Evaluation of the *Approaches to Community Wellbeing* Program

Final Report

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Chi'Miigwetch for allowing us to be on traditional lands of the First Nations of the Anishinaabe people of Lac Seul First Nation (Obishikokaang) of Treaty 3 to conduct this work. We were honoured to be on your territory and learn of your strength and beauty to continue to overcome a legacy of flooding, displacement, residential schooling, assimilation and ongoing intergenerational trauma. We hope this report captures your resilience to remain vibrant and self-determined communities that believe in creating stronger health and wellness strategies for the next seven generations. GGI & Otter Daughters are forever grateful for your kindness and generosity.

Miigwetch,

GOSS GILROY INC.

Otter Daughters Consulting

Executive Summary

Sioux Lookout First Nations Health Authority (SLFNHA) serves 33 rural and remote First Nation communities in the Sioux Lookout region. As is the case elsewhere, public health has received less attention in the region in the past than primary or "downstream" health interventions. In response, over a decade ago, SLFNHA launched an effort to promote health through public health programming that came to be known as the Approaches to Community Wellbeing (ACW) Program with a mission "to develop integrated, sustainable, and community-owned approaches to community wellbeing… rooted with the traditional teachings of our people and [promoting] healthy lifestyles, active leaders, and positive Anishinaabe people."

As several key funding agreements for ACW are now coming to an end, SLFNHA commissioned an evaluation to assess the progress and impacts that have been achieved from the time the project started to present. A developmental – i.e., informal, evolving, responsive – approach was taken. The methodology involved three sources of evidence: individual key informant interviews (face-to-face or by telephone) with 22 partners who were involved in the Program's activities, a sharing circle with SLFNHA Community Health Directors (n = 3), a sharing circle with CWFs and Harm Reduction Workers (n = 6); and, a review of Program documentation, literature, and other secondary sources.

The evaluation observed several key ACW accomplishments, as follows:

- strengthened First Nations governance for public health;
- increased capacity for public health planning;
- prevention of harm associated with addiction;
- increased community capacity for mental health promotion;
- increased youth engagement in promoting wellbeing;
- creation of health status reports; and,
- increased capacity for digitization of health records.

At the same time, a number of strengths were developed that form a solid foundation for future programming, including the following:

- the ability to respond to needs of First Nations communities;
- the current Harm Reduction strategies;
- strong, reciprocal and meaningful relationships among partners;
- Community Wellbeing Facilitators;
- the incorporation of First Nations traditions into programming; and,

- a strong sense of teamwork among ACW staff.

The evaluation identified opportunities for further strength building as well, as follows:

- decolonizing ACW internally to ensure it is a culturally safe environment;
- creation of an inclusive team of individuals that is based on life experience, including further supporting community workers;
- enhancing communication with key partners and northern and remote communities, including creating greater public knowledge of public health; and,
- ensuring continued innovative and community contextual-based funding.

The evaluation concluded that ACW has established a solid foundation for public health in the region. ACW Program has begun the building of both formal and informal planning, governance and communications infrastructures within communities and between First Nations and the SLFNHA. Related capacity, interest and engagement have increased markedly. The Program has put in place a number of mechanisms that have resulted in significant advances. Moreover, the Program has introduced new ways of conceptualizing public health that respect traditional teachings and practices while making use of western medicine.

Perhaps most importantly, the early experience of ACW has shed light on critical lessons with respect to improving public health in First Nations communities in northern Ontario – i.e., what works – and on the most pressing needs for the future. These include the following:

- Public health interventions in the SLFNHA catchment area work best when conceived and implemented based on First Nations approaches. This replaces the idea of "bringing western health practices to remote First Nations communities," with a decolonizing approach that respects and draws from First Nations knowledge and traditions. It gives primacy to First Nations languages and terminology. It puts an emphasis on employing First Nations workers, while expanding notions of what qualifies a person to practice public health. It puts an emphasis on what First Nations consider sacred, including water and the earth, and on land-based programming.
- Interventions work best when they are tailored to local community needs and circumstances, with substantial involvement on the part of local players, including youth, elders, and community leaders. Every community should own their public health program.
- Boundaries between service areas need not be rigid. A community public health worker can provide education and health promotion one day, and more direct services the next day.
- Trust is a crucial ingredient. Trust is gained by engaging and listening to local community members, learning from them, and being present "on the ground" for sufficient periods of time.

Continued funding for ACW is warranted; indeed, reductions in funding that have already started jeopardize services and could undo initial progress and serve to drive a wedge of mistrust between northern Ontario First Nations communities and the provincial government with respect to public health matters. Ideally, funding will be substantially increased to enable effective programming to reach every community. Also, funding time horizons should be lengthened to provide greater stability, and funding terms and conditions should be relaxed to provide the flexibility to adapt to local conditions. This aligns with findings from a previous evaluation of the program, which found that sustainability depends on renewed funding to ensure continuity in program staffing, capacity and momentum.[1] Extending and expanding ACW in the years to come represents a unique opportunity to build public health programming that is locally-driven, conceived and delivered in respect of Indigenous holistic concepts of health. Specific recommendations are as follows:

1. In any future ACW or other public health programming, SLFNHA should continue to emphasize and enable the engagement of local First Nation communities throughout the region.

2. Continue to support to harm reduction and support emergency response, in a public health role, where needed and empower First Nations communities to adopt tailored strategies for health promotion. Youth should continue to be engaged and involved in local health promotion programming. Continuous funding needs to maintain this program within the communities.

3. Continue to support community driven programming and services that inform SLFNHA staff, therefore ensuring that the work being produced by SLFNHA is produced from the ground up. Supporting First Nations communities in this manner will continue to inspire decision making processes and self-determination among communities.

4. Allocate more funding to support engagement and relationship building. Current funding only supports a fraction of the efforts that could be made to reach a wider audience. While some of the SLFHNA team are viewed as promising practices, where trust has been built with a few communities, trust takes time and ACW needs to spend longer lengths of time in the community. Lessons learned regarding engagement with community level stakeholders should be shared with the ACW Working Group so that strategies for relationship building can be improved.

5. Rebuild the CWF model so that there is a CWF in each community. The CWF component was viewed by many community members as a key source of relationship building between the community and SLFNHA.

[1] Caislyn Consulting Inc. (2015). *Public Health Project Year Three Evaluation Status Report.*

6. Continue to support programs and services that are based on First Nations traditions and philosophy to ensure that spiritual, mental, emotional, and physical health is being addressed. Different communities are at different points on their journey toward reclamation of First Nation traditions and cultures, and respond to requests for support accordingly.

7. In any future ACW or other public health programming, SLFNHA should continue to emphasize and enable strong staff team development.

8. Enhance cultural training to ensure it includes a history that is specific to the Nishnawbe Aski Nation and has a larger focus on anti-oppression training that is more relevant to decoding unconscious biases and challenging settler privilege. Create more spaces that prioritize Indigenous people to be part of and ensure that their voices are heard when it comes to engagement and the application of delivery of cultural training.

9. While it was noted that there are challenges in hiring and recruitment in the North, there should be a transformation of ACW hiring standards (vis-à-vis SLFNHA Human Resources) to decolonize the current approach and ensure that hiring criteria value real-lived experiences alongside, and in some cases instead of, academic/professional credentials. Hiring a more diverse staff that would include community members would assist greatly in achieving community-driven results.

10. Additional funding should be sought to enable a greater extent of travel to all areas, include more remote areas[2] – and more visits for longer periods – to accomplish the critical task of trust building and working directly with local indigenous communities.

11. Future funding terms should be lengthened, and greater flexibility should be built into funding agreements to enable the varying needs of all communities to be addressed.

[2] While the entire catchment area may be considered remote relative to southern Ontario, community members interviewed as part of this evaluation used the term "remote" to refer to communities furthest from Sioux Lookout, such as Fort Severne and Kitchenuhmaykoosib Inninuwug.

1.0 Introduction

1.1 Objectives of the Evaluation

As several key funding agreements for the Approaches to Community Wellbeing (ACW) Program come to an end, Sioux Lookout First Nations Health Authority (SLFNHA) commissioned an evaluation to assess the progress and impacts that have been achieved from the time the project started in 2012 to present. The evaluation was conducted by the independent firm Goss Gilroy Inc. (GGI) in partnership with Otter Daughters Consulting. The evaluation examined the roles and activities supported by SLFNHA at the community and Tribal Council levels as well as those within SLFNHA, to understand the full scope of services. It should be noted that while the evaluation was originally focused on more standard questions of relevance, effectiveness, efficiency and impact, as the evaluation evolved a more developmental approach was taken by the researchers. This is further discussed in the methodology section.

1.2 Program Background

SLFNHA serves 33 rural and remote First Nation communities in the Sioux Lookout region. These communities are often described as "isolated", which depicts the social, economic, and geographic distance that separates these communities from mechanisms, providers, and supports that define Canadian society as a whole. While many community members are still fluent in their Anishinabe language, each community can encompass a variety of languages and dialects (e.g., Oji-Cree, Cree, Ojibway) and they have diverse cultural needs that require different type of support. SLFNHA is dedicated to strengthening First Nations by contributing in unique ways to a strong health system for the Anishinaabe. Services provided by SLFNHA include primary health care, mental health counselling and crisis response, accommodations, transportation, physician services, research, public health, and, most recently, developmental disability services.[3]

It has been previously reported that the area of Public Health has been neglected in First Nations communities, both historically in community based practice, and in the design of their current health system. Many First Nations communities focus their attention on the "downstream" priorities of acute care as a result of chronic health problems and the overwhelming demands on health services created by the generally poor health status. As a result, communities and their existing service providers have a hard time addressing more "upstream" or underlying causal needs when caught in the cycle of treating those most in need.[4]

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[3] Rowlandson, J. (2017). An Evaluation Needle Distribution Services in the Sioux Lookout area: Increasing Acceptance/Reducing Harm.
[4] Tarrant, F. & Sarsfield, P. (2010). Sioux Lookout First Nations Health Authority: Public Health Project Final Report.

In 2006 SLFNHA conducted an assessment of health services available in the communities and created an Anishinabe Health Plan (AHP). The AHP outlined how health services should be provided to communities, and it identified that there is a huge gap in preventive/promotive health services. In 2009/10, SLFNHA conducted a public health services assessment of 10 randomly selected communities, which further highlighted gaps in Public Health services.[5] This assessment resulted in the development of a comprehensive plan for initial preparations/actions needed for SLFNHA to implement a comprehensive healthcare reform. Recommended actions included the preparation of a memorandum of understanding (MOU) that allowed for the immediate implementation of the Ontario Health Protection and Promotion Act in the Sioux Lookout area, the development of a negotiation framework to secure necessary resources and the development of a community based Public Health Working Group to provide community direction on the strategic implementation of the new Public Health system.

Through Resolution 10-06, the Chiefs-in-Assembly mandated that SLFNHA establish and implement a regional and integrated Public Health System for the 33 communities it services. SLFNHA then received a three-year grant from Health Canada through the Health Services Integration Fund to fulfill this mandate.[6] Thus, the ACW Program at SLFNHA had its beginnings as a public health project in 2012 aimed at identifying preventive and promotive health services needed in the region's First Nation communities. The overall goal of this innovative program was to integrate existing services and deliver core public health functions such as population health assessment, health surveillance, health promotion, disease and injury prevention and health protection. Such a model represented a significant shift from an approach that was grounded in delivery of acute health care to one that supported a population health framework.[7] An evaluation of ACW (completed in 2015) acknowledged that most health care delivery had been focused on acute care given the burden of illness in these First Nations communities. Changing this to integrate the proposed First Nations public health model would therefore require changing the expectations of patients/clients and healthcare professionals who serve the communities with regards to health care delivery, all of which takes time. This report proposed "a focused project approach to encourage and support implementation and recognition that this work is intensive and upholds the grass roots approach to change".[8]

In 2014, SLFNHA expanded the health services assessment to include more communities and get a more complete picture of the public health services available in the region. The Public Health Working Group also conducted an environmental scan of other public health systems in Canada servicing remote First Nations communities to serve as examples during model development.[9]

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[5] Tarrant, F. & Sarsfield, P. (2010). Sioux Lookout First Nations Health Authority: Public Health Project Final Report.
[6] SLFNHA. (February, 2015). *Approaches to Community Wellbeing: Model Description*.
[7] Caislyn Consulting Inc. (July, 2013). Public Health Project Year Two Evaluation Status Report.
[8] Caislyn Consulting Inc. (2015). *Public Health Project Year Three Evaluation Status Report.*
[9] Ibid.

