Barrie

15 Sperling Drive

Barrie, Ontario

Phone: (705) 721-7520

Fax: (705) 721-1495

www.simcoemuskokahealth.org

SMDHU INDIGENOUS ENGAGEMENT LEARNING JOURNEY

Situational Assessment Report (External Version)

July 2023

simcoe muskoka DISTRICT HEALTH UNIT

ACKNOWLEDGMENTS

Authors

Ainslie Butler, PhD, BSc (Hons) – Epidemiologist, Population Health Assessment, Surveillance and Evaluation

Melanie Dupuis, MSc, BSc (Hons) – Research Analyst, Population Health Assessment, Surveillance and Evaluation

Kerri Grummett, MA, BA (Hons) – Health Promotion Specialist, Health Equity, Health Promotion and Communications

Emily House, MPH – Epidemiologist, Population Health Assessment, Surveillance and Evaluation

Megan Williams, MPH, BJ (Hons), BA – Program Manager, Health Equity, Health Promotion and Communications

Carol Yandreski, RN, BA, BScN – Public Health Nurse, Health Equity, Health Promotion and Communications

Reviewers

Ad hoc members of SMDHU Indigenous Engagement Work Group:

- Brenda Armstrong, Program Manager, Healthy Environments
- Mary Bouffard, Public Health Nurse, Healthy Growth and Development
- Mia Brown, Program Manager, Substance Use and Injury Prevention
- Karen Ellis, Vice President, Program Foundations and Finance Department
- Dr. Lisa Simon, Associate Medical Officer of Health
- Amber Venner, Registered Practical Nurse, Health Connection

Members of SMDHU Executive Committee

Members of the Indigenous Health Circle for Simcoe Muskoka

NOTE: The full content of this external version of the report is intact. The only alteration is the removal of hyperlinks to documents saved to the health unit's internal network.

CONTENTS

LIST OF FIGURES AND TABLES

EXECUTIVE SUMMARY

Building and further developing relationships with Indigenous communities and organizations in a meaningful and culturally safe way is a key requirement under the Health Equity Foundational Standard of the *Ontario Public Health Standards (OPHS), 2018*, and one that has been welcomed by the Board of Health and staff of the Simcoe Muskoka District Health Unit (SMDHU).

As a starting point to inform meaningful engagement and mutually desired collaborative working relationships with Indigenous Peoples, organizations and communities in Simcoe Muskoka, the health unit began a learning journey in 2018. At the outset, an internal working group was established to gather information that would help to move the health unit towards culturally safe practice and stronger relationships with Indigenous Peoples, communities and organizations. The intended outcomes of the information gathering were for the health unit to:

1. Understand the health status of Indigenous Peoples in the Simcoe Muskoka area and the factors impacting their health.
2. Understand SMDHU's knowledge, readiness and capacity to engage with Indigenous populations.
3. Understand the external factors that may influence engagement.
4. Explore engagement and relationships principles and models.

A situational assessment was initiated to answer the following question: *What does SMDHU need to know to inform the agency of how to proceed with building and maintaining meaningful engagement and mutually desired collaborative working relationships with Indigenous Peoples, organizations and communities in Simcoe Muskoka?*

The situational assessment involved several activities, all taking place between 2018 and 2021. The first was gathering and synthesizing resources shared by the Indigenous Health Circle (IHC) as well as information from hand searched grey literature and surveillance reports to produce a summary of local Indigenous demographics and health status. It is acknowledged that this information gathering is a starting point, and that our understanding of the health status of local Indigenous Peoples and the factors impacting their health will be substantially furthered through our Indigenous engagement in the coming years.

The second was the completion of two scoping reviews on key areas of interest: a) engagement practices and models of engagement with Indigenous communities, and b) federal, provincial and local government jurisdictional considerations related to public health services for Indigenous Peoples. Search strategies were undertaken for both reviews that identified relevant grey literature, documents and other resources from which data and information were assessed and extracted.

The third was an environmental scan of SMDHU's management and MOH Office, conducted using a survey tool to identify the health unit's past and current activities working and/or partnering with Indigenous communities. Information was also gathered to quantify the level of

training amongst staff in Indigenous cultural awareness, sensitivity or safety and/or anti-oppression and anti-racism.

The fourth was consultations with two key groups. Internally, focus groups took place with SMDHU staff who had or who were working with Indigenous partners or communities to hear and to learn about their experiences and perspectives from this work and the relationships they had built. Externally, several engagement sessions were held with local Indigenous partners and communities to hear their perspectives, needs and priorities related to public health issues, programs and services, and to learn if and how they would like to work with the health unit on public health issues affecting their populations.

In addition to these planned components of the situational assessment, a summary of learnings from engagement activities with Indigenous partners and communities that were initiated during the health unit's COVID-19 pandemic response was compiled and is included in this report.

Although the pandemic was an opportunity for the health unit to engage with Indigenous partners, it also became a limitation of the situational assessment in that it affected the report's timely completion by a couple of years. This delay created a significant gap in time between when some activities had begun and when they were completed, therefore resulting in dated information in some components of the assessment.

The findings of the health status and demographic data gathering, scoping reviews, environmental scan, internal and external consultations, and the COVID-related engagement activities were synthesized and analyzed to identify common themes and learnings. The synthesis process was completed using a virtual whiteboard exercise. Once themes and key points were identified, a deeper analysis of the information took place for the purpose of identifying possible future actions the health unit could take to build and maintain meaningful engagement and mutually desired collaborative working relationships with Indigenous Peoples, organizations and communities in Simcoe Muskoka. To help align future actions with the Ontario Public Health Standards, findings from the analysis were grouped under the five guiding relationship principles identified in the OPHS Relationships with Indigenous Communities Guideline, and are summarized as follows:

Relationship Building:

- Foundational to building relationships with Indigenous Peoples, organizations and communities is the intention behind that process and that relationships are formed from a place of respect, trust, recognition and openness.
- Relationship building must be based on the needs, priorities and desires of Indigenous Peoples, organizations and communities.
- Relationship building takes place at the system, program and individual level, and different levels within the health unit will have different roles to play (i.e., Board of Health, Medical Officers of Health, Vice Presidents, Managers, Staff).

- To achieve authentic relationships with Indigenous Peoples, organizations and communities, the health unit must consider and may need to adjust the way we plan, implement and deliver our programs and services to be culturally safe and appropriate.

Recognition, Respect and Mutuality:

- Recognizing and acknowledging the diversity of Indigenous Peoples' culture, language, protocols and history is fundamental to this concept and can be achieved through education and self-reflection.
- Indigenous communities may have common issues but may also have diverse needs and priorities that require unique responses from the health unit. Recognizing and respecting the diversity of experiences and perspectives within Indigenous communities become building blocks upon which collaborative, meaningful and mutual relationships are built.
- Adapting our process to meet the needs of Indigenous communities shows respect and recognition.
- Mutuality is expressed through recognizing the strengths and diversity of Indigenous Peoples and communities and building this into collaborative program planning and services with Indigenous Peoples.

Self-Determination:

- Self-determination is supported when community-based Indigenous organizations and communities can lead or influence relevant decision-making processes.
- SMDHU can support self-determination by providing the opportunity for Indigenous communities and organizations to lead or influence relevant decision-making processes that impact Indigenous Peoples and facilitate greater opportunities for control over their health.

Timely Communication and Knowledge Exchange:

- Building relationships with Indigenous Peoples, organizations and communities must involve intentional, dynamic and ongoing communication that is transparent, reciprocal and frequent.
- Building communication pathways at all levels of the organization where they do not already exist will support engagement with Indigenous Peoples, communities and organizations.
- Using communications strategies to support learning more about each other and how we can work together is important to building trust and reducing knowledge gaps.

Coordination:

- Coordination and integration of public health programs, services and supports entails collaboration and co-development with Indigenous Peoples, organizations and

communities, as well as with partners across the health care system and other sectors that overlap with public health initiatives and that cross all levels of government.

- Awareness of governmental jurisdictional considerations in providing public health services is important and should not become a barrier to collaboration and/or to the provision of service.
- Coordinated and culturally safe public health services planned with and for Indigenous Peoples is an important component of a comprehensive strategy for engagement, relationship building and service delivery using the lens of equity, diversity and inclusion under an agency anti-racism and anti-oppression strategy that embeds these critical concepts into SMDHU culture and practice.
- Creating an Indigenous Liaison position within the health unit could help to coordinate organizational work with Indigenous partners, and whose other roles could be to act as a main point of contact with Indigenous partners and leaders in Simcoe Muskoka, and identify and facilitate internal system changes (i.e., policies, procedures, planning) as required to support SMDHU Indigenous engagement.

The key learnings of the situational assessment analysis have informed the creation of the following recommendations for a longer-term Indigenous engagement strategy for SMDHU:

1. Intentionally pursue and enhance respectful and reciprocal relationships with Indigenous Peoples, communities and organizations.
2. Through respectful and reciprocal ongoing consultation and partnership, identify, invite, and respond to requests from Indigenous communities and organizations for potential formal mechanisms (i.e., processes, policies or agreements) to enhance public health programming and services for Indigenous Peoples. Such programming and services would be guided by the principle of Indigenous self-determination in decision-making.
3. Develop an internal approach to support relationship-building processes and collaborative partnerships with Indigenous communities and organizations.
4. Commit to the resourcing (staffing, time, training, internal committee creation, etc.) required to develop and maintain relationships and prioritize the implementation of requested public health programming and services in collaboration with Indigenous communities and organizations.
5. Co-develop knowledge exchange and communications strategies with Indigenous partners based on their identified needs.
6. Create an agency Indigenous Liaison position, who working with an internal Indigenous engagement steering committee, will support and enhance the development of relationships with Indigenous communities and partners, facilitate the integration and implementation of culturally safe policies and practices within SMDHU, and help improve local access to public health programs and services for Indigenous communities, organizations and Peoples.

Potential actions and/or mechanisms to achieve these recommendations have been identified within the body of the report.

BACKGROUND

Building and further developing relationships with Indigenous Peoples, communities and organizations in a meaningful and culturally safe way is a key requirement under the Health Equity Foundational Standard of the Ontario Public Health Standards (OPHS), 2018, and one that has been welcomed by the Board of Health and staff of the Simcoe Muskoka District Health Unit (SMDHU). The requirement directs boards of health to engage with local Indigenous communities and organizations and to build collaborative partnerships in accordance with the Relationship with Indigenous Communities Guideline, 2018.

On May 16, 2018, SMDHU's Board of Health endorsed Motion 5.1.1 which states:

> THAT the Board of Health support agency engagement of Indigenous populations within Simcoe and Muskoka, including First Nations communities, to explore collaborative public health planning and work.
>
> AND FURTHERMORE THAT the Board of Health support the possible identification of work with Indigenous populations as an agency priority, dependent on the engagement outcome.

To support the motion's intent of Indigenous engagement, agency resources were allocated towards action and implementation under the Relationships priority of Simcoe Muskoka District Health Unit's Strategic Plan (2019-2022), Goal 2, Objective 1: *Enhance relationships with community partners to address social determinants of health and improve the health of priority populations*.

As a starting point to inform further meaningful engagement and mutually desired collaborative working relationships with Indigenous Peoples, organizations and communities in Simcoe Muskoka, the health unit began a learning journey, known as our Journey of Growth (depicted graphically in Appendix A). An internal Indigenous Engagement Work Group (IEWG) was created in July 2018 to coordinate information-gathering activities that was guided by the Relationship with Indigenous Communities Guideline, 2018 and designed to move the health unit along the Journey of Growth towards culturally safe practice and stronger relationships with Indigenous communities and organizations. The intended outcomes of the information-gathering were for the health unit to:

1. Understand the health status of Indigenous Peoples in the Simcoe Muskoka area and the factors impacting their health.
2. Understand SMDHU's knowledge, readiness and capacity to engage with Indigenous populations.
3. Understand the external factors that may influence engagement.
4. Explore engagement and relationships principles and models.

To accomplish a fulsome understanding and exploration of such components, it was determined the IEWG would commence a comprehensive situational assessment.

Situational Assessment

A multi-pronged situational assessment was initiated to address the information-gathering outcomes noted above and to answer the following research question:

> What does SMDHU need to know to inform the agency of how to proceed with building and maintaining meaningful engagement and mutually desired collaborative working relationships with Indigenous Peoples, organizations and communities in Simcoe Muskoka?

To support the agency's understanding of the health status of Indigenous Peoples in the Simcoe Muskoka area and the factors impacting their health (Outcome 1) and to provide context to support staff in reciprocal engagement with Indigenous populations, communities and organizations, the health unit gathered and synthesized resources shared by the local Indigenous Health Circle (IHC) as well as information from hand searched grey literature and surveillance reports to produce a summary of local Indigenous demographics and health status. It is acknowledged that this information gathering is a starting point, and that our understanding of the health status of local Indigenous Peoples and the factors impacting their health will be substantially furthered through our Indigenous engagement in the coming years.

To address Outcomes 2 - 4, the health unit undertook three research activities, two of which had multiple components:

1. Scoping reviews – collect information on two key areas of interest:
    a. Engagement practices and models of engagement with Indigenous communities.
    b. Government jurisdictional considerations for providing public health services to Indigenous Peoples and communities.
2. Environmental scan – conduct an internal scan of SMDHU management to explore the health unit's past and current relationships and experiences working and/or partnering with Indigenous communities, including an inventory of staff Indigenous cultural awareness, sensitivity or safety training and/or anti-oppression and anti-racism training.
3. Consultations with two key groups:
    a. SMDHU staff – to learn from staff who are or have been engaged in activities with local Indigenous partners/communities and to hear their experiences and perspectives around their work and relationships with Indigenous partners.
    b. Local Indigenous partners and communities - to learn about their perspectives, assets, strengths, needs and priorities, particularly as they relate to public health and the social determinants of health, and to learn if and how they would like to work with the health unit on public health issues affecting their populations.

In addition to the planned situational assessment components, the COVID-19 pandemic created an immediate and organic opportunity as part of SMDHU's pandemic response activities to engage with Indigenous partners and communities in new ways and to support critical aspects

of their COVID-19 response activities serving their First Nation and/or urban Indigenous populations. This opportunity allowed for new relationships to be forged and current relationships to be strengthened. As such, although not included as part of the original situational assessment plan, an additional summary of SMDHU's engagement with Indigenous communities and partners was produced reflecting our work throughout the pandemic. The COVID-19 Indigenous Engagement Activities summary highlights experiences and important reflections to inform our journey towards working with Indigenous partners and supporting them to address the public health and social determinants of health needs of local Indigenous Peoples.

Separate reports were generated for each situational assessment activity noted above. Each report (linked in box below) includes a description and summary of the background, methods, results, limitations and conclusions of the topic being researched.

