QUEBEC FIRST NATIONS' HEALTH AND SOCIAL SERVICES GOVERNANCE PROCESS

SUMMARY REPORT REGIONAL MEETING

NOVEMBER 2016

REPORT PRODUCED BY

FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION

CSSSPNQL • FNQLHSSC

QUEBEC FIRST NATIONS'
HEALTH AND SOCIAL SERVICES
GOVERNANCE PROCESS

SUMMARY REPORT REGIONAL MEETING NOVEMBER 2016

AUTHORS
Emilie Grantham, FNQLHSSC
Patrice K. Lacasse, FNQLHSSC
Suzie Nepton, FNQLHSSC

COLLABORATION
Georges-Auguste Legault, Université de Sherbrooke

TRANSLATION
Anglocom

LAYOUT
Mireille Gagnon, FNQLHSSC
Patricia Carignan

This document is available in French and can be downloaded from the website of the FNQLHSSC at www.cssspnql.com.

First Nations of Quebec and Labrador Health and Social Services Commission
250 Place Chef-Michel-Laveau, Suite 102
Wendake, Quebec G0A 4V0
info@cssspnql.com

Photo credit: 123rf, Tapiskwan, CSSSPNQL, Shutterstock

ISBN: 978-1-77315-077-2
Legal deposit – 2017
Bibliothèque et Archives nationales du Québec / Library and Archives Canada

TABLE OF CONTENTS

APPENDICES

LIST OF PARTICIPATING COMMUNITIES

BARRIERE LAKE

EKUANITSHIT

ESSIPIT

KAHNAWAKE

KAWAWACHIKAMACH

KEBAOWEK

KITCISAKIK

KITIGAN ZIBI

MANAWAN

MASHTEUIATSH

MATIMEKUSH-LAC-JOHN

NUTASHKUAN

PAKUA SHIPU

PESSAMIT

UASHAT MAK MANI-UTENAM

UNAMEN SHIPU

WENDAKE

WINNEWAY

WÔLINAK

NOVEMBER 9, 2016

1 WELCOME ADDRESS

Willy Fournier, facilitator of the meeting, welcomed the participants to Mohawk territory. Before opening the meeting, Mr. Fournier asked everyone to take a moment to ground themselves.

He mentioned a Truth and Reconciliation Commission conference he had attended the week before where it was said that such conferences often look at the needs of politicians and not those of First Nations. The Minister for Indigenous and Northern Affairs Canada (INAC), Carolyn Bennett, had attended the conference and said that we know what governments want, and what is important now is to know what First Nations want.

As part of the governance process, it is time for First Nations to take back control and develop their own model. The new model will require a bottom-up approach. It is not about determining how to adapt the existing model, but how to create a new one.

2 OPENING REMARKS

Michel Paul, president of the FNQLHSSC Board of Directors, welcomed the participants and greeted them on his own behalf and also on behalf of the Board and all FNQLHSSC members. The goal of the meeting was to continue the collective discussion already in progress to create a model designed by and for First Nations. From the start, the purpose had been to improve the wellbeing of our populations while respecting our traditions. The legitimacy of the process had been reiterated to our partners and the AFNQL adopted a protocol in April 2016. Mr. Paul pointed out that the FNQLHSSC is the vehicle for transmitting and coordinating the process, while the communities' role is to state their vision and the guidelines for creating the new model. In addition to continuing the reflection on integrating the governance model into our cultures, the meeting addressed health planning, an important factor in effective governance. There will be discussion on responsibilities, regulation processes, accountability, and skills in line with our values.

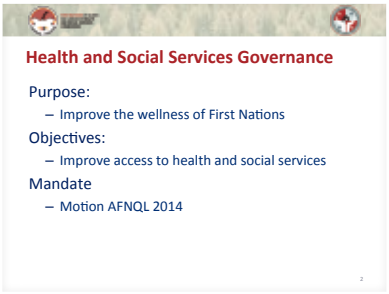
Mr. Paul reported on the committee of partners meeting he had attended the previous day. All members present had seemed motivated to work together on the new model designed by and for First Nations. Discussion had included coordination of childhood issues, including Jordan's principle.

Mr. Paul asked for everyone to do their part in drawing up a model relevant to First Nations. Another regional meeting would take place in winter 2017 to continue the conversation.

3 BACKGROUND AND UPDATE[1]

Patrice K. Lacasse, governance counsellor to the FNQLHSSC, welcomed the participants and highlighted that for many, this was their first time at a regional meeting on the governance process. He reiterated that the FNQLHSSC team is available to help communities. It was important for the information to be properly understood and for the FNQLHSSC to hear points of view and opinions from everyone.

As the second phase in the process was beginning, Mr. Lacasse summarized what had been done in the first, since 2014. He started with a reminder of the goal for the initiative, which is to improve First Nations health and wellness. It is also about better access to services. During talks on drawing up the 2007-2017 Blueprint, the limited power to act had been an important observation. The process therefore sought to increase autonomy for communities, giving them more powers and better-suited services and programs.



The process had officially begun in 2014 with a mandate issued by the chiefs. The first phase had involved putting together an overview of the First Nations environment and gathering the communities' feedback. The second would involve a presentation of the options and a decision. The overview, particularly of the juridical and legal environment, would be ongoing as it is constantly changing. Communities are key stakeholders in the process, and their opinion would continue to be sought. Various scenarios would be drawn up and the final decision would be made by the chiefs.

In the first phase, partnerships had been established with universities to produce reference documents to guide First Nations throughout the process. As mentioned, the first phase made it possible to inform and mobilize communities, including chiefs, general directors, and health and social services directors. A definition of governance, a vision, values and principles, and a list of challenges facing communities had been drawn up. This phase had also made it possible to become more familiar with First Nations government partners and learn about other governance methods developed by Canadian First Nations. By the end of the first phase a framework model had been created, setting out the points on which the model would be based: integration of the governance model into the culture, autonomy for communities, the ability to develop strategies, programs, and policies, the involvement of families and individuals, the need to take action on human, material, and financial resources, and reporting.

1 The PowerPoint used by Mr. Lacasse and Ms. Nepton is in Appendix B.

The concept of effective governance had also been developed across all three dimensions (political, structure – regulation and intervention, and stakeholder involvement). These three dimensions would be expanded upon in the second phase according to the collective objective of improving wellness.

Development of the three steps in the process would continue in the second phase. The first step was information gathering. The second step, consultation and coordination, was a very important part of the process as it gave the communities a chance to have their say. The third step, communication and evaluation, allowed the FNQLHSSC to refocus its messages and constantly adapt. Governance is a complex notion, and we needed to make sure we stayed on track. Mr. Lacasse told attendees that an FAQ document had been created. An initial set of basic questions and answers had been drawn up to help communities continue the conversation locally and answer residents' questions. A second set of questions and answers would be distributed at the next regional meeting. Still on the topic of communication, community visits had been made and the FNQLHSSC team was always available to go and meet with communities to address their questions and concerns.

The second phase was the time to change our approach and work on the new model in a more targeted fashion. The chiefs' resolution, adopted in April 2016, had helped with the continuation of the process and the start of negotiations with governments. Mr. Lacasse stressed that the model would not be drawn up by the FNQLHSSC. The FNQLHSSC's role was to coordinate the process, whereas First Nations would be responsible for creating the new governance model.

4 QUESTIONS

Participants were invited to ask questions about the process.

Question: Were all the chiefs present at the April 2016 chiefs assembly and did they all support the resolution?

Answer: Many of them, about 25, were present. During the vote on the resolution, one abstained. When a resolution is presented to the chiefs, the chiefs present at the assembly vote on and adopt the resolution.

Question: How is autonomy defined in this context?

Answer: The new model will be drawn up in partnership with all communities and will apply to health and social services locally and collectively. First Nations must discuss which federal responsibilities they want to remain at the federal level and which they must take on themselves. The intention is for communities to have greater powers for establishing strategies, programs, and rules on allocating funds and reporting.

Question: How will increased powers be granted to First Nations?

Answer: First Nations will seek greater powers through an agreement with the federal government.

Question: How many communities are represented in the governance process? Are general directors represented and involved?

Answer: Right from the start, communities have been well represented at regional meetings. A list of meeting attendees is available upon request. As for the involvement of general directors, throughout the process updates have been given at the regular meetings of community general directors. General directors from all communities were invited to take part in the last two regional meetings.

Question: What about each Nation's autonomy?

Answer: The health and social services governance process will have an impact on the Nations' autonomy. The FNQLHSSC's job is to seek greater autonomy for health and social services. The other governance processes conducted by First Nations must be taken into account and we will need to see how these processes can be brought closer together.

5 BACKGROUND AND UPDATE (CONT.)

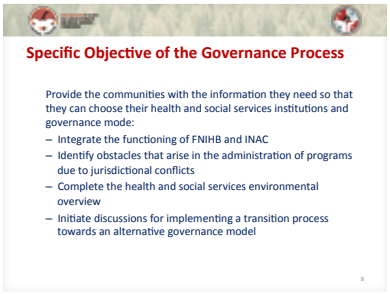
Suzie Nepton, FNQLHSSC health and social services governance assistant advisor, gave a more detailed explanation of the second phase in the governance process. First and foremost it was important to remember that this was a phase for taking ownership. During the first phase, the FNQLHSSC had been given a task, gathered information, and passed this information on to communities. This had resulted in a collective understanding.