In order to develop the model, SLFNHA conducted a comprehensive community consultation process to ensure community priorities and feedback were incorporated into the system. The consultation process involved a Health Directors' conference in February 2014, five community visits, two round table discussions, a presentation to the Chiefs at SLFNHA's Annual General Meeting, and a series of video conferences with Health Directors and community representatives.[10]

According to program documents10, findings from consultations with Sioux Lookout region communities in 2014 indicated that SLFNHA's 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. Findings also emphasized 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 evident that parenting and support for families should be fundamental, as having a strong family and supportive upbringing is a determinant of health. Consultations also revealed that the system must focus on capacity building, as many health workers felt inadequately trained for their positions. Finally, training in various areas was suggested, including in data collection and analysis to improve their abilities to identify priority areas and plan programs accordingly.

During this community consultation process, SLFNHA contracted a Graphic Facilitator to lead some sessions. The Graphic Facilitator was involved in the Health Directors conference, and captured ideas from the group on large pieces of white paper. Copies of these images can be found in Appendix A. This facilitator was also involved in two of the five community visits, where she facilitated the sessions and captured their ideas on paper. This process was visual and engaging for the audience. According to SLFNHA's ACW model description, it helped to improve the participants' understanding of public health, and it allowed SLFNHA to map out the strengths and challenges in the communities, and visualize the way forward.[11]

This led to the development of a program design plan that was officially adopted by the Chiefs in Assembly in 2015. SLFNHA was directed to implement the AWC Program starting in 2016. Since implementation began, ACW Program:

- combined existing SLFNHA programs (Tuberculosis Control Program, Needle Distribution Service, Community Wellness Development Team, Hepatitis C Support and Treatment Service, First Nations Inuit Health Information System, Aboriginal Health and Wellness Strategy, and Mental Health Trainer) under the Approaches to Community Wellbeing;
- restructured existing programs into new teams, and hired additional personnel;
- prioritized the following programs in the initial implementation phase[12] --

[10] SLFNHA. (October, 2014). *Community Consultation: Public Health Project.*
[11] SLFNHA. (February, 2015). *Approaches to Community Wellbeing: Model Description*.
[12] SLFNHA. (April 2019). *Approaches to Community Wellbeing Briefing Note.*

- *Preventing Infectious Diseases* (hepatitis C treatment and support service, harm reduction programming, tuberculosis prevention and care, infection prevention and control support, and health promotion),
- *Raising our Children* (mentorship and training for community maternal and child health workers, youth engagement and programming),
- *Regional Wellness Response Program* (mentorship and training for community health staff on mental health and addictions, needs assessments and training for Suboxone programs, mental health promotion);
- *Roots for Community Wellbeing* (data collection and analysis, integration of Indigenous Knowledge into public health policies, planning and evaluation support)[13];

- supported Tribal Councils and two Independent communities through contribution agreements to hire CWFs to support public health planning at the community-level; and,
- Supported three communities with Harm Reduction services.

It should be noted that due to lack of funding, the development of Preventing Chronic Diseases and Safe Communities, as well as Research and Ethics areas of the program have not been fully developed. In order to make progress in these areas committed funding is required to work with Sioux Lookout area First Nations, the Province of Ontario and other health system partners.

Between January 2015 and May 2016 SLFNHA's Community Wellbeing Project Team conducted twelve community visits to provide information about the ACW model, and to gain input from each of the communities in order to develop program priorities and directions for the future. The focus of these visits was on the *Raising our Children* aspect of the ACW model.14 According to a report of the feedback gathered during these visits the project team spoke with various stakeholders, including the Chief and Council members and each community's Health Director. Efforts were also made to speak with as many additional health and youth staff as possible. This approach aimed to gain information on what was currently being done in their communities as well as to help identify any gaps in services. Engagement activities included participating in local radio shows, hosting a community or youth forum and/or school visits. With regard to youth engagement specifically, the project team hosted a Youth Art Challenge, visited eight different schools, and conducted two surveys to gain input into the Youth Development aspect of ACW's *Raising our Children*. This allowed the team to identify health issues that were priorities among youth, and determine what initiatives that promote health should be available to First Nations youth in these regions.15

[13] Two additional programs, *Safe Communities* and *Preventing Chronic Diseases*, have not been designed or implemented at this stage.
[14] SLFNHA. (May 2016). *Community Engagement: Summary Report for January 2015 - May 2016.*
[15] SLFNHA. (March 2016). *Youth Engagement: Summary Report.*

1.3 Approaches to Community Wellbeing Logic Model

As mentioned previously, the development of SLFNHA's model of public health involved a community consultation process to ensure that community priorities and feedback were incorporated into the system. According to the *Approaches to Community Wellbeing Model Description*[16], a public health project team received advice from two public health residents from the Thunder Bay District Health Unit (TBDHU). The idea behind the model was to change the landscape for how public health is perceived and promoted within the communities in order to best suit the needs of the residents and their ways of life. It was important for the Public Health Project Team to develop a First Nations public health system that was flexible and could be adapted to each community. The project, entitled "Public Health Model," was changed to "Approaches to Community Wellbeing" to represent a more holistic view of health that could be better adapted to First Nations communities.

Information gathered from the consultation phase (described in the previous section) allowed for a group work process with First Nations representatives on SLFNHA's Public Health Working Group to produce the vision, mission, values, and goals of ACW.. The key components from all of the community consultation processes were stitched together to identify key themes. These key themes are summarized below:

Vision: "The Anishinaabe people of this land are on a journey to good health by living healthy lifestyles rooted in our cultural knowledge."

Mission: "Our mission is to develop integrated, sustainable, and community-owned approaches to community wellbeing. The approach will be rooted with the traditional teachings of our people and will promote healthy lifestyles, active leaders, and positive Anishinaabe people."

Values:

- The teachings of our People
- Family
- Language
- Holistic
- Honour Choices and Respect Differences
- Share Knowledge
- Connection to the Land
- Supporting Relationships and Collaboration

Goals:

[16] SLFNHA. (February, 2015). *Approaches to Community Wellbeing: Model Description*.

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

These goals have informed the 4 main ACW Program areas: raising our children, healthy living, safe communities, and roots for community wellbeing.

According to ACW Logic Models Guidance Document[17], each active program area will have a program specific logic model that aligns with ACW Overall Program Logic Model. ACW Department will also have a separate logic model for the operational components of the program.

Below is ACW Overall Program Logic Model (Figure 1) which identifies the linkages between ACW's activities and outputs and the intended immediate, intermediate and ultimate outcomes of these interventions. ACW Operational Logic Model (Figure 2) outlines the Administrative and Operational functions for the department.

1.4 Methodology

The evaluators employed a collaborative model[18] throughout three separate phases: 1) evaluation design, 2) data collection and analysis, and 3) reporting. This approach aimed to enable non-hierarchical exchanges of knowledge, empower participants of the research process and provide authenticity to the research outcome.

The evaluation study methodology involved three sources of evidence: individual key informant interviews (face-to-face or by telephone) with 22 partners who were involved in the Program's activities[19], a sharing circle with SLFNHA Community Health Directors (n = 3), a sharing circle

[17] Keesic Health Strategies. Approaches to Community Wellbeing (ACW) Logic Models: Guidance Document.
[18] Collaborative models are part of a broad movement toward Participatory Action Research (PAR). PAR involves a social action process that is biased in favor of unheard, disenfranchised and exploited groups of people. Personal narratives and lived experiences of the community participants are encouraged and celebrated throughout the research process.
[19] Categories of key Program partners include: Ontario Ministry of Health and Long-Term Care; SLFNHA staff from each Program stream (Raising our Children; Roots for Community Well-Being; and Regional Wellness Response Program); SLFNHA Executives and Senior Management; First Nations Inuit Health Branch (GOC); Tribal Council Health Directors; SLFNHA (Voting) Board Members; External Medical Officers; Community Health Directors and Community Wellbeing Facilitators.

with CWFs and Harm Reduction Workers (n = 6); and, a review of Program documentation, literature, and other secondary sources[20].

[20] Secondary data included the following Program-related documentation: the Anishinaabe Health Plan. relevant evaluations and existing related frameworks; relevant strategies (e.g., Early Childhood Screening, Oral Health, Nursing); relevant reports (e.g., Community Engagement summaries, Child and Youth Health Status Report); ACW Work Plans; ACW Funding Reports (including financial reports); and other programming documentation (i.e. community engagement reports, policies and procedures).

