed felt that they would be considered part of a public health system, however in some cases home and community care saw themselves as independent from a public health system but also independent from the clinic.

Staffing

In general, more staff is needed to fulfill the mandates of community level projects. It was highlighted that administrative support staff would be helpful for program and clinic staff to alleviate other aspects of their workload and concentrate on where their expertise can be best used. In several communities there are vacant positions, which either leads to certain services being unavailable or another worker taking on additional roles. Salary and other initiatives must be considered to improve staff retention. Also, mental health and NNADAP programs felt that additional staffing in those areas could help support them. In all of the communities it was felt that there needs to be at least one more worker in the suboxone program, since the programs have expanded rapidly but the number of staff has not increased. There needs to be more counsellors in the community, including youth counsellors, parenting counsellors and suicide prevention counsellors. It was also identified that more home care

program staff are also needed, especially personal support workers who can follow up on care when the home care nurse is away from the community. There also needs to be another CHR, or another staff, who takes care of chronic medications. Currently it is a big part of the CHR's job and takes them away from public health initiatives. If one staff was dedicated to chronic medications, it will leave more time for the CHR to focus on public health. There needs to be a community spokesperson for Public Health, which would be an appropriate role for a CHR. Traditional healers should also be employed in the system to help community members feel hopeful. It was suggested that a local case manager or liaison position could help patients navigate the health system and serve as a link between medical nurses, public health nurses and the patient. Within the community there should be a public health nurse, or an additional nurse, so that more time can be spent on Public Health initiatives. Regionally, there should be a public health nurse who travels to the different communities. It would also be beneficial to have a visiting nutritionist or dietitian who knows the northern context and can suggest feasible foods for them to eat and provide tangible examples/recipes. Other specialized professionals were suggested such as chiropractors and podiatrists. It was also highlighted throughout the visits that programs would benefit from community volunteers to assist with running events and workshops.

Training

More training needs to take place in the community for workers, so they do not always have to travel. Counsellors need more training to help support them in what they are doing and feel more confident in their skills. For example, solvent abuse, family healing, and grief recovery trainings. Other trainings suggested for community level staff include: CHR refresher training, health and safety training, parenting instructor training, safe food handling training, community engagement, facilitation, communication, conflict resolution, confidentiality, teambuilding, navigating reporting system, data collection, and how to use data. It was also suggested that the health service providers that visit the communities need to receive more cultural native studies trainings so they understand things like the legacy of residential schools.

Location

Many respondents stated that there is a need for more office space and for better space to conduct workshops. All programs should be brought together in one building. The building would need to be built with the foresight into future needs. Participants feel this will improve communication and teamwork. The one exception to this was that people feel that the suboxone program could be in its own building if necessary, since it needs more space. The Brighter Futures program also feels their office might be better off located elsewhere, such as at the youth centre, since that is where many of their activities take place. If the programs and clinic were integrated better it would avoid a clinic versus program mentality (or "us versus them"). On the other hand, it is also felt that the public health system should be separate from the nursing station or it will get pulled into acute situations. It was also noted that a transportation system between programs, or between communities in the case of Lac Seul, might facilitate patients attending services. Other infrastructure that would be beneficial to the health of the community would include a weight/exercise room to allow for year-round exercise, a walking path, and a nice green park. In terms of the regional structure for the public health system, one respondent suggested that it should be based at the Tribal Council level since they know the issues and are tuned into the communities.

Management

Overall, it was felt that the Health Director should manage the health system with a possibility of an Assistant Health Director. It was also suggested that there should be health managers for different areas, so fewer people report straight to the health director. Although the Health Director should manage the system, there could be an office in Sioux Lookout that offers support to the Health Director and program staff. This central entity could provide a sound model at the core that is understood by all communities and then allows for flexibility within each community. One respondent suggested that the manager of the system, whoever it is, should act as a healthy role model for community members. It was noted that techniques such as weekly program visits, monthly staff meetings, and staff socials are helpful in managing the system and strengthening teamwork. It was suggested that there should be a new contribution agreement that allows the community to hire their own nurses, since there is a different mindset when working for the community instead of for Health Canada.

Governance

Throughout the community visits there were some split opinions about whether a Health Board would be helpful or not. Some expressed that with a previous health board there used to be a tendency for workers to go straight to the health board with issues and not follow the chain of command. Others mentioned a lack of participation related to health concerns, so they were not sure if there would be enough interest for a health board. However, the majority felt that the health board could be very helpful in governing the system and assisting the Health Director, especially when dealing with challenging situations. The Health Board can provide support to the Health Director, so he or she does not feel overwhelmed with the workload. Various roles of the health board were outlined, including supporting workers and staff, oversee programs, evaluate workers, ensure accountability of reports, and/or act as an advisory group. The health board could also ensure that everything is happening that is supposed to happen without overlapping other programs. It was suggested that the health board could have regular meetings to discuss and plan priorities. However, it was cautioned that if they are not experienced in health related issues than their oversight and power should be limited to an advisory role.

Opinions on the role of Chief and Council in governing the public health system were also divided. Some felt that there should be more involvement by the Chief and Council, but others worried that the system would become too political if they were involved. Generally it was felt that the health staff and the Chief and Council need to work together more but that they should not necessarily be involved in day to day things. There should be one councillor assigned with a health portfolio (which there usually was), but the exact role of the person with the health portfolio needs to be clarified. Some felt that the person assigned with the health portfolio should be more involved and take roles in human resources, tracking work time, and monitoring progress in programs. However, these activities were also felt as part of the Health Board's responsibilities.

The Chief and Council could act as a venue for staff to approach when they need to raise issues and have them dealt with. However, this could also be a role better suited for the Health Board. A good role for the Chief and Council would be to advocate for more funding, especially in relation to current cutbacks that are happening. Chief and Council should give recommendations and input on bigger picture concerns as well as meeting with staff occasionally to hear how things are going. The Chief and Council should address community issues such as housing, food prices, water quality, registering children, and

community engagement. They should also play a role in health-related bylaw creating and enforcement, such as a kids' curfew or a stray dog policy. One community noted that sweets and pop used to be banned in their community, so returning bylaws like that may promote healthy eating. Chief and Council should also be a positive role model to the community and the employees. They should be visible in the community, so people know what they do.

It was noted that people do not seem to respect their leaders anymore, and when the leaders try to do something in the community parents and grandparents get defensive. In general, the community needs to understand how powerful they can be if they group together, and that they can influence the role and decisions of Chief and Council. On the other hand, the Chief and Council need to understand that sometimes fingers may be pointed at them, but it is not personal and everyone needs to work together for the betterment of the community.