Indigenous Engagement Situational Assessment Reports

1. Scoping reviews
    a. Engagement Practices and Models of Engagement Scoping Review
    b. Government Jurisdictional Considerations Scoping Review
2. SMDHU Management Environmental Scan
3. Consultations
    a. SMDHU Staff Consultations Report
    b. Indigenous Partners and Communities Consultations
4. COVID-19 Indigenous Engagement Activities

The remainder of this report contains a summary of the methods and findings of each of the situational assessment components, an overall analysis of their findings, general limitations, and overall recommendations for how the health unit can continue its journey to achieve meaningful, respectful and reciprocal relationships, contacts and connections with Indigenous communities, organizations and Peoples in Simcoe Muskoka.

To provide context for this report and its recommendations, readers are encouraged to reflect on broader principles of Indigenous cultural safety. Materials and training opportunities are available to SMDHU staff and listed on the intranet.

METHODS

This section provides a summary of the methodology used for each of the separate situational assessment activities noted above.

Local Indigenous Demographics and Health Status

Health status and demographic data describing local Indigenous populations were identified and gathered in two ways. First was the compilation of a variety of resources that were shared by members of the local Indigenous Health Circle (IHC). These resources, including reports,

documents, presentations and websites, were reviewed and the information pertaining to health status and demographics was synthesized and summarized. Information was also gathered from a hand search of the grey literature, websites and other resources. The second method was collating an inventory of existing data sources accessed as part of routine surveillance and reporting activities conducted by the health unit, including but not limited to SMDHU, Public Health Ontario, the Census of Canada, and the Canadian Community Health Survey (CCHS).

The health unit is aware of the importance of interpreting the data about Indigenous populations within the context of the data source as well as with a broader understanding of the Indigenous populations and communities, including their assets, Indigenous-specific determinants of health, and perspectives on health.

The First Nation principles of ownership, control, access, and possession, formally known as OCAP®, were considered in the gathering of this data. Under the guidance of OCAP® principles, the decision was made not to seek out or request access to additional data sources at this stage of the health unit's learning journey.

Scoping Reviews

Two scoping reviews were completed as part of the situational assessment: a review of engagement practices and models of engagement, and a review of government jurisdictional considerations for the delivery of public health services. The methodology for each is described in more detail below.

Engagement Practices and Models of Engagement

A search of the grey literature was undertaken in May 2019, guided by the following question:

> What engagement practices and relationship models are being implemented locally, provincially, and nationally with Indigenous Peoples that can be applied to public health?

Several sources were used to identify Indigenous engagement-related grey literature and documents from Ontario public health units and other key organizations or resources, including databases, SMDHU Board of Health minutes, professional networks, key organizations' websites, key provincial guiding documents and key national documents.

Documents were included if they met the following criteria: the document discussed activities leading up to an Indigenous engagement strategy; the document was related to the development or evaluation of an Indigenous engagement strategy or activities; or the document discussed carrying out the activities in an Indigenous engagement strategy related to public health.

Documents were excluded for the following reasons: the document only provided descriptive statistics about Indigenous communities; the document focused on a topic not readily applicable to public health (e.g., commercial business); engagement was focused on the federal level; or it

did not specifically focus on Indigenous communities or Peoples (e.g., general engagement strategies).

The documents were assessed based on the extent they were authored by a reputable organization and the extent Indigenous partners were involved in the development. A total of 26 documents were included for review and synthesis for the scoping review.

Government Jurisdictional Considerations

A scoping review was completed, guided by the following question:

> What are the federal, provincial, and local government jurisdictional considerations (e.g., financial, territorial, political) related to public health services for Indigenous Peoples that may impact the health unit's efforts to undertake meaningful engagement and build collaborative relationships with local First Nation communities, organizations and individuals?

Between April 2019 and January 2022, several search strategies were employed to identify sources of local, provincial and federal government jurisdictional considerations (e.g., financial, territorial, political) related to public health services for Indigenous Peoples. Key websites, grey literature and other known documents were hand searched. Additional websites and sources of information identified through references within the reviewed key documents and websites were also reviewed. A request for information from professional networks and a consultation with federal and provincial key informants were also used to gather information about jurisdictional considerations.

SMDHU Environmental Scan

In October 2018, a survey was sent to SMDHU managers, vice-presidents (formerly called directors) and the Medical Officer of Health (MOH) office (including the medical officer of health, the associate medical officers of health, and the chief nursing officer) with the following objectives:

1. To create an updated inventory of SMDHU's past and current experience working and/or partnering with Indigenous Peoples or communities.
2. To identify the number of staff with formal Indigenous cultural awareness, sensitivity or safety training.
3. To identify the number of staff with formal anti-oppression and anti-racism training.

The survey was customized for each program and department and pre-populated with previously identified activities for each program to reduce duplication of effort. Respondents were asked to identify activities, partnerships and training over the previous five years.

Consultations

SMDHU Staff Consultations

As part of the SMDHU environmental scan management survey (see section above), respondents were asked to identify staff involved in activities or partnerships with Indigenous

partners. With management support, these staff (and others identified after the fact) were invited to participate in one of three 2.5 hour in-person consultation sessions in March and April 2019. A follow-up survey was disseminated to invited staff following the consultations, providing further opportunity to respond to questions asked during the consultation sessions.

The consultations had the following objectives:

1. To gain knowledge of existing SMDHU relationships with local Indigenous individuals, partners, groups and/or communities.
2. To gain an understanding of the nature of those relationships.
3. To learn what has worked well and not so well in our work with local Indigenous individuals, partners, groups and/or communities.
4. To share ideas for how to engage with local Indigenous individuals, partners, groups and/or communities.

The questions asked in the consultation sessions and follow-up survey are available in Appendix A of the Staff Consultation Report.

Indigenous Partners and Communities Consultations

In collaboration with SMDHU's internal Indigenous Engagement Work Group (IEWG), and with input and feedback from members of the Indigenous Health Circle (IHC) in Simcoe Muskoka, Cambium Indigenous Professional Services (CIPS) was hired to help plan and facilitate consultations on behalf of the health unit with key Indigenous partners in the region throughout 2019 and 2020, with the following objectives:

1. To listen and learn about how local Indigenous partners view and perceive the health unit and its work.
2. To receive input that will inform organizational self-reflection about what an engaged SMDHU looks like.
3. To explore Indigenous partners' interest in becoming more engaged with SMDHU.

Key informants from Indigenous organizations and First Nation communities participated in scheduled consultation sessions (in person and online). A total of eight engagement sessions were held, with a total of 40 participants in attendance. The following questions were used to guide discussions and to facilitate objectives being met:

1. How do you view SMDHU?
2. How can we be a responsive partner with you to address public health issues?
3. What does an engaged health unit look like to you?
4. What are your expectations of a partnership with us?
5. What have we done with/for/to you in the past that has affected our relationship either positively or negatively (if anything)?

6. How can we do better for your communities?

COVID-19 Indigenous Engagement Activities

In 2022, the health unit compiled a list of key activities that summarized and described how representatives from the First Nation and urban Indigenous communities were engaged during SMDHU's COVID-19 response, including case management, vaccination promotion, and vaccination clinic planning and implementation in partnership with the health unit. This list was circulated by e-mail to health unit staff who worked directly with members of the local First Nation and urban Indigenous communities to support these activities for their review and input. Staff were asked to add their reflections on lessons learned, including successes, barriers and what worked and didn't work with the partnerships and activities described. The document also included references to the results of the urban Indigenous COVID-19 vaccination strategy evaluation report.

RESULTS

This section provides a summary of the results for each of the separate situational assessment activities previously noted.

Local Indigenous Demographics and Health Status

Using the resources shared by members of the local Indigenous Health Circle (IHC) in 2019, as well as information available from hand searched grey literature and surveillance reports in 2019, a summary of local Indigenous information was developed. This summary included information about health and health behaviours as well as demographic information about Indigenous Peoples.

The Simcoe Muskoka District Health Unit also has access to publicly available data about social and cultural determinants of health as collected and described in the Census by Statistics Canada. This provides information about education, income, workforce participation, housing, family structure and other characteristics of local Indigenous and non-Indigenous populations. This information, as collected by Statistics Canada, may not adequately or accurately describe the experiences of Indigenous Peoples and do not necessarily align with the framework of Social Determinants and Indigenous People's Health as described in the OPHS.[1-2]

Given that SMDHU has not yet engaged in collaboration with local Indigenous communities and organizations to explore data from the Census or other sources, or how it represents local experiences and what determinants are not represented from available resources, a fulsome exploration of social determinants of health is not included in this report. In the future, SMDHU hopes to work together with local Indigenous partners to better understand and communicate

about social and structural determinants of health and the experiences of Indigenous Peoples in the region.

Interpretating Data and Data Limitations

In 2015, the Canadian government acknowledged and affirmed its responsibility for the continued inequities experienced by Indigenous Peoples across Canada. Through policies and practices supporting colonialism and the assimilation of Indigenous Peoples (including residential schools) which have led to embedded racism and discrimination in our structures and systems, Indigenous Peoples in Canada continue to experience health inequities and limited access to culturally appropriate health care.[3]

Nationally recognized data gaps for Indigenous and other equity deserving populations are reflected in our local data where we see substantial gaps in data availability. Compared to our knowledge about the broader Simcoe Muskoka population, there is a lot we do not know about local Indigenous Peoples and communities and their health-related status.

Interpretation of data must also take into consideration the limitations of available surveillance tools. The Census may undercount urban Indigenous populations, who may also be at risk of not participating in the Census due to factors such as increased rates of mobility and its associated lack of living at a fixed address, historical distrust of government due to past and present colonial policies and migration between geographical locations.[1]

It is important to interpret data about Indigenous populations within the context of the data as well as with a broader understanding of the populations and communities, including their assets, determinants of health, and perspectives on health. Part of the health unit's learning journey is to better appreciate this context and to work with Indigenous partners as to how Indigenous-related data will be interpreted, used and shared.

To date, the health unit has not collected additional sources of information related to Indigenous populations or health status until further discussions have taken place with local Indigenous partners regarding shared purposes and appropriate processes related to the collection, ownership and reporting of Indigenous-related data, as per the importance of following the First Nations Principles of OCAP®. OCAP® refers to the principles of ownership, control, access, and possession, which assert "that First Nations have control over data collection processes, and that they own and control how this information can be used."[4]

Demographics

First Nations

Within the boundaries of Simcoe Muskoka, there are four First Nation communities (also known as reserves):

- Beausoleil First Nation
    - Statistics Canada Census Geography: Christian Island (#30 and #30A).

    - Also referred to as Chippewas of Beausoleil.
- Chippewas of Rama First Nation
    - Also referred to as Rama (#32B), Mnjikaning First Nation, Mnjikaning, or Chippewas of Rama.
- Moose Deer Point
    - Statistics Canada Census Geography: Moose Point 79.
- Wahta Mohawks
    - Statistics Canada Census Geography: Wahta Mohawk Territory.
    - Also referred to as Gibson #31, Gibson Mohawk, or Indian River.

Métis Councils

There are three community councils of the Métis Nation of Ontario within Simcoe Muskoka:

- Métis Nation of Ontario (MNO) Georgian Bay Métis Council
- Métis Nation of Ontario (MNO) Moon River Métis Council
- Métis Nation of Ontario (MNO) Barrie South Simcoe Métis Council.

Indigenous Organizations

In addition to the First Nations and Métis Community Councils within Simcoe Muskoka there are many Indigenous associations and organizations (e.g., Friendship Centres, health centres, child and family services, and women's groups) who support and serve local Indigenous Peoples in urban settings and/or in Indigenous communities. There is one Indigenous, interdisciplinary wellness and primary health care team providing service throughout North Simcoe Muskoka, which is called Mamaway Wiidokdaadwin – a service of the Barrie Area Native Advisory Circle. There are also several provincial and national Indigenous associations and organizations.

Indigenous Population

According to data from the 2021 Census, 5% (27,200 people) of the Simcoe Muskoka population reported identifying themselves with at least one Indigenous group, this includes 1,575 people living in the four First Nation communities and 25,625 who do not primarily live in First Nation communities. In comparison, 3% (406,590 people) of Ontario residents reported having an Indigenous identity.

Of the 27,200 people who self-identified as Indigenous in Simcoe Muskoka, 13,040 reported a First Nation (North American Indian) identity only, 12,930 reported a Métis identity only, 180 reported an Inuk (Inuit) identity only, 500 reported having more than one Indigenous identity and 550 reported other Indigenous identities.

Among all communities in Simcoe County and the District of Muskoka, First Nation communities have the highest percentages of their populations who self-identify as Indigenous. In Beausoleil First Nation, 96% (or 655 people) self-identify as Indigenous, in Chippewas of Rama First Nation, 78% (or 775 people) self-identify as Indigenous, and in Moose Deer Point, 67% (or 145) self-identify as Indigenous. Census data are not available for Wahta Mohawks.

Outside of local First Nation communities, the Census subdivisions with the highest percentage of the population self-identifying as Indigenous in Simcoe County are Penetanguishene (22% representing 2,010 people) and Midland (14% representing 2,495 people). In the District of Muskoka, Georgian Bay (10% representing 335 people) and Muskoka Lakes (4% representing 325 people) have the highest percentage of the population self-identifying as Indigenous. Within Barrie, 4% (or 5,320 people) of the population self-identify as Indigenous and in Orillia 6% (or 1,970 people) of the population self-identify as Indigenous.

Simcoe Muskoka is also home to a large community self-identifying as Métis, with 2% (or 12,930 people) self-identifying as Métis. Census subdivisions within Simcoe Muskoka with the highest percentage of the population self-identifying as Métis included Penetanguishene (19% or 1,715 people), Tiny (11% or 1,395), Tay (10% or 1,135) and Midland (10% or 1,750). Throughout Ontario, Penetanguishene (1st) is the Census subdivision with the largest Métis population, while Tiny (15th), Tay (17th), and Midland (20th) all fall within the top 20 Census subdivisions with the largest population self-identifying as Métis.

Among those who self-reported an Indigenous identity, 48.5% (or 13,195 people) were men+ and 51.4% (or 14,000 people) were women+. "Men＋" includes men (and/or boys), as well as some non-binary persons. "Women＋" includes women (and/or girls), as well as some non-binary persons.[5]

Among those who reported Indigenous identity, the average age is 36 years in the County of Simcoe and 38 years in the District of Muskoka. This is younger than the average age of the total population, which is 42 years in Simcoe County and 48 years in the District of Muskoka according to the 2021 Census. Of those who self-identify as Indigenous, 22% (5,935 people) are children aged 0-14, 67% (or 18,170 people) are a part of the working age population aged 15 to 64, and 11% (or 3,100 people) are seniors over the age of 65. In comparison, for the total population 16% (or 95,235 people) are children aged 0 to 14, 63% (or 379,840 people) are part of the working age population aged 15 to 64, and 21% (or 124,765 people) are seniors over the age of 65.