Figure 1. ACW Overall Program Logic Model

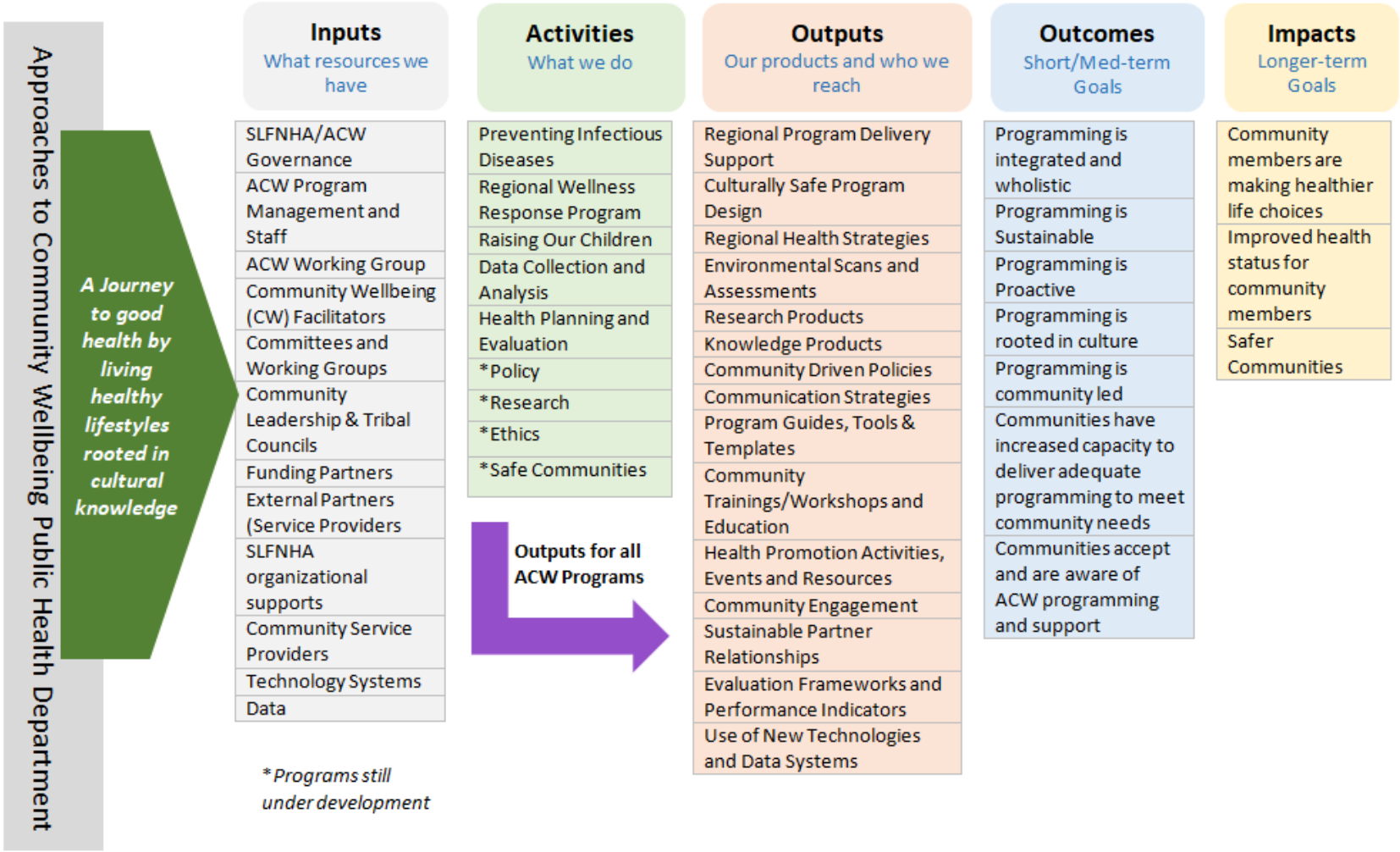
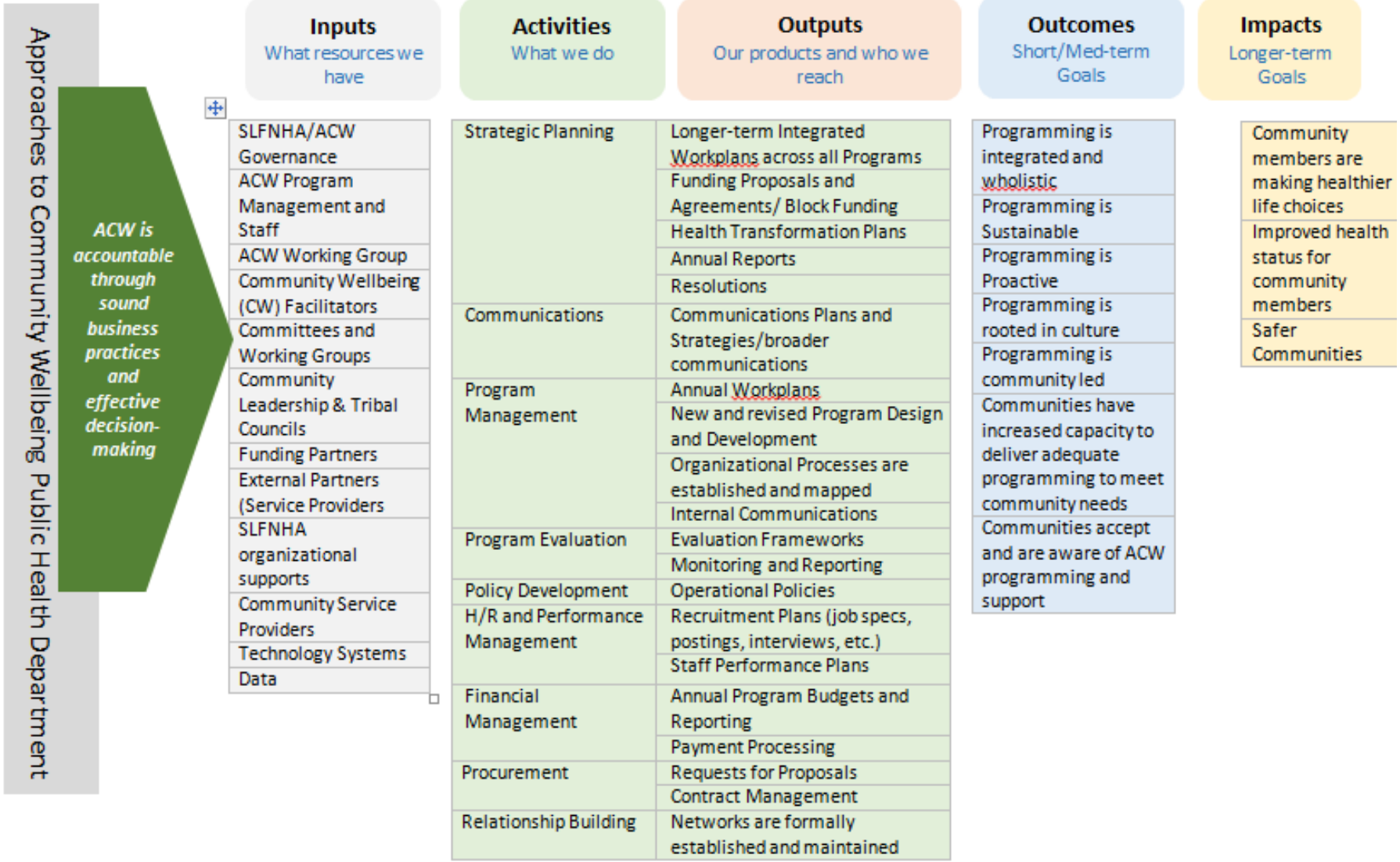


Figure 2. ACW Operational Logic Model



The evaluation approach described in the methodology report included four main areas of focus (relevance, effectiveness, efficiency and impact) with 14 evaluation questions and a master interview guide comprised of 28 questions. However, after beginning the key informant interviews it became clear that this detailed evaluation plan was not appropriate to ACW's current context, nor was it a workable methodology. For instance, because the program has been running for less than three years[21], it was determined to be too early to thoroughly assess program impacts. As a result, the evaluators adopted a more practical approach that fits with the needs, interests and culture of ACW communities while still constituting a valid evaluation exercise. In other words, this shift in approach was essentially an evolution from standard evaluation research to helping ACW tell its stories relating to program accomplishments and opportunities. Taking a more developmental and open-ended approach, findings[22] across all evidence sources were synthesized to identify themes. This report contains a summary of these themes along with resulting recommendations.

The chapters that follow contain findings related to ACW Program's accomplishments resulting from Program activities, and promising areas for future Program focus. Recommendations are included, as warranted, under each section.

[21] While ACW began as a public health project in 2012, it was adopted by the Chiefs in Assembly in 2015, and SLFNHA was directed to implement it as a program in 2016.
[22] All data collected for this evaluation was qualitative data, i.e., narrative responses. These were content-analyzed to identify themes. In most cases, findings represent majority views. However, the strength of sentiments expressed by interviewees was also taken into consideration, and contradictions and subtleties were noted in order to be a precise as possible in describing findings.

2.0 Findings

2.1 ACW Accomplishments

The evaluation found that ACW Program generally functions well. Because the Program is still within its preliminary years it is challenging to determine the overall impact that ACW Program has had on the communities it works with. Nevertheless, a briefing note published in April of 2019[23] outlines several notable Program accomplishments:

- **Strengthened First Nations governance for public health**: A MOU was developed and signed between SLFNHA, the federal government, and the provincial government outlining support for ACW Program.[24] Agreements with two northern health units (Thunder Bay District Health Unit and Northwestern Health Unit) were established for data sharing and transitioning communicable disease control to SLFNHA.[25]
- **Increased capacity for public health planning**: CWFs in five Tribal Councils and two Independent communities, whose role is to support community-level public health planning and capacity building, developed regional strategies for Early Childhood Screening, Oral Health, and Nursing.
- **Helped to prevent harm associated with addiction**: ACW contributed to the establishment of 21 Needle Distribution Programs, eight Opioid Overdose Prevention Programs, and three Harm Reduction worker positions in communities. Training for frontline community health staff including a Harm Reduction Conference (with over 150 delegates), and Suboxone Program Coordinator orientation/training. Hepatitis C workshops and implementation of Dried Blood Spot testing were undertaken in collaboration with the Public Health Agency of Canada.
- **Increased community capacity for mental health promotion**: Training for frontline community health staff and community members was provided, including *Mental Health First Aid First Nations* courses and *Orientation to Family Healing* sessions.
- **Increased youth engagement in promoting wellbeing**: ACW implemented a Youth Arts Festival, health promotion events for high school students, and provided training for frontline community Youth Workers.
- **Created health status report**: Access to data sources was negotiated to bring data under First Nations governance. In addition, the first regional Child Health Status report in over 30

[23] SLFNHA (April, 2019). *Approaches to Community Wellbeing Briefing Note*.
[24] Memorandum of Understanding for Approaches to Community Wellbeing. Signed May 8th, 2018.
[25] Protocol for Management of Diseases of Public Health Significance in Sioux Lookout area First Nations (June 4, 2019).

years was produced[26], as were individual community child health status reports for 24 communities.

- **Increased capacity for digitization of health records**: Information technology infrastructure upgrades were purchased and installed for communities and Tribal Councils. Licenses for community-based electronic medical records were purchased for communities and ongoing support was provided for implementation. A First Nation governed digital immunization repository was created for the region.

As mentioned previously, the Roots for Community Wellbeing program area involves the collection, use, and sharing of health information to support public health decision-making. This program area provides support and key information to the ACW's other three program areas through elements such as capacity building, policy, ethics, and communications. According to program documents[27], resolutions #12-07 Health Monitoring Surveillance, and #15-25 Health Data Management passed by the Sioux Lookout area Chiefs in Assembly support the creation of a health surveillance system by SLFNHA. They also allow SLFNHA to develop and distribute health status reports at both the regional and community level; these reports address different health indicators that help to describe the health of the population. In 2016-17 ACW undertook an engagement process to hear from communities about indicators they would like in health status reports, aiming to improve the process of health information collection and feedback to communities. The engagement process sought to:

- identify community priorities for illness indicators;
- identify wellness indicators;
- determine how communities would like their information shared back with them;
- identify how communities would like to be updated; and
- identify future measures that will help communities with current program planning and evaluation.

The ACW conducted community visits between September 2016 and November 2016 with remaining engagement activities (e.g. phone interviews) conducted from November 2016 to June 2017. Although the ACW team was not able to receive feedback from every community, the engagement process resulted in a better understanding of health indicators that were important for particular communities and allowed SLFNHA to uncover what currently exists in communities relating to health information, and what health indicators communities would like to see included in health status reports. Furthermore, SLFNHA learned which areas ACW may be able to provide additional support to communities, whether through advocacy, support, or service delivery.[27]

According to program documents[28], ACW also aims to continually identify gaps in the system and address them as part of their programming as well as improve communications between the

[26] SLFNHA. (September, 2018). *Our Children and Youth Health Report*.
[27] SLFNHA. (November 2017). *Community Health Indicators: Engagement Summary Report.*
[28] SLFNHA. (February, 2015). *Approaches to Community Wellbeing: Model Description*.

communities, Tribal Councils and SLFNHA. In addition, it has committed to improving communications between funding stakeholders and facilitate partnerships between other stakeholders involved in community wellbeing, such as education and social services. A great example of this the partnership agreement established between SLFNHA and Weeneebayko Area Health Authority (WAHA) on February 22, 2018.[29] This agreement recognized the importance of establishing partnerships to promote better outcomes, secure more resources, and develop best practices amongst fragmented community health initiatives. It has enabled the design and implementation of a data surveillance system that supports public health initiatives for both organizations (SLFHA-WAHA), which improves the collection, analysis, dissemination and use of First Nations data by SLFNHA. An evaluation of this partnership and its intended deliverables for 2018/19 was completed in 2018.[30] According to this evaluation, supportive and sustainable infrastructure for First Nations health data was developed and community capacity continues to be developed to assist in "steering the canoe". This report states that health authorities and partnership organizations understand the value of data tracking to evidence-based decision-making on quantitative and qualitative data/trends.