She pointed out the key stakeholders in the process were First Nations, as they would be making the decisions. The new model would be developed over the next four years. Up to now, government programs and standards had been imposed on First Nations. It had been stated many times that the status quo was no longer acceptable.

Two outcomes were expected from the second phase:

- An effective health and social services governance model that would be available and applicable and meet the needs of First Nations
- Clarified jurisdiction for health and social services at the federal, provincial, and First Nations levels

One of the tasks falling to the Committee of Partners, made up of First Nations and government representatives, would be to clarify jurisdictions. At the same time, the committee would support the governance process as this process tied in closely with better access to services.



The specific objective for the second phase would be to give First Nations the information they needed to choose their institutions and their new governance method. This would involve gathering information about the roles and responsibilities of the First Nations and Inuit Health Branch (FNIHB), Health Canada, and INAC. Numerous meetings with teams from these ministries had already been held, and they had shown openness to the governance process. It was important to understand how the ministries operated to determine which responsibilities First Nations were seeking to transfer and which they wanted to take on themselves. The process would also involve a better understanding of the obstacles in program management that result from conflicts of jurisdiction, further analyses to provide an overview of the environment, and the start of negotiations for a transition to the new health and social services governance model.

The FNQLHSSC pre-Annual General Assembly had marked the launch of the second phase. The integration of the governance model into the culture of communities had been discussed at this event. The conversation would be continued at the current meeting. Activities continued with an overview of FNIHB and INAC, which would be presented over the course of the upcoming regional meetings. Community visits had taken place and would continue for communities that ask for them. Such meetings were extremely valuable for the FNQLHSSC team as they allowed the needs and concerns of communities to be heard and thus made it easier to pass on information.

Question: With the overview that has been drawn up, at this time do we know how much it will cost and what it will involve?

Answer: In 2015 Valérie Gideon, Assistant Deputy Minister, presented the FNIHB on two occasions. She talked about funding and responsibilities. At the next regional meetings, information will be passed on and decisions about funding and responsibilities will be made. Costs will also need to be analyzed. In addition, the communities themselves will be deciding which regional structure they want to put in place and which collective responsibilities will be transferred to them.

6 TAKING OWNERSHIP OF CULTURE IN LOCAL AND REGIONAL INSTITUTIONS[2]

Carol Hopkins—Biography

Nozhem ("Mother Wolf"), of the Wolf Clan, is from the Delaware First Nation of Moraviantown, Ontario. She is the mother of four and grandmother of six.

Carol Hopkins is the executive director of the National Native Addictions Partnership Foundation, an organization whose mandate is to support Canada's First Nations addiction programs. Carol came to this position from Nimkee NupiGawagan Healing Centre Inc., a youth solvent abuse treatment centre that is founded on Indigenous culture and life ways, where she was the founding Director for 13 years.

Carol was co-chair of the First Nations Addictions Advisory Panel whose mandate was to develop a renewal framework for the National Native Alcohol and Drug Abuse and Youth Solvent Abuse programs. Carol now co-chairs the Leadership Team whose mandate is to implement the renewal framework. This process is a partnership between the Assembly of First Nations, the National Native Addictions Partnership Foundation, and the First Nations and Inuit Health Branch of Health Canada.

Carol's work in the field of addictions also included serving as the Chairperson for the National Youth Solvent Addiction Committee (YSAC) from 2000 to 2007. This national committee has maintained a partnership with many groups to develop best practice guidelines for culturally based inhalant abuse treatment.

Carol has represented First Nations clients on the board of directors of the Canadian Council for Health Services Accreditation, now known as Accreditation Canada. With YSAC, Carol was involved in the development of the Accreditation program and standards. She also was a surveyor for CCHSA in both the mainstream healthcare system within Canada and within First Nations community health and addictions organizations.

Her strength in the health profession is the ability to blend western and Native traditional health & healing practices in a competent and responsive manner. In this regard, Carol has taught for various postsecondary institutes, including the Anishinabek Education Institute Native Social Work program at Laurentian University and currently is also a professor in the Social Work Program at Kings University College of the University of Western Ontario. She holds a Masters of Social Work Degree from the University of Toronto. Carol has received the Walter Dieter Award from the Assembly of First Nations in recognition of her academic achievements made in the field of social work with First Nations.

2 Ms. Hopkins' presentation can be found in Appendix C.

Carol has presented nationally and internationally to indigenous audiences, government bodies, and professional and academic audiences.

Source: http://nnapf.com/bio-carol-hopkins/

Carol Hopkins, executive director of the Thunderbird Partnership Foundation, thanked the FNQLHSSC for the opportunity to address the meeting. She began her presentation by explaining what had led the foundation to choose the "thunderbird" as its symbol. The thunderbird represents spirituality and is present in all First Nations languages.

Ms. Hopkins reminded attendees that better governance had been sought by numerous First Nations throughout Canada. A number of agreements had been signed between the government and First Nations, many in the form of partnerships, with joint decision making. However, First Nations were still dependent on a system they did not create and were required to meet expectations formulated by the government. It was time to ask ourselves what we wanted, what our needs were, and how we were gong to meet them.

Ms. Hopkins presented the First Nations Mental Wellness Continuum Framework,[3] developed as a result of consultations across Canada. This is a comprehensive and complex model, with each layer representing an important point. The red outer layer represents First Nations knowledge and the centre circle is the medicine wheel shared by all First Nations.

Research had been conducted at the same time as the Framework was being developed and had attempted to define what created wellness among First Nations. Few research projects had addressed First Nations culture, but in this case, there had been a desire to tell the story of First Nations and promote First Nations knowledge. The research had identified four fundamental components of wellness: hope, belonging, meaning, and purpose. So we had to consider how we could work with these four factors. For example, how could we create hope?

According to Ms. Hopkins, governance should be built on First Nations knowledge. We needed to consider how we could use culture and spirituality in the way we governed communities and organized programs and services. She said that our discussions on governance should be guided by a two-part question: what did we want to put in place, and why? The "How?" and "When?" were secondary. Referring to the "What?", Ms. Hopkins stressed the importance of looking at what wellness meant to us, as First Nations.

She mentioned the importance of language as more than just a means of communication. It was also a way to link back to creation and to reconnect with our ancestors. In communities where the use of First Nations language was decreasing, there had also been a decrease in the population's wellness.

3 Mental wellness is a concept meant to bring mental health and substance use together in the context of indigenous social determinants of health by relying on cultures as the foundation for a strengths-based approach across the life span.

Application of the First Nations Mental Wellness Continuum Framework was leading to significant changes in perception. Instead of highlighting weaknesses, greater emphasis needed to be given to First Nations' strengths. The approach to social determinants for health also needed to be highlighted. In the same vein, community wellness indicators must also measure strengths and not be based on weaknesses.

Tools to support communities can be found on the Thunderbird Partnership Foundation website (http://nnapf.com/). The Foundation also offers training courses.

Question: How can we include our healers, midwives, and ceremonies in our services?

Answer: We must determine, and then apply, what is important to us. For example, we can decide to support home births with midwives. There are people in our communities who have the knowledge to do this. It is up to us to take another look at the environment our communities' children are born into, such as the presence of extended family around newborns.

7 WORKSHOP 1

GOVERNANCE MODEL AND CULTURE

The first workshop offered to attendees was directly related to Ms. Hopkins' presentation. The objectives were to recognize the cultural elements all First Nations shared despite differences between Nations and to discuss the role of culture in the new governance.

Three groups were formed, each with French-speaking and English-speaking participants. Discussions were led by moderators who were asked to summarize their group's thoughts in a plenary session at the end of the workshop.

The first group, led by Richard Gray, listed identity, language, and territory as the fundamental aspects of culture to be highlighted. For young people in the communities, culture had lost the significance it deserved. This group felt that identity was the crucial aspect. It was also important to work towards a shared vision of wellness so everyone would understand it the same way.

The group led by Nadine Rousselot found that the dominant culture had had a strong impact on our communities by imposing a value system. We therefore needed to take back our culture, draw on the knowledge of our members, and establish a connection between elders and the young. The key elements shared by all Nations were respect, self-determination, pride, mutual support, and language.

Nancy Gros-Louis McHugh, moderator of the last group, reported that culture had been identified as central to governance. It was important not to replicate the current system. First Nations' vision of the world must be reflected in our institutions. Culture was visible in our way of life and was not static. It was also experienced in the connection to our territory. Culture must not only be discussed in terms of health. We needed a community vision, with culture as the common thread. This group also mentioned that use of the term "*governance*" could have been an obstacle for some communities.

Willy Fournier summarized the groups' feedback. It was clear that culture is at the heart of First Nations' way of life. But there were challenges associated with the ability to take back culture, primarily for young people. Future discussions must include integrating the governance model into the different cultures of communities.

8 FUNCTIONS AND RESPONSIBILITIES OF FNIHB[4]

Ms. Nepton explained the efforts underway to improve understanding of how FNIHB and INAC worked. Meetings that had been held up to now with both organizations had helped shed light on their system of governance, funding methods, and approach to carrying out their responsibilities. The presentation reflected the FNQLHSSC team's understanding and emphasized the responsibilities relevant to First Nations.