Other Considerations

When asked if there was any other information they would like us to know, respondents discussed how many community members are seasonal workers and there are many low-income families, which makes getting proper nutrition, pampers, or formula very difficult. A couple of people pointed out that they are quiet, private people in the community and they do not always speak up. Respondents noted that community members do the best they can with the support and resources they have available. There is a willingness to help the community, and if the staff are pointed in the right direction and provided with the necessary tools they will flourish.

Participants discussed the need to teach children their history, so that they know the community did not always live like this. However, it should be taught in a way that does not create more bitterness. One participant said "We carry our hurts every day. Just because we see someone laughing and smiling, really we don't know how they feel inside." It was emphasized, however, that when it comes to traditional practices and values it can vary significantly between communities. For example, in some communities traditional values are Christian values and some teachings will not resonate with them. This emphasizes the need for flexibility within the system and community input.

It was noted more than once that the community members tend to focus on the negative and need to change their attitudes to focus more on the positives in the community and in their lives. When asked what gives the community hope, participants indicated community events, starting to get back to traditions, and hunting season as key activities that bring hope to the members of the community. Changes need to start within each family unit, and spread to the community as a whole.

Participants urged us to follow through with the structure, since it is common to set up a structure and "let it fly", but there needs to be more organization and capacity to run the structure properly.

Way Forward

Community

In order to achieve the vision, most aspects can be tackled at the community level. First and foremost, community members can look out for each other and help each other to maintain healthy lifestyles. The community can foster a sense of working together to support each other and achieve a common goal.

The community can work towards the vision by talking about these issues (through group or community meetings), planning, taking action, and setting timeframes to accomplish goals. The community must take the lead on engaging their leadership and community members in the process to gain their ideas and have a cohesive vision. In this way, ownership over the public health system and health in the community could be achieved. Before tackling some of the components of the vision, a community assessment should be conducted to learn about the needs and interests of community members. The scan should include what partners exist in the community and review the various strategic plans of the different organizations to see how services can be carried out most efficiently to avoid duplication or gaps. In order to accomplish this scan, they need to bring everyone together and report their findings back to the community for feedback. In each community, there are “natural helpers”, which might carry a lot of the power and should be included in the discussions. To build community engagement and work towards the vision, relationships within the community need to be strengthened. Within the health system, the health service providers can build teamwork through staff retreats and monthly meetings where they debrief, share and learn from each other, discuss priorities and solutions. Teamwork between sectors within the community should also be strengthened. Community leadership and relationships between the leaders and community members can also be improved. The session participants stated that leadership starts with each and every person, and they have the power to decide who is in a leadership position and what the priorities should be. The Leadership, in turn, can assist towards the vision by advocating for funding and resources. The leadership can also encourage people to volunteer for activities. After building community relationships, they could also seek outside partnerships, such as North–South Partnership for Children, to work on anti-bullying programs in the community.

A change in attitude from focusing on the negative to embracing the positives must occur, and that shift can only happen from within the community. The communities developed long lists of strengths throughout the visits, which can be built on to improve the health of the community. One of the biggest things may be just remembering who they were as a community (before internet, TV and video games) and getting back to it. The community also recognized that they could play a substantial role in building a sense of community pride, and working to pick up garbage and keep the community clean. This sense of caring about the community, as well as each other, must come from within the community itself.

The community needs to work together to recognize a balance between traditional knowledge (also referred to as “down river teachings”) and school/academic learning. In order to facilitate learning traditional teachings, it is important that the community, schools, and workplaces acknowledge that learning from Elders and parents outside of the classroom, and time spent on the land, is valuable learning experiences. The community also mentioned working with the education director, community leadership, teachers and parents to raise the level of education in schools, put rules in place and enforce them, and develop a board of education.

The community also has the potential to address the dog control issues. In some communities, it was felt that this could be dealt with by creating and enforcing bylaws such as keeping dogs on leads, limiting the number of dogs per household. Moreover the community can also tackle the dog control issue by having dog calls, where they can pick up unwanted dogs. However, in other communities it was felt that bylaws or band council resolutions would not be efficient in their context as it is not their traditional way and they would be difficult to enforce. Instead, the community needs to return to traditional practices and the natural laws by which they live. The laws relate to honesty, kindness, sharing, having a strong heart, caring for the environment, etc. These are messages we are trying to pass on to the children and would forgo the need for bylaws. Communities could also deal with the dog populations by building

partnerships with outside organizations to provide spay and neutering clinics. However, in order to get these sorts of initiatives started, the community should host a “dog meeting” to discuss possible solutions.

The community can also be very innovative and think outside the box on how to improve the health of the community - through gatherings, events, and medicine walks – even without external funding. There are many activities that can be done within the community by individuals or groups to keep the population healthy, including hunting festivals, cooking classes, community gardens, greenhouses, youth gatherings, traditional skills classes, sewing classes, and sports for all ages. Parenting should also be tackled at the community level, through radio shows, newsletters, flyers, posters, classes and workshops that highlight traditional parenting. Parenting knowledge could be shared between families either formally or informally. In general, program staff can take part in raising awareness and sharing information through about healthy lifestyles and existing programs through their programming, radio shows, door to door visits and social media. The Health Director and the Chief and Council should lead these public health initiatives, but they could also hire a community member to coordinate these efforts. Program staff can write funding proposals, while Chief and Council can advocate for funding.

SLFNHA

SLFNHA can play a role in advocating for services and can also assist with proposal submissions. They have the potential to push the agenda of public health ahead in order to gain more support and increase resources allocated to public health services. SLFNHA can provide resources to enhance community level programs and provide a support system for community-level workers. SLFNHA can also look at their existing services – i.e. Mental Health – and see how it could be improved to be more in line with community needs and focus on upstream prevention initiatives. SLFNHA can help with creating consistent, relevant and culturally appropriate messages on specific health topics. SLFNHA can assist by conducting workshops or trainings in the community. SLFNHA could play a role in gathering data, developing a data system, conducting trainings, and research. SLFNHA can develop processes to help and protect communities throughout the research process and ensure that research is returned to the community once it is completed. SLFNHA may also be well-suited to play a role in Emergency Preparedness. They can also assist in the development of technology systems that are simple to use. It was also suggested that SLFNHA could provide cultural sensitivity training to professionals that come to work in the communities (whether hired by SLFNHA, FNIHB, or other organizations). SLFNHA could play a role in providing additional trainings as well to community level staff. SLFNHA can also play a big role in communication, keeping connected with communities and helping them to improve their own communication systems. SLFNHA can also facilitate the sharing of information and experiences between communities so they can learn from each other. They could help by linking the community to other supports and organizations, and/or by helping to navigate funding opportunities.