It is important to emphasize that the development and signing of the MOU for ACW Program and the Data Transfer Agreement for the First Nations and Inuit Health Information System (FNIHIS) and the data sharing agreement was a major accomplishment by ACW; this allowed SLFNHA access to databases that held information on health outcomes for First Nations in the Sioux Lookout area. As indicated in the *Our Children and Youth Health Report*[26], health status reports for this particular region have not been available since the early 1990s. Access to this health information enabled SLFNHA to tackle communicable disease control, plan and advocate for improved health and undertake analysis and health status reporting. Furthermore, on June 4th, 2019, the Protocol for Management of Diseases of Public Health Significance in Sioux Lookout area First Nations was developed. This document established clear mechanisms, processes, roles and responsibilities between SLFNHA, the two northern health units (Thunder Bay District Health Unit and Northwestern Health Unit), as well as the federal and provincial government for data sharing and transitioning communicable disease control to SLFNHA. The development of this protocol is also a great example of improved communication between SLFNHA and funding stakeholders, as well a way to ensure that best practices are shared and utilized, and highlights the organizational ability among community health units.

Finally, the ACW aims to facilitate the communication and sharing of best practices between communities, so that communities can learn from each other. An excellent example of ACW's efforts in this area is the *Stronger Together: Sharing Wise Practices in Harm Reduction* conference hosted by SLFNHA in November of 2018. Training at this event aimed to build capacity through

[29] Partnership Agreement SLFNHA-WAHA (February 22, 2018).
[30] KEESIC Health Strategies. (2018). *Final Evaluation of the SLFNHA and WAHA Partnership: Data Management Strategy*.

providing knowledge and takeaway tools for participants to better meet the challenges associated with harm reduction concerns in their communities. In total, 138 people attended the training from 41 different communities. The conference received overwhelmingly positive feedback from the large amount of expert attendees and provided valuable discourse on First Nations public health.[31] This conference was also an attempt for the ACW to bridge western and Indigenous culture.

2.2 ACW Strengths

The evaluation identified numerous strengths developed as a result of the implementation of ACW program in its first three years. These were consistently described by CWFs, ACW Staff and Management and Community Health Directors. These strengths were viewed as process indicators and outcomes of ACW that, through the continuation of ACW Program's work, ideally will be maintained. By way of summary, strengths resulting from the implementation of ACW include:

- the ability to respond to needs of First Nations communities;
- the current Harm Reduction strategies;
- strong, reciprocal and meaningful relationships among partners;
- Community Wellbeing Facilitators;
- the incorporation of First Nations traditions into programming;
- a strong sense of teamwork among ACW staff.

Strength: ACW Program's ability to respond to needs of First Nations communities

With the high burden of preventable illness in the Sioux Lookout area the ACW has successfully improved the delivery of public health services, which has great potential to reduce the burden of preventable diseases. Many of the key informants who were interviewed agreed that ACW Program, although still in its early years, has made great strides in responding to the needs and interests of First Nations communities. Some of the more common challenges mentioned by interviewees include chronic illness (e.g., diabetes), mental health and suicide, and addiction issues (e.g., alcohol, opioids). It was acknowledged that each of the First Nations communities served by ACW has their own distinct culture, and it is very challenging for one program to address these differences. At the same time, many internal

"ACW Program has brought attention to the real health issues in First Nations communities that did not have a dedicated voice before." – external partner

[31] SLFNHA. (December, 2018). Stronger Together Sharing Wise Practices Harm Reduction. Brief Activity Report.

partners commented that the program has done an excellent job at engaging and adapting to better meet the unique health needs and challenges faced by these communities. In particular, most partners agreed that the Program's front-line services have done excellent work, and that ACW staff have been effective in engaging with communities to deliver activities that respond to both longstanding needs as well as new, emerging needs (e.g., Hepatitis C, youth development). In particular, several key informants mentioned program successes with youth development and engagement. As one internal partner mentioned, within the two years ACW program has successfully reached out to communities to engage with youth and empower them to get involved in community events. Another partner observed that First Nations youth are starting to reach out to ACW to ask for particular workshops or support for the first time. Findings reveal that youth in many communities have shown specific interest and are keen to get involved in health promotion activities. Interviewees agreed on the value of continued ACW health promotion activities.

Another strength of the program mentioned by many participants was ACW's ability to quickly respond to communities in crisis. Although the Program's mission is rooted in the prevention of illnesses and the promotion of healthy lifestyles, the reality is that there is a continued need for crisis response support in remote First Nations communities. Some partners expressed that although it is crucial that ACW Program continues to focus on macro-level health determinants such as poverty, lack of housing and intergenerational trauma, they appreciate that often a community's most pressing needs are immediate and ground-level. While ACW staff does not respond to crises they still work under the SLFNHA organization, as a result they are sometimes asked to chip in and support SLFNHA staff in times of need. As one participant stated, when there is an emergency ACW staff members can support SLFNHA, in a public health role, to meet the community's basic needs. According to one CWF, ACW recently collaborated with emergency responders and provincial resources to address a fire tragedy in one of the communities. Often, this emergency response is conducted in collaboration with other provincial resources. Another partner explained that while ACW spends time and resources responding to crises, many communities have continued to make prevention a health priority. For instance, Lac Seul identified a need for a drug strategy and a land-based healing camp; they are also now working on drug prevention planning.

Recommendation 1: In any future ACW or other public health programming, SLFNHA should continue to emphasize and enable the engagement of local First Nation communities throughout the region.

Strength: Harm Reduction Strategies

In September of 2012 Chiefs-in-Assembly directed the Sioux Lookout First Nations Health Authority to implement the harm reduction strategy developed by the Sexually Transmitted and Blood-borne Infections Working Group (STBBI WG). In 2013, SLFNHA launched its Needle Distribution Service (NDS). Following almost four years of continuous service a formal evaluation

of the NDS and its community-based needle distribution services (CBNDS) was conducted.32 The goal of this evaluation was to determine how to improve and expand on harm reduction services to support communities. The key findings from this evaluation are outlined below:

- The NDS is supported by a one-of-a-kind regional partnership where First Nations, federal, and provincial participants contribute to a common harm reduction goal: making new equipment available in northern communities to reduce the amount of time that used injection drug equipment is in circulation.
- In its current state, the NDS is a supply chain. It brings harm reduction equipment (alcohol swabs, condoms, filters, needles, sterile spoons, sterile water and tourniquets) to a central location where it is warehoused and packed into kits. When orders are received, the NDS ships new equipment to CBNDS endpoints.
- There is a growing demand for new equipment. The volume of new equipment sent to northern communities increased by 43 percent between January of 2014 and December 2016. During this three-year period, the NDS shipped more than 500,000 needles and associated safe injection equipment to 17 CBNDS endpoints.
- Access to the NDS supply chain is not enough. Best practices show that harm reduction is most effective at achieving intended results when CBNDS endpoints have the necessary knowledge and capacity to innovate, work with local IDU populations, and engage their social networks.
- The NDS capacity development role imagined by the 2012 harm reduction strategy was not resourced.
- NDS aligns most closely with Canadian best practices and CBNDS endpoints with culturally-informed practice.
- CBNDS endpoints improve IDU life chances. Many former CBNDS clients are enrolled in local opioid substitution therapy programs and still others have taken on full-time work.
- Community clinicians agree that CBNDS access is an effective way to reduce high risk behaviours linked to drug use but gaps in CBNDS service model design and delivery reduce endpoint capacity to slow the spread of infectious disease and other harms.

Several key informants mentioned that ACW Program's Harm Reduction strategies, which aim to reduce negative consequences associated with substance abuse, represent a great strength of the program. Such strategies offered through ACW include Community-based Needle Distribution Programs and Suboxone programs. Informants highlighted many benefits of these programs (e.g., providing safer drug use practices), while also acknowledging that these strategies create more awareness and education, as well as represent more realistic measures for their communities since they allow community members to reveal their struggles rather than expecting abstinence. For instance, the Needle Distribution Program follows a non-judgmental harm-reduction public

[32] Rowlandson, J. (March, 2017). An Evaluation Needle Distribution Services in the Sioux Lookout area: Increasing Acceptance/Reducing Harm.

health strategy, working in collaboration with community groups and nursing stations to distribute clean drug-use supplies.[33] This program also focuses on education to reduce unsafe drug-use and prevent blood-borne infections. According to program documents, these harm reduction strategies and activities are aimed "to reduce judgement and stigma around substance use and harm reduction approaches; to increase knowledge around harm reduction practices using an Indigenous Strength Based Approach; and, to promote sharing of wise practices and build and strengthen community partnerships"[34]. One participant explained that in many communities, the acceptance of this particular type of treatment program is a challenge as specific community group members (i.e., elders) lack adequate information about how the treatment works and the risks associated with it. Once these community members are engaged and involved in local harm reduction programming, however, the treatment can be introduced to the community with great success. Many interviewees also highlighted the success of the community-based Suboxone training that was offered to several communities through ACW. This model of opiate replacement therapy (where the drug Suboxone is provided to minimize the effects of withdrawal) can be used by First Nation communities for a variety of reasons, such as limited access to maintenance therapy and/or a preference for the holistic approach of the community-based Suboxone service model. According to key informants, when offered, Suboxone training programs tend to have high participation rates and have proven to be very helpful for communities dealing with high rates of addiction.

> **"Harm reduction programs (such as the Hepatitis C prevention program) have had great success. A lot of this is because of the awareness and education – it is building healthier and safer communities where people can better manage their addictions." – Community Wellbeing Facilitator**

Since the formal evaluation of the NDS took place ACW has continued to build on its recommendations, for instance, through funding community workers and supporting a naloxone program. In particular, ACW has been working towards improving/expanding culturally-informed practice and taking a more indigenous approach in their programming. This can be evidenced by the "Stronger Together: Sharing Wise Practices in Harm Reduction" conference hosted by SLFNHA in November 2018. ACW also continues to work on formalizing policies and procedures related to this program.

According to an ACW partner, there is a lack of funding in this area of the program and it is imperative that financial support continues. This partner explained that the program has received requests from two other communities who would like this funding, however the program is unable to support them.

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[33] [33] SLFNHA. (February, 2015). *Approaches to Community Wellbeing: Model Description*.
[34] SLFNHA. (December, 2018). Stronger Together: Sharing Wise Practices in Harm Reduction. Brief Activity Report.

Recommendation 2: It is important to highlight the successes of the harm reduction workers in the community. It would be useful for FNIHB to position these workers as a dedicated resource for community-level positions. Continue to support to harm reduction and support emergency response, in a public health role, where needed and empower First Nations communities to adopt tailored strategies for health promotion. Youth should continue to be engaged and involved in local health promotion programming. Continuous funding needs to maintain this program within the communities.

Strength: ACW Enables Independence and is Non-Paternalistic

Based on the documents reviewed, and confirmed by key informant interviews, the mission of ACW model is to develop integrated, sustainable, and community-owned approaches to community wellbeing. There is general understanding of the ACW's mission among ACW staff, CWFs and health directors. One of the key factors of the model is its ability to foster community-owned approaches to public health and thereby contribute to a transformation of understanding of health and wellbeing in the context of self-determining Nations. It was viewed by some that fostering environments where communities can thrive and take ownership of their health and wellness will ultimately lead to positive outcomes and respond to the needs of First Nations. Previous approaches to health and wellbeing have largely been based on a colonial model characterized by paternalistic ownership over First Nations health. Health models that are largely owned by federal and provincial bodies have routinely defined health from a western point of view and have had their mandates, programs and expected outcomes based on these understandings. Western concepts differ from the First Nations perspective of holistic health and wellness and more specifically from an Anishinaabe perspective that treats together the mental, physical, emotional and spiritual components of individuals and communities. Having this alignment of First Nations health and wellness embedded within the ACW's framework is viewed as a key strength.