Languages

For people who self-identify as Indigenous in Simcoe Muskoka, Ojibway-Potawatomi languages (66.7% or 150 people) was the most common Indigenous language reported as the mother tongue in the 2021 Census, 2016 Census and 2011 National Household Survey.[5-7] The second most common reported Indigenous language from the 2021 Census was ‘Indigenous languages, not otherwise specified’ (17.8% or 40 people), followed by Cree-Innu languages, which accounted for approximately 8.9% (or 20 people) of reported Indigenous languages. Approximately 1.0% of people who self-identified as Indigenous reported speaking an Indigenous language at home; however, 6.3% (or 100 people) of those who self-identified as

Indigenous living in Chippewas of Rama First Nation, Beausoleil first Nation, or Moose Deer Point identified that an Indigenous language was most often spoken at home.

Health Status

The 2010 First Nations Regional Health Survey (RHS) of Ontario[8] was the most recent, comprehensive source of information about the health status and health behaviours of First Nation adults in Ontario that was identified as part of our initial information gathering in 2019. Given that this comprehensive information is over a decade out of date, it is not included in this report. A subsequent national survey was conducted in 2015 and 2016[9], but province-specific information is not publicly available at the time of this report.

Several other key resources identified as part of our information gathering represent programs or data collection initiatives that are not recent. This highlights a significant gap in our access to and understanding of information related to the health status and health behaviours of Indigenous Peoples.

Highlighted through the available literature is that Indigenous Peoples within Simcoe Muskoka region and the broader Ontario region are experiencing greater health inequities than the non-Indigenous population. This is driven by disproportionate current prevalence of risk factors and exposures, fundamentally rooted in extensive histories of colonialism and racism.

Physical Health

- Cancer Care Ontario's Prevention System Quality Index states that First Nations, Inuit, and Métis populations in Ontario have a disproportionately higher prevalence of several behavioural risk factors and exposures compared to the general population. This leads to a greater risk of chronic disease and of certain cancers.[10]
- Chiefs of Ontario and Cancer Care Ontario note that physical inactivity is one of the greatest contributing factors of cancer rates within First Nations people in Ontario, so there is need for culturally tailored community services to address this issue.[11] Rural First Nation adults have lower levels of physical activity than urban First Nation adults: 44% and 27% of rural First Nations men and women are physically active, compared to 60% and 50% of urban First Nations men and women that are physically active.[11] This highlights the differing risks experienced among rural and urban Indigenous populations.
- Indigenous populations in Ontario have been reported to experience higher prevalence of other chronic conditions, including arthritis, asthma, high blood pressure, diabetes, obesity and cancer.[11-15]
- Though survivability improved between 2001 – 2010, First Nations people still have a reduced likelihood of surviving cancers in comparison to non-Indigenous populations.[15-16]
- Colonialism, racism, and social exclusion are factors that continue to profoundly disrupt community and individual wellbeing, which may attribute to the greater incidence of cancer within Indigenous populations.[10]

- The Wiisinadaa Diabetes Project of the Ontario Federation of Indigenous Friendship Centres describes diabetes as a consequence of colonialism, and an issue which requires a multi-faceted and culturally grounded approach to address policy and government services.[13]

Mental Health and Well-being

- The Barrie Area Native Advisory Circle notes that mental health and well-being and healthy mental and intellectual development among infants, children and youth have been identified as priorities among surveys of Indigenous children and youth services and Indigenous caregivers in the Barrie/Midland region.[17-18]

Spiritual/Cultural Wellbeing

- Indigenous community members have highlighted “intergenerational trauma, poverty, and cultural disconnection” as pervasive challenges infringing upon the livelihood of Indigenous people within North Simcoe Muskoka.[19]
- Community initiatives, programs, and events are a significant tool and means of unifying community spirit.[20]
- The Indigenous-Led Opioid Strategy in Simcoe Muskoka describes community-identified and community-led cultural and spiritual practices as part of providing appropriate treatment for opioid use among Indigenous individuals.[19]

Food (In)security

- In 2007 to 2014, “a significantly higher percentage of on- and off-reserve First Nation adults were food insecure than [non-Indigenous] Ontarians” according to work from Cancer Care Ontario, and one-third of on-reserve First Nation adults were in moderately food insecure households, compared to 13.8% of off-reserve First Nation adults.[10] Additionally, 20.8% of Metis households were either marginally, moderately, or severely food insecure in comparison to 11.5% of non-Indigenous households in Ontario.[10]
- The absence of a healthy diet is identified as a major risk factor for cancer. In Ontario, 12% and 20% of rural First Nations men and women meet the daily standard of four servings of fruits and vegetables, whereas 22% and 28% of urban First Nations men and women match the daily quota.[11] In comparison, 23% and 37% of non- Indigenous men and women in Ontario meet the daily standard of fruit and vegetable servings.[11]
- Toronto’s First Indigenous Health Strategy suggested the application of an Indigenous lens to support the creation of community gardens, policies for green spaces designed for food sustainability, affordability strategies, and accessibility to prenatal vitamins.[21]

Substance Use

- The rate of opioid-related emergency department visits was seven times higher among First Nations people compared to non-First Nations people in Ontario, and the rate of deaths was four times higher in 2019.[22]

- The Chiefs of Ontario and the Ontario Drug Policy Research Network report an increase in opioid agonist therapy (OAT) used to treat opioid use disorders among First Nations people from 2013 to 2019. This is occurring alongside a higher rate of opioid use and opioid prescription, and rapid increases in the rate of emergency department visits and deaths among First Nations adults.[22]
- In a 2015 feasibility assessment from the Barrie Area Native Advisory Circle (BANAC) "94% of respondents to a community survey know someone affected by substance abuse and/or addictions", and 88% knew someone who previously attended a substance abuse and/or treatment programs.[23]
- Through the BANAC feasibility study (2015) and the Indigenous-Led Opioid Strategy for Simcoe Muskoka (2018), Indigenous peoples have identified a need for addiction-based resources to address rising community concerns of substance abuse.[19, 23] Such resources could be additional addictions counsellors, a residential addictions treatment center, and an improved understanding of how addiction and substance abuse affects Indigenous populations differently.[19, 23] Progress on some of these recommendations has been made through the work of the Indigenous Health Circle in Simcoe Muskoka, and further work is underway.

Alcohol

- The 2016 Cancer in First Nations in Ontario report stated that rural First Nations men were twice as likely to abstain from drinking alcohol (35%) than urban First Nations men (19%) and non-Aboriginal men (16%).[11] Furthermore, this trend extended to abstaining rural First Nations women (38%) in comparison with urban First Nations women (24%) and non-Aboriginal women (25%); however, it was noted that though rural First Nation adults are more likely to abstain from drinking, a greater total of rural First Nations adults drank excessively compared to others.[11]
- This was echoed in the 2018 Prevention System Quality Index from Cancer Care Ontario which stated that rural First Nation individuals were more likely to abstain from alcohol than urban First Nation groups and non-Indigenous people.[10]

Smoking

- As noted by the Chiefs of Ontario and partner agencies, cigarette smoking is the greatest and most modifiable cause of cancer among Indigenous groups, being responsible for 15% of all cancer diagnoses and 71% of all lung cancer diagnoses in Ontario annually.[11, 15-16]
- From 2007 to 2013, approximately 49.8% of rural First Nation and 42.7% of urban First Nation adults age 20 and older in Ontario smoked daily or occasionally; however, it is noted that the prevalence of smoking within urban First Nation adults decreased during these years.[10-11, 15-16] In comparison, 21.7% of the non-Indigenous population smoked either daily or occasionally. [10-11, 15-16]

- Second-hand smoke is also a significant issue, First Nations, Métis, and Inuit populations within Ontario were observed as sometimes having a 2 – 4 times greater exposure than the non-Indigenous population. [10-11, 15-16]

Scoping Reviews

Engagement Practices and Models of Engagement

The results were divided into two sections: principles with associated practices; and models of engagement.

Indigenous-Public Health Principles and Practices

The reviewed literature outlined several frequently cited principles and practices, many of which are interconnected, that help in forming partnerships[1], building mutually respectful relationships[24] or guiding effective engagement[25] between Indigenous and non-Indigenous Peoples, organizations and communities. Historical events, adverse experiences, and the impacts of colonization and suppression have significantly contributed to the importance of these principles[3]. The following principles and associated practices were frequently cited:

Respect: Respect encompasses many elements including honouring, acknowledging, understanding, and appreciating history, present context, cultural practices, traditions, protocols, lands, diversity, knowledge, and worldviews.[26] Practices include respecting the autonomy of each community, and completing cultural safety, human rights and/or anti-racism training.

Trust: Trust involves being open to talking, listening and learning from each other.[27] Building trusting relationships takes time.[26, 28] Practices include early engagement and ongoing communication and commitment.

Self-Determination: Self-determination acknowledges that Indigenous Peoples have the inherent right to choose their own pathways and make decisions about all aspects of their communities.[1, 29-30] Practices include Indigenous communities leading or being authentically engaged in decision-making processes that impact Indigenous Peoples or communities and involvement in health planning.

Commitment: Commitment involves ongoing long-term engagement.[26, 31] Practices include maintaining an expectation of meeting again and continuously working together, and purposeful Indigenous hiring.

Accountability: Accountability involves producing tangible outcomes or actions from engagement.[31] A lack of action or tangible results after consultation may harm relationship building.[27, 32] Practices include reporting back on the results of consultations and developing performance measurements with Indigenous organizations to evaluate the organization's relationship with Indigenous Peoples.

Honesty and Transparency: Honesty involves being able to have a clear and open discussion and transparency involves being forthright and sharing relevant information.[1] Practices include

being upfront about expectations, intentions, resources or any limitations, and being critical of one's own motivations for engagement.

Reciprocity: Reciprocity involves the practice of exchanging things (tangible or intangible) with others for mutual benefit.[1,25] In engagement, "we should offer something, not only ask."[33] Practices include reciprocal learning and offering compensation, honorarium, travel assistance or other appropriate remuneration for Indigenous partners that are sharing their knowledge and time.

Humility: Humility involves being humble in one's knowledge and being open to listening, learning, and trying to understand another's experience.[27, 33] Practices include recognizing that communities hold unique knowledge, teachings, strengths and capacities, and being interested to learn and ask questions about communities.

Flexibility: Being flexible involves being adaptable and accommodating with meeting agendas, approaches to programming and timelines.[26, 34] Practices include listening and learning without an agenda or expectations in mind, providing options for program delivery, and adjusting timelines for meetings.

Models of Engagement

Four Ontario public health units and one First Nation's regional health authority, each with well-documented relationships, were examined to better understand how they are engaging, who is involved in Indigenous engagement, what their role is, and what is in place to support engagement.

Among the five organizations, several similar and unique practices were identified that had been developed by or with Indigenous partners to create respectful relationships. Similar practices included the creation of Indigenous engagement strategies, Indigenous health strategies and action plans. All four of the public health units also engaged with committees composed of Indigenous representatives. The composition and purposes of the committees varied by local region, along with the roles and responsibilities of each participating individual or organization. Other practices, some of which were unique to specific organizations included:[30]

- Indigenous representation on the board of health.
- Indigenous community representation on an advisory group or Indigenous advisory committee.
- Formal written agreements such as a Section 50 agreement under the *Health Protection and Promotion Act* or a memorandum of understanding.[1]
- Informal or unwritten agreements.
- Organizational commitment statements.
- Land acknowledgements.
- Purposeful Indigenous employment.

- Having a lead who works across teams to support engagement with Indigenous communities.
- Cultural awareness/competency/safety training.
- Policies or guidelines for engaging with Indigenous communities.
- Consideration of the needs of Indigenous communities in strategic planning or program planning.
- Translation of resources and publications into Indigenous languages.
- Providing internal updates to staff on First Nation community engagement.
- Communicating with First Nation communities to provide updates on public health activities.

In summary, this report provides a synthesis of frequently cited principles and practices in the reviewed literature that help in building mutually respectful relationships between Indigenous and non-Indigenous organizations, as well as examples of models of engagement. This information can be used by SMDHU to increase its knowledge of documented principles, practices and models of engagement while looking forward to learning and understanding the preferred principles, practices and relationships of local Indigenous communities in Simcoe and Muskoka in the next phase of its learning journey towards culturally safe practice.

Government Jurisdictional Considerations

The health system that supports Indigenous Peoples is described as a "…complex patchwork of policies, legislation and relationships",[35] particularly in relation to Métis, Inuit, and urban Indigenous Peoples. This has resulted in some lack of clarity around accountability and responsibility for some areas of health care provision for Indigenous Peoples, including primary care, public health and health promotion services between the federal and provincial governments.[36]

Federal

The federal government's delivery of health care services to First Nation communities currently occurs through Indigenous Services Canada's (ISC) First Nations Inuit Health Branch (FNIHB). The FNIHB mandate utilizes the principles and pillars of the 1979 Indian Health Policy[37] to:

- Ensure the availability of, or access to, health services for First Nation and Inuit communities.
- Assist First Nation and Inuit communities with addressing health barriers and disease threats and attain health levels comparable to other Canadians living in similar locations.
- Build strong partnerships with First Nation and Inuit Peoples to improve the health system.[38-39]

The FNIHB offers funding to First Nation communities for health promotion and disease prevention, public health protection including environmental health, communicable disease

control and immunization, primary care services, supplemental health benefit coverage (for goods and services not provided through provincial health programs or private insurance plans) and health infrastructure support including community health planning;[40-41] however, the public health programming available through FNIHB is not as comprehensive as what is mandated throughout Ontario by the Ontario Public Health Standards via local public health units. Also, the FNIHB does not cover the provision of health care services for Métis communities, non-status and urban Indigenous Peoples and doesn't clearly articulate whether Inuit Peoples are included.[42]

The Indian Health Policy led to the creation of the Health Transfer Policy Framework[43] in 1989 and later the Health Services Integration Fund (HSIF)[44-45] in 2010. The fund's key objectives are to improve the integration of and access to federal and provincially funded health services and increase the participation of First Nations, Inuit and Métis Peoples in the design, delivery, management and evaluation of health programs and services in First Nation communities.