Tribal Council

The role of the Tribal Councils is largely political advocacy and technical support, although it varies slightly depending on the Tribal Council. . The Tribal Councils can assist with technical services, including water, housing, all-season roads, and keeping the community clean. They can work with the community to control building standards and ensure buildings are being constructed to the conditions of the area. The participants also felt that the role of Tribal Councils involves assisting with funding proposals and helping to gather and share information for the community on public health (i.e. through websites and

other resources). Tribal Councils can provide advisory support at the regional level and direct staff where to call when specific questions arise. Funding and support for some of the programs may also be provided through Tribal Councils. For example, Paawidigong provides resources and support for programs including Aboriginal Diabetes Initiative, Healthy Babies Healthy Children, Aboriginal Health and Wellness and E-health. Tribal Councils can also support the link between health and education through their Education Director. They could also assist by covering some of the expenses that are not covered by NIHB, such as certain medications, wheelchairs, canes, etc. They can also play a role helping the communities revitalize community healing. The Tribal Councils could also host regular Health Directors meetings and cover the related travel expenses. Finally, the Tribal Council can provide regular updates, conduct more community visits and have a bigger presence in the community.

Provincial Territorial Organizations

The PTOs' (NAN and Grand Council Treaty 3) largest role would be to advocate for funding for infrastructure (i.e. physical space for the programs) and political advocacy. NAN can also play a large role in food security through their food co-ops, Good Food Box program, and gardening programs. NAN can also assist with traditional medicine specialists. NAN could also assist in Train the Trainer programs. Finally, they could simplify their reporting process.

Funding Partners

Funding stability is necessary to ensure job security and sustainability of efforts. The funding partners need to look at how resources flow and understand the disconnect between the amount of money provided, what needs to be done and the amount of reporting necessary. Removing barriers around integration of funding and simplifying reporting processes would be helpful. Funding agencies could also assist with the public health system by returning the data reports back to the community with feedback, so the community know how they are doing and can make adjustments to improve services. It was also suggested that FNIHB could re-examine their non-insured health benefits eligibility because it is often challenging for Lac Seul community members to return to the community between appointments and they are not covered to stay in the hostel. Finally, it was suggested that they could provide regular updates to keep the community informed about health issues and decisions that affect them.

Others

Chiefs of Ontario can act as a patient advocate. LHINS could assist with indirect funding. INAC could assist with funding and information sharing. Community and Social Services fund social services, including Ontario Works and Employment services. They could also assist with training programs.

Muskrat Dam could be supported by the First Nations Family Physicians Health Services, which provides supportive services to physicians right now. However, the organization is open to suggestions for other ways it can support communities and thus, could be a potential partner in a public health system.

For road-access communities – especially Wabigoon Lake, Wabauskang and Eagle Lake – Northwestern Health unit could be an excellent partnership in achieving the public health vision. Northwestern Health Unit could support training by inviting staff from the communities to their training sessions. They could also look at reciprocal knowledge exchange activities between the communities and the health unit, for

example, through a job-shadowing program. They could also help with IT support, since they have an IT department that already develops websites, etc. Furthermore, they could give the community their COHI data since currently the NWHU reports it to Health Canada, but Health Canada does not report it back to the community. In cases of emergencies or environmental health concerns, the NWHU has the authority to respond immediately (at the request of Chief and Council) and has an agreement with the federal government that they will be reimbursed afterwards. In many cases, NWHU can have the fastest response time because they are already prepared to service the municipalities surrounding the reserves. There is also a possibility of developing a Section 50 agreement from the Health Protection and Promotion Act (HPPA) (see Appendix C). This could involve providing support relating to infrastructure, training, part-time worker, and/or services. It would be up to the band to negotiate with NWHU the level of services/assistance desired. The band would then be able to appointment someone to the NWHU board. In return for these services, there would be a levy taken from the community to help fund the services.

Consolidation of Feedback

Following the community consultation process, we hosted a two-day meeting in Sioux Lookout with our First Nations representatives from the Public Health Working Group. We also invited Mary Raukar, MD, a resident in Public Health and Preventive Medicine from the Northern Ontario School of Medicine (NOSM), as our guest. Dr. Raukar is familiar with the Ontario Public Health Standards and was able to help us ensure our model would be informed by the Provincial practices. During this meeting we discussed how “Public Health” is a difficult term to understand and does not translate nicely into the Anishinabe languages. Furthermore, we felt that “system” or “model” was too clinical. We proposed a title which may be more appropriate for our communities: “Approaches to Community Wellbeing.” We developed a vision statement, as well as values and objectives for these Approaches to Community Wellbeing. We also discussed the roles SLFNHA and Tribal Councils could play in the approaches, and developed guidelines for establishing community wellbeing in communities. Finally, we developed models for the Approaches to Community Wellbeing.

Vision

The Anishinabe people of this land are on a journey to good health by practicing healthy lifestyles rooted in our cultural knowledge.

Mission

Our mission is to develop an integrated, sustainable, and community-owned public health system. This system will be rooted in the traditional teachings of our people. The system will promote active leaders and positive Anishinabe people.

Values

The Teachings of our people: We value the teachings of our people, including respect, wisdom, love, bravery, humility, trust and truth.

Family: Our families take responsibility for each other and are integral to community wellness.

Language: Language is rooted in our culture as an Anishinabe. It connects us with the land, our ancestors, and each other.

History: We value learning from our history and allowing it to guide us toward the future. Through understanding our history we can recognize and embrace our resilience.

Holistic: We value honouring the Circle of Life and ensuring balance between the four elements: spiritual, mental, physical, and emotional.

Honour Choices and Accept Differences: We value that everyone is different and we honour and accept these differences. Everyone has the ability to make the choices that are best for them.

Share Knowledge: We value and share Anishinabe Way of Life Knowledge. We value the sharing of best practices and learning from each other.

Connection to the Land: We are the stewards of the land and we value our connections to the land. The land is our teacher and provider.

Supportive Relationships and Collaboration: We value supportive connections and relationships both within and outside the community, which promote participation and inclusiveness.