It was noted by all key informants that the current ACW model is well suited to deliver health and wellness from a First Nations perspective. Since it operates from "arms-length," ACW can establish itself as a partner, rather than a funder/manager. ACW goes directly to communities with staff constantly on the road, providing direct support and not just money. Many consider this very notion of supporting the independence of communities to define their own health and wellness needs as a key strength of ACW – an approach that is still foreign to some communities due to their historical relationship with Indigenous Services Canada's First Nations and Inuit Health Branch (FNIHB, as further discussed elsewhere). This is coupled by the fact that one of the key intentions guiding ACW is that communities inform ACW staff regarding key drivers within their community pertaining to ongoing and new challenges around health. The notion of ACW guiding work based on each community's definition and understanding of how health and wellness should be implemented is very different from other western models. This was identified as one of the more innovative aspects of ACW that could have the ability to change the health landscape with First Nations communities if fostered correctly.

Recommendation 3: Continue to support community driven programming and services that inform SLFNHA staff, therefore ensuring that the work being produced by SLFNHA is produced from the ground up. Supporting First Nations communities in this manner will continue to inspire decision making processes and self-determination among communities.

Strength: Building Relationships and the Community Wellbeing Facilitators Model

Having a respectful, meaningful and reciprocal relationship with Indigenous communities, ACW delivers programming targeted directly to locally-identified health and wellness concerns. Not only does this differ from pre-existing health models, the concept of the relationship is a fundamental principle that aligns with Indigenous world-views and speaks to respectful co-existence35. This aligns with established ACW Working Group roles and responsibilities, which outline the development and implementation of a community engagement strategy that incorporates the views of community level stakeholders.

It was identified by CWFs, health directors, members of the Chiefs Committee on Health (CCOH), and SLFNHA board members that some of their communities have a very respectful and supportive relationship with the ACW staff who facilitate training and information sessions and those who bring supplies for training into the communities (e.g. for the Needle Exchange training).[36]. It was noted by these communities that there has been a shift in the way the community interacts with ACW Staff to establish themselves as partners to the community and leadership. The arms-length approach to these relationships is seen as helpful and appreciated by the communities and their health staff / service providers. This was a very promising practice that ACW should continue and work towards developing in other communities. It was also identified by several ACW Staff and CWF workers that when there is outreach and capacity building (e.g., health education seminars, presentations and training), there is a large turnout from community members, and there remains a continuous growth in the number of attendees.

As for the work being conducted by the CWFs, it was identified by community members, health directors and ACW staff that the CWF relationship is pivotal to successful outreach and effective communication, informing ACW programming to meet the needs of First Nations communities. Their role is viewed as being fundamental to enhancing the relationship between SLFNHA, ACW and the communities they serve. Having someone that is representative of ACW acting as the on-the-ground contact was viewed as a promising practice by all. The CWF can advocate for the priorities and needs of the communities they work with and filter this information to ACW who will then provide substantive programming. Not only does this help support ACW meet the needs

[35] First Nations philosophies are built on the idea of having a reciprocal interconnected relationship between animals, humans, and the land. From an Anishinaabe lens, these relationships are grounded by the Seven Sacred Teachings: Love, Respect, Courage, Honesty, Wisdom, Humility and Truth. Each teaching represents they key basic values to living mino-bimaadziwin (the good life).

36 This team of ACW staff was often referred to by CWFs as the "Primary Health Team" although it is acknowledged that SLFNHA does not have a team by this name.

of First Nations communities, but it also ties in accountability measures to ensure their work is representative of the realities in community.

It was identified by most key informants (ACW staff, ACW management, community health directors, and CWFs) that there needs to be ongoing investment in terms of time and resources to continue to strengthen relationships with the communities including those that are currently being underserved. It was identified by all CWF's that at times it feels that their work is spread too thin and there are numerous communities that are not being reached. The communities that are being reached require more time and resources to enhance these relationships. At this point, there is typically one CWF for several communities. It was viewed by CWF's and community health directors that a greater impact of services would be achieved if there were more CWF's on the ground, alongside more funding to allow for longer site visits and visits to more rural areas, including areas located further in the North.

It was recommended by all health directors and CWF's that the recommended minimum time to visit a community is three days. However, longer periods of stay would be ideal. It should be noted that all ACW staff and CWF's recognized that there are challenges that prevent longer visits into communities such as resources[37], personnel and a significantly large catchment area in each community[38]. This was a sentiment that was echoed by all respondents with respect to the general need to strengthen relationships with communities and allocate resources (both financial and human) to support these efforts.

Recommendation 4: Allocate more funding to support engagement and relationship building. Current funding only supports a fraction of the efforts that could be made to reach a wider audience. While some of the SLFHNA team are viewed as a promising practices, where trust has been built with a few communities, trust takes time and ACW needs to spend longer lengths of time in the community. Lessons learned regarding engagement with community level stakeholders should be shared with the ACW Working Group so that strategies for relationship building can be improved.

Recommendation 5: Rebuild the CWF model so that there is a CWF in each community. The CWF component was viewed by many community members as a key source of relationship building between the community and SLFNHA. This would help with removing the fragmentation among services within communities. Since every First Nation community in ACW catchment varies in terms of need, it would be ideal if there was someone in the community knowing what the gaps are, which prevention activities work within the community, how to integrate these types of

[37] It is important to note that there are limitations in funding that allow for longer visits. One of the challenges being the availability of office space to do the work that is required. While there are rooms for community sessions, there can also be a lack of accommodations to stay overnight.
[38] Resource funding is also a challenge in this area, SLFNHA is continually having an ongoing ethical debate of how to allocate the resources it already has. It was seen by SNFNHA Management that it is often difficult to decide which and how many communities to support with the limited funds.

initiatives, and how to collaborate with service providers and identify the capacity within the community. This type of role is challenging from a regional level; having this information sent up from the community directly to ACW would prove to be successful. For example, in one community there is one CWF for the community. While they are an independent nation, their arrangement with ACW differs from the regional model. This particular community was identified as a promising way of coordinating and facilitating health and wellness programs and services within the community. The CWF of a community indicated that there were no challenges in coordinating with other programs and services to provide effective programming. Further, they were aware of the ongoing realities and health and wellness cost drivers facing the community.

There are efforts being made on behalf of ACW to further enhance its presence and relationship within First Nations communities. The challenge is a lack of resources to further enhance these efforts. Throughout the course of the data collection phase of the evaluation, the evaluation team saw the efforts made by ACW staff to connect with the communities and provide outreach. All ACW staff stressed the importance of building better relationships with communities and expressed the desire to continue this work.

Strength: Willingness to infuse First Nations tradition into Health & Wellbeing Programs

Part of ACW's mission is to ensure that the work conducted is rooted within the traditional teachings of the Anishinaabe people, ensuring that programs and services are culturally aligned with Indigenous worldviews. What is significant about ACW is its flexibility to ensure that the very notion of "health" is understood through a holistic lens that incorporates the spiritual, mental, emotional, and physical health and well-being of an individual. Developed and guided by First Nations participation, the mission of ACW is a product of the Sioux Lookout area Chiefs, Chiefs Committee on Health, and First Nations communities, its programmatic framework is well aligned with the philosophies and teachings of First Nations understanding of health and wellness. However, when asked whether ACW's integrated approaches to community wellbeing had been rooted in First Nations traditions, the evaluators received mixed responses.

From one perspective, many felt that there are several promising practices of what First Nations traditional health and wellness programming could look like. ACW is seen as an effective model in facilitating this. Highlights include the Indigenous Doulas Program that was based on key recommendations made from the Indigenous Midwifery Summit held in February 2019. The Indigenous Doulas Program will be the first of its kind in Northwestern Ontario and will work to towards supporting culturally safe and healthy birth practices for Indigenous families. Another promising practice was the "Water is Life" conference that was hosted in the Lac Seul community and supported by FNIHB and ACW Program. This conference was focused on the importance of water and the water treatment centre through a traditional lens, incorporating First Nation teachings about their relationship with water. According to one key informant, participation at this conference was so high that the meeting was extended by one day. It was also mentioned that

ACW is very supportive of land-based programming, it was noted by one CWF that ACW had been very supportive of working alongside the community in a more 'ally' type role during events, for instance, offering to help wherever the community felt it was needed and appropriate. Lastly, it was noted that the incorporation of Elders into meetings, programs and services was highly valued among key informants.

By way of contrast, other interviewees were unaware of programs or services that were rooted in First Nations traditions. While traditional First Nation culture vary from community to community, when pressed if they could expand on that response, most noted that many communities within ACW catchment area are undergoing their own reclamation of First Nations traditions and culture as a result of the intergenerational trauma inflicted by colonialism and various assimilationist-based policies. According to program documents, community consultations conducted by SLFNHA also found that the definition of "traditional" is very different between each community, thus there must be flexibility in the system.[39] ACW's role should be to continue to help support these efforts, when invited to do so, without impeding their journey, and creating culturally safe environments for communities to thrive.

Recommendation 6: Continue to support programs and services that are based on First Nations traditions and philosophy to ensure that spiritual, mental, emotional, and physical health is being addressed. Different communities are at different points on their journey toward reclamation of First Nation traditions and cultures, and respond to requests for support accordingly.

Strength: A Strong Sense of Teamwork among ACW Staff

It was noted by several interviewees that ACW staff headquartered in Sioux Lookout maintain good internal working relations and collaborate well across Program areas to provide effective programming for the communities they serve. When discussing their work environment, many ACW staff members highlighted the shared vision that most employees across the different programs hold, which contributes to a collaborative and supportive workplace culture. Despite a high rate of staff turnover reported by several respondents (which can lead to limited capacity) employees work hard to ensure that services are delivered to the best of their abilities. As one staff member explained: "Staff here collaborates well to do more effective programming. They do a good job of not creating silos on the floor. In some ways I think things are moving towards the bigger picture (for example, developing logic models to map out the objectives and to see how the smaller activities contribute to the larger goals). I see ACW moving towards that approach, thinking bigger picture." It should also be noted that this collaborative effort marks a big accomplishment for ACW, as staff has been brought together from different departments, supervisors, buildings and backgrounds to work towards shared goals.

[39] SLFNHA. (October, 2014). *Community Consultation: Public Health Project.*

Recommendation 7: In any future ACW or other public health programming, SLFNHA should continue to emphasize and enable strong staff team development.

2.3 ACW Opportunities

There are a number of positive efforts that support ACW Program's strengths. Many of these bring opportunities that can allow for the Program to excel and enhance successes in the future. Noted opportunities include:

- decolonizing ACW internally to ensure it is a culturally safe environment;
- creation of an inclusive team of individuals that is based on life experience, including further supporting community workers;
- enhancing communication with key partners and northern and remote communities, including creating greater public knowledge of public health; and
- ensuring continued innovative and community contextual-based funding.

Opportunity: Decolonizing ACW to create a culturally safe environment (Internal & External)

ACW has been effective in supporting cultural revitalization efforts whenever Program representatives are present or invited to do so. It was noted by ACW employees that these efforts could be furthered within ACW organization itself. Some respondents noted that when it comes to creating culturally appropriate and safe environments, efforts being conducted on the ground should be matched to those within the offices of the ACW.[40] Several cultural sensitivity training opportunities are available for new employees teaching about the ongoing history of Indigenous peoples in Canada while incorporating Indigenous knowledge and tradition. These training sessions are viewed as a highly positive approaches to deconstructing misunderstandings of Indigenous people while developing meaningful relationships based on mutual understanding. Alongside intergenerational trauma, one of the greatest barriers that Indigenous peoples face is ongoing systemic settler colonialism that still permeates community driven opportunities. These sensitivity training spaces can often be susceptible to pan-Indigenous approaches (as opposed to a more appropriate approach tailored to the Nishnawbe Aski Nation) that establish a narrative of all Indigenous peoples in Canada. These lessons should go further and incorporate lessons on anti-oppression that speak to decoding unconscious biases and challenging settler privilege within the workplace.