DIAGRAM OF THE CURRENT FEDERAL GOVERNANCE FOR FNIHB

Canadian Parliament: Federal spending

Treasury Board: Management of public funds
Funding allocated to First Nations

Health Canada/FNIHB Headquarters
- Development of health programs
- Development of accountability procedures
- Preparation of budget requests
- Accountability to Treasury Board

The Canadian Parliament, which managed all federal expenses, was at the top of FNIHB's current governance system. The Treasury Board dealt with the federal government and managed the public funds and financing allocated to First Nations. The central management office (national level, in Ottawa) of Health Canada's FNIHB drew up programs and reporting procedures, prepared budget requests, and was required to report to the Treasury Board (financial reports and activity reports). Each region participated on national committees, and the needs expressed by the regions reflected the needs of First Nations.

The responsibilities taken on by the FNIHB regional office in Montreal could be classified into three main groups: health program management, contribution agreement management, and community accompaniment.

4 The PowerPoint Ms. Nepton used is in Appendix D. A summary table of FNIHB's responsibilities was given to attendees and can be found in Appendix E.

Management of health programs

Meetings at FNIHB had made it clear that community health plans were central to programming. Such plans were considered a priority and seen as a funding requirement as well as a way for communities to identify their needs and the resources required to meet them. All FNIHB teams contributed their expertise and were involved in the process of drawing up health plans. Health plans assessment was no longer a requirement but was still considered an important factor in a community's development. Health program management also included mandatory health protection and environmental hygiene services as well as program reporting.

Management of contribution agreements

These responsibilities included drawing up agreements (including risk analysis), funding, default management, the Non-Insured Health Benefits program, and the Health Services Integration Fund, which were managed separately from global funding agreements, and financial reporting.

Community accompaniment

Support provided by FNIHB tied in closely with the development of community health plans. This support was provided upon request from the communities. Agents from the liaison unit were the first point of contact for communities. Support for communities was also offered by the nursing team and by the Action Forum associated with the health plan and with emergency situations that could arise.

9 INTRODUCTION TO WORKSHOPS 2 AND 3

Georges-Auguste Legault, professor at Université de Sherbrooke and consultant on the governance process, began his presentation with an overview of progress since 2014. In the first phase, current governance with the federal government and obstacles and annoyances experienced by First Nations had been addressed. Top-down governance had hurt First Nations, and it was time to think about governance that was a true reflection of First Nations' vision. Drawing on the consultations carried out, the concept of effective governance had been developed and everyone had agreed on the ultimate goal of improving collective wellness.

In connection with the meetings at FNIHB, the first step was to discuss how First Nations could take ownership of health plans. To that end, two workshops were offered. In the first, participants would discuss the current process for drawing up health plans. The second workshop would address the desired changes and guidelines.

Question: What we want to see replaced is the regional FNIHB office. Will the Canadian government still have a say?

Answer: Regulation does not come from the regional office in Montreal or the INAC regional team in Quebec City. So we also need to look at responsibilities on a national level (Ottawa). In British Columbia, First Nations sought resources from the national government that were allocated to their region. The agreement to be signed with the federal government will explain how responsibilities are to be shared. There will be a meeting with British Columbia First Nations to learn more about their experience.

10 WORKSHOP 2

APPROPRIATION OF THE HEALTH PLAN: SHARING PERSONAL EXPERIENCES

The goal of the second workshop was a better understanding of how health plans were drawn up in communities. As in the first workshop, discussions took place in small groups of French and English speakers. The moderator of each group was asked to summarize the discussion in a plenary session after the workshop. A complete list of topics raised by the three groups can be found in Appendix F.

The role of the health plan in all health services

The participants said that the current role of health plans was different in each community. For some, the health plan was just a document that provided access to funding. This perception meant that practitioners did not use it. Participants wanted to know whether the plan met the requirements of Health Canada or of First Nations. Policies drawn up by Health Canada did not seem applicable in the communities. Although having a process for drawing up health plans had given First Nations a bigger role in defining health priorities, this opportunity was limited by the imposed framework, i.e. programming and the criteria developed by the national Health Canada office.

The participants said they wanted the health plan to be a reference tool for developing annual work plans for practitioners because it identified the targets to be reached. The health plan must be a living document, and each practitioner must be responsible for a part of the plan. As well as being a basis for reporting, the plan must be used by communities as a guide for allocating resources and assessing the achievement of their objectives by including realistic measurement indicators for which data had already been collected. Seen in this way, the health plan made it possible to create structures and projects that met local requirements and fostered protection factors such as culture.

Contents of the health plan

To develop the content of their health plan, communities assessed clientele-specific needs. Participants said that for the plan to reflect the community, work needed to be done to avoid replicating Health Canada's approach. It was also reported that several communities were implementing activities not included in their health plan because the expenditure involved was ineligible under Health Canada criteria. Furthermore, participants complained that the health plan did not cover all the needs of the population, including access to services offered by the province. Health plan development should always begin with a discussion of what was working in the existing plan. Finally, the health plan must be flexible enough to allow for adjustments to the schedule of activities based on opportunities, unforeseen circumstances, or changes in the population's needs.

Creation of the health plan

In most communities the health sector was responsible for creating the health plan. Some communities hired a consultant, but all participants agreed that this was not the preferred approach, as it made it much more difficult to take ownership of the plan. In cases where a consultant was hired to draft the plan, it was important to provide support from a local team. Several communities had put in place a committee with representatives from various sectors and from the population. As for health plan approval, for some communities the band council was required to approve the plan before it was passed on to Health Canada, whereas for others, approval was given by the health committee tasked with doing so. Some communities submitted their health plan to the population. Political interference was mentioned as one of the challenges in drafting the health plan.

As for funding, participants complained about not having been allocated any funds for drawing up their health plan. Funding for activities was based on previous decisions and was not indexed according to the population's needs or community remoteness. The fact that health services and social services were not funded by the same donor agency was a challenge in itself and made it difficult to establish connections between teams and the services offered. Participants also reiterated that due to current funding guidelines, certain needs expressed could not be met.

Consultations to develop the health plan

To get residents involved, many communities used questionnaires or focus groups. Although involvement by the population was not a Health Canada requirement, communities wanted their residents to be involved in planning. Participants also felt it was important to make individuals more accountable for their health.

As for involving other stakeholders in the process for drawing up health plans, the preferred approach was based on social determinants of health. To that end, contributions from other sectors of the community were important. It was critical for everyone to fully understand this approach so they could contribute to planning, notably by sharing data. The group pointed out that if practitioners were more engaged in planning, they would use the health plan more. Some communities were guided by consultations with Health Canada, while others did not want Health Canada to be involved.

Discussions on the current process for drawing up health plans helped determine how much remains to be done to reach the goal for the process and how the process works in communities. It seems that the Health Canada program and funding guidelines do not allow communities to plan their activities according to the analysis of their population's needs. In many cases, health plans are drawn up as a funding requirement and not as a management, mobilization, and assessment tool, which is what the communities want it to be. In light of the comments, it is clear that changes are needed to make the health plan holistic, open-ended, and flexible.

NOVEMBER 10, 2016

11 RECAP OF THE FIRST DAY

Willy Fournier welcomed attendees and gave a recap of the previous day's discussion. He spoke about Carol Hopkins' presentation, which had emphasized the importance of looking at structures in a new way to bring First Nations culture and knowledge, including language, symbols, and traditions, to the forefront. She had also stressed the importance of focusing on the "What?" and "Why?" of effective governance. The current top-down structure needed to be replaced by a structure that was centred on communities. The first two workshops had shown that empowerment and ownership are two factors that must guide the process for drawing up the new governance model.

12 WORKSHOP 3

APPROPRIATION OF STRATEGIC PLANNING FOR HEALTH AND WELLNESS (GUIDELINES)

The objective of the third workshop, moderated in a plenary session by Willy Fournier and Georges-Auguste Legault, had been for First Nations to appropriate planning for community health and wellness and draw up guidelines for the plan to reflect their identity, needs, and realities.

Each proposed guideline had been accompanied by an overview of the current planning context with the strengths and weaknesses of the process as required by Health Canada. The context and proposed guidelines had been improved in light of comments from participants in the second workshop. The workshop had then identified the desired changes that could be included in the effective governance model.

Participants had been able to vote in real time using mobile voting devices, thus making the workshop interactive. During the workshop, participants had been asked for their opinion on the proposed guidelines, indicating whether they *fully agreed, agreed somewhat*, or *disagreed* with each. They had also been invited to explain their point of view, for the purpose of improving the guidelines. A table summarizing the votes for each proposed guideline and participants' comments can be found in Appendix G.

Participants had then drawn up fourteen guidelines to ensure planning for community health and wellness was conducted by and for First Nations. The conversation would continue with communities to fine tune these guidelines.

ROLE OF COMMUNITY HEALTH AND WELLNESS PLANNING IN EFFECTIVE GOVERNANCE

Current situation:

The health and wellness planning process communities are currently required to follow is based on programs offered in isolation and a health plan that is not integrated with other community sectors and not founded on a common vision shared by all community stakeholders. In some communities, the health plan ends up being shelved while in others it is used as a guideline for interventions. At the moment, health plans are drawn up based on reporting and do not adequately meet the population's needs.