Indigenous Services Canada initiated the Urban Programming for Indigenous Peoples (UPIP)[46] program in 2017 to assist First Nation Peoples (status and non-status), Inuit and Métis with living in or transitioning to living in urban centres and support organizational capacity building, programs and services for vulnerable populations, local coalition development and research and innovation. The program includes funding for Friendship Centres, Métis Nations and Inuit. There are no organizations, projects or coalitions funded in Simcoe Muskoka through the UPIP program at this time.[46]

From 2020 to 2021, ICS focused on several priority areas, one of which was to improve health outcomes with a focus on public health-related issues, including developing a tuberculosis reduction plan, addressing food insecurity in First Nation communities, promoting mental wellness, investing in social service infrastructure, and implementing Jordan's Principle[47] to ensure that First Nations children have access to the health, social, and educational supports and services they need, when and where they need them. Jordan's Principle is a child-first principle aimed to eliminate service inequities and delays for First Nations children living in Canada. It states that First Nations children can access the products, services and supports they need, when they need them without delay or denial due to jurisdictional funding issues. The principle means that the wellbeing and safety of the child must be the paramount consideration in resolving jurisdictional disputes – the child must come first before the needs of governments in all instances.[47]

In January 2021, ISC initiated a national consultation[48] with First Nations, Inuit, and Métis Nations in preparation for co-developing distinctions-based Indigenous health legislation. A distinctions-based approach is intended to ensure that the unique rights, interests and circumstances of First Nations, Inuit and Métis are acknowledged, affirmed and implemented by working together to offer the opportunity to establish overarching principles for health services, support the transformation of health service delivery through collaboration with Indigenous

Peoples, provinces, territories and affiliate organizations, and advance the Government of Canada's commitment to reconciliation. This consultation process is ongoing.

In response to the COVID-19 pandemic, ISC offered the Indigenous Community Support Fund (ICSF) up to March 2023 as part of the federal COVID-19 Economic Response Plan.[49-50] The ICSF was intended to support First Nations, Inuit, Métis and urban Indigenous communities and Indigenous organizations with developing and implementing community-based solutions to prevent and respond to the spread of the COVID-19 virus.[51] Several local communities and organizations received ICSF funding as identified on the ISC website.

Provincial

In Ontario, the first key legislation to consider public health services to Indigenous Peoples was the *Health Protection and Promotion Act* (HPPA) of 1990.[52] This Act includes a section (Section 50) that allows boards of health to enter into an agreement with local band councils regarding the provision of public health programs and services to members of the band. This includes the appointment of a band representative to the board of health. In turn, the band council would agree to accept the responsibilities similar to that of a municipality with the health unit. As an example, a Section 50 agreement was established between Peterborough Public Health[53] and Curve Lake First Nation in 1998 and Hiawatha First Nation in 2007. Both First Nations have representation on Peterborough Public Health's Board of Health.[53]

In 2018, under Section 7 of the HPPA, the Ministry of Health updated the Ontario Public Health Standards (OPHS), which set out the provision of mandatory public health programs and services in Ontario. Included with the revised OPHS was a new *Relationship with Indigenous Communities Guideline.*[1] Written by the Public Health Working Group of the Trilateral First Nations Health Senior Officials Committee (TFNHSOC), this guideline offers guidance to public health units on forming meaningful relationships with Indigenous communities that come from a place of trust, mutual respect, understanding and reciprocity. It indicates several types of relationship models that can be explored. For First Nation communities, this ranges from strengthening relationships between Indigenous communities and boards of health, to shared delivery of public health services, to informal agreements and/or memorandums of understanding (MOUs), to formal agreements (e.g., HPPA Section 50). For urban Indigenous organizations, this may include an informal arrangement, referral relationship, collaboration or formal partnership.

The Ontario Aboriginal Health Policy[54] was established in 1994 (renamed the Aboriginal / Indigenous Healing and Wellness Strategy[55] in 2014) to offer a network of programs and supports both in First Nation communities and for the urban Indigenous population to provide:

- Healing, health and wellness services (e.g., health navigators and community wellness workers).
- Mental health and addictions services and supports.

- Supports for individuals experiencing or at risk of experiencing violence.
- Pre-natal, post-natal and early years support (i.e., Indigenous Healthy Babies, Healthy Children Program, and the Maternal and Child Centre).
- Supports for Indigenous communities and organizations (e.g., community development support workers, health policy analysts).[55]

This strategy is funded by the Ministries of Children, Community and Social Services (lead ministry), Health, and Indigenous Affairs. The strategy has resulted in the creation of Aboriginal Health Access Centres (AHAC) / Aboriginal Community Health Centres (ACHC) across the province. As such, opportunities for local collaboration exist between public health units and AHACs / ACHCs and other primary care services (an example in Simcoe Muskoka is Mamaway Wiidokdaadwin Primary Care Team) to offer health promotion and disease prevention programs.[56]

In 2013, the Ministry of Children, Community and Social Services engaged with representatives of First Nations, Inuit, and Métis communities, as well as Indigenous service providers to develop the Ontario Indigenous Children and Youth Strategy (OICYS). This strategy is intended to improve services to better meet the needs of Indigenous children and youth and enable Indigenous communities and service providers to have greater authority over child and family services.[57]

In 2018, the Urban Indigenous Action Plan was developed by the provincial Urban Indigenous Health Table to support reconciliation between urban Indigenous communities, the provincial government, and the broader public service. The action plan includes the four key action areas of relationship building, policy engagement and co-development, service planning, design and delivery, and evaluation. Public health is noted under the action area of service planning, design and delivery whose aim is to ensure that Indigenous and non-Indigenous organizations, service providers and governments are partners in policy and program design and delivery and that services are accessible, person-centered, culturally rooted and delivered in safe, culturally sensitive environments.[58]

In response to the COVID-19 pandemic, the provincial government worked with Indigenous partners to develop a mass immunization plan for First Nations, Inuit and Métis Peoples, encouraging partnerships between local Indigenous organizations and public health units to address local community needs.[59] An overview of the local response to the COVID-19 pandemic is included in other sections of this report.

Local

Mapping of local Indigenous health care programs and services took place in 2006 by the North Simcoe Muskoka Local Health Integration Network (LHIN) (now knowns as Ontario Health Central Region) on behalf of the Ministry of Health and Long-Term Care, and again in 2016 by the Barrie Area Native Advisory Circle (BANAC) on behalf of the Ministry of Children and Youth

Services' (MCYS) Ontario Indigenous Child and Youth Strategy. The 2006 report[60] provides an overview of the local Indigenous health care system including programs and services, and highlights funding sources, gaps and barriers, planning priorities, and opportunities for integration and coordination. The 2016 report offers a series of recommendations under five themes aimed to enhance the programs and services being provided to Indigenous children and youth in Simcoe County and Muskoka District.[17] Under the theme of "Community Capacity" (most relevant to public health), the recommendations highlighted the importance of the MCYS taking the lead to:

- Provide annualized, stable and properly resourced funding to Indigenous agencies supporting families.
- Move funding to local Indigenous organizations to offer Indigenous-focused programs and services.
- Address transportation issues (e.g., subsidize travel costs to programs and services).
- Include poverty reduction strategies addressing food security, housing, continued education and employment as part of the ICYS.
- Offer prevention and early intervention opportunities (e.g., create an Indigenous Family Hub, hiring of Indigenous workers in the early years sector).[17]

Within Simcoe Muskoka, many urban Indigenous organizations provide prevention and health promotion programming for Indigenous Peoples living in the broader community. These organizations include an Indigenous primary care team (Mamaway Wiidokdadwin), a Community Health Centre with Indigenous populations as an area of focus (Chigamik), Friendship Centres, local Métis Councils and local chapters of the Ontario Native Women's Association. Friendship Centres are funded by various provincial ministries as the programs and services offered address health, social, and economic needs and issues.[61]

Currently, health programming and services in local First Nation communities is supported by both federal and provincial governments. The delivery of federally funded programs is dependent on whether programs and services are federally funded and community delivered or federally funded and federally delivered based on the HSIF agreement that is in place (e.g., fully independent with health staff employed by the First Nation Band; partially independent with nursing stations staffed by federal employees). Provincially funded programs through the Indigenous Healing and Wellness Strategy are offered through provincial organizations such as the Union of Ontario Indians and the Association of Iroquois and Allied Indians where each First Nation is invited to self-govern these programs.[57] As such, the implementation of federally and provincially funded health programs varies greatly across First Nation communities. Some of the health services being offered in the four First Nation communities locally include the following:

- Chippewas of Rama First Nation provides public health programming independently, with support from SMDHU when needed and as requested by the community. Community members can access health care services and programs from both their

community and from non-Indigenous health care providers located in the broader community.

- Beausoleil First Nation employs a Community Health Nurse who offers primary and community health care including immunizations. Community members can also access health care services and programs from other non-Indigenous health care providers located in the broader community.
- Moose Deer Point First Nation and Wahta Mohawks First Nation are smaller communities and have nurses employed by the federal government who visit once or twice per month for one or two days delivering public health programming (e.g., well-baby visits). Indigenous community members can receive primary care from the nurse practitioner through the West Parry Sound Health Centre Rural Nurse Practitioner-led Clinic (Moose Deer Point) or the Muskoka Community Health Hub - Wahta Site or by non-Indigenous health care providers in the broader community.

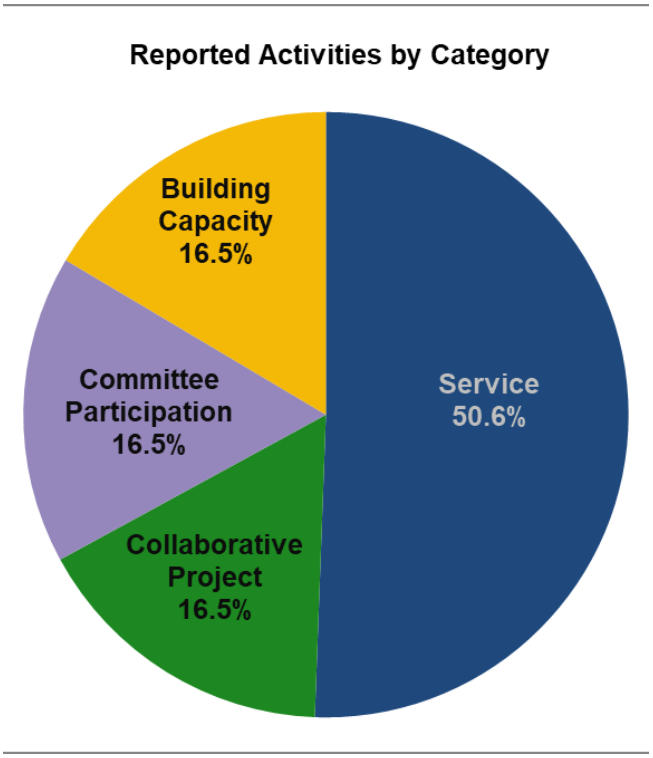
SMDHU Environmental Scan

The environmental scan survey was conducted in October 2018. Of the 31 surveys sent to supervisors, managers, vice presidents (formerly called directors) and the MOH office (the medical officer of health, the associate medical officers of health, and the chief nursing officer), 26 were completed for an overall response rate of 84%. The 26 surveys completed represented 34 managers, co-managers, supervisors, vice presidents and MOH office members. There was a higher response rate among program managers and supervisors (95%) compared to vice presidents and the MOH office (60%). Survey results are summarized below according to the objective they inform.

Objective #1: Experience working and/or partnering with Indigenous Peoples or communities

There were 85 unique activities within the last five years identified across four categories. The majority of activities were categorized as service (n=43, 51%), while the remainder were split equally across the remaining three categories (n=14, 17%, each).

Figure 1 Proportion of activities, classified by category



Service: requests for services, presentations, workshops, material distribution, screening and other service activities.

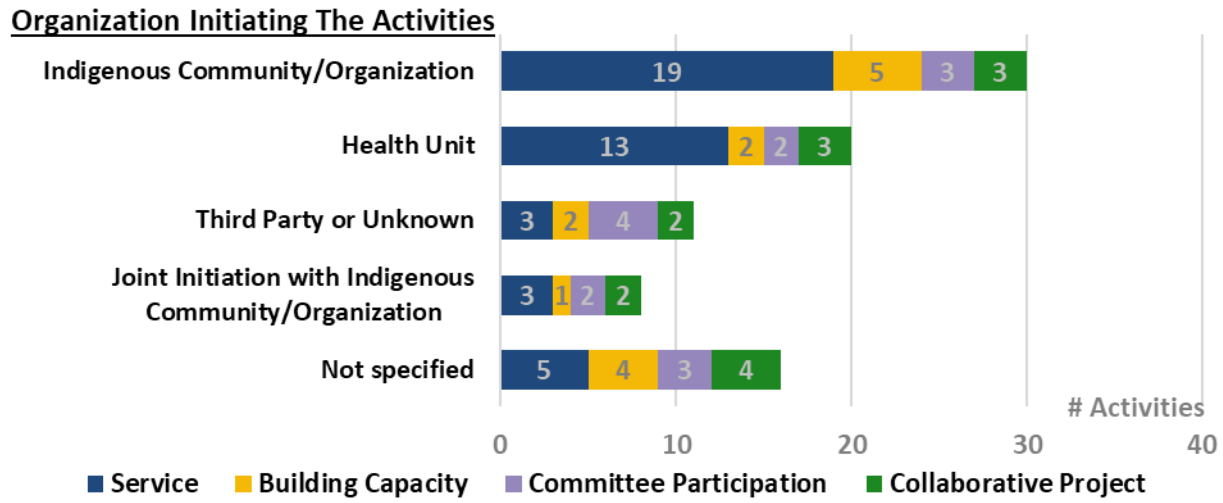
Building Capacity: activities where SMDHU staff support professional development of Indigenous health staff or volunteers, or vice versa, including exchange of information and resources.

Committee Participation: activities where SMDHU staff participate in committees, workgroups or similar with Indigenous partners.

Collaborative Project: activities where SMDHU staff and Indigenous organizations partnered, including applying for grants, developing resources, and completing tasks.

Roughly one-third (n=30, 35%) of these activities were initiated by Indigenous communities or organizations, a quarter were initiated by SMDHU staff (n=20, 24%), 19 (22%) were initiated either in collaboration between SMDHU and Indigenous communities and organizations, or by external parties (e.g., LHIN), and 16 (19%) did not identify an initiating organization. Activities initiated by Indigenous organizations or communities were largely (n=19, 63%) one-time requests for service, activities initiated by the health unit were also predominantly service (n=13, 65%) and included both one-time and ongoing services. Activities initiated by external organizations were most commonly committee participation (Figure 2).