In other instances, non-Indigenous people can inadvertently take over the spaces where cultural training is happening and thereby take opportunities away from Indigenous people on their cultural reclamation journey. For instance, a number of key informants explained that non-

[40] According to senior program staff, the ACW has been working on a regional/cultural guide for new staff, which was recently piloted and will continue to be a work in progress. Once this training guide is more established it could potentially be applied across the organization.

Indigenous people can sometimes take up space from Indigenous peoples who are on their cultural reclamation journey. When non-Indigenous peoples take over these spaces in cultural training it acts as form of colonial power – opposite of what is trying to be achieved. This is not to suggest that this type of training should not happen or that non-Indigenous people should not be invited to participate. Instead, when developing training priority should be given to self-identified Indigenous personnel to attend training opportunities that adopt Indigenous ceremony and tradition. This will help ensure that ACW is fostering a culturally appropriate and inclusive work environment on the ground and within its own organization.

Recommendation 8: Enhance cultural training to ensure it includes a history that is specific to the Nishnawbe Aski Nation[41] and has a larger focus on anti-oppression training that is more relevant to decoding unconscious biases and challenging settler privilege. Create more spaces that prioritize Indigenous people to be part of and ensure that their voices are heard when it comes to engagement and the application of delivery of cultural training. For instance, some of these training sessions could be reserved for Indigenous peoples only, to ensure they receive an opportunity to participate fully.

Opportunity: Creating an inclusive team of individuals that is based on life experience

ACW staff and those working on the ground have good intentions of making significant systemic changes for First Nations related to health and well-being. The staff is diverse with respect to their educational backgrounds and they have significant experience in implementing ACW framework. It was noted, however, that there an inappropriately small number of Indigenous employees. To add to this point, it was raised by many ACW employees and CWFs that if the purpose of ACW is to ensure that culturally appropriate health and well-being programs and services are driven by Indigenous communities, than internally, the Program should be led and driven by Indigenous staff. That is not to say that there are not excellent allies within ACW team, however it was noted that increasing the number of Indigenous staff could further enhance the reputation of ACW. Several ACW employees described the hiring standards to be too rigid and placed within a Western model that is based on credential validation and on a contractual basis. It was pointed out by several CWF's and ACW staff that due to these rigid hiring standards, there are not enough staff to get into every community and effectively help them in the way they need it. This was identified as one of the biggest issues of ACW.

Recommendation 9: While it was noted that there are challenges in hiring and recruitment in the North, there should be a transformation of ACW hiring standards (vis-à-vis SLFNHA Human Resources) to decolonize the current approach and ensure that hiring criteria value real-lived experiences alongside, and in some cases instead of, academic/professional credentials. Hiring a

[41] Presently ACW is working on a pilot regional/cultural guide for new staff. It is currently underway.

more diverse staff that would include community members would assist greatly in achieving community-driven results.

Opportunity: Enhancing Communication with Key Partners & Northern and Remote Communities

As previously mentioned, the relationship between ACW and the communities is generally effective, but there is room for growth. It was identified by many that a key obstacle is the large size of the catchment area, and a lack of funding that does not allow for access to all communities. Many key informants mentioned that Program lacks access to far northern communities due to the high cost of travel, yet these more remote communities have important needs that are not being met.[42] ACW staff and management, CWF's and health directors indicated that while there are several communities that have a good working relationship with ACW, there are others that are proving to be more challenging for building relationships.

"The [ACW] Program does not go up north as much… we need more program exposure in the north" – community health director

For communities that are proving to be more of a challenge to establish relationships with, a few respondents felt that there may still be a culture of uncertainty and fear among some community members as a result of an ongoing history of mistrust with both federal and provincial health counterparts. As such, ACW is up against a history of mistrust and is work very hard to break down those barriers. It was identified by some that First Nations communities are quick to assume that the relationship being built from ACW has ulterior motives; these communities would rather work with their Tribal Councils with respect to health and community wellbeing programs and services.

Although it was previously mentioned that ACW's approach to helping communities is different from other Western models of health care and prevention, many key informants indicated that there is a lack of understanding among community members with regard to the concept of public health. As one informant explained, this type of philosophy and approach is complex and it is expected that more time and knowledge sharing is needed for community members to fully grasp the different components of health. Thus, it is important to consider how the concept of public health for the purpose of this Program could be better aligned with Indigenous holistic concepts of health.

In a recent evaluation of the Aboriginal Healing and Wellness Strategy (AHWS) Non-Residential Mental Health Program (NRMHP) a senior management representative from SLFNHA suggested that mental health treatment and healing programs delivered over an extended period of time (i.e.

[42] While the entire catchment area may be considered remote relative to southern Ontario, community members use the term "remote" to refer to communities further from Sioux Lookout such as Fort Severne and Kitchenuhmaykoosib Inninuwug

over a 3-week period) might be more effective. They also indicated that programs be hosted in a community setting, and organized in collaboration with community Elders and leaders.[43]

Recommendation 10: Additional funding should be sought to enable a greater extent of travel to all areas, include remote areas – more visits for longer periods – to accomplish the critical task of trust building and working directly with local indigenous communities.

Opportunity: Innovative and Contextual based Funding Opportunities

It was mentioned by several key informants that developing health promotion strategies and activities can be challenging when working with short-term funding. It was suggested that opportunities for longer-term funding within ACW Program be granted to allow for more meaningful work. Moreover, because each community has unique needs with regard to health and well-being, more flexibility around how funding is used would be beneficial.

Recommendation 11: Not only should funding be continued and increased, but funding terms should be lengthened, and greater flexibility should be built into funding agreements to enable the varying needs of all communities to be addressed.

[43] SLFNHA. (March, 2018). *AHWS Non-Residential Mental Health Evaluation.*

3.0 Conclusions

The evaluation of ACW Program was based on a review of relevant documentation and a systematic program of interviews and sharing circles with a wide range of partners. Resources did not allow the evaluators to visit communities, to collect data directly from beneficiaries, or to conduct a cost-benefit analysis. Nevertheless, the weight of evidence and high degree of consensus among respondents generated clear conclusions.

Despite pockets of resistance from communities and funders, administrative hurdles, and challenges associated with building working relationships with a wide range of geographically dispersed partners and beneficiaries with diverse concerns and needs, ACW has established a solid foundation for public health in the region. ACW Program has begun the building of both formal and informal planning, governance and communications infrastructures within communities and between First Nations and the SLFNHA. Related capacity, interest and engagement have increased markedly. The Program has put in place a number of mechanisms that have resulted in significant advances. Moreover, the Program has introduced new ways of conceptualizing public health that respect traditional teachings and practices while making use of western medicine.

Perhaps most importantly, the early experience of ACW has shed light on critical lessons with respect to improving public health in First Nations communities in northern Ontario – i.e., what works – and on the most pressing needs for the future. These include the following:

- Public health interventions in the SLFNHA catchment area work best when conceived and implemented based on First Nations approaches. This replaces the idea of "bringing western health practices to remote First Nations communities," with a decolonizing approach that respects and draws from First Nations knowledge and traditions. It gives primacy to First Nations languages and terminology. It puts an emphasis on employing First Nations workers, while expanding notions of what qualifies a person to practice public health. It puts an emphasis on what First Nations consider sacred, including water and the earth, and on land-based programming.
- Interventions work best when they are tailored to local community needs and circumstances, with substantial involvement on the part of local players, including youth, elders, and community leaders. Every community should *own* their public health program. This aligns with findings from SLFNHA's community consultations in 2014.[44]
- Boundaries between service areas need not be rigid. A community public health worker can provide education and health promotion one day, and more direct services the next day.

[44] SLFNHA. (October, 2014). *Community Consultation: Public Health Project.*

- Trust is a crucial ingredient. Trust is gained by engaging and listening to local community members, learning from them, and being present "on the ground" for sufficient periods of time.

Continued funding for ACW is warranted; indeed, reductions in funding that have already started jeopardize services and could undo initial progress and serve to drive a wedge of mistrust between northern Ontario First Nations communities and the provincial government with respect to public health matters. Ideally, funding will be substantially increased to enable effective programming to reach every community. Also, funding time horizons should be lengthened to provide greater stability, and funding terms and conditions should be relaxed to provide the flexibility to adapt to local conditions. This aligns with findings from a previous evaluation of the program, which found that sustainability depended on renewed funding to ensure continuity in program staffing, capacity and momentum.[45] Extending and expanding ACW in the years to come represents a unique opportunity to build public health programming that is locally-driven, conceived and delivered in respect of Indigenous holistic concepts of health. By way of summary, specific recommendations, detailed in the preceding chapter, are as follows:

1. In any future ACW or other public health programming, SLFNHA should continue to emphasize and enable the engagement of local First Nation communities throughout the region.

2. Continue to support to harm reduction and support emergency response, in a public health role, where needed and empower First Nations communities to adopt tailored strategies for health promotion. Youth should continue to be engaged and involved in local health promotion programming. Continuous funding needs to maintain this program within the communities.

3. Continue to support community driven programming and services that inform SLFNHA staff, therefore ensuring that the work being produced by SLFNHA is produced from the ground up. Supporting First Nations communities in this manner will continue to inspire decision making processes and self-determination among communities.

4. Allocate more funding to support engagement and relationship building. Current funding only supports a fraction of the efforts that could be made to reach a wider audience. While some of the SLFHNA team are viewed as a promising practices, where trust has been built with a few communities, trust takes time and ACW needs to spend longer lengths of time in the community. Lessons learned regarding engagement with community level stakeholders should be shared with the ACW Working Group so that strategies for relationship building can be improved.

[45] Caislyn Consulting Inc. (2015). *Public Health Project Year Three Evaluation Status Report.*

5. Rebuild the CWF model so that there is a CWF in each community. The CWF component was viewed by many community members as a key source of relationship building between the community and SLFNHA.

6. Continue to support programs and services that are based on First Nations traditions and philosophy to ensure that spiritual, mental, emotional, and physical health is being addressed. Different communities are at different points on their journey toward reclamation of First Nation traditions and cultures, and respond to requests for support accordingly.

7. In any future ACW or other public health programming, SLFNHA should continue to emphasize and enable strong staff team development.