Desired changes:

There is a desire to break down silos and achieve a community vision of health and wellness. The health plan should be a tool for engagement and should be based on a process of continuous improvement that does not take reporting into account.

Modified guidelines in light of participant comments and suggestions:

1. Community health and wellness planning should be developed using a holistic approach that:
   - Aligns with the community's Vision;
   - Includes an analysis of the communities' health needs;
   - Includes an analysis of the social determinants that influence community health needs, in order to provide better services to the community.
2. Community health and wellness planning should be a tool that mobilizes all community actors, including the population, to actively pursue the Vision for holistic health and wellness, and give the community specific objectives to improve community health and wellness.
3. In the constant pursuit of the community's Vision for health and wellness, the community health and wellness planning should be designed as a continuous improvement tool for the community's health and wellness activities and services, allowing for ongoing review according to the achievement of objectives.
4. Planning for health and wellness should strengthen our culture, our values, and our way of life.

CREATION OF COMMUNITY HEALTH AND WELLNESS PLANNING IN EFFECTIVE GOVERNANCE

Current situation:

Health plans are the responsibility of the community's health director and drawn up in consultation with various stakeholders. Questions about the data currently used to draw up health plans and about data credibility have been raised.

Desired changes:

Communities want interdisciplinary and cross-sector structures for drawing up their health plan. Accountability procedures must be put in place to hold the committee accountable to all community stakeholders. The data used in drawing up the health plan must be accepted by the community and other stakeholders. The health plan must also be agreed on by members of the community and, to be legitimate, approved by the politicians.

Modified guidelines in light of participant comments and suggestions:

5. The responsibility for community health and wellness planning should be entrusted to a committee led and coordinated by the health director and made up of the community stakeholders involved in health services and related activities as well as those whose activities touch on the social determinants of health in the community.
6. Community health and wellness planning should be developed from data gathered, including data from consultations with the community.
7. Ideally, committee members should arrive at a consensus or a similar type of agreement on community health and wellness planning.
8. To gain legitimacy, planning for health and wellness should be approved by the band council, or a delegated authority.

Reaction and comments:

- One of the challenges in drawing up a plan is ensuring the involvement of all community stakeholders and the various sectors of the band council. General directors play a key role in bringing all these people together.
- Those living outside reserves or the territory must not be forgotten and it is critical to take their needs into account.
- Consensus is not required. It is desirable, but it could have the negative effect of restricting discussion and ideas. Likewise, it is hardly realistic to expect consensus with the population, considering the many different dynamics at play from a political point of view. In short, the preferred method for decision making is specific to each community.

COMMUNITY HEALTH AND WELLNESS PLANNING CONTENT IN EFFECTIVE GOVERNANCE

Current situation:

Certain communities do not understand the concepts of analyzing the population's needs and using the social determinants approach. It is also difficult to integrate data taken from such analyses into the planning process.

Desired change:

Planning for community health and wellness must be based on exhaustive data taken from a needs analysis and an analysis of social determinants of health.

Modified guidelines in light of participant comments and suggestions:

9. To the extent possible, analyzing community health needs should be done using a rigorous and systematic approach to give credibility to the results.

10. To the extent possible, analyzing the social determinants that influence community health needs should be done using a rigorous and systematic approach to give credibility to the results.

11. The results of the analyses of health needs and social determinants should be included in the objectives set by the community health and wellness planning process.

Reaction and comments:

- A rigorous approach is certainly commendable. However, in the current circumstances, work needs to be done to comply with these guidelines. Data analysis capabilities need to be developed.
- The social determinants approach is absolutely necessary, but not all stakeholders are familiar with it and standardization is desirable.
- Knowledge and previous experience must not be excluded from the planning process and these factors must be considered an integral part of a rigorous approach.

SETTING PRIORITIES IN COMMUNITY HEALTH AND WELLNESS PLANNING

Current situation:

At the moment prioritization is limited by Health Canada's program and funding guidelines. Therefore prioritization criteria are not determined by First Nations or developed according to the needs analysis and analysis of social determinants.

Desired change:

Communities want to establish priorities based on the needs analysis and analysis of social determinants of health, but also on other factors they will have identified.

Modified guideline in light of participant comments and suggestions:

12. Prioritizing objectives during the planning must take several factors into account:

- the severity of the impacts on people and the community if no intervention takes place
- the scope, i.e. the number of people affected
- the actual potential of achieving the desired result
- the costs related to the interventions needed to achieve the desired results
- the community's perception of the urgency of responding to these needs
- community culture and way of life
- a general health strategy

Reaction and comments:

There are several challenges in terms of prioritization:

- Balanced budgets
- Some activities, such as those related to culture, are not eligible for funding under federal rules
- Emerging phenomena, such as virtual games, and the lack of resources to address them

PROGRAMMING ACTIVITIES AND SERVICES IN COMMUNITY HEALTH AND WELLNESS PLANNING

Current situation:

Communities define the needs of their population but must draw up a program based on pre-defined programs. Therefore there are few opportunities for communities to introduce new procedures. Required reporting is based more on activity reports than on a true assessment of whether health plan objectives have been achieved. Indicators are chosen by Health Canada and do not necessarily meet the communities' needs.

Desired changes:

Prioritization should be more consistent with the choice of activities. Communities need to use indicators that allow them to track achievement of their objectives as part of a continuous improvement process.

Modified guidelines in light of participant comments and suggestions:

13. The programming of activities and services should be determined according to the objectives specified in the prioritization, while allowing for a degree of flexibility.

14. Indicators that make it possible to evaluate the achievement of each objective should be defined to allow activities and services to be assessed for the purpose of continuous improvement.

Reaction and comments:

- Indicators must also be qualitative. We should not be afraid to get off the beaten track and rely on perceptions. One participant asked: How can we quantify wellness?
- The health plan must be revised and the necessary adjustments made as soon as possible. We should not be afraid to modify the health plan if achieving the objectives seems impossible.

13 NEXT STEPS IN THE GOVERNANCE PROCESS

Patrice K. Lacasse explained the next steps in the second phase of the governance process. Planning was the foundation for the new governance model and the first step was to develop the process locally before seeing what would need to be set up regionally. First Nations must consider how to work together despite each having different realities. In winter 2017, another regional meeting would be held to continue discussing planning and how the federal government works. The issue of clarifying jurisdictions would also be addressed in the second phase.

It was important for the information passed on at regional meetings to be shared within communities. Documents were available on the website for the governance process and others, such as subject-specific information sheets, would be created to facilitate the transfer of knowledge.

14 CLOSING REMARKS

Marjolaine Siouï, FNQLHSSC executive director, thanked attendees for the productive dialogue that took the discussion even further. She pointed out that to fully support First Nations in the process, the FNQLHSSC was in listening mode. For Ms. Siouï, the takeaway was that the governance process allowed First Nations to reconnect as a group and allowed each participant to reconnect with themselves as individuals. Ms. Hopkins' presentation had helped everyone get back to their roots.

It was important to each community to have a say and share its strengths and unique characteristics. The process was an opportunity for First Nations to define their collective vision of wellness.

15 CLOSING PRAYER

A closing prayer was led by one of the attendees.

16 CONCLUSION

The goal of the regional meeting held November 9 and 10, 2016, bringing together attendees from 19 First Nations communities, was to continue the conversation on integrating the governance model into culture and start a discussion on health planning, which is central to effective governance. To that end, the transfer of knowledge on the roles and responsibilities of FNIHB was continued. These responsibilities were classified into three main groups: health program management, contribution agreement management, and support for communities.

Given that local planning is the basis for the new governance model for First Nations health and social services, the first step was to discuss how health plans are drawn up in communities and how First Nations can get involved in planning for health and wellness. The workshops produced fourteen guidelines to ensure planning for community health and wellness was conducted by and for First Nations and reflected their identity, needs, and realities. Discussions with communities to fine tune these guidelines will continue throughout the second phase of the governance process.

In March 2017, another regional meeting will provide an opportunity to continue taking ownership and developing knowledge on how FNIHB and INAC operate, allowing First Nations to determine what they want to include in their effective governance for health and social services.