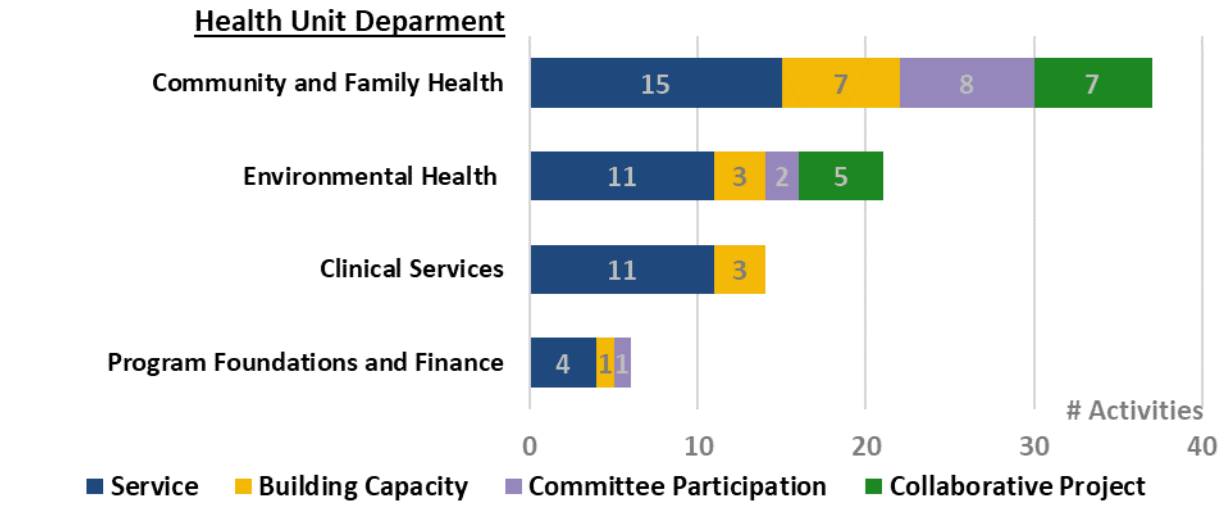
Figure 2 Activities by initiating organization or organization type, classified by category.



The Community and Family Health Department (CFH) identified the largest number of activities (n=37, 44%), followed by the Environmental Health Department (EHD, n=24, 25%). Community and Family Health staff were involved in the largest number of committees, capacity building activities and collaborations (**Error! Reference source not found.**).

Activities in these departments were initiated evenly by the health unit, Indigenous communities and organizations and other organizations. Indigenous communities or organizations initiated the majority of activities identified by Clinical Services Department (CSD, n=10, 91%) and Program Foundations and Finance Department (PFF, n=4, 67%).

Figure 3 Activities by health unit department, classified by category.



Relationships with 20 Indigenous partners were identified, including First Nations, Indigenous health programs, Indigenous programs within other organizations, and women's groups (see

Management Survey Report Table 2 for a list of organizations and the activities the health unit was involved in with them). These activities represented relationships with almost all the local Indigenous organizations and communities in the SMDHU area.

Objective #2: Number of staff with formal cultural awareness, sensitivity or safety training

Thirty-eight percent (n=11/34) of supervisors, managers, vice presidents and the MOH office had received or were planning to receive formal Indigenous-specific training. Among staff, only 7% (n=23/311) were reported to have received such training as of October 2018 when the survey was conducted. Training had been taken through a range of organizations including the Barrie Area Native Advisory Circle (BANAC), Cancer Care Ontario (CCO), the San'yas Indigenous Cultural Safety Training Program, the First Nations Information Governance Centre, the University of Alberta, Enaahtig Healing Lodge and the Simcoe County District School Board.

Informal Indigenous-specific cultural training was provided through department in-services to all programs, excluding Human Resource and Infrastructure who did not participate in the management survey. Supervisors, managers, vice presidents and the MOH office also reported additional informal cultural safety training opportunities attended by themselves or their staff including webinars, conferences or workshops (n=11), Nursing Practice Day 2018 with a special focus on Indigenous-specific cultural training (n=5), and guest speakers at team meetings (n=4).

Objective #3: Number of staff with formal anti-oppression and anti-racism training

Out of 34 survey respondents (from supervisors, managers, vice presidents and MOH office), 9% (n=3) reported they had or planned to receive formal anti-oppression and anti-racism training. No formal training was reported for any staff. One-third of respondents (n=11) reported they or their staff had received informal training via conferences, and fewer than five reported informal training for themselves or their staff at webinars, in-services or guest speakers at team meetings.

In summary, the findings of the survey identified several activities the health unit had worked and/or partnered with Indigenous communities and organizations within the five years prior to October 2018. The majority were identified as services and were predominantly initiated by Indigenous communities and/or organizations. The Community and Family Health Department identified the largest number of activities. It is unclear which activities were current as of the time of survey completion. The survey also showed that a higher proportion of management had completed formal Indigenous cultural awareness, sensitivity or safety training compared to staff. All participating departments reported informal Indigenous cultural safety training at in-services. Anti-oppression and anti-racism training was reported by very few management or staff. Informal and formal training was reported from a variety of courses, organizations and formats. Department in-services were a good opportunity for informal training. The most reported formal training was Cultural Awareness Training provided by BANAC.

Consultations

SMDHU Staff Consultations

A total of 30 staff participated in the staff consultation that took place in the spring of 2019, including 21 who attended one of the three in-person events and nine who provided responses only to the survey.

Questions 1 & 2: Facilitators and challenges to building and sustaining relationships

Participants were asked what worked well and not so well when building and sustaining relationships with Indigenous partners. Key facilitators and challenges are outlined in Table 1. Many of the identified facilitators helped to overcome the identified challenges. For example, respondents highlighted that it can be difficult to step back from our default role of being directive and presenting as an expert, but that being prepared to listen and learn and to engage in reciprocal sharing with Indigenous partners can open the door to more productive engagement.

Table 1 Facilitators and Challenges to Building and Sustaining Relationships

Facilitators	Challenges
Building upon existing staff and external partner relationships with Indigenous partners. Engaging on topics that are a priority of the Indigenous community, including engaging early and allowing Indigenous partners to take the lead. Being flexible with the agenda and typical health unit work processes (i.e., one's priorities and expectations). Being open to listening to and learning from Indigenous partners. Having patience and taking time in building relationships with Indigenous partners. Inviting Indigenous representation on non-Indigenous organizations' committees or board of directors or asking Indigenous partners the best way to engage.	Presenting as an expert. Working within fixed health unit work processes and workplans. Learning about the range of public health priorities and processes between the community health office, schools, the Chief and Council, and members of the community in First Nation communities. Health unit staff navigating federal and provincial jurisdictional boundaries when providing services.

Additional topics identified included the importance and challenges of maintaining consistent connections between the same contacts within organizations, organizing face-to-face contact which may require work outside of core health unit hours, and acknowledgement of the historic mistreatment of Indigenous communities by governments which has led to a lack of trust.

Question 3: Cultural or organizational practices

Participants reported several cultural or organizational processes they had observed that should be considered by the health unit when interacting with Indigenous partners and communities. These included:

- Practices such as smudging ceremonies, traditional healers, passing of the feather, healing blankets, gifting of traditional tobacco, introductions, and land acknowledgements.
- Being sensitive to cultural practices when delivering public health messages (e.g., tobacco-free living and sacred tobacco).
- Diversity between First Nation communities and individuals within Indigenous communities.
- Broader perspective on what constitutes valid and reliable evidence.
- Greater flexibility or fluidity of time.

Participants expressed an interest to better understand the meaning behind practices and processes, what to expect and how to behave and respectfully participate.

Question 4: Assets and strengths

Participants were asked to describe the assets or strengths they observed while working with Indigenous partners. Several key themes emerged:

- Sense of community and social connectedness
- Knowledge of community
- Wholistic approach to health
- Use of storytelling.

Respondents noted that the strong social connectedness within Indigenous communities extended to a willingness to build relationships and help those in need. Discussions also highlighted resiliency, environmental stewardship, the importance of traditional ecological knowledge and respect for community members, especially Elders, as additional strengths within Indigenous communities. Notably, some participants identified a desire for training on how to incorporate storytelling into health unit work.

Question 5: Recommendations for next steps

Participants were asked for recommendations on next steps to inform the development of an agency-wide strategy to enhance relationships and engage with local Indigenous partners

and/or communities. Drawing on the facilitators and challenges, practices, assets and strengths outlined above, the following key recommendations were suggested by staff:

- Provide Indigenous cultural safety training to all health unit staff, including anti-oppression and anti-racism training, with a focus on extensive, ongoing education and how to apply this training in working with local Indigenous communities and partners.
- Develop staff understanding of local Indigenous communities, cultural practices, and governance structures.
- Develop staff understanding of public health-related jurisdictional issues, specifically including Jordan's Principle.[25]
- Create greater staff awareness of existing relationships between Indigenous partners and health unit staff.
- Consider an Indigenous Liaison position to facilitate engagement between health unit staff and Indigenous First Nation communities and urban Indigenous Peoples.
- Consider Indigenous representation on the Board of Health and staff committees and hiring of Indigenous staff.
- Focus on Indigenous-led strategy development, for example working with an Indigenous advisory council or committee and involving Indigenous staff within the health unit.
- Incorporate flexible agency work processes, including flexibility with policies and with time.

Additional next steps discussed by participants included further understanding of the health unit's role in answering the Calls to Action from the Truth and Reconciliation Commission,[62] having access to culturally-informed resources, being conscientious when accessing or reporting on data which identifies Indigenous populations, having consistent and intentional engagement with partners, approaching from a place of learning not teaching, and prioritizing capacity to respond to requests for service (RFS) or opportunities to engage with Indigenous communities and partners.

In summary, several key themes emerged during the staff consultation and were reflected in discussions of facilitators and challenges to engagement, cultural and organizational practices, assets and strengths of Indigenous communities and in recommendations for next steps.

Staff feedback suggested that building and maintaining respectful and consistent relationships with Indigenous communities and organizations can facilitate engagement and help the health unit to understand community priorities, but staff turnover can create challenges. Additionally, the health unit could focus on responding to the needs and priorities of local Indigenous communities, rather than trying to fit within health unit priorities and practices. The health unit could also adapt policies and procedures to allow more flexibility in both practice and availability of health unit staff to meet the needs of Indigenous communities and Indigenous partners. Finally, health unit staff could approach engagement with a goal of self-reflective practice, listening and learning, rather than a goal of educating. As part of our learning journey, we as individuals and as an organization need to be open to learning how best to engage with Indigenous partners in intentional, respectful and appropriate ways.

Indigenous Partners and Communities Consultations

Key results from the eight engagement sessions with 40 Indigenous partners, in which partners provided feedback about their perceptions of SMDHU, identified priorities and gaps in public health services for Indigenous Peoples, and gave suggestions for future public health actions are listed below.

Perceptions

- Most participants were generally unaware of the services and programs available through SMDHU.
- Participants identified there have been few opportunities to engage with SMDHU or to define what programs and services may be beneficial to their Indigenous communities and organizations, and uncertainty about how to access SMDHU programs and services.
- SMDHU is sometimes viewed as a monitoring agency rather than a service provider.
- Overall, those who have worked with SMDHU have had positive experiences.
- Several health unit programs were identified as being accessed, with the Healthy Babies Healthy Children program and tobacco cessation services identified most often.

Priorities and Gaps

- Empower and provide support
    - Support community-identified opportunities for capacity building to create changes that will support better health (attitudes, behaviours, systems).
    - Provide access to immunizations/vaccinations.
    - Provide access to clean needles, ways to dispose of used needles.
    - Offer support to develop emergency preparedness management plans and determine designated responsibilities of SMDHU.
    - Support the development of Indigenous community health plans and resource them where possible.
    - Support local community health programs and initiatives.
- Communicate
    - Continue the health unit's learning journey with open and honest communication.
    - Co-develop and communicate an easy approach to navigate health unit programs and provide support to Indigenous individuals to navigate the health unit programs and services (e.g., continue to offer presentations about SMDHU services). Identified priorities for system navigation were substance use, chronic diseases, vector borne diseases, clinical services/sexual health, and immunization.
    - Co-develop and deliver communication, education/awareness workshops on specific topics (e.g., immunization, substance/opioid use).

    - Appoint SMDHU staff to a dedicated liaison role for each community and organization.
    - Provide information and easy access to resource templates for modification and tailoring for Indigenous communities and population.
    - Develop resource list of Simcoe Muskoka community programs and services to share with communities and organizations.
- Engage
    - Facilitate meetings with communities and organizations to identify and share knowledge and resources and ensure there is no overlap in the delivery of services.
    - Create engagement and relationship opportunities between SMDHU staff and people from Indigenous communities and organizations to build trust.
    - Support presence of public health nurses (PHNs) within Indigenous communities and organizations.
    - Ensure a transition/exit strategy is in place when staff who have built relationships with communities and organizations leave their positions.
- Advocacy and allyship
    - Ensure SMDHU and affiliated organizations are inviting and inclusive of Indigenous populations, and services have an Indigenous perspective and understanding of distinctness of communities.
    - Advocate and be a voice to push for and ensure policy changes that will help to fill the service gaps and halt the jurisdictional conflicts.
    - Continue SMDHU Indigenous awareness and cultural safety training and make it part of annual performance reviews.

Recommendations for Consideration

The results of the consultations identified eight key actions for SMDHU to consider. Three were noted as being more immediate actions that SMDHU could implement with fewer resources or time:

1. Continue our learning journey with open and honest communication to build and/or strengthen meaningful relationships with the Indigenous communities and organizations ensuring the services SMDHU offers are known, accessible and culturally appropriate.
2. Provide information/resources that outline health unit programs and services and that include other community resources relevant to the work of public health.
3. Ensure all health unit staff complete cultural safety training to assist them in understanding the needs of the Indigenous populations, overcome any bias as well as avoid creating triggers of trauma.

Five actions were identified that would require more resources and time to implement:

4. Work with Indigenous communities/organizations to develop a systems navigation structure to help people understand the services provided as well as how people can access them.
5. Ensure programs, services and spaces are inclusive of the Indigenous perspective and are culturally safe as well as relevant.
6. Advocate in collaboration with Indigenous Peoples by being a voice to push for and ensure policy and structural change that no longer continues to marginalize Indigenous Peoples and that supports culturally appropriate services and spaces.
7. Ensure that once the relationship is built that it is sustained and supported.
8. Initiate and support capacity building within each community and organization as well as assist in the coordination and facilitation amongst communities and organizations of health-related services.

In summary, the findings of the Indigenous partner and community consultation sessions highlighted:

- The overall perception of the SMDHU was positive with interactions to date being identified as very respectful.
- Many services provided by SMDHU were unknown.
- Good relationships with some communities and organizations have been created and maintained by SMDHU staff.
- Indigenous communities and organizations are interested in continuing to engage with SMDHU.
- Although communities and organizations may have similar needs that can be addressed as a collective, some needs should be addressed on a case-by-case basis.
- There is much work to be done in the building and/or strengthening of the partnerships and relationships with the Indigenous population including identifying specific needs and services with each individual community and organization.
- Health unit initiatives can be improved to be culturally and community appropriate and meet the needs of the Indigenous population.