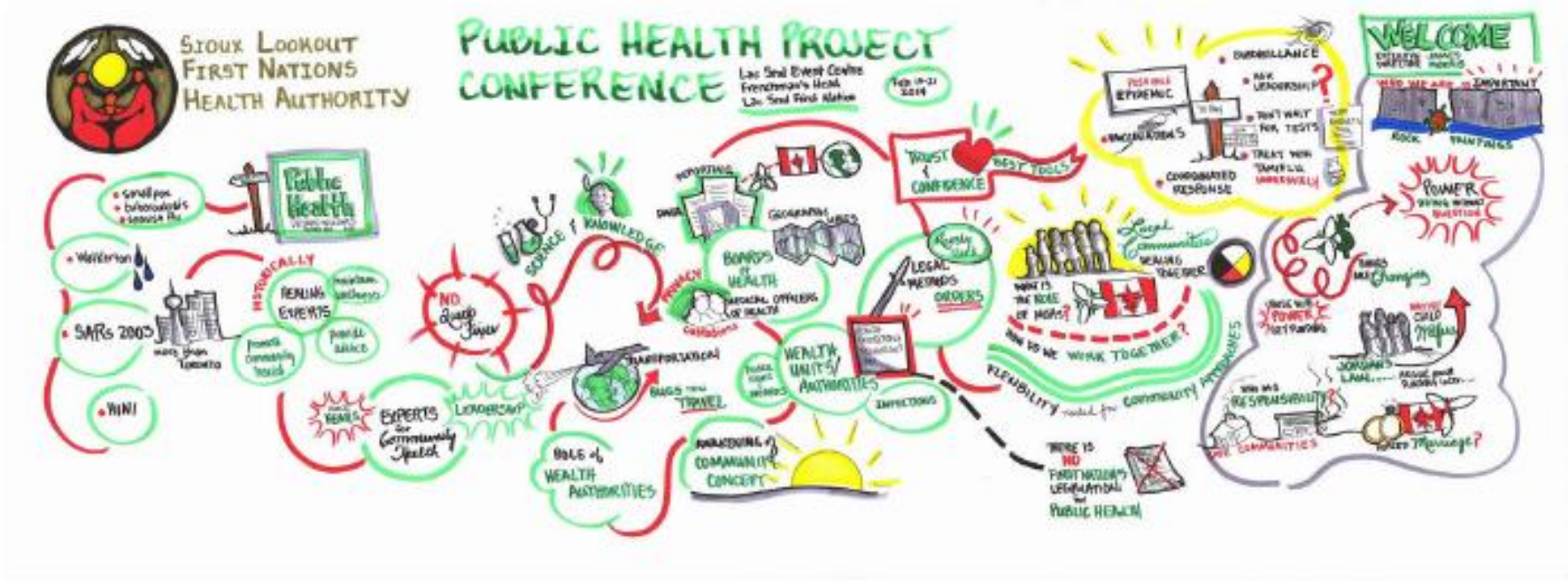
8. Enhance cultural training to ensure it includes a history that is specific to the Nishnawbe Aski Nation and has a larger focus on anti-oppression training that is more relevant to decoding unconscious biases and challenging settler privilege. Create more spaces that prioritize Indigenous people to be part of and ensure that their voices are heard when it comes to engagement and the application of delivery of cultural training.

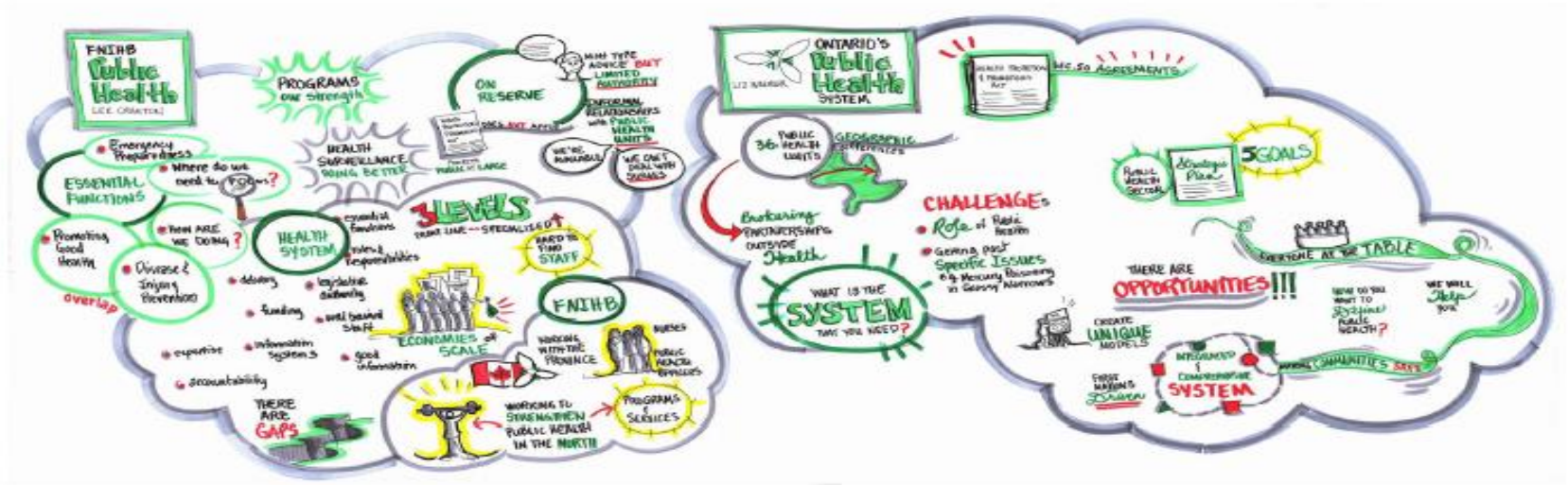
9. While it was noted that there are challenges in hiring and recruitment in the North, there should be a transformation of ACW hiring standards (vis-à-vis SLFNHA Human Resources) to decolonize the current approach and ensure that hiring criteria value real-lived experiences alongside, and in some cases instead of, academic/professional credentials. Hiring a more diverse staff that would include community members would assist greatly in achieving community-driven results.

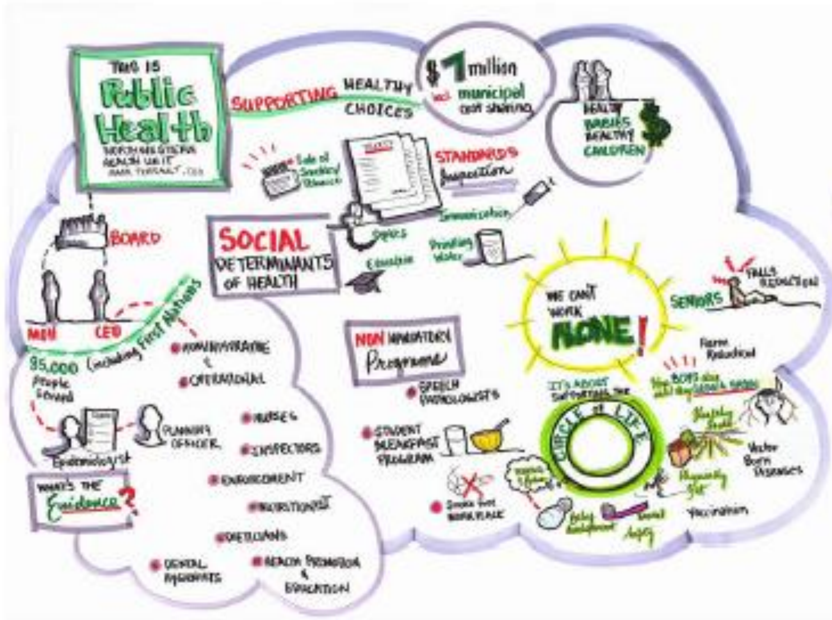
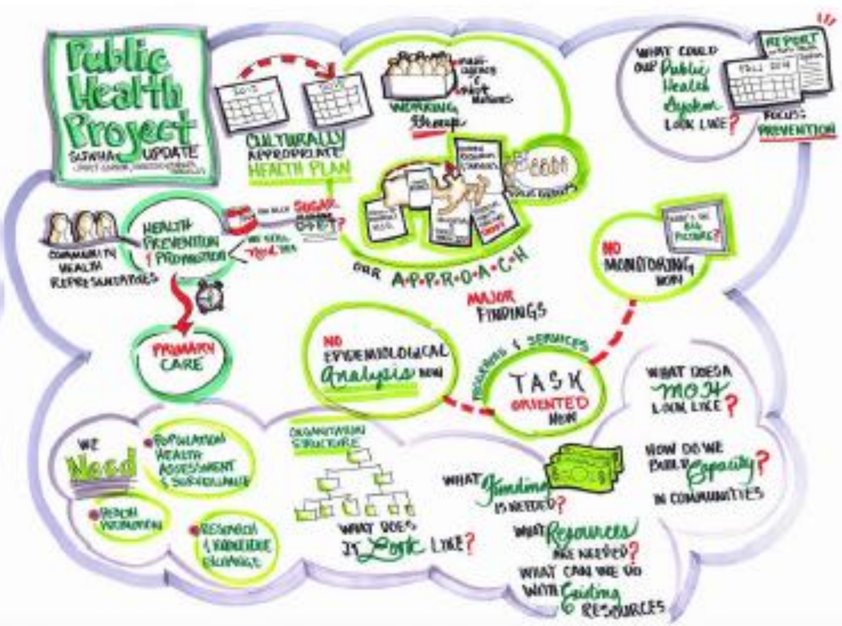
10. Additional funding should be sought to enable a greater extent of travel to all areas, include remote areas – more visits for longer periods – to accomplish the critical task of trust building and working directly with local indigenous communities.

11. Future funding terms should be lengthened, and greater flexibility should be built into funding agreements to enable the varying needs of all communities to be addressed.

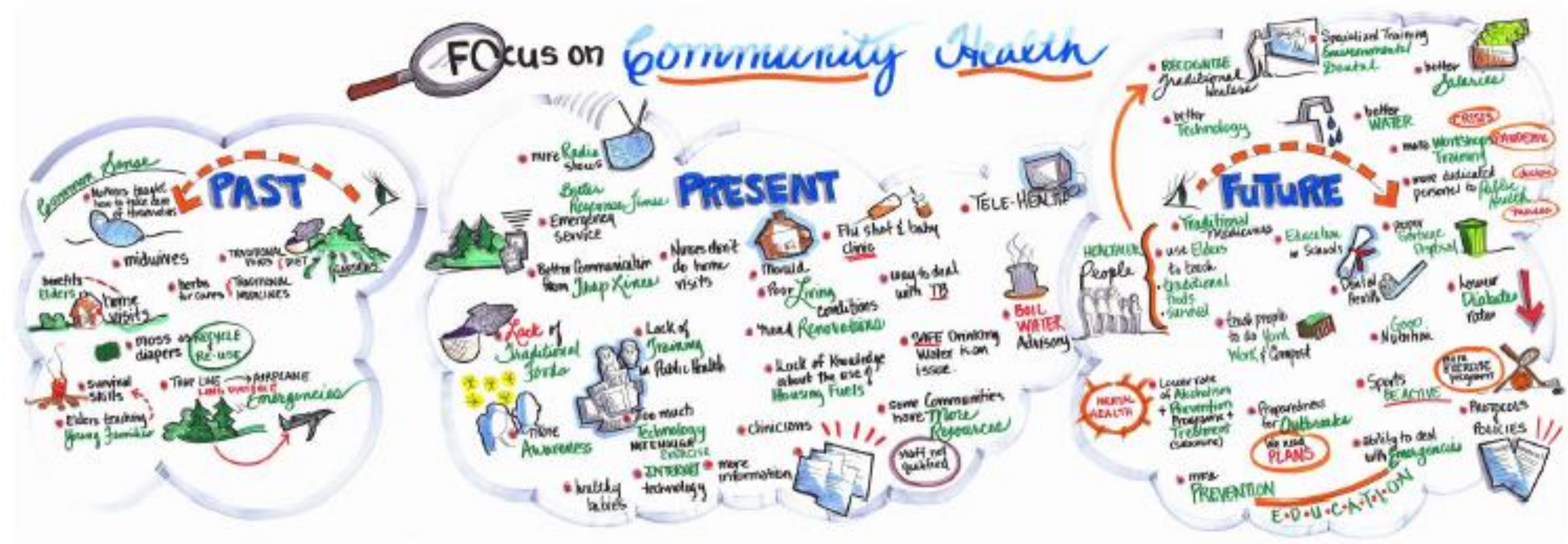
Appendix A: ACW Model: Graphics Captured from the Health Director Conference




FNIHB
Public Health
PROGRAMS our strength
ON RESERVE
HEALTH SURVEILLANCE
ESSENTIAL FUNCTIONS
Emergency Preparedness
Where do we need to focus?
How ARE WE DOING?
Promoting Good Health
Disease & Injury Prevention
HEALTH SYSTEM
3 LEVELS
HARD TO FIND STAFF
FNIHB
ECONOMIES of SCALE
THERE ARE GAPS
PROGRAMS & SERVICES
ONTARIO'S Public Health SYSTEM
MOU SO AGREEMENTS
Public Health Units
Brokering Partnerships Outside Health
WHAT IS THE SYSTEM THAT YOU NEED?
CHALLENGES
Role of Public Health
Gaining past Specific Issues
3 GOALS
Strategic Plan
EVERYONE AT THE TABLE
THERE ARE OPPORTUNITIES!!!
CREATE UNIQUE MODELS
INTEGRATED & COMPREHENSIVE SYSTEM
WE WILL help you