A APPENDIX

AGENDA

PLACE: HYATT REGENCY MONTRÉAL, ROOM SYMPHONIE 3

NOVEMBER 9, 2016

7:30 a.m.	Welcome and registration
8:30 a.m.	Opening prayer and welcoming remarks
8:45 a.m.	Context and update
9:15 a.m.	Culture – Carol Hopkins
10:15 a.m.	Break
10:30 a.m.	Workshop 1: Governance model and culture
11:30 a.m.	Plenary session
11:45 a.m.	Lunch
1:15 p.m.	Federal functions and responsibilities
1:45 p.m.	Workshop 2: health plan
3:00 p.m.	Break
3:15 p.m.	Workshop 2: health plan (cont'd)
3:45 p.m.	Plenary session and feedback
4:00 p.m.	Summary
4:15 p.m.	Adjournment

NOVEMBER 10, 2016

7:30 a.m.	Welcome and registration
8:30 a.m.	Context and orientations
8:45 a.m.	Workshop 3: Planning in the communities
10:15 a.m.	Break
10:30 a.m.	Workshop 3: Planning in the communities (cont'd)
11:30 a.m.	Plenary session and feedback
11:45 a.m.	Next steps
12:00 p.m.	End of the meeting

B **APPENDIX**

HEALTH AND SOCIAL SERVICES GOVERNANCE PROCESS – REGIONAL MEETING, NOVEMBER 9 & 10, 2016
(POWERPOINT)

Health and Social Services Governance

Purpose:

- Improve the wellness of First Nations

Objectives:

- Improve access to health and social services

Mandate

- Motion AFNQL 2014

2

Steps

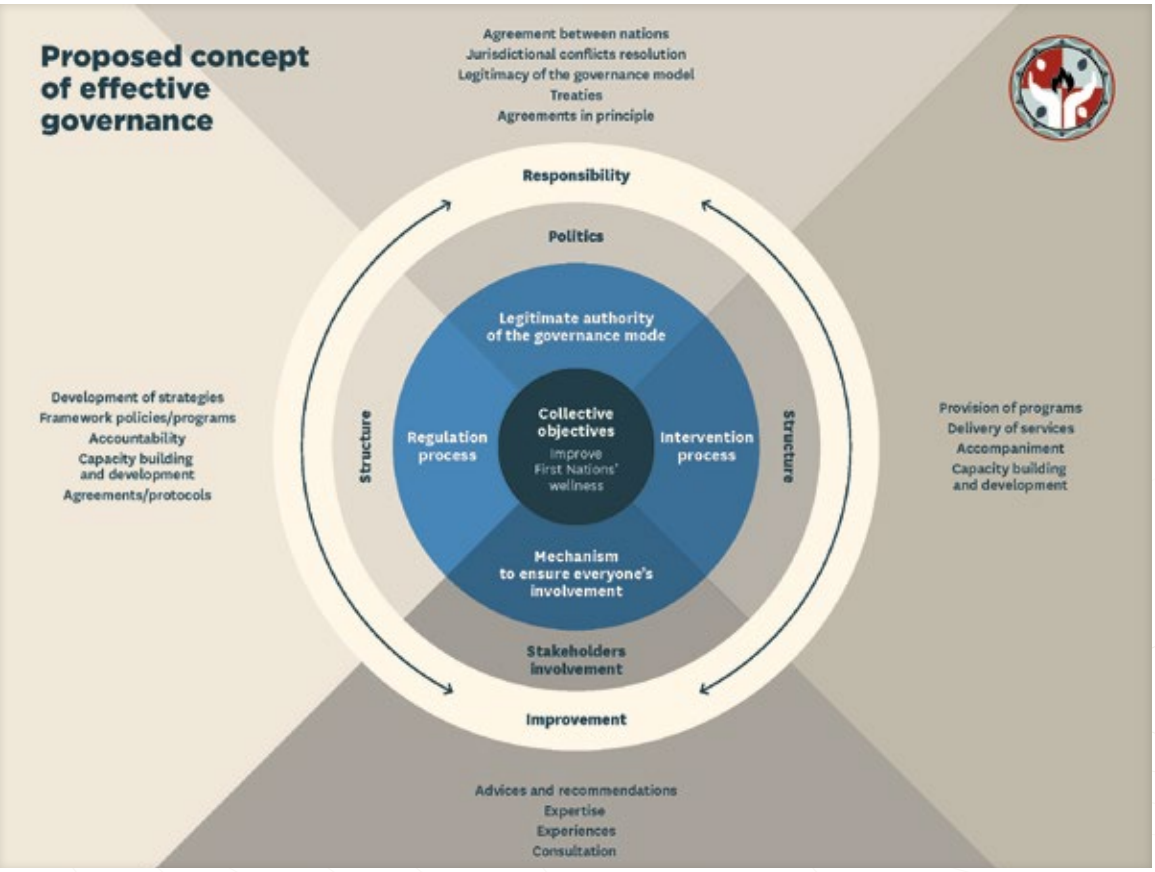
Phase 1	Portrait of the situation	Your opinion
Phase 2	The options	The choice

Focus

Focus 1 Information gathering and research

Focus 2 Consultation, coordination and experience sharing

Focus 3 Communication, monitoring and evaluation



Phase II

- BE IT RESOLVED that the **Chiefs support the continuation of** the health and social services **governance process mandate** given to the FNQLHSSC and further mandate the FNQLHSSC to undertake, within 4 years, **proceedings and discussions with the federal and provincial governments** in order to formally agree upon a **process to transition to a new governance model** that will give Quebec First Nations **more autonomy** in the area of health and social services in order to improve their well-being. These actions will be implemented in collaboration with the Chiefs' Advisory Committee while ensuring consistency with the principles and values adopted in February 2014.

Phase II – April 2016 – March 2020
Expected Results

- That an effective health and social services governance model be available, applicable, and that it meet the needs of First Nations
- That the areas of jurisdiction of the federal and provincial governments, as well as First Nations, are clarified

7

Specific Objective of the Governance Process

Provide the communities with the information they need so that they can choose their health and social services institutions and governance mode:

- Integrate the functioning of FNIHB and INAC
- Identify obstacles that arise in the administration of programs due to jurisdictional conflicts
- Complete the health and social services environmental overview
- Initiate discussions for implementing a transition process towards an alternative governance model

8

Phase II: Summer and Fall of 2016

- Pre-AGA on July 13
- Establish an overview of the management of FNIHB - September 2016
- Establish an overview of the management of INAC - October 2016
- Committee of Partners - November 8
- Regional meeting - November 9 and 10, 2016
- Visits to communities (upon their request)

9

Wela'lin Meegwetch Tià:wen Nià:wen Tshi Nashkumitin

Patrice Lacasse, placasse@cssspnql.com
Suzie Nepton, snepton@cssspnql.com

10

C APPENDIX

INDIGENOUS GOVERNANCE: THE FIRST NATIONS MENTAL WELLNESS CONTINUUM FRAMEWORK AND CULTURE AS THE FOUNDATION FOR GOVERNANCE IN HEALTH AND SOCIAL SERVICES (POWERPOINT)

Governance Interests

- Explore key elements that need to be considered in developing a new model of governance in health and social services.
  - Existing models of First Nations health and social services governance in Canada rely on the type of agreement that is based on legislative and political provisions to define jurisdiction and funding
- A model of governance that will respect our "common" culture and nations cultures.
  - First Nations want to institute a governance model that integrates their culture and understanding of health.
  - First Nations lay claim to the right to offer their population health and social services that are culturally adapted.

Indigenous Governance

- A way forward that will ensure the right outcomes
- Puts a stop to the loss of resources

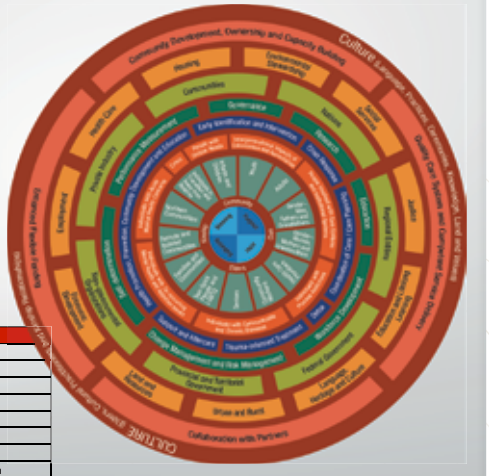
First Nations Mental Wellness Continuum Framework

Key Themes:

1. Culture as foundation
2. Community Development and Ownership
3. Quality Health System and Competent Service Delivery
4. Collaboration with Partners
5. Enhanced flexible funding investments

Supporting Elements:

Performance Measurement
Research
Workforce Development
Change Management
Governance
Self-Determination



Legend: (from centre to outer ring)
4 Directions (outcomes)
Community
Populations
Specific Population Needs
Continuum of Essential Services
Supporting Components/Infrastructure
Partners in Implementation
Indigenous Social Determinants of Health
Key Themes for Mental Wellness
Culture as Foundation

Mental Wellness

- The First Nations Mental Wellness Continuum Framework (FNMWC) is meant to address “mental wellness” which is a concept meant to bring mental health and substance use issues together in the context of the indigenous social determinants of health by relying on culture as the foundation for a strengths based approach across the life span.