Goals

- ❖ Improved approaches to community wellbeing, which are integrated, holistic, sustainable, and proactive.
- ❖ Increased community ownership over our health and health system
- ❖ More people leading the way who are committed to healthy communities
- ❖ Safer communities
- ❖ More people making healthy choices
- ❖ More children are being raised to be healthy community members
- ❖ Increased connection to the teachings of our people

Roles of SLFNHA

The Sioux Lookout First Nations Health Authority will support community wellbeing by:

- ❖ Ensuring up to date health standards are in place and shared with the communities
- ❖ Assisting with data collection and reporting
- ❖ Conducting regular monitoring and evaluation
- ❖ Developing and implementing policies and procedures
- ❖ Conducting research according to OCAP principles
- ❖ Advocating on behalf of communities
- ❖ Conducting community health education
- ❖ Conducting training and development of health care providers
- ❖ Planning (i.e. human resources)

Roles of Tribal Councils

The Tribal Councils will assist the First Nations in all areas of implementation, according to need and ability, including:

- ❖ Assisting with transitioning and ensuring readiness
- ❖ Providing advice and advocacy
- ❖ Assisting in monitoring, reporting, and evaluation
- ❖ Strengthening partnerships between sectors
- ❖ Delivering some social programs
- ❖ Providing expertise in housing, water, sewer, winter roads, training (i.e. environmental monitoring) and can strengthen these areas and resolve issues.
- ❖ Assisting with planning

Guidelines for Establishing Community Wellbeing in communities

We shall make every effort to ensure:

- ❖ Community wellbeing is a priority
- ❖ Each community to adopts and adapts the Vision, Values and Goals to make it meaningful/relevant for them
- ❖ Each community decides how to structure/deliver their community wellbeing program
- ❖ Each community decides on a leadership model that will champion community wellbeing
- ❖ Any person/agency/services providers/workers/companies in, or visiting, the community acknowledges and works toward community wellbeing
- ❖ Communities share knowledge and network with each other with regard to community wellbeing
- ❖ Communities have plans in place to build capacity to support community wellbeing
- ❖ Communities have data/information that is used to improve/respond to community health and wellbeing and its communicated in a timely way
- ❖ Communities identify what kind of relationships are needed (what kind of support is needed and from whom)
- ❖ Communities identify existing resources and additional resources needed and explore opportunities

Proposed Models

During the meeting we developed a central model for our Approaches to Community Wellbeing. To see the model, please see Appendix E.

We placed our values at the centre of the diagram to represent that they will be at the core of everything we do. We divided the areas of public health into four main program areas: Roots for Community Wellbeing, Safe communities, Raising our Children, and Healthy Living. Encircling these program areas are key elements that will be both included in the public health system and will be results

of the public health system. These include: the teachings of our people, community ownership, active leadership, and positive people.

Each of the four main program areas related to public health has its' own model to represent the subtopics they encompass. The centre of each of these diagrams is divided into four quadrants to represent the four elements: spiritual, mental, physical and emotion. This represents that in each area of programming all elements will be addressed to ensure a holistic approach to health.

The colours used in the diagram are shaded according to a gradient instead of solid and there are no lines between program areas in any of the documents. This symbolizes that program areas are not distinct but overlap with the other areas. We felt this was important to represent, since as a holistic system we want to promote collaboration and avoid silos. The colour gradient also symbolizes that within each program area there will be many programs and health topics addressed.

Conclusion

After receiving feedback from the Health Directors Meeting we decided a more extensive community consultation process was required to develop the public health model. We visited five communities, which were chosen based on interest, population size, access, health structure and Tribal Council. We also conducted a round table discussion with two communities. When necessary, we sought input from FNIHB personnel to round out the perspectives. We then consolidated the input from the consultation process with members of our public health working group to refine the model. We now have proposed a vision statement, values, goals, roles of SLFNHA, roles of Tribal Councils, guidelines for establishing community wellbeing, and models for Approaches to Community Wellbeing. This report serves as a means of sharing our findings with other communities, and as an invitation for community members to share their feedback and provide additional input that should be considered and included.

Miigwetch

Appendix A: Resolution 10-06



Sioux Lookout First Nations Health Authority

"IN PARTNERSHIP WITH FIRST NATIONS TO DEVELOP FUTURE HEALTH CARE SYSTEMS"

P.O. Box 1300
61 Queen Street
Sioux Lookout, ON
P8T 1B8

Phone: (807) 737-1802
Fax: (807) 737-1076
Toll Free: 1-800-842-0681

SIOUX LOOKOUT ZONE CHIEFS MEETING SIOUX LOOKOUT FIRST NATIONS HEALTH AUTHORITY ANNUAL GENERAL MEETING

Resolution #10-06

Implementation of a Public Health System

WHEREAS, Sioux Lookout First Nations Health Authority (SLFNHA) has received funding to work with communities on the development of a public health system; and

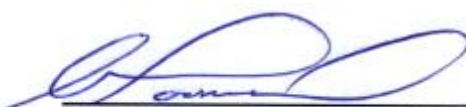
WHEREAS, a report was completed this past year which provides a gap analysis of existing First Nations public health system in comparison to the Public Health Standards that are applicable within the Province of Ontario; and

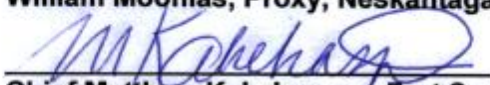
WHEREAS, the report, in alignment with the Anishinabe Health Plan, identifies a plan for the development, coordination and delivery of a comprehensive public health system for the Sioux Lookout area;

THEREFORE BE IT RESOLVED THAT, the Sioux Lookout Zone Chiefs in Assembly direct SLFNHA to take the lead on establishing a tri-partite process between Sioux Lookout area First Nations, First Nations and Inuit Health –Ontario Region and the Province of Ontario; and

BE IT FINALLY RESOLVED THAT, the Sioux Lookout Zone Chiefs in Assembly direct SLFNHA, in collaboration with Chiefs Committee on Health, to develop a negotiations framework that will support the tri-partite table in securing the necessary resources to establish and implement a fully-integrated culturally appropriate regional public health system as envisioned in the Anishinabe Health Plan and to be guided by the public health report.

Dated this 8th DAY OF SEPTEMBER 2010 IN Sioux Lookout, Ontario.