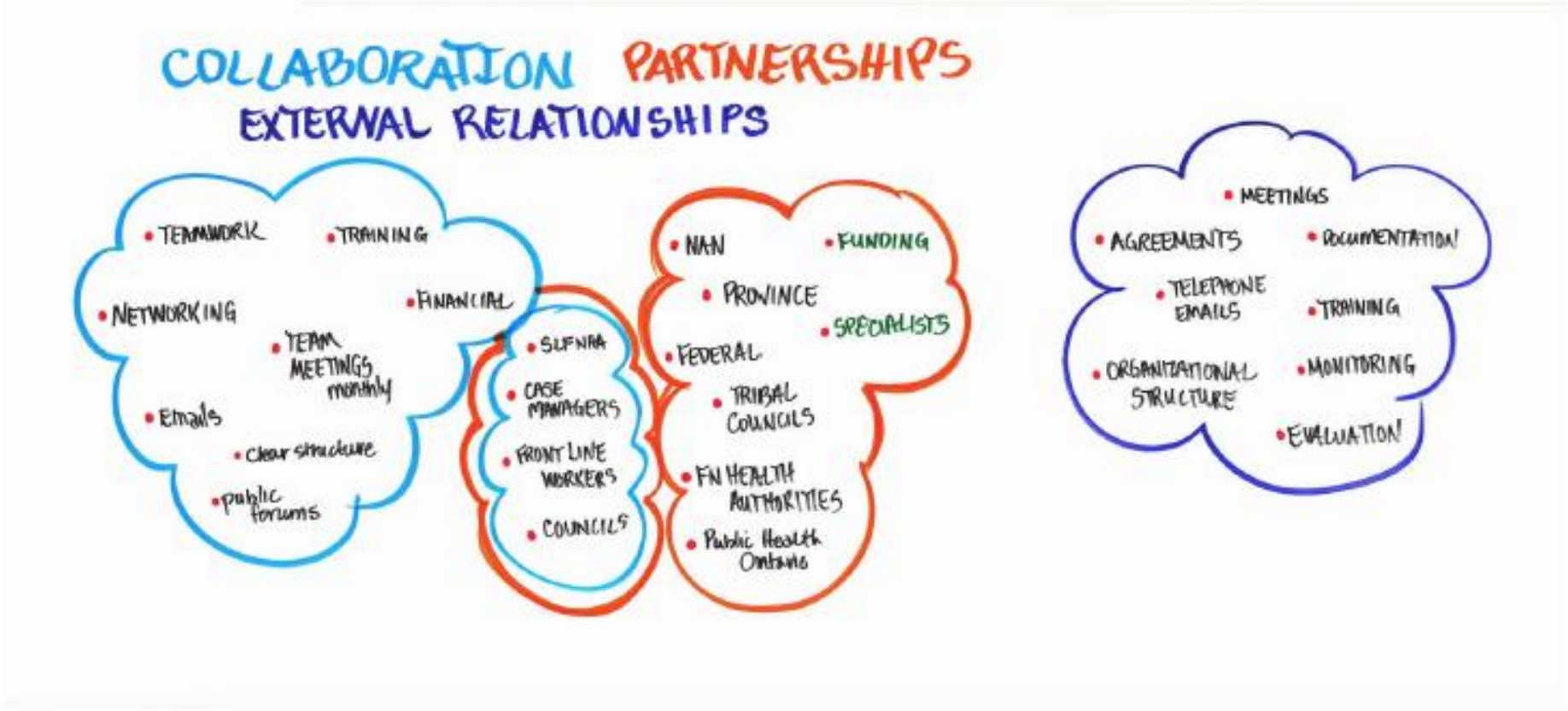

THIS IS
Public Health
SUPPORTING HEALTHY CHOICES
$7 million
municipal
cost sharing
HEALTHY BABIES HEALTHY CHILDREN
STANDARDS
Inspection
Immunization
BOARD
SOCIAL DETERMINANTS OF HEALTH
Education
Drinking Water
MOH
CEO
including First Nations
95,000 People Served
ADMINISTRATIVE & OPERATIONAL
NON MANDATORY Programs
SPEECH PATHOLOGISTS
STUDENT BREAKFAST PROGRAM
Smoke free WORKPLACE
WE CAN'T WORK ALONE!
SENIORS
FALLS REDUCTION
Harm Reduction
IT'S ABOUT SUPPORTING THE
CIRCLE OF LIFE
Vector Born Diseases
Vaccination
Epidemiologist
PLANNING OFFICER
NURSES
INSPECTORS
ENFORCEMENT
NUTRITIONIST
DIETICIANS
DENTAL HYGIENISTS
HEALTH PROMOTION & EDUCATION
WHAT'S THE Evidence?

Public Health Project
UPDATE
CULTURALLY APPROPRIATE HEALTH PLAN
WORKING Group
SUGAR
COMMUNITY HEALTH REPRESENTATIVES
HEALTH PREVENTION & PROMOTION
PRIMARY CARE
OUR A•P•P•R•O•A•C•H
MAJOR FINDINGS
NO EPIDEMIOLOGICAL Analysis NOW
PROGRAMS & SERVICES
TASK ORIENTED NOW
NO MONITORING NOW
WHAT COULD OUR Public Health System LOOK LIKE?
REPORT
FOCUS: PREVENTION
WE Need
POPULATION HEALTH ASSESSMENT & SURVEILLANCE
HEALTH PROMOTION
RESEARCH & KNOWLEDGE EXCHANGE
ORGANIZATIONAL STRUCTURE
WHAT DOES IT Look LIKE?
WHAT Funding IS NEEDED?
WHAT Resources ARE NEEDED?
WHAT CAN WE DO WITH Existing RESOURCES
WHAT DOES A MOH LOOK LIKE?
HOW DO WE BUILD Capacity? IN COMMUNITIES


A Partnership
IN HEALTH SERVICE DELIVERY.....
WORKING IN PLANNING & SERVICE DELIVERY TO MAKE A Difference
TRANSFER of HEALTH SERVICES
MEMBERSHIP AGREEMENT
NITHA GOVERNANCE
4 PARTNERS
DIVERSITY of PARTNERS
NITHA
EXTERNAL WORLD
BRIDGE
SUCCESSES
HEALTH STATUS REPORTS
FIVE YEAR OPERATIONAL HEALTH PLAN
INFECTION CONTROL
TELE HEALTH NETWORKS
EMERGENCY RESPONSE
HEALTH PROMOTION
CERTIFIED HEALTH DIRECTORS
VACCINATION & IMMUNIZATION TRACKING
NITHA can serve as a TEMPLATE
CHECK OUT OUR ANNUAL REPORT
NEEDS ASSESSMENT
SURVEILLANCE UNIT
3 LEVELS OF SERVICE
7 PILLARS
WE HAVE CHALLENGES!!
ELDER ADVISORY COUNCIL
BOARD of CHIEFS
GROUNDS NITHA
GOVERNANCE
PUBLIC HEALTH UNIT
WORKING GROUPS
EXPERT STAFF
EXPERT ADVISORS
PARTNERS


FOcus on Community Health
PAST
Common Sense
midwives
herbs for cures
Traditional medicines
home visits
moss diapers
Recycle Re-use
survival skills
Elders teaching young families
Emergencies
PRESENT
more Radio shows
Better Response Time
Emergency service
Better Communication
Nurses don't do home visits
Flu shot & baby clinic
TELE-HEALTH
way to deal with TB
Poor Living conditions
Need Renovations
Lack of Traditional foods
Lack of Training in Public Health
Lack of knowledge about the use of Housing Fuels
SAFE Drinking Water is an issue
BOIL WATER Advisory
more Awareness
Too much Technology
INTERNET technology
more information
healthy babies
clinicians
some Communities have More Resources
staff not qualified
FUTURE
RECOGNIZE Traditional Healers
Specialized Training
better Salaries
better Technology
better WATER
Traditional medicines
Education in Schools
HEALTHIER People
use Elders to teach
Dental health
lower Diabetes rates
Good Nutrition
Sports BE ACTIVE
MENTAL HEALTH
Preparedness for Outbreaks
We need PLANS
ability to deal with Emergencies
PROTOCOLS & POLICIES
more PREVENTION
E•D•U•C•A•T•I•O•N


OUR Strategic Vision
CLIMATE CHANGE
considers
wildlife
water
HAS TO INCLUDE
ENVIRONMENTAL
HEALTH
AWARENESS & PROTECTION
PERSONAL EMPOWERMENT
QUALITY HOUSING
HEALTHY INFRASTRUCTURE
SPIRITUAL
PHYSICAL
MENTAL
SOCIAL
WE MUST BE HOLISTIC
HEALTHY LEADERS are well
ADVOCACY
PREVENTION
PROMOTION
STRONG
FLEXIBLE
HEALTH SERVICES
CULTURAL HEALTH SERVICES
NURSING STATIONS & CLINICS
CULTURAL SPACES to RESERVE
WORKSHOPS & TRAINING
RESEARCH INITIATIVES
CUTTING EDGE
ADAPTABILITY TO ISSUES
TRADITIONAL PRACTICES
DEDICATED TRAINED
PUBLIC HEALTH WORKERS
POPULATION HEALTH
ADAPTABLE TO EACH COMMUNITY
ACCESS HEALTHY FOOD
FOOD SECURITY
GOOD NUTRITION
CULTURAL UNDERSTANDING & SENSITIVITY
BACK TO MOSS
DOG CONTROL
INDIVIDUAL HEALTH & SAFETY
COMMUNITY
FUNDING & EDUCATION
NEW TEACHINGS
TRADITIONAL LIFESKILLS
FUNDING to SUPPORT EMPLOYMENT
WORK SAFETY
FIRST AID
WHMIS


LEADERSHIP
CHIEF & COUNCILLORS
BAND COUNCILLOR
YOUTH PORTFOLIO
BF BRC
HEALTH AUTHORITY
HEALTH COMMITTEE
GOVERNANCE
HEALTH TASK FORCE
HEALTH BOARD
PUBLIC HEALTH NURSE
OUR COMMUNITY HEALTH
HEALTH DIRECTOR
MANAGE
EMERGENCY RESPONSE TEAM
ELDERS
RESOURCE TEAM
TEACHERS
POLICE
YOUTH
GOVERNANCE & MANAGEMENT
EACH community IS DIFFERENT!!
COMMUNITY
FUNDERS
REMEMBER
indicators & tracking
ACCOUNTABILITY & STEWARDSHIP
INTERNAL REPORTING
quarterly report
financial report
PERFORMANCE EVALUATION
dedicated RESOURCES
EXTERNAL REPORTING
Communicate
newsletters
work plans


COLLABORATION PARTNERSHIPS
EXTERNAL RELATIONSHIPS
TEAMWORK
TRAINING
NETWORKING
FINANCIAL
TEAM MEETINGS monthly
Emails
clear structure
public forums
SLFNNA
CASE MANAGERS
FRONT LINE WORKERS
COUNCILS
NAN
FUNDING
PROVINCE
SPECIALISTS
FEDERAL
TRIBAL COUNCILS
FN HEALTH AUTHORITIES
Public Health Ontario
MEETINGS
AGREEMENTS
documentation
TELEPHONE EMAILS
TRAINING
ORGANIZATIONAL STRUCTURE
MONITORING
EVALUATION