First Nations Mental Wellness Continuum

Who? Across the lifespan and for families and communities

What? Access to the full basket of mental wellness services:
- Health Promotion, Prevention, Community Development, and Education
- Early Identification and Intervention
- Crisis Response
- Coordination of Care and Care Planning
- Detox
- Trauma-informed Treatment
- Support and Aftercare

How?
- **Culture as the Foundation / Strengths Based Approach**
- Partnerships, collaboration, aggregation, alternative service delivery models, flexible funding, elimination of program silos, quality improvement
- Team-based approaches, link with primary care and public health approaches, including with communicable and chronic disease
- Focus on individuals, families, and communities, across the lifespan

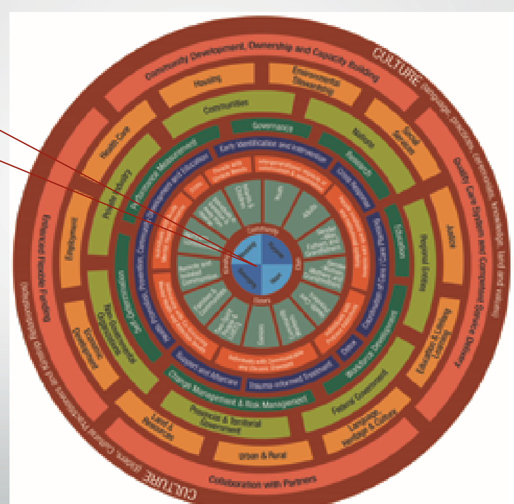
Outcomes

Hope: identity, belief/world view, values

Belonging: relationship, family, community, attitude

Meaning: intuitive, rational, understanding

Purpose: way of being, way of doing, wholeness



Applying the Framework: Conceptual Shifts

From: Focus on deficits	To: Discovery of strengths
Evidence that excludes Indigenous worldview, values, culture	Indigenous worldview, values, and culture that are the foundation to determine the relevance and acceptability of various sources of evidence in a community context
Focus on inputs for individuals	Focus on outcomes for individuals, families and communities; holistic collaborative approaches
Uncoordinated, fragmented programs and services	Comprehensive planning and integrated federal/provincial/territorial/ sub-regional/First Nations models for funding and service delivery
Communities working within program silo restrictions	Communities optimize and realign their mental wellness programs and services based on their priorities
FN Collaboration without capacity	FN Capacity strengthens multi-sectoral links, connecting health programs and social services, across provincial/territorial and federal systems to support integrated case management taking into account the First Nations social determinants of health

Wellness is not the absence of disease

- Throughout the history of First Nations people, the definition of health evolved around the whole being of each person-the physical, emotional, mental and spiritual aspects of a person being in balance and harmony with each other as well with the environment and other beings. This has clashed with the western medical model which, until very recently, has perpetuated the concept of health as being "the absence of disease" (Favel-King, 1993:125).10

Outcomes

Mental wellness is a balance of the spiritual, emotional, mental, and physical. This balance is enriched as individuals have:

- **HOPE** for their future and those of their families that is grounded in a sense of identity, unique Indigenous values, and having a connection to an indigenous world view which is grounded in a belief in spirit
- a sense of **BELONGING** and connectedness within family, to community, having relationship with Creation and an attitude towards "living"
- a sense of **MEANING** that is created by indigenous knowledge and from the accumulation of education
- **PURPOSE** in their daily lives whether it is through education, employment, care-giving activities, is grounded in cultural ways of being and doing

Standard Components of Governance

1. Set of ideas - a model or philosophy for governing
2. Direction to collective human activity or form of action:
   - governing is not about doing the job of operations, administration and management and instead it is about giving direction
3. Process for decision making according to policies that set out clear relationship and boundaries between governance and management
4. Determining who is involved and why
5. Rendering account to stakeholders: clear measurable change

=

Promotion and Protection of your stakeholders and their interests

What's Missing?

Ever since first contact, indigenous people have been attempting to achieve *their* definition of intelligence, to be as productive as *they* are, as successful as *they* are and as intelligent as *they* are. In doing so, indigenous people have lost the encompassing nature of *our* definition of intelligence — *indigenous intelligence*.

Elder Jim Dumont

First Nations Governance Center

- Governance is the traditions (norms, values, culture, language) and institutions (formal structures, organization, practices) that a community uses to make decisions & accomplish its goals.
- At the heart of the concept of governance is the creation of effective, accountable and legitimate systems and processes where citizens articulate their interests, exercise their rights & responsibilities and reconcile their differences (2009, p. vii)

Indigenous Knowledge is foundation of Governance

- Intelligence involves more than the acquisition of knowledge and the manipulation of thoughts; intelligence has to do with activating knowledge into something useable *within a system that is charged with meaning*.
- Indigenous intelligence is the wise and conscientious embodiment of exemplary knowledge and the use of this knowledge in a good, beneficial and meaningful way.

(Elder Jim Dumont)

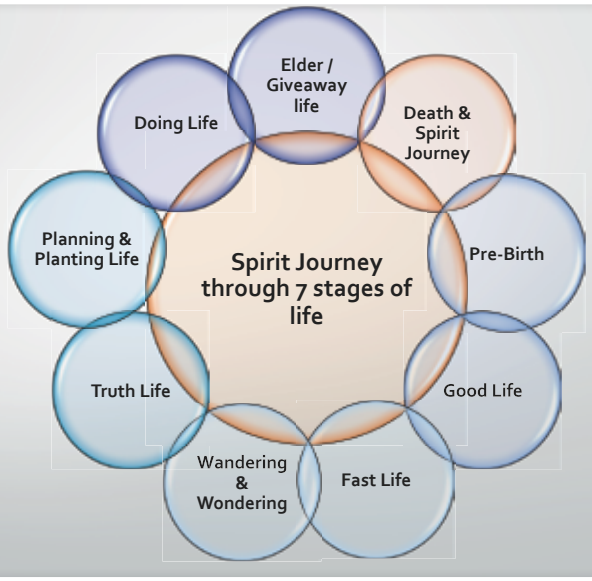
RESEARCH QUESTIONS

1. What is a whole and healthy person?
2. How does Indigenous Culture facilitate wellness?
3. When we rely on culture to promote wellness, what should we expect the outcomes to be?

First Nations Voice said…

Hope, Belonging, Meaning, & Purpose Across the 7 Stages of Life

(Based on Peter Ochiese, Aki winini and enhanced to include prebirth and death)

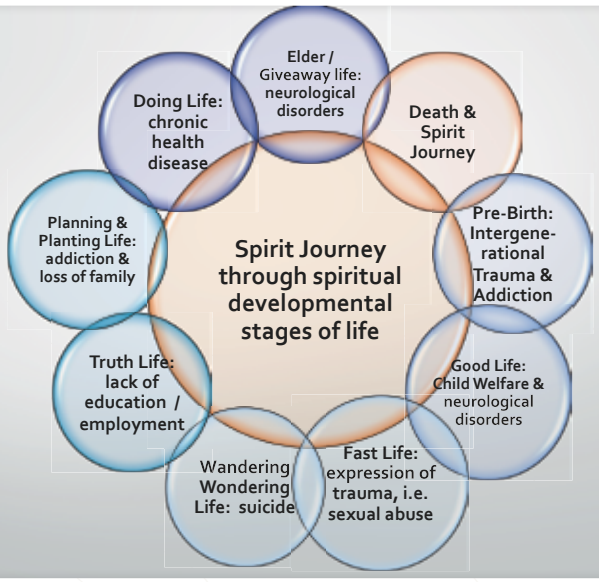


"Prevention goes hand in hand with a traditional healthy lifestyle. Good health is achieved when we live in a balanced relationship with the earth and the natural world. Everything we need is provided by our common mother, earth: whole foods, pure water and air, medicines and the laws and teaching which show us how to use things wisely. Combined with an active lifestyle, a positive attitude, and peaceful and harmonious relations with people and their spiritual world good health will be ours."1Malloch, 1989

Touches the earth for the first time

The Stages of Life without culture

(Based on Peter Ochiese, Aki winini and enhanced to include prebirth and death)



Decolonizing Indigenous Governance

- Understand how governance works across different governing bodies
- Putting forward Indigenous world view:
  - Guided by spirit / Accountable to spirit
  - Community inclusion and ensuring the voice of the people
  - Relearning Indigenous Worldview – understanding colonization as a "surface view/ way of thinking
  - Developing indigenous based evidence / drawing upon indigenous based evidence

Clan system as Structural order for Governance

- Clans go across cultures and nationhood to unite people as family.
- A bear clan person in the Mohawk nation is related as family to a person who is bear clan from the Innu nation. Clan systems provide structure for family relationships, social order and governance. The identity of beings within Creation, as given by the Creator, are what inform a person's role as a doctor, counselor, teacher/philosopher, leader/chief, singer/artist, peace keeper, strategist, person who works with the medicines, child welfare—adoption, building/construction and all other roles necessary for "nationhood". In this way, clan systems provide social order to community living and provide structure for indigenous governance. Clans facilitate an understanding of ones spiritually gifted roles, responsibilities, belonging, purpose and meaning in life.

(FNMWC, p5)

Governance Responsibilities for FNMWC

- champion efforts to facilitate the shift to "culture as the foundation";
- help bridge gaps and promote a systems approach;
- set out objectives, including how members will be accountable to existing structures for implementation;
- incorporate strong partnerships, collaboration, meaningful engagement of stakeholders;
- and monitor and evaluate progress on implementation opportunities.

Hope Belonging Meaning & Purpose

Every investment towards wellness should be measured by the extent to which it creates a sense of:

- Hope
- Belonging
- Meaning
- Purpose

Community Wellness Indicators

Community Wellness Indicators

Health indicators are measurements. They measure different aspects of health within a community or group. Each indicator is like a piece of a puzzle contributing to an overall picture. When indicators are tracked over time, the picture becomes a movie, allowing us to see how the health story is changing.

However, if all we are tracking are deficit based indicators, then how do we ever know what the state of wellness is or how it was achieved.

- It requires a shift in focus from health professional assessed outcomes to client outcomes. In the current problem-based model, the most important outcomes are patient satisfaction and rates of mortality and morbidity (Wong and Cummings 2007). Strengths-based outcomes are concerned with the human spirit and the whole person and would enlarge the spotlight to include health, healing, quality of life and subjective well-being. (Gotlieb, 2012)

Native Wellness Assessment ™

Is made up of 2 assessment forms:

(1) Self-Report Form (completed by client)
(2) Observer-Report Form (completed by service provider)

The assessment is administered twice during services.