COVID-19 Indigenous Engagement Activities

Several pandemic-related outreach and engagement activities took place beginning in April 2020 with both First Nation communities and urban Indigenous organizations. Initial engagement activities focused on identifying COVID-related issues and concerns by First Nation communities and urban Indigenous organizations and identification of supports the health unit could offer to assist in addressing them. This engagement facilitated the development of ongoing collaboration and communication efforts with both First Nation

communities and urban Indigenous partner agencies that included the health unit, resulting in the following activities:

- Responding to requests for support in relation to client case management including assessment, screening and testing, accessing resources (e.g., personal protective equipment), developing and sharing key messages and/or promotional communication resources, and implementing public health measures.
- Inviting Indigenous partner participation on the Simcoe Muskoka COVID-19 Vaccination Advisory Committee.
- Inviting Indigenous partner participation on the health unit's Regional Vaccination Planning Task Groups.
- At the request of urban Indigenous organizations, chairing the COVID-19 Urban Indigenous Vaccination Strategy Working Group to plan and coordinate vaccine promotion and Indigenous community vaccination efforts. This included planning and implementing many Indigenous-focused vaccination clinics in various locations.
- Ongoing communication through such activities as sharing of Indigenous-specific COVID-19 updates with First Nation communities and the Indigenous Health Circle and sending general updates (e.g., Public Health Alerts, Partner Updates) to all key local partners.

Reflecting on lessons learned, health unit staff identified that there were varying degrees of initial engagement when COVID-19 emerged, particularly with First Nation communities as these communities and urban Indigenous partners were very busy, and some relationships with the health unit were in the early stages of development. Each First Nation community and urban Indigenous organization were unique with varying levels of resources and staffing to support ongoing vaccination promotion and clinics. As a result, a variety of strategies were undertaken to engage with Indigenous communities and organizations including established groups (i.e., Indigenous Health Circle), groups that emerged because of COVID-19 (i.e., COVID-19 Indigenous Leadership Group), and the health director/staff and community leadership of each First Nation community.

Other key lessons learned by the health unit included the importance of Indigenous-led and consensus decision making on key issues as well as the importance of respecting and honouring Indigenous practices and knowledge (e.g., vaccination clinic opening ceremony that included a blessing of the vaccine at each clinic). Health unit medical directives were modified to

reflect the needs of local Indigenous communities (e.g., decision to prioritize the vaccination of urban Indigenous household members when eligibility criteria were restricted to only Indigenous Peoples and adapting the process for demonstrating proof of Indigenous identity at clinics). Fears of and barriers to vaccination were quickly and effectively addressed (e.g., preference for offering the Pfizer vaccine). In addition, health care providers and staff from urban Indigenous organizations and communities supported clinic promotion (e.g., broad promotions and targeted phone calls to clients to address vaccine hesitancy concerns), clinic coordination (e.g., contacts to assist community members with booking appointments) and clinic operations (e.g., involvement in all aspects of service delivery with leadership roles) and facilitating vaccine uptake. The planning and implementation of clinics built on existing relationships between Indigenous organizations and their history of working together.

Regarding communication, all updates, correspondence and meetings offered by the health unit seemed to be appreciated. Indigenous partners who received this communication reported they shared the information with members of their respective organization, networks and communities as appropriate. Health unit staff reported that representatives from First Nation communities appreciated having ongoing contact with a health unit liaison and participating in networking meetings hosted by the health unit liaison. Representatives from the urban Indigenous community appreciated participating on a vaccination strategy working group to plan and implement a vaccination strategy and felt that communication was direct, timely and informative.

In summary, First Nation and urban Indigenous communities were engaged in COVID-19 case management and vaccination promotion and implementation strategies in partnership with health unit staff. The involvement of First Nation communities and urban Indigenous community leaders and organizations in equitable partnership with SMDHU, including within the decision-making process and implementation of vaccination clinics, was pivotal in increasing the acceptability and cultural safety of the clinics and in turn likely increased the rate of vaccination within this population group. The process of shared leadership and consensus decision-making helped to build understanding and trust between partners and aided in addressing systemic barriers of fear and vaccine hesitancy for some Indigenous community members stemming from existing mistrust of the health care system and government. This work highlights the importance of meaningful partnerships with Indigenous communities and organizations in decisions that affect their communities, as well as dedicated resourcing of this population-specific work. This leads to better, more equitable outcomes and further opportunities for future collaboration.

ANALYSIS

Findings from the individual components of the situational assessment activities were reviewed, synthesized and analyzed together to answer the question:

> What does SMDHU need to know to inform the agency of how to proceed with building and maintaining meaningful engagement and mutually desired collaborative working relationships with Indigenous Peoples, organizations and communities in Simcoe Muskoka?

Methodology

The Indigenous Engagement Working Group (IEWG) conducted an analysis of the summarized findings using a virtual whiteboard exercise with the online tool Padlet. Group members reviewed the Indigenous demographic and health status data and the individual situational assessment reports. For efficiency purposes, each member was assigned specific components from which to pull key points and enter them into the online whiteboard and to identify broad themes as they emerged. Themes and key points were then reviewed independently by the IEWG members.

The IEWG then met as a group to synthesize the key findings. At its first meeting, the group identified that the high-level themes and the key learnings from the situational assessment reports aligned well with the five guiding relationship principles identified in the OPHS *Relationships with Indigenous Communities Guideline:*[1] Relationship Building; Recognition, Respect and Mutuality; Self-Determination; Timely Communication and Knowledge Exchange; and Coordination. The group chose to use these principles as categories under which to theme the key learnings. In this way, a direct connection could be established between the key points from the situational assessment analysis and the principles of engagement embedded in the guideline.

Once the synthesis of the data was completed, a deeper analysis of the themed points was conducted by the IEWG for the purpose of identifying possible future actions the health unit could take to build and maintain meaningful engagement and mutually desired collaborative working relationships with Indigenous Peoples and communities in Simcoe Muskoka. When this was completed, further discussion took place with all members (core and ad hoc) of the IEWG to develop the recommendations that would be included in this report for a longer-term Indigenous engagement strategy for SMDHU.

Findings

As stated above, findings from the analysis were grouped and themed under the following five guiding relationship principles identified in the OPHS *Relationships with Indigenous Communities Guideline:*[1] Relationship Building; Recognition, Respect and Mutuality; Self-Determination; Timely Communication and Knowledge Exchange; and Coordination (see pgs. 16-17 of the Guideline for definitions of each principle). This section contains a summary of the

synthesis and analysis of the situational assessment components that apply to each principle, and their potential impacts on SMDHU.

Relationship Building

Foundational to building relationships with Indigenous Peoples, organizations and communities is the intention behind that process and that relationships are formed from a place of respect, trust, recognition and openness. For SMDHU, this means the intentional incorporation of these, and all other engagement principles identified through the *Engagement Principles and Models of Engagement Scoping Review,* in the relationship building process. These principles are the contextual foundation upon which practices and/or models of engagement between Indigenous populations and Ontario public health units are successfully built. Relationship building with Indigenous communities takes place at the system, program and individual level, and different levels within the organization will have different roles to play (i.e., Board of Health, Medical Officers of Health, Vice Presidents, Managers, Staff).

To achieve authentic relationships with Indigenous Peoples, organizations and communities, the health unit could consider the way we plan, implement and deliver our programs and services. At the operational level this means examining our processes and policies and consider ways that they may need to be adjusted and/or adapted to meet the needs of all Indigenous Peoples. For instance, this could be approving staff to work outside of core health unit hours to suit the needs of our partners, or changes to data collection and reporting practices to align with OCAP® guidance. The way we plan, implement and deliver our programs and services could also be enhanced and supported by an Indigenous Liaison position within the agency. At an organizational level, this would entail shifting our approach to engaging with Indigenous Peoples from a colonial approach (e.g., institutional practices, processes and policies that embed systemic oppression and racism that privilege or disadvantage people based on race or other factors of oppression) to one that is centered in the notion of self-determination: "…the inherent right of Indigenous Peoples to freely determine their own pathways and make decisions about all aspects of their communities and livelihoods".[1] This implies that relationship building should be based on the needs, priorities and desires of Indigenous Peoples and communities. It requires that health unit staff and Board of Health members receive comprehensive Indigenous cultural safety training that promotes meaningful self-reflective practice to provide a foundation of knowledge and understanding upon which all members of the agency can help to support open, trusting, reciprocal and meaningful relationship building with Indigenous Peoples, organizations and communities.

Recognition, Respect and Mutuality

The analysis identified that this principle is both a principle and a practice. It is also a supportive element of relationship building, as it describes the actions that will help to build relationships. Recognition, respect and mutuality are three distinct concepts that will support future

collaboration and that should be integrated into public health practice to help guide operational and program planning of services with Indigenous groups.

Recognizing and acknowledging the diversity of Indigenous Peoples' culture, language, protocols and history can be achieved through ongoing education and encouragement of self-reflective practice, such as cultural safety training and other opportunities for learning from Indigenous lived experience. The importance of staff being educated about the diverse aspects of First Nation, Métis and Inuit Peoples and communities cannot be understated as a method for gaining this insight. Education also serves as a means to enhance organizational readiness for meaningful engagement, and as a tool for the agency to be adaptive to the diverse needs, processes and protocols within Indigenous populations and communities.

Diversity of needs amongst Indigenous communities is an area the health unit could undertake to learn and understand better in order to establish relationships and collaborations with Indigenous Peoples and communities that are responsive to their specific issues, needs and priorities. Although some issues and needs may be common to all or many Indigenous Peoples and communities, the way in which they are addressed or responded to may vary within and amongst communities.

Self-reflection as individuals and as an agency on how our current processes and procedures function and how they may be adapted for Indigenous communities is another method by which recognition and respect for Indigenous ways, needs and capacity can be integrated into SMDHU practice. Change or adaptation of processes could range from those that are very functional, such as how we run meetings and schedule our time when collaborating with Indigenous partners, to those that are more systematic, such as pursuing opportunities for collaboration based on Indigenous-identified needs and/or requests for support to the health unit. Another way to identify and facilitate areas for adaptation is through the creation of one or more Indigenous Liaison positions within the agency whose roles in part could be to act as the main point of contact with Indigenous partners and leaders in Simcoe Muskoka, to coordinate organizational work with Indigenous partners, and identify and facilitate internal system changes (i.e., policies, procedures, planning) as required to support SMDHU Indigenous engagement strategy outcomes.

Respect can also be shown through the development of relationships between the senior leadership of our agency (i.e., Board of Health and Medical Officer of Health) and the Chief and Band Council of the First Nation communities, and between members of SMDHU Executive and/or Management and Indigenous organizations within Simcoe Muskoka.

The concept of mutuality – mutual recognition, respect, sharing and responsibility – is expressed through recognizing the strengths of Indigenous communities, which includes a strong sense of community and social connectedness and ensuring that recognition is built into collaborative program planning and services with Indigenous Peoples. When we recognize and

respect the diversity of experiences and perspectives within Indigenous communities and invite those rich insights to be part of our work, they become the building blocks upon which we build collaborative, meaningful and mutual relationships.

Self-Determination

According to the OPHS definition of this principle, one of the ways public health units can support self-determination is to provide the opportunity for Indigenous communities and organizations to lead or influence relevant decision-making processes that impact Indigenous Peoples and facilitate greater opportunities for control over their health. Based on the analysis of the situational assessment components, there are several ways the health unit can do this.

Consulting with Indigenous communities to determine what their priorities are and if and/or how the health unit can support them in addressing these priorities is a key strategy. An additional strategy is providing Indigenous partners with assistance and support, when asked, related to quantitative and/or qualitative data collection, analysis, reporting or research, grounded in Indigenous priorities, perspectives, and methods, as a foundation for decision-making and priority setting.

Needs and priorities that are identified can help guide the health unit in collaborative work with Indigenous communities, thereby supporting the principle of self-determination for Indigenous control over health. Self-determination can also be supported by providing more information to Indigenous communities and organizations about public health standards (programs, services), resources and activities to support them in identifying potential areas of collaboration with the health unit based on their needs and the roles public health can play. In addition, the health unit may support advocacy initiatives on behalf of Indigenous partners, communities and Peoples in our area upon their request.

Self-determination is created when community-based Indigenous organizations and communities have the opportunity to lead or influence relevant decision-making processes. There is a great deal of opportunity and direction to be pursued in this regard. For example, the health unit can support this through creating leadership opportunities for Indigenous representation in public health decision-making, such as participation as a member on the Board of Health, participation on a potential future SMDHU Indigenous advisory committee, engaging in program and service planning, and engaging in discussions pertaining to formal (or informal) agreements, memorandums of understanding, and/or letters of relationship as identified as an area of interest by Indigenous partners. The health unit can also continue to participate in the Indigenous Health Circle, a key collaborative Indigenous-led forum in Simcoe Muskoka.

Timely Communication and Knowledge Exchange

Good communication is an essential part of any healthy relationship. It involves both talking and listening. Communication helps to build trust between partners, defines expectations, needs, and desires, and is essential to resolving conflict and uncertainty. Communication is also required to build knowledge and understanding about and between people. Building relationships with Indigenous partners and communities therefore must involve intentional, dynamic and ongoing communication that is transparent, reciprocal and frequent.

The health unit could build communication pathways at all levels of the organization, as appropriate, where they don't already exist that will open opportunities to engage with Indigenous partners. This could be facilitated through an Indigenous Liaison position at the health unit and/or through our continued participation on the Indigenous Health Circle (IHC). In particular, pathways could be created between the Board of Health and the Medical Officer of Health and the Chief and Band Councils of the four First Nation communities in our area, thus displaying our support of Indigenous self-determination and opening the way for respectful relationship building at the senior level of our organization.

Communication can be used to develop relationships as well as to maintain and nurture existing relationships. Developing communications processes that are clear, open, transparent and on-going will be essential to this process. These will facilitate consultation, collaboration and co-development of programs, services, resources and other supports that have been identified by Indigenous partners and supported by the health unit.

Learning more about each other and how we can work together is a clear direction provided by Indigenous partners, many of whom identified a desire to learn more about what the health unit can offer to their communities. Having a communications strategy that includes processes and products to fill this request will be important to reduce this knowledge gap.

In a very practical way, providing information about SMDHU programs, services and resources through communications products, and engaging in knowledge exchange strategies for pertinent public health topics, data and products will help to bridge information gaps. The health unit should be prepared that the sharing and/or adaptation of public health resources and products may be required, in consultation and co-development with Indigenous partners, so that they are more relevant and culturally appropriate for the Indigenous population.

Coordination

Coordination and integration of public health programs, services and supports entails collaboration and co-development with Indigenous partners and communities. It also requires collaboration with external partners from the broader health care system and other sectors that overlap with public health initiatives. It also crosses all levels of government. Coordination is required to avoid duplication of services, provide clarity around jurisdictional issues, and maximize integration with other public health and health care policy and program initiatives.

Due to the complexities associated with government jurisdiction over public health and health promotion services for Indigenous Peoples, it is important for the health unit to be clear of the jurisdictional considerations. Additionally, it is critical to make connections with appropriate departments and bodies at all levels of government that are responsible for service provision, and with the leadership of First Nation communities and Indigenous organizations that are providing these services and who are often best informed on the jurisdictional questions. Most importantly is to seek to enhance public health services available to Indigenous populations, and not to view jurisdictional questions as a barrier to collaboration and service. This, along with the agency's requirements under the OPHS, will help the health unit to determine the scope and breadth of the support it can provide and that is desired by First Nations, Métis and urban Indigenous communities.