Moved by: 
William Moonias, Proxy, Neskantaga First Nation

Seconded by: 
Chief Matthew Kakekaspar, Fort Severn First Nation

Decision: Carried

Signature of Meeting Chair: 

Appendix B: Community Selection Process

Interested communities, separated by population sizes (used in the Anishinabe Health Plan) with their Tribal Councils represented in brackets. Communities represented in italics can be accessed by an all-season road. Communities represented in bold were the five communities chosen.

<100	~200	~500	~1000	~2000
<i>New Saugeen (Treaty 3)</i>	Muskrat Dam (IFNA)	Cat Lake (Windigo)	Deer Lake (KO)	Sandy Lake (Independent Band)
	<i>Slate Falls (Windigo)</i>	Fort Severn (KO) ¹	Lac Seul (INFA)	
		North Spirit (KO)	<i>Mishkeegogamang (Independent Band)</i>	
		Poplar Hill (KO)		
		Sachigo Lake (Windigo)		
		Nibinamik (Matawa)		

¹ Fort Severn was originally selected, but due to scheduling conflicts was unable to participate in the consultation process

Appendix C: Health Protection and Promotion Act, Section 50

Agreement with council of band

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

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

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

Appointment of member by council of band

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

Joint appointment

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

Term

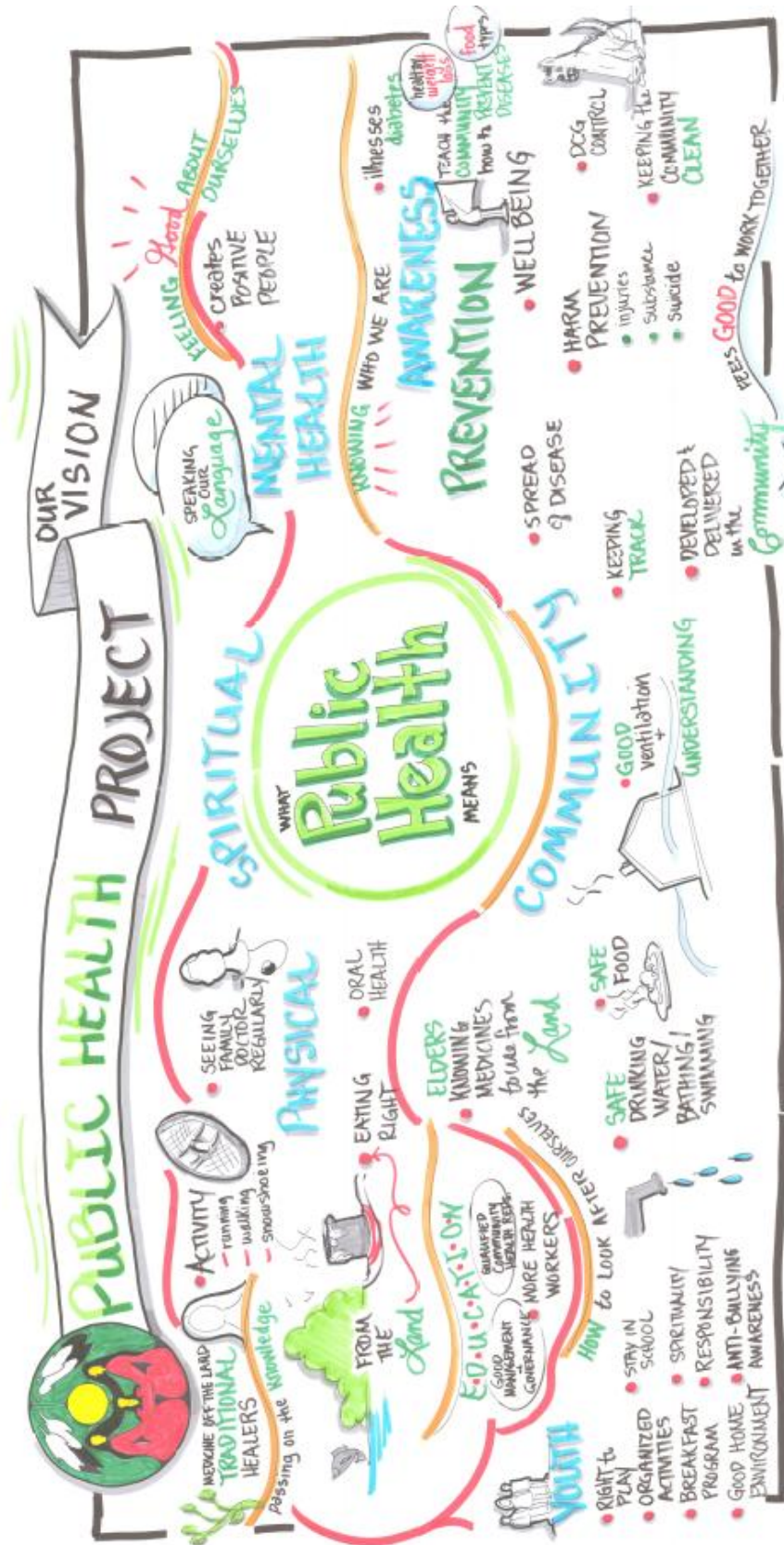
(4) An appointment under this section may be for one, two or three years. R.S.O. 1990, c. H.7, s. 50 (4).