Communities can access aggregate data for groups/populations within the community or for the community as a whole


Www.thunderbirdpf.org
Native Wellness Assessment
The Native Wellness Assessment™ (NWA™) instrument was launched on June 25, 2015 and is the first of its kind in the world. It is a product of the Honouring Our Strengths: Indigenous Culture as Intervention in Addictions Treatment (CasI) research project whose team included Indigenous and non-Indigenous researchers from across Canada, Elders, Indigenous knowledge keepers, cultural practitioners, service providers, and decision makers. The NWA™ is now available for use.
Click here to access the NWA
Western treatment practices generally take a narrow view of the addiction instead of the person's overall wellness. An Indigenous approach to wellness is holistic in nature; health from an Indigenous perspective is broadly envisioned as wellness and is understood to exist where there is physical, emotional, mental, and spiritual harmony as outlined in the First Nations Mental Wellness Continuum Framework. It is recognized at accredited National Native Alcohol and Drug Abuse Program (NNADAP) and Youth Solvent Addiction Program (YSAP) treatment centres that Indigenous traditional culture is vital for client healing.


Thank you
Carol Hopkins
chopkins@thunderbirdpf.org
519.692.9922 ext. 301
1.866.763.4714
www.thunderbirdpf.org

D **APPENDIX**

DIAGRAM OF THE CURRENT FEDERAL GOVERNANCE FOR FNIHB (POWERPOINT)

DIAGRAM OF THE CURRENT FEDERAL GOVERNANCE FOR FNIHB

Canadian Parliament: Federal spending

Treasury Board: Management of public funds
Funding allocated to First Nations

Health Canada/FNIHB Headquarters

- Development of health programs
- Development of accountability procedures
- Preparation of budget requests
- Accountability to Treasury Board

1

FNIHB Regional Office in Montréal
Management of health programs

Development of health plans with the communities

- Expertise in each of the programs for improving the health plan

Assessment of health plans

- With a view to developing the agreements
- Codification for funding

Health protection/Mandatory programs

- Environmental health, infectious diseases control and management, primary care, what is governed by a professional order

Accountability: relating to programs

- Report analysis; reporting to Headquarters

2

FNIHB Regional Office in Montréal
Management of contribution agreements

Development of agreements

- Capacity and risk analysis
- Financial analysis (eligibility)

Funding

- Regular management; commitment of funds, payments, eligibility of expenses

Default management

- Crisis management and service disruption

Non-Insured Health Benefits
Health Services Integration Fund

Accountability: relating to financial management

FNIHB Regional Office in Montréal
Community accompaniment

Liaison unit (single window)

- Community accompaniment for the implementation of the commitments
- Represents the communities for the internal committees

Nursing

- Health plan
- Clinical component

Action Forum

- Health plan
- Emergency situations to ensure community services

E APPENDIX

SUMMARY TABLE – DIAGRAM OF THE CURRENT FEDERAL GOVERNANCE FOR THE FIRST NATIONS AND INUIT HEALTH BRANCH (FNIHB)

Canadian Parliament: Federal spending
Treasury Board: Management of public funds; funding allocated to First Nations

Health Canada/FNIHB Headquarters:
• Development of health programs • Development of accountability procedures • Preparation of budget requests • Accountability to Treasury Board

FNIHB Regional Office in Montreal		
Management of health programs	**Management of contribution agreements**	**Community accompaniment**
Development of health plans with the communities • Expertise in each of the programs for improving the health plan **Assessment of health plans** • With a view to developing the agreements • Codification for funding **Health protection/Mandatory programs** • Environmental health, infectious disease control and management, primary care, what is governed by a professional order **Accountability**: relating to programs • Report analysis; reporting to Headquarters	**Development of agreements** • Capacity and risk analysis • Financial analysis (eligibility) **Funding** • Regular management; commitment of funds, payments, eligibility of expenses **Default management** • Crisis management and service disruption **Non-Insured Health Benefits** **Health Services Integration Fund** **Accountability:** relating to financial management	**Liaison unit (single window)** • Community accompaniment for the implementation of the commitments • Represents the communities for the internal committees **Nursing** • Health plan • Clinical component **Action Forum** • Health plan • Emergency situations to ensure community services

F APPENDIX

OUTCOME OF THE WORKSHOP ON *APPROPRIATION OF THE HEALTH PLAN: SHARING PERSONAL EXPERIENCES*

TOPIC	RESPONSES
The role of the health plan in all health services	**The plan's current role in communities:** _ For some, the health plan is just a document that provides access to funding. _ Many community practitioners do not use the health plan. _ There is a concern about the purpose of the health plan, namely, whether it meets the requirements of Health Canada or of First Nations. The policies drawn up by Health Canada do not seem applicable in the communities, and this leads to management problems. Communities must meet its members' needs, which may lead to shortfalls. _ Before the health plan came into use, funding was allocated by program. Now that health plans are in place, First Nations play a bigger role in defining priorities provided they fit into the Health Canada framework. **The role communities would like the health plan to play:** _ The health plan can be used as a reference tool for each practitioner's annual work plan as it helps identify targets to be reached. _ The health plan is a reference document for reporting as it contains measurement indicators. _ It also serves as a guide for the allocation of resources. _ The health plan must be a living document, and each practitioner must be responsible for a part of the plan. _ For assessing the health plan, it is more realistic to use indicators for which practitioners have already collected data. _ The objectives set out in the plan should be realistic and achievable. _ Communities have a management committee to monitor the health plan. _ When the health plan is based on a logical model, it becomes possible to assess the achievement of objectives. _ To obtain measurable indicators, it is important for the health plan to be operational. _ Some think the health plan makes it possible to create structures or projects that meet local requirements and foster protection factors based on culture.

TOPIC	RESPONSES
Contents of the health plan	_ Communities assess clientele-specific needs. _ The community health plan doesn't cover all needs (e.g. access to services offered by the province). _ Some feel it replicates Health Canada's approach and work must be done for the plan to better reflect the community. _ Many activities implemented in the community are not part of the health plan. _ Before the health plan can be drawn up, it is necessary to look at what is working well and must be continued. _ It is important to recognize existing skills in communities even if the individuals with such skills are not certified professionals. _ It is important for the health plan to be flexible. Planning must be adjusted regularly. An annual plan assessment can help with adjusting activities. _ Communities have to manage crisis situations and when such crises occur, other scheduled activities must be put aside. _ Processes that take collective wellness into account must be put in place. The scope needs to go beyond the individual and be mindful of the community environment. _ Strategic planning is closely linked to the health plan as both are based on the same priorities. _ Activities are defined according to identified priorities.
Creation of the health plan	**Health plan drafting:** _ In general, the health sector is in charge of drafting the health plan. _ Consultants are sometimes used for drafting the health plan, but this is not preferred. _ When a consultant is hired, he or she is often supported by a local team. _ In many communities, a committee representing residents and different sectors has been created. _ When the health plan is drafted by consultants, it is more difficult for the community to take ownership. _ The health plan is approved by the Chief and the band council, then by Health Canada. For other communities, the health plan is approved by the health committee tasked with doing so. _ Some communities submit the health plan to their residents. _ If services are not transferred to a community, that community does not create a health plan. _ Political interference was mentioned as an occasional challenge to drafting the health plan.

TOPIC	RESPONSES
Creation of the health plan (cont.)	**Health plan funding:** _ No funds are allocated to the communities/to certain communities for drafting the health plan. _ Funds allocated to communities are not indexed according to needs but based on previous decisions. _ Health and social services are funded by different federal departments that do not necessarily communicate with each other. _ Priorities are often set according to funds available at Health Canada. _ Health Canada funds do not take community remoteness into account. _ Depending on the type of funds granted to the community (predetermined, general, etc.), the community has varying degrees of flexibility to redirect its activities when a crisis occurs. _ Certain needs identified in a needs analysis cannot be met because the costs are ineligible under federal programs.
Consultations to develop the health plan	**Citizen involvement:** _ To get residents involved, communities use questionnaires or focus groups. _ There is a desire for greater citizen participation in the process, although Health Canada has not requested this. However, members of the public do not always have the necessary perspective (administrative structure, legal framework, etc.). _ There is a desire for citizens to be more accountable for their health. Community members must not only have their say but must also share responsibility. **Involvement of other stakeholders:** _ An approach based on health determinants is preferred, and it is important for all sectors to contribute. Work must not be carried out in silos. However, not everyone has a good understanding of this approach. _ The other sectors of the community can contribute, for instance by sharing the data they collect. _ Some communities consult Health Canada for guidance in drafting their health plan while others do not want Health Canada to be involved. _ If the health plan is not approved by community stakeholders, it is likely to remain shelved.

G APPENDIX

OUTCOME OF THE WORKSHOP ON *APPROPRIATION OF STRATEGIC PLANNING FOR HEALTH AND WELLNESS*

Objective for Workshop 3: To appropriate health planning in the First Nations' effective governance model by seeking a consensus for the guidelines on what community health and wellness planning should be.