Coordination should also occur within the health unit as part of a comprehensive strategy for engagement, relationship building and service delivery. Key to this is developing an agency collaborative approach to program planning, knowledge gathering and sharing, and data collection and research with Indigenous partners using the principles of OCAP®. It will also entail a review of health unit processes, procedures and policies that may need to be adapted to support collaboration and coordination of services with Indigenous partners. This internal work could be built on the key engagement principles identified in the scoping review and the core concepts of Indigenous cultural safety. It could also be done using the lens of equity, diversity and inclusion under an agency anti-racism and anti-oppression strategy that embeds these critical concepts into SMDHU culture and practice.

LIMITATIONS

In addition to the limitations presented in most of the situational assessment reports linked above, there are limitations related to the consultations with First Nations and Indigenous organizations that were not included in that specific report, as well as limitations related to the impacts of the pandemic on the overall situational assessment. These limitations are outlined below.

COVID-19 impact on timelines and methodology

Due to the pandemic, completing the situational assessment took longer than expected. While several components of the situational assessment were completed or nearly completed prior to the beginning of the COVID-19 pandemic in March 2020, shifts in SMDHU's structure, programs, services and policies due to the pandemic extended the timeline for completing the Indigenous engagement situational assessment. The timelines and methodology of the jurisdictional scoping review and the consultations with First Nations and Indigenous organizations were directly impacted by the pandemic, while an additional unplanned component was added to reflect engagement activities with First Nation communities and urban Indigenous organizations during the pandemic and lessons learned from those activities.

While the extended timeline has dated the information in some components of the situational assessment, two components that were completed during the pandemic were able to include more current information. This included content of the jurisdictional considerations scoping review and a summary of SMDHU Indigenous engagement activities and learnings during the pandemic.

Consultations with First Nations and Indigenous organizations

The methodology for consultations with Indigenous organizations and First Nation communities changed due to the COVID-19 pandemic (in-person versus video conference). The use of video conferencing software to conduct consultations after the pandemic began may have influenced what information and feedback was shared at the consultation, for example based on quality of existing relationship and/or comfort with participating using online technology. Reduced capacity and the use of online technology could have been a barrier to participation. Although COVID-19 or the use of video conferencing was not specifically stated as a reason for not participating, it is important to note three of the 12 Indigenous organizations identified in planning the consultations were unable to participate; therefore, the results of that report and the final report do not include their perspectives.

Some of the scheduled consultations with Indigenous community organizations and First Nations were delayed, with the first four occurring in February 2020 and the rest not being able to happen until November 2020. The consultations occurred at different points in time because of the pandemic, which may have resulted in the information shared in November being influenced by activities and relationships that developed during the early part of the pandemic (March – October 2020).

Situational assessment synthesis methodology

A key limitation related to the synthesis of information from all components of the situational assessment is that the initial thematic analysis work was conducted in parallel by a small group of different reviewers. While it would have been preferable for all reviewers to consider all of the situational assessment components, this was not possible within the timelines and constraints of the project. To mitigate this limitation, opportunities to verify, add to and adjust the synthesized information were provided to the small group of reviewers. This was then extended to the full Indigenous Engagement working group.

Generalizability

While the purpose of this situational assessment was to answer specific questions to inform the development of a longer-term Indigenous engagement strategy for SMDHU, it is important to note that the inclusion of information specific to SMDHU and local First Nations and Indigenous organizations will limit the generalizability of some of the recommendations and conclusions to readers outside of SMDHU and Simcoe County and the District of Muskoka.

CONCLUSION AND RECOMMENDATIONS

This situational assessment was undertaken at the beginning of the health unit's learning journey to inform the agency of how to proceed with building and maintaining meaningful engagement and mutually desired collaborative working relationships with Indigenous Peoples, organizations and communities in Simcoe Muskoka. The results of the information gathering have provided the health unit with a starting point of knowledge and understanding of the health status and demographics of local Indigenous Peoples and some of the factors impacting their health that can be built upon and substantially furthered through our future Indigenous engagement in the coming years.

The findings have identified where relationships have already been developed between the health unit and Indigenous partners and communities and the collaborative work that has taken place over the last many years that has helped to nurture and broaden those relationships over time. The research has also highlighted the foundational principles and practices to consider incorporating into relationship building and to help guide the agency towards developing relationships that are meaningful, respectful and reciprocal. Insights have been gained into the complex web of governmental jurisdictional issues that the health unit must consider in its collaboration with Indigenous Peoples, organizations and communities in the delivery of public health programs and services to them.

Indigenous partners identified where gaps may exist in their awareness and/or understanding of the health unit and have provided suggestions for how to address those gaps. Ideas were shared as to what future relationships and/or programs and services would be useful and meaningful to them.

If the health unit is to successfully work in a collaborative, respectful, reciprocal, meaningful, and culturally safe way towards reducing health disparities experienced by Indigenous Peoples in Simcoe Muskoka, it should learn from and apply the findings of this situational assessment to its work and the way we do this work. Deepening our engagement with Indigenous Peoples, communities and organizations will be assisted by the grant SMDHU has received from the Ministry of Health annually since 2019 to enable the health unit to offer Indigenous cultural safety training to staff and to support other Indigenous engagement activities.

It should be noted that these learnings align with the four principles of meaningful engagement and collaboration developed by the Indigenous Health Circle:

Principle 1: Appropriate and meaningful consultation

Principle 2: True and equal partners

Principle 3: Right to self-governance

Principle 4: Indigenous health in Indigenous hands[63]

Although these principles were developed to support the successful engagement and potential partnership opportunities between Ontario Health Team applicants and Indigenous health leadership for the transformation of Indigenous health systems in Ontario, they can also apply in a public health context. Reflected in these principles are the findings and themes drawn from

multiple components of the situational assessment, all of which can help guide the health unit's on-going and future work with Indigenous Peoples, communities and organizations.

Based on the findings of the situational assessment, it is recommended that SMDHU take the following actions towards building and maintaining meaningful engagement and mutually desired collaborative working relationships with Indigenous Peoples, organizations and communities in Simcoe Muskoka:

1. Intentionally pursue and enhance respectful and reciprocal relationships with Indigenous Peoples, communities and organizations. This may include, but is not limited to:
    a) Continuing to participate as an invited member at the Indigenous Health Circle (IHC).
    b) Inviting and receiving opportunities to engage with and discuss relationships between First Nation Chiefs, Councils, and Health Directors, Métis Council leaders, and leaders of urban Indigenous organizations in Simcoe Muskoka, with the SMDHU Board of Health and Medical Officer of Health or designate.

2. Through respectful and reciprocal ongoing consultation and partnership, identify, invite, and respond to requests from Indigenous communities and organizations for potential formal mechanisms (i.e., processes, policies or agreements) to enhance public health programming and services for Indigenous Peoples. Such programming and services would be guided by the principle of Indigenous self-determination in decision-making. This may include, but is not limited to mechanisms such as:
    a) Proposing to IHC partners the drafting of a letter of relationship with the health unit.
    b) Proposing to one or more specific Indigenous communities or organizations the drafting of a letter of relationship or a memorandum of understanding with the health unit.
    c) Exploring the potential to invite one or more Indigenous communities or organizations to participate on the SMDHU Board of Health, and the potential role of a Section 50 Agreement under the *Health Protection and Promotion Act*.

3. Develop an internal approach to support cultural safety in our internal and external work, relationship-building processes and collaborative partnerships with Indigenous communities and organizations. This may include, but is not limited to, activities such as:
    a) Enhancing internal communications to ensure staff awareness of resources and education opportunities available to support relationship-building.
    b) Continuing to support mandatory Indigenous cultural safety (ICS) training for health unit staff and Board of Health, and other ongoing learning and reflection opportunities for cultural safety.
    c) Initiating anti-racism and anti-oppression (ARAO) activities, with the intention of considering the future development of a comprehensive agency ARAO strategy, within which ICS would be included.
    d) Identifying, prioritizing and reviewing SMDHU policies and procedures (i.e., recruitment, selection and hiring policy; smoke-free policy; guidebooks for public health practices, such as breastfeeding, parenting, etc.) to ensure they align with ICS and/or broader anti-racism and anti-oppression principles and practices.

e) Consulting with Indigenous and other community partners addressing ARAO to ensure that the internal approach complements community partner priorities, strategies and best/promising practices.

4. Commit to the resourcing (staffing, time, training, internal committee creation, etc.) required to develop and maintain relationships and to prioritize the implementation of requested public health programming and services in collaboration with Indigenous communities and organizations. This may include, but is not limited to activities such as:
    a) Creating an internal steering committee to support, coordinate and facilitate the planning and implementation of Indigenous engagement and relationship-building work within the agency, including all recommendations within this report.
    b) Developing processes with Indigenous communities and organizations to guide the collaborative planning, implementation and evaluation of public health programs and services.
    c) Developing an internal system to record and track engagement opportunities and program activities to ensure coordination of resources amongst health unit programs and staff.
    d) Offering to work with Indigenous communities and organizations to determine Indigenous priorities and approaches to collaborative data collection, analysis, and reporting using OCAP® principles.

5. Co-develop knowledge exchange and communications strategies with Indigenous partners based on their identified needs. This may include, but is not limited to:
    a) Informing and updating Indigenous partners and communities of health unit services, programs, and current priorities.
    b) Sharing and/or adapting resources to be culturally appropriate and useful for Indigenous partner needs.

6. Create an agency Indigenous Liaison position, who working with an internal Indigenous engagement steering committee, will support and enhance the development of relationships with Indigenous communities and partners, facilitate the integration and implementation of culturally safe policies and practices within SMDHU, and help improve local access to public health programs and services for Indigenous communities, organizations and Peoples. This role may include, but is not limited to the following responsibilities:
    a) Help to build relationships with Indigenous communities, partners and leaders.
    b) Be a key point of contact with Indigenous communities, partners and leaders.
    c) Liaise with Indigenous communities and organizations on public health issues, needs and priorities.
    d) Assist with offering to work with Indigenous partners to develop approaches to collaborative data collection, analysis and reporting, using OCAP® principles.
    e) Provide advice to ensure an Indigenous health equity lens is integrated into the planning and implementation of SMDHU programs and services.
    f) Help to inform the planning, reviewing and implementation of culturally safe policies and practices at SMDHU to ensure they align with ICS and/or broader anti-racism and anti-oppression principles and practices.

g) Provide support and resources for SMDHU staff related to local Indigenous cultural practices.
h) Assist with developing a process for coordinating and evaluating SMDHU work with Indigenous communities and organizations.

APPENDICES

Appendix A – SMDHU's Indigenous Engagement Journey of Growth

REFERENCES

1. Ministry of Health and Long-Term Care. Ontario Public Health Standards: Relationship with Indigenous Communities Guideline. Queen's Printer for Ontario. 2018 [cited 2023 Jun 28]. Available from: www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Relationship_with_Indigenous_Communities_Guideline_en.pdf

2. Greenwood M. The web of being. Prince George, BC: National Collaborating Centre for Aboriginal Health; 2009.

3. Barrie Area Native Advisory Circle (BANAC). Culture Card: A Guide to Build Cultural Awareness [Internet]. Barrie: BANAC; 2022 [cited 2023 Jul 18]. Available from: https://banac.on.ca/wp-content/uploads/2022/02/banac-cultue-card.pdf

4. First Nations Information Governance Centre. The Fundamentals of OCAP® [online course]. Akwesasne: FNIGC ; 2022 [cited 2022 6 Dec]. Available from: https://fnigc.ca/ocap-training/

5. Statistics Canada. Census profile, 2021 census of population [Internet]. Catalogue no. 98-316-X2021001. Ottawa, ON: Government of Canada; 2022 [cited 2023]. Available from: https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E

6. Statistics Canada. Census profile, 2016 census of population [Internet]. Catalogue no. 98-316-X2016001. Ottawa, ON: Government of Canada; 2017 [cited 2023]. Available from: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E

7. Statistics Canada. Census profile, 2011 national household survey. Catalogue no. 99-004-XWE. Ottawa, ON: Government of Canada; 2012 [cited 2023]. Available from: http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E

8. First Nations Information Governance Centre (FNIGC). First Nations Regional Health Survey (RHS) 2008/10: National report on adults, youth and children living in First Nations communities [Internet]. Ottawa: FNIGC; 2012 [cited 2023 Jul 18]. 236 p. Available from: https://fnigc.ca/wp-content/uploads/2020/09/5eedd1ce8f5784a69126edda537dccfc_first_nations_regional_health_survey_rhs_2008-10_-_national_report_adult_2.pdf

9. First Nations Information Governance Centre, National Report of the First Nations Regional Health Survey Phase 3: Volume One, (Ottawa: 2018). 181 pages. Published in March 2018. Revised edition July 2018. Online. Available from: https://fnigc.ca/wp-content/uploads/2020/09/713c8fd606a8eeb021debc927332938d_FNIGC-RHS-Phase-III-Report1-FINAL-VERSION-Dec.2018.pdf

10. Cancer Care Ontario. Prevention System Quality Index: health equity. [Report online]. Toronto: Queen's Printer for Ontario; 2018 [cited 2023 June 28]. Available from: https://www.cancercareontario.ca/en/statistical-reports/prevention-system-quality-index-2018

11. Chiefs of Ontario, Cancer Care Ontario. Cancer in First Nations in Ontario: Risk Factors and Screening. [Report online]. Toronto: Cancer Care Ontario; 2016 [cited 2023 June 28]. Available

from:
https://www.cancercareontario.ca/sites/ccocancercare/files/assets/CCOFNIMRiskFactorsReport2016.pdf

12. Lalonde Rankin, S. A Snapshot of the Aboriginal Population in Simcoe County and Muskoka District. [Report online]. Simcoe County: Centre for Addictions and Mental Health, 2012. Available from: \\Jenner\Sharedata\Health Unit\Indigenous\3. Planning\Situational Assessment\Local Indigenous Health Information\Resources for Local Indigenous Resources Workbook\snapshot FNMI.doc

13. Ontario Federation of Indigenous Friendship Centres. Wiisinaadaa: Let's Eat Discussion Paper on the Traditional Foods & Diabetes Research Project [Internet]. Toronto: OFIFC; 2016 Spring [cited 2023 Jul 18]. 31 p. OFIFC Research Series, Volume 3. Available from: https://ofifc.org/wp-content/uploads/2020/03/2016-Wiisinadaa-Lets-Eat.pdf

14. Seventh Generation Midwives Toronto. Our Health Counts Toronto: Adult Chronic Health Conditions [Internet]. Toronto: Seventh Generation Midwives Toronto / Well Living House; 2018 [cited 2023 Jul 18]. Available from: http://www.welllivinghouse.com/wp-content/uploads/2018/02/Chronic-Health-Conditions-OHC-Toronto.pdf