Definitions

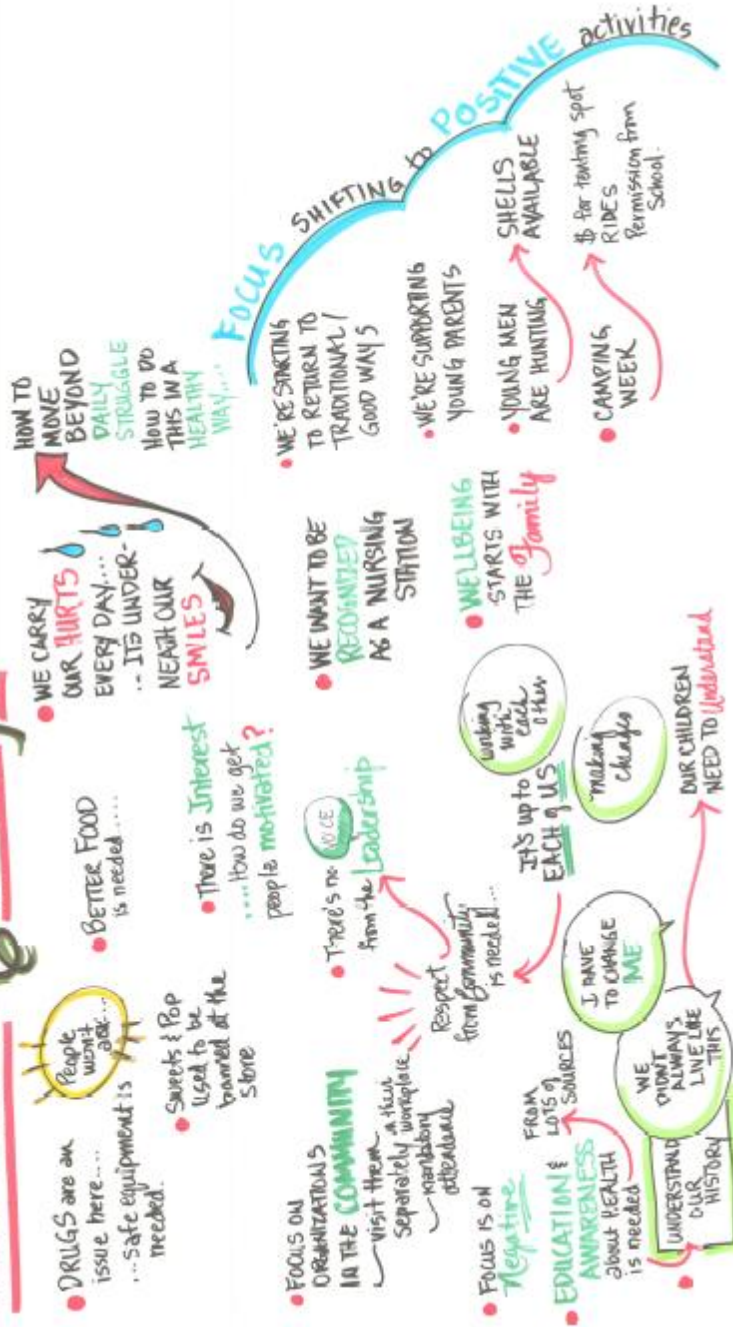
(5) In this section,

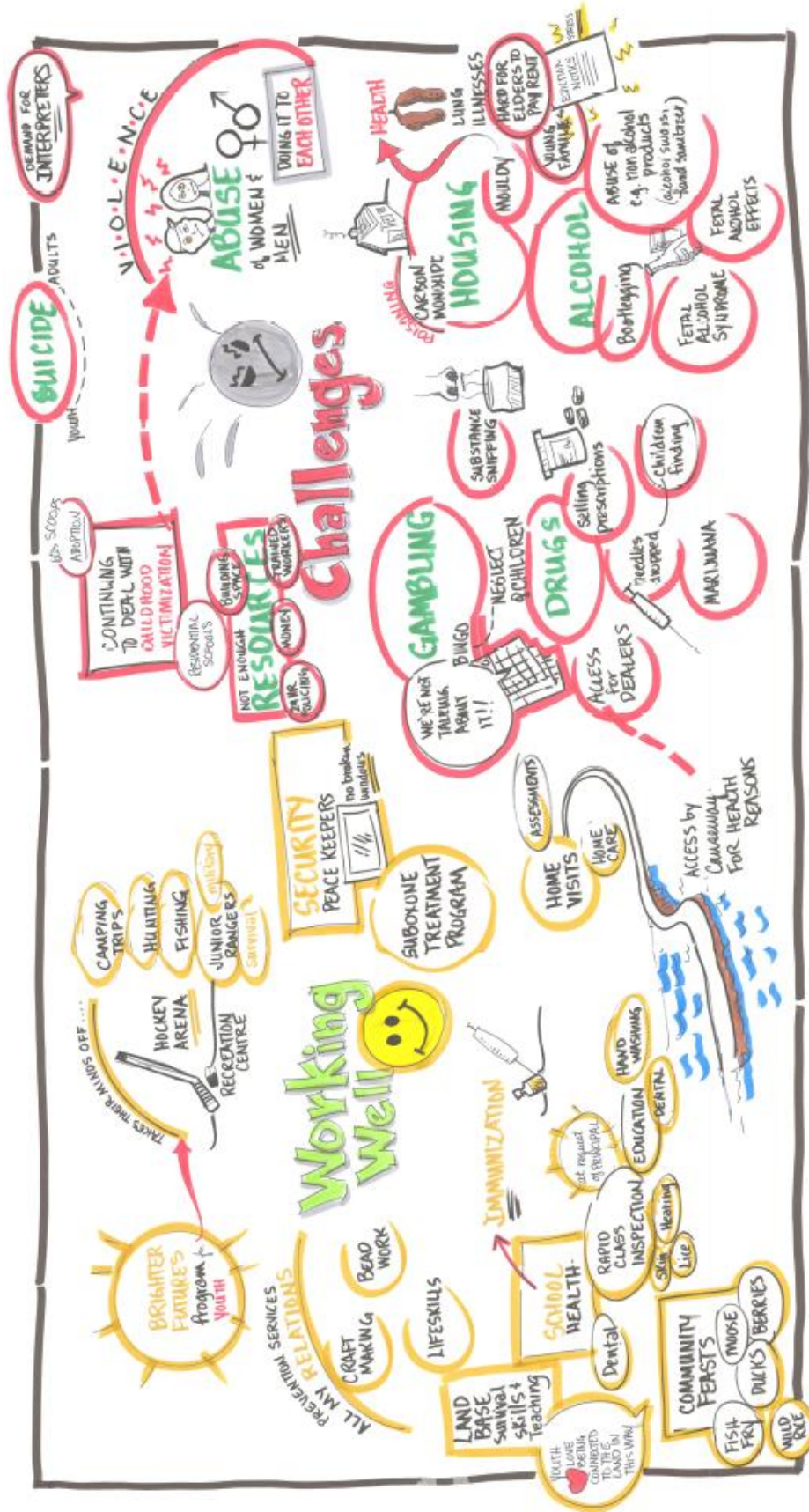
“band”, “council of the band” and “reserve” have the same meanings as in the *Indian Act* (Canada). R.S.O. 1990, c. H.7, s. 50 (5).