TOPICS	PROPOSED GUIDELINES	VOTING RESULTS	DISCUSSION AND COMMENTS FROM PARTICIPANTS	GUIDELINES MODIFIED OR ADDED
Role of community health and wellness planning in effective governance	Community health and wellness planning should be developed using a holistic approach that: **a.** Aligns with the community's Vision; **b.** Includes an analysis of the communities' health needs; **c.** Includes an analysis of the social determinants that influence community health needs, in order to provide better services to the community. **d.** The plan should take all these points into consideration.	**a.** 100% totally agree **b.** 100% totally agree **c.** 100% totally agree **d.** 100% totally (voting by show of hands)		Community health and wellness planning should be developed using a holistic approach that: _ Aligns with the community's Vision; _ Includes an analysis of the communities' health needs; _ Includes an analysis of the social determinants that influence community health needs, in order to provide better services to the community.

TOPICS	PROPOSED GUIDELINES	VOTING RESULTS	DISCUSSION AND COMMENTS FROM PARTICIPANTS	GUIDELINES MODIFIED OR ADDED
Role of community health and wellness planning in effective governance (cont.)	Community health and wellness planning should be a tool that mobilizes all community actors to actively pursue the Vision for holistic health and wellness, and give the community specific objectives to improve community health and wellness.	93% totally agree 7% slightly agree	_ There are concerns about the feasibility of this aspect. _ What is meant by "actors" needs to be defined more clearly. The population must be included in the definition. _ Including all groups within a community, such as elders, is important.	Community health and wellness planning should be a tool that mobilizes all community actors, including the population, to actively pursue the Vision for holistic health and wellness, and give the community specific objectives to improve community health and wellness.
	In the constant pursuit of the community's Vision for health and wellness, the community health and wellness planning should be designed as a continuous improvement tool for the community's health and wellness activities and services, allowing for ongoing review according to the achievement of objectives.	100% totally agree		In the constant pursuit of the community's Vision for health and wellness, the community health and wellness planning should be designed as a continuous improvement tool for the community's health and wellness activities and services, allowing for ongoing review according to the achievement of objectives.
	Planning for community health and wellness should strengthen our culture, our values, and our way of life.	100% totally agree (voting by show of hands)	_ Culture must be an integral part of the community's vision.	Planning for health and wellness should strengthen our culture, our values, and our way of life.
Creation of community health and wellness planning in effective governance	The responsibility for community health and wellness planning should be entrusted to a committee led and coordinated by the health director and made up of the community actors involved in health services and related activities as well as those whose activities touch on the social determinants of health in the community (mandate and actor membership/ commitment).	65% totally agree 35% slightly agree	_ Comfortable with the idea of a committee, but the committee should have a neutral coordinator and strong leadership to mobilize other sectors. Still plenty of work in silos. The general management should make a decision to bring all community players together. Responsibility should be shared. There should not be multiple committees in the same community. _ Change the word "actor" to "stakeholder." For example, support is needed from the political arena. Even if the issue does not directly affect politics, political involvement can provide support or guidelines. _ Strong leadership from politicians and the government makes it easier to implement projects.	The responsibility for community health and wellness planning should be entrusted to a committee led and coordinated by the health director and made up of the community stakeholders involved in health services and related activities as well as those whose activities touch on the social determinants of health in the community.

TOPICS	PROPOSED GUIDELINES	VOTING RESULTS	DISCUSSION AND COMMENTS FROM PARTICIPANTS	GUIDELINES MODIFIED OR ADDED
Creation of community health and wellness planning in effective governance (cont.)	Community health and wellness planning should be developed from data gathered, including data from consultations with the community.	85% totally agree 15% slightly agree	— People who do not live in communities (outside reserves) and those who are temporarily absent are being forgotten. Planning must take all First Nations into account, no matter where they live. — Activities that are already successful must also be considered. — Relevant data must be specified, for example, data on education, housing, police, and so on. — Cultural data must be included.	Community health and wellness planning should be developed from data gathered, including data from consultations with the community.
	Committee members should arrive at a consensus on community health and wellness planning.	58% totally agree 34% slightly agree 8% disagree	— It is not realistic for the population to approve health plans by consensus. For some communities, reality and emergencies can compromise consensus, particularity in decision making. — Consensus is desirable, but for large communities, existing dynamics and the different interests of various groups cannot be ignored, which makes consensus impossible. However, that does not mean it is acceptable to do nothing. — Different ways to make decisions must be identified. — When consensus is sought, sometimes people will challenge what is being said, for a more in-depth discussion. If the objective is to reach consensus, discussion can be restricted. — The population must be involved. Committee members must submit and propose, and the population must accept. The notion of consensus is not always desirable (achievable). There must be a procedure for resolving conflict. — The goal must be conciliation among communities, because it is not certain that communities will always be in harmony.	Ideally, committee members should arrive at a consensus or a similar type of agreement on community health and wellness planning.
	To gain legitimacy, community health and wellness planning should be approved by the band council.	67% totally agree 29% slightly agree 4% disagree	— The insertion of "or a delegated authority" has been suggested since in certain communities, drafting the health plan is a delegated task. — There is a concern about the feasibility of a band council reading the entire document. It has been proposed that an advisor chair the health plan drafting committee.	To gain legitimacy, planning for health and wellness should be approved by the band council, or a delegated authority.

TOPICS	PROPOSED GUIDELINES	VOTING RESULTS	DISCUSSION AND COMMENTS FROM PARTICIPANTS	GUIDELINES MODIFIED OR ADDED
Community health and wellness planning content in effective governance	Analyzing community health needs should be done using a rigorous and systematic approach to give credibility to the results.	50% totally agree 46% slightly agree 4% disagree	_ There should also be a procedure for sharing data. _ This disciplined approach must not become a requirement. Sometimes we have to take risks and get off the beaten path. We have to be realistic. Not all communities have the necessary expertise, knowledge, and resources. This is not always the approach recommended by the community. _ Efforts must be made to develop capabilities so that data, and by extension, needs, can be analyzed. _ This statement seems too firm. We need more flexibility. We do need credible data, but such data is not always available. Although not always scientific, knowledge and experience can be useful data.	To the extent possible, analyzing community health needs should be done using a rigorous and systematic approach to give credibility to the results.
	Analyzing the social determinants that influence community health needs should be done using a rigorous and systematic approach to give credibility to the results.	40% totally agree 60% slightly agree	_ The approach for social determinants is not fully understood and incorporated by all stakeholders. For example, in one community, the housing sector does not keep useful data, so we cannot count on that. So data credibility is an issue. There is a need for training and for data management systems and associated resources. _ Land use must be included as an important factor for health.	To the extent possible, analyzing the social determinants that influence community health needs should be done using a rigorous and systematic approach to give credibility to the results.
	The results of the analyses of health needs and social determinants should be included in the objectives set by the community health and wellness planning process.	76% totally agree 24% slightly agree	_ Should we have culture indicators? With the implication that culture is integral to wellness (100% fully agree by show of hands).	The results of the analyses of health needs and social determinants should be included in the objectives set by the community health and wellness planning process.

TOPICS	PROPOSED GUIDELINES	VOTING RESULTS	DISCUSSION AND COMMENTS FROM PARTICIPANTS	GUIDELINES MODIFIED OR ADDED
Setting priorities in community health and wellness planning	Prioritizing objectives during the planning should take several factors into account: **a.** the severity of the impacts on people and the community if no intervention takes place **b.** the actual potential of achieving the desired results **c.** the costs related to the interventions needed to achieve the desired results **d.** the community's perception of the urgency of responding to these needs **e.** a general health strategy	**a.** 73% totally agree 27% slightly agree **b.** 38% totally agree 62% slightly agree **c.** 39% totally agree 52% slightly agree 9% disagree **d.** 74% totally agree 26% slightly agree **e.** 91% totally agree 9% slightly agree	_ In addition to the severity of the impacts, the incidence of illnesses must be considered. _ Sometimes, priorities are determined based on existing structures that are not meeting needs. This practice should stop. _ Balancing various budgets is also an issue. Some actions are necessary and meet needs, but they are not approved by donor agencies. _ The human dimension must be taken into account. For example, a hospital admission can be traumatic. Cultural aspects must be considered to make hospitals stays much less difficult. _ Success for just one person is already a considerable achievement and therefore must be a priority (such as when a person breaks free from an addiction). _ There must be more openness and flexibility in relation to drug use. Health Canada is stuck on Western ways of doing things. The population feels ill equipped to deal with the issue. _ Young people use technology and there are no resources available to address these situations. There is a need for openness to changes in technology and media. _ Work must also be done to strengthen cultural practices.	Prioritizing objectives during the planning must take several factors into account: _ the severity of the impacts on people and the community if no intervention takes place _ the scope, i.e. the number of people affected _ the actual potential of achieving the desired result _ the costs related to the interventions needed to achieve the desired results _ the community's perception of the urgency of responding to these needs _ community culture and way of life _ a general health strategy
Programming activities and services in community health and wellness planning	The programming of activities and services should systematically be done according to the objectives specified in the prioritization.	79% totally agree 21% slightly agree	_ Putting the objectives aside, there should be some flexibility to allow for incidents and unexpected events and to encourage innovation. _ There should be enough flexibility to discontinue an activity if it is not producing the expected results.	The programming of activities and services should be determined according to the objectives specified in the prioritization, while allowing for a degree of flexibility.
	Indicators that make it possible to evaluate the achievement of each objective should be defined to enable an evaluation of activities and services with a view to continuous improvement.	82% totally agree 18% slightly agree	_ Indicators