15. Chiefs of Ontario, Cancer Care Ontario, Institute for Clinical Evaluative Sciences. Cancer in First Nations People in Ontario: Incidence, Mortality, Survival and Prevalence [Report online]. Toronto: Cancer Care Ontario; 2017 [cited 2023 June 28]. Available from: https://www.cancercareontario.ca/sites/ccocancercare/files/assets/CancerFirstNationsReport.pdf

16. Chiefs of Ontario, Cancer Care Ontario, Institute for Clinical Evaluative Sciences. Lung Cancer in First Nations People in Ontario: Incidence, Mortality, Survival and Prevalence [Report online]. Toronto: Cancer Care Ontario; 2017 [cited 2023 June 28]. Available from: https://www.cancercareontario.ca/sites/ccocancercare/files/assets/CancerFirstNationsReport.pdf

17. Barrie Area Native Advisory Circle. Community-Based Mapping of Indigenous Children and Youth Services in Barrie/Midland Region. [Internet]. 2016 [cited 2023]. Available from https://www.simcoecountycoalition.ca/wp-content/uploads/2016/06/BANAC-Final-Report-Community-Map-Dec-19-2016-4-40-pm-Final.pdf

18. Seventh Generation Midwives Toronto. Our Health Counts Toronto: Child Development [Internet]. Toronto: Seventh Generation Midwives Toronto / Well Living House; 2018 [cited 2023 Jul 18]. Available from: http://www.welllivinghouse.com/wp-content/uploads/2018/02/Child-Development-OHC-Toronto.pdf

19. Simcoe Muskoka District Health Unit. (2018). *Simcoe Muskoka Opioid Strategy*. Barrie. https://preventod.ca/about-smos

20. Chippewas of Rama First Nation [Internet]. Rama: Chippewas of Rama First Nation; 2023 [cited 2023 Jul 18]. Rama Departments; 2023 [cited 2023 Jul 18]. Available from: https://www.ramafirstnation.ca/rama-departments/

21. Toronto Indigenous Health Advisory Circle. A Reclamation of Well Being: Visioning a Thriving and Healthy Urban Indigenous Community [Internet]. Toronto: Toronto Indigenous Health Advisory Circle; 2016 [cited 2023 Jul 18]. Available from: https://www.toronto.ca/wp-content/uploads/2018/02/9457-tph-tihac-health-strategy-2016-2021.pdf

22. Chiefs of Ontario and Ontario Drug Policy Research Network. Opioid Use, Related Harms, and Access to Treatment among First Nations in Ontario, 2013-2019. Toronto, ON: Chiefs of Ontario; 2021 [cited 2023 July]. https://odprn.ca/wp-content/uploads/2021/11/First-Nations-Opioid-Use-Harms-and-Treatment-Report.pdf

23. Barrie Area Native Advisory Circle. (2015). Feasibility Study and Preliminary Business Plan. [Internet]. 2015 [cited 2019]. Available from: https://banac.on.ca/resources/

24. Barrie Area Native Advisory Circle. Consultation protocol framework. Barrie Area Native Advisory Circle; 2010 [cited 2023 June 28]. Available from: http://www.simcoecountycoalition.ca/wp-content/uploads/2016/06/fnmi-consultation-protocol-framework.pdf

25. Indigenous Primary Health Care Council. Cultural competency guideline for Ontario public health units to engage successfully with Aboriginal communities. 2018 [cited 2023 June 28]. Available from: https://www.nccih.ca/634/Cultural_Competency_Guideline_for_Ontario_Public_Health_Units_to_Engage_Successfully_with_Aboriginal....nccih?id=1082&col=3

26. Talking Together to Improve Health Project Team. Talking together to improve health: Literature review. Sudbury, ON: Locally Driven Collaborative Projects; 2017 [cited 2023]. Available from: https://www.publichealthontario.ca/-/media/documents/ldcp-firstnations-lit-review-report.pdf?la=en&hash=A6BDF4AA58EB71ABEC89EA6CA9CD7D47B55E1EE1

27. Middlesex-London Health Unit. Taking Action for Reconciliation: An Organizational Plan for Middlesex-London Health Unit. London, ON: Middlesex-London Health Unit; 2018 [cited 2022]. Available from: https://www.healthunit.com/uploads/2018-09-20-mlhu-reconciliation-plan.pdf

28. Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. Chapter 9: Research involving the First Nations, Inuit, and Métis Peoples of Canada. In Tri-Council policy statement: Ethical conduct for research involving humans. 2022 [cited 2023]. Available from: https://ethics.gc.ca/eng/tcps2-eptc2_2018_chapter9-chapitre9.html

29. Toronto Public Health. Toronto's first Indigenous health strategy. Toronto, ON: Toronto Public Health; 2016 [cited 2023]. Available from: https://www.toronto.ca/community-people/health-wellness-care/health-programs-advice/toronto-indigenous-health-strategy/

30. United Nations. United Nations Declaration on the Rights of Indigenous Peoples. 2011 [cited 2023]. Available from: https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html

31. Talking Together to Improve Health Project Team. Talking Together to Improve Health: Ontario Public Health Unit Survey. Sudbury, ON: Locally Driven Collaborative Projects; 2018 [cited 2023]. Available from: https://www.publichealthontario.ca/-/media/documents/ldcp-firstnations-engagament-survey-report.pdf?la=en&hash=0D03325DD72DA61C1100179741338C98EF7CFE23

32. North Simcoe Muskoka Local Health Integration Network. Aboriginal community engagement. 2006 [cited 2022]. Available from: http://www.banac.on.ca/downloads/ace_report.pdf

33. Talking Together To Improve Health Research Team. Talking together to improve health: Key informant interviews. Sudbury, ON: Locally Driven Collaborative Projects; 2018 [cited 2023]. Available from: https://www.publichealthontario.ca/-/media/documents/L/2019/ldcp-firstnations-key-informant.pdf

34. Barrie Area Native Advisory Circle. Consultation protocol focus group feedback Aug 10 website [online]. Barrie: Child Youth & Family Services Coalition of Simcoe County. [updated 2010 Aug 10; cited 2019 Apr 17]. Available from: http://www.simcoecountycoalition.ca/first-nation-metis-inuit/fnmi-report-stats/

35. Indigenous Services Canada: Indigenous Health Care in Canada [webpage online]. Ottawa: Government of Canada; [cited 2022 Jan 24]. Available from: https://www.sac-isc.gc.ca/eng/1626810177053/1626810219482

36. National Collaborating Centre for Indigenous Health. The Aboriginal Health Legislation and Policy Framework in Canada. [Report online]. Prince George, British Columbia: University of Northern British Columbia; 2011 [cited 2022 Oct 8]. Available from: https://www.nccih.ca/495/The_Aboriginal_health_legislation_and_policy_framework_in_Canada.nccah?id=2

37. Health and Welfare Canada. Indian Health Policy 1979 [webpage online]. Ottawa: Government of Canada; [cited 2021 June 23]. Available from: https://publications.gc.ca/collections/collection_2018/sc-hc/H14-296-1979.pdf

38. Health Canada: The First Nations and Inuit Health Branch [webpage online]. Ottawa: Government of Canada; 2004 [cited 2022 Jan 24]. Available from https://www.canada.ca/en/health-canada/services/health-care-system/health-care-system-

delivery/federal-provincial-territorial-collaboration/first-ministers-meeting-year-plan-2004/information-first-nations-inuit-health-branch.html

39. Health Canada: First Nations and Inuit Health Strategic Plan: A shared path to improved health [report online]. Ottawa: Government of Canada; 2012 [cited 2022 Oct 18]. Available from https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/pubs/strat-plan-2012/strat-plan-2012-eng.pdf

40. Health Canada: First Nations and Inuit Health Branch Program Overview [webpage online]. Ottawa: Government of Canada; 2015 [cited 2022 Jan 24]. Available from: https://www.canada.ca/en/news/archive/2015/04/health-canada-first-nations-inuit-branch-program-overview.html

41. Indigenous Services Canada: First Nations and Inuit Health Branch Program Plan [webpage online]. Ottawa; Indigenous Services Canada; 2018 [cited 2022 Jan 24]. Available from: https://www.sac-isc.gc.ca/DAM/DAM-ISC-SAC/DAM-HLTH/STAGING/texte-text/health-care-serviceshealth-care_fn-inuit-health-funding-agreement-models_program-plan_1584558706601_eng.pdf

42. National Collaborating Centre for Indigenous Health. Looking for Aboriginal Health in Legislation and Policies, 1970 to 2008. [Report online]. Prince George, British Columbia: University of Northern British Columbia; 2011 [cited 2022 Jan 24]. Available from: https://www.nccih.ca/docs/context/RPT-LookingHealthLegislationPolicies-EN.pdf

43. Health Canada. Transfer of Health Programs to First Nations and Inuit Communities: Handbook 1 [webpage online]. Ottawa: Government of Canada; [revised 2004 Mar; cited 2022 Jan 24]. Available from: https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/fnihb-dgspni/pdf/pubs/agree-accord/2004_trans_handbook-guide_1-eng.pdf

44. Indigenous Services Canada: Health Services Integration Fund [webpage online]. Ottawa; Indigenous Services Canada; [modified 2022 Aug 10; cited 2022 Jan 24]. Available from: https://www.sac-isc.gc.ca/eng/1583705358726/1583705378757

45. Ontario Region Health Services Integration Fund Advisory Committee. Ontario Health Services Integration Fund Integration Plan 2011. [Report online]. Nepean: First Nations and Inuit Health — Ontario Region, 2011 [cited 2022 Jan 24]. Available from: http://eriestclairlhin.on.ca/Page.aspx?id=11882

46. Indigenous Services Canada: Urban Programming for Indigenous Peoples [webpage online]. Ottawa: Government of Canada; [Modified 2018 May 29; cited 2022 Jan 24]. Available from: https://www.sac-isc.gc.ca/eng/1471368138533/1536932634432

47. Jordan's principle [webpage online]. Government of Canada; Indigenous Services Canada. 2022 [cited 2022 Nov 2]. Available from: https://www.sac-

isc.gc.ca/eng/1568396042341/1568396159824?utm_campaign=not-applicable&utm_medium=vanity-url&utm_source=canada-ca_jordans-principle

48. Indigenous Services Canada — Engagement guide: Co-developing federal distinctions-based Indigenous health legislation [webpage online]. Ottawa; Indigenous Services Canada; [Modified 2021 Oct 28; cited 2022 Jan 24]. Available from: https://www.sac-isc.gc.ca/eng/1626810643316/1626810705013#s4

49. Indigenous Services Canada: Indigenous Community Support Fund [webpage online]. Ottawa; Indigenous Services Canada; [Modified 2022 Jan 13; cited 2022 Jan 24]. Available from https://www.sac-isc.gc.ca/eng/1585189335380/1585189357198

50. Indigenous Services Canada: Indigenous Community Support Fund: needs-based funding requests [webpage online]. Ottawa; Indigenous Services Canada; [Modified 2022 Jun 14; cited 2022 Jan 24]. Available from: https://www.sac-isc.gc.ca/eng/1603990521589/1603990645077

51. Indigenous Services Canada: COVID_19 vaccines and Indigenous peoples [webpage online]. Ottawa; Indigenous Services Canada; [Modified 2022 Sep 21; last accessed 2022 Oct 18]. Available from: https://www.sac-isc.gc.ca/eng/1606941379837/1606941507767.

52. Health Protection and Promotion Act, R.S.O. 1990, c. H.7. [cited 2023]. Available from: https://www.ontario.ca/laws/statute/90h07

53. Peterborough Public Health. Indigenous Public Health [webpage online]. Peterborough: Peterborough Public Health; [Modified 2019; cited 2022 Jan 24]. Available from: https://www.peterboroughpublichealth.ca/about-us/indigenous-public-health/

54. Ontario. Ministry of Health. New Directions: Aboriginal Health Policy for Ontario. Toronto: Ministry of Health Ontario 1994 [cited 2021 July 28]. Available from: https://ofifc.org/wp-content/uploads/2020/03/Aboriginal-Health-Policy-for-Ontario-full-document.pdf

55. Ontario. Ministry of Children, Community and Social Services. Ontario's Aboriginal Healing and Wellness Strategy [webpage online]. Toronto: Ministry of Children, Community and Social Services; [published 2014 Nov 20; cited 2019 Oct 11]. Available from: https://news.ontario.ca/mcys/en/2014/11/ontarios-aboriginal-healing-and-wellness-strategy.htmlhttps://news.ontario.ca/en/backgrounder/31038/ontarios-aboriginal-healing-and-wellness-strategy

56. Ontario. Ministry of Children, Community and Social Services. Ontario's Aboriginal Healing and Wellness Strategy [webpage online]. Toronto: Ministry of Children, Community and Social Services; [updated 2022 Apr 28; cited 2022 Oct 11]. Available from: https://www.ontario.ca/page/indigenous-healing-and-wellness-strategy

57. Ontario. Ministry of Children, Community and Social Services. Ontario Indigenous Children and Youth Strategy [webpage online]. Toronto: Ministry of Children, Community and Social

Services; [updated 2021 Dec 10; cited 2022 Oct 18]. Available from: https://www.ontario.ca/page/ontario-indigenous-children-and-youth-strategy

58. Ontario. The Urban Indigenous Action Plan. [Government report online]. Toronto: Queen's Printer for Ontario; 2018 (ISBN 978-1-4868-1844-0) [cited 2022 Jan 24]. Available from: https://www.ontario.ca/page/urban-indigenous-action-plan

59. Ontario. COVID-19 vaccines [webpage online]. Toronto: COVID-19; [updated 2022 Oct 17; cited 2022 Oct 18]. Available from: https://www.ontario.ca/page/urban-indigenous-action-plan

60. North Simcoe Muskoka Local Health Integration Network. Aboriginal Community Engagement. [Government report online]. Barrie Ontario: North Simcoe Muskoka Local Health Integration Network; 2006 [cited 2019 Oct 10]. Available from file://jenner/Sharedata/Health%20Unit/Indigenous/3.%20Planning/Situational%20Assessment/Scoping%20Review/Resources/2006%20BANAC%20ace_report.pdf

61. Simcoe Muskoka District Health Unit. Telephone consultation with Susy Faria (Manager, Indigenous & Intergovernmental Relations Unit, Ontario Ministry of Health, Teresa Gillespie (Practice Consultant-Public Health, Indigenous Services Canada), Liz Walker (Director, Accountability and Liaison Branch, Population and Public Health Division, Ontario Ministry of Health). 2019 April 15.

62. Truth and Reconciliation Commission of Canada: Calls to Action. 2015 [cited 2023]. Available from: https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Calls_to_Action_English2.pdf

63. Indigenous Primary Health Care Council. Indigenous Health Systems Transformation: Foundations for Indigenous Primary Health Care Council's Ontario Health Team Provincial Framework. Toronto, 2022 [cited 2023]. Available from: https://iphcc.ca/wp-content/uploads/2022/09/Indigenous-HST_Booklet.pdf