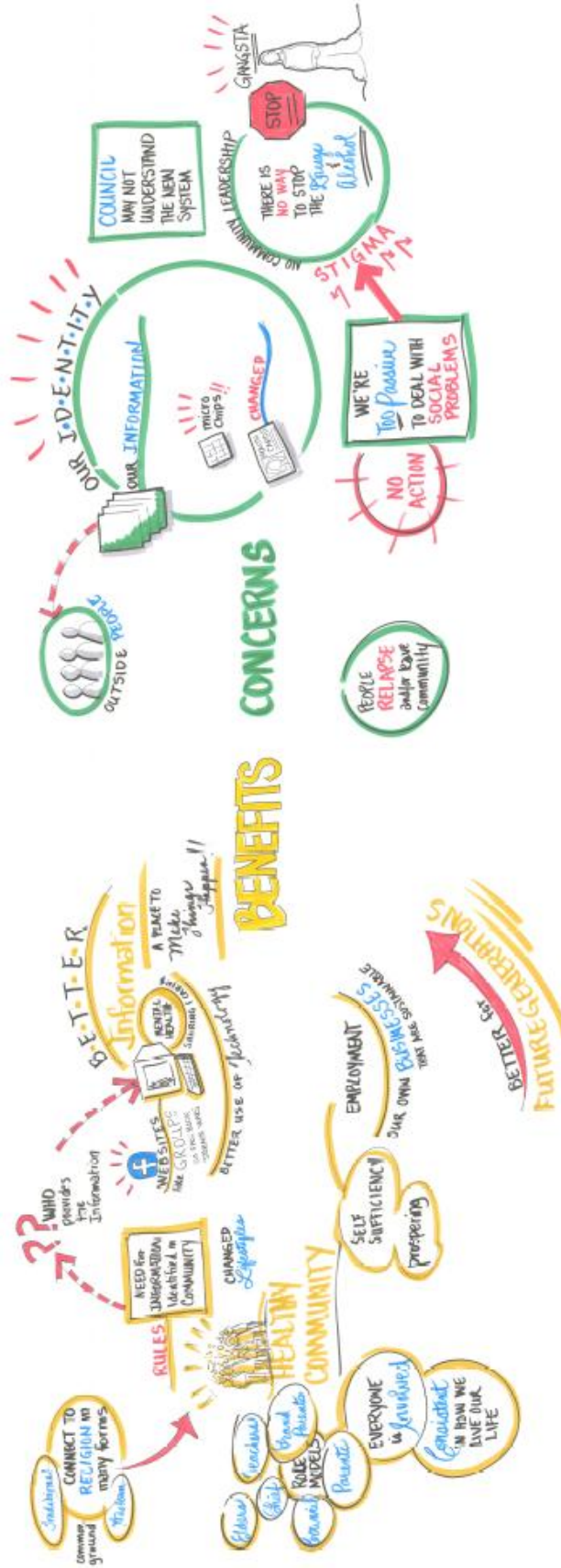
Appendix D: Graphic Recordings from Community Consultations



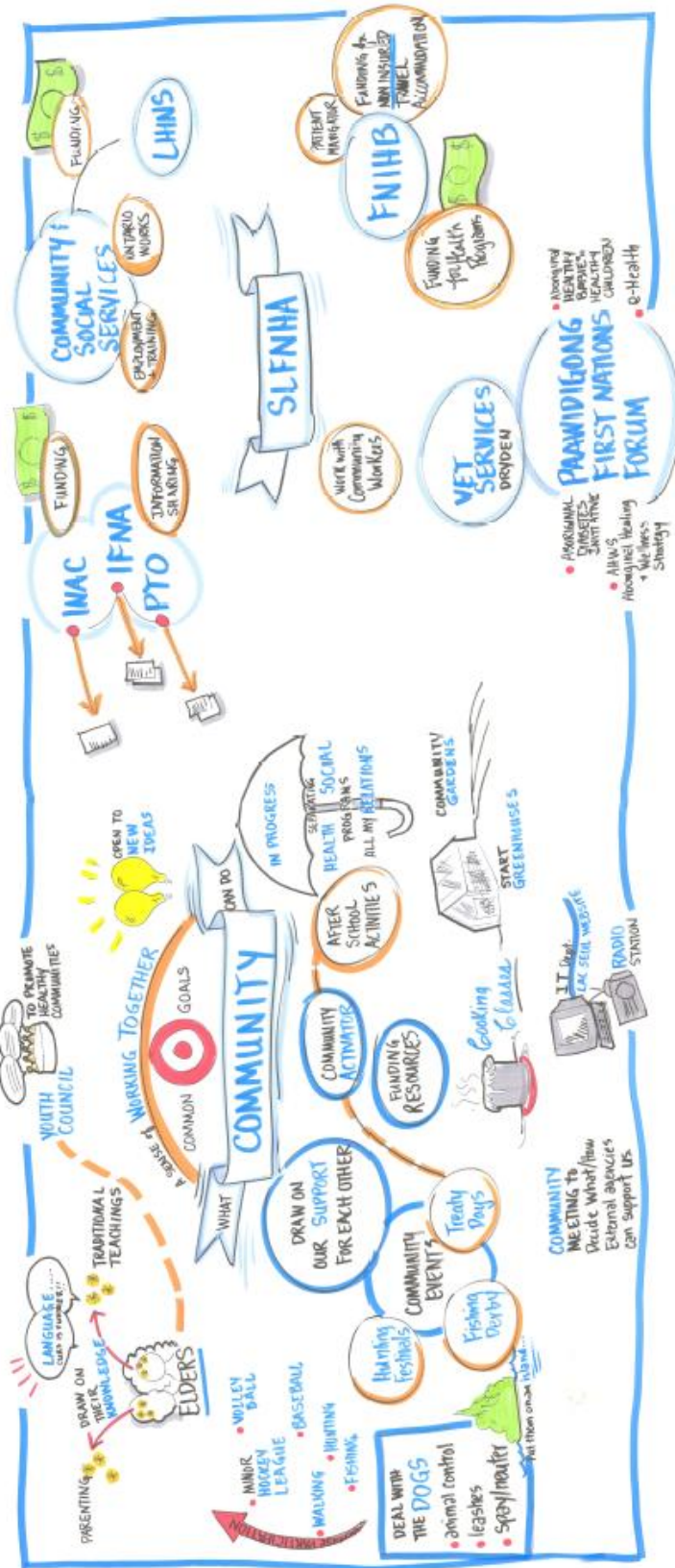
WHAT SLFNHA NEEDS TO KNOW about our Community...

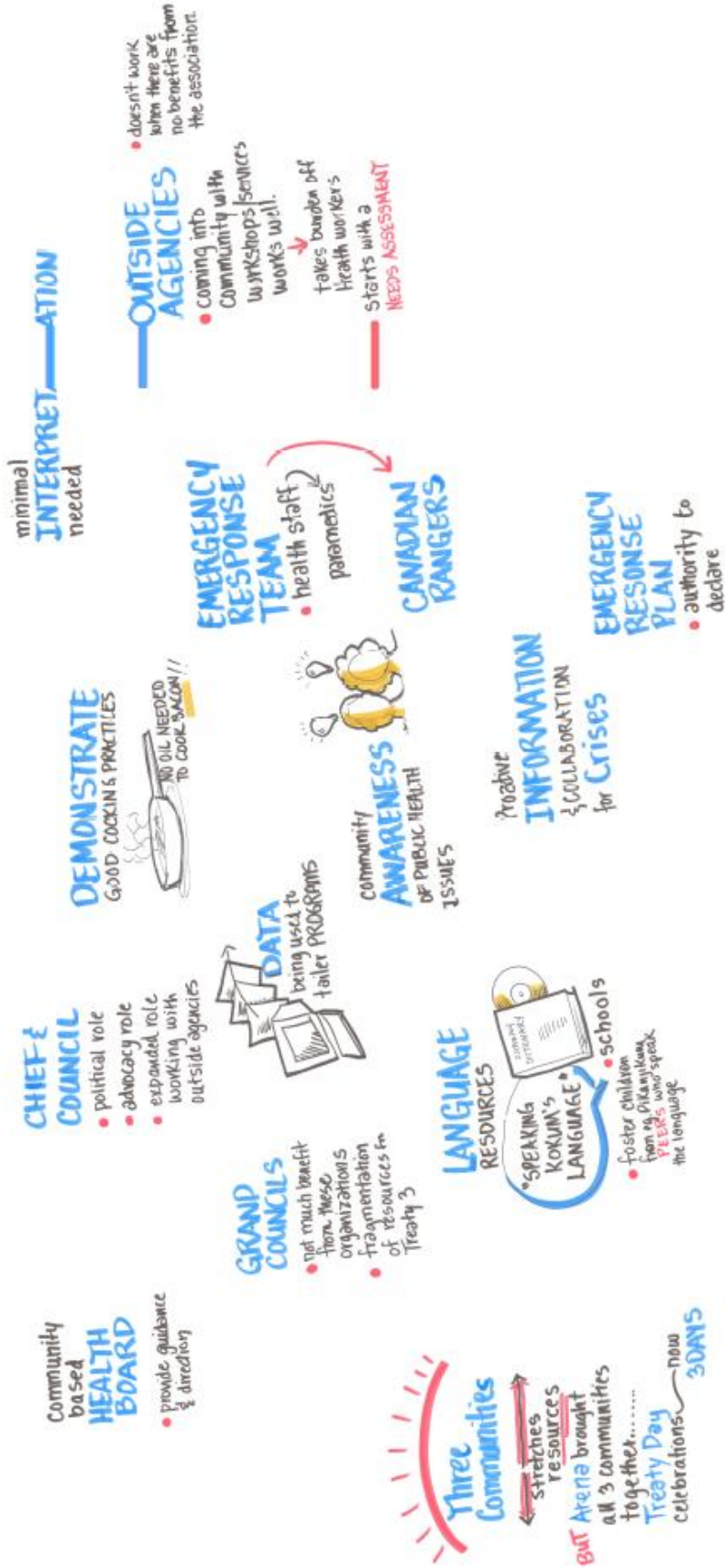






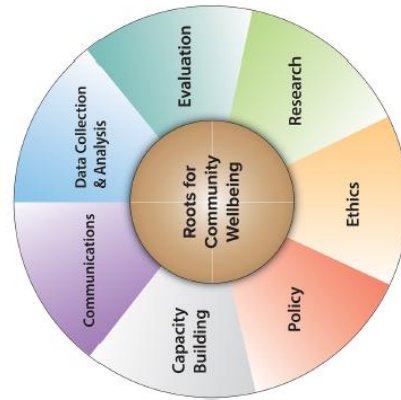
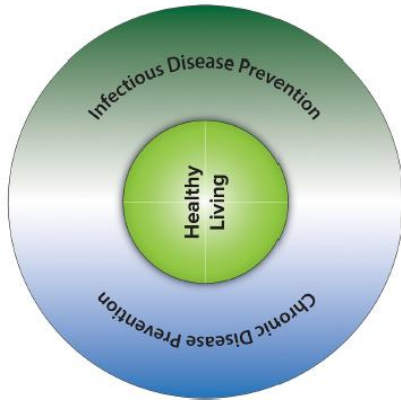
ALL COMMUNITIES SHARE THE SAME HOPES..... WE CAN HELP EACH OTHER



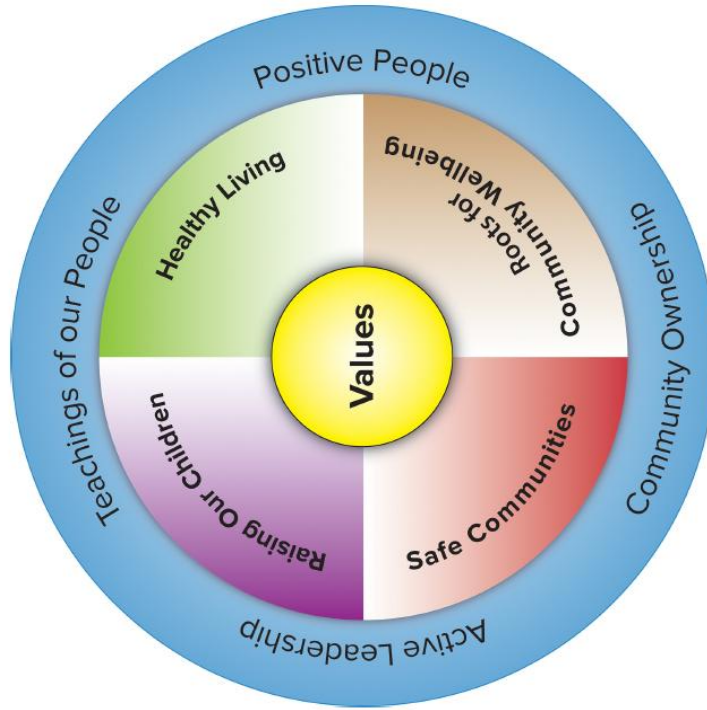


Three Communities
 stretches resources
 BUT Arena brought all 3 communities together.....
 Treaty Day celebrations now 3DAYS

Appendix E: Approaches to Community Wellbeing



Approaches to Community Wellbeing



DRAFT
September 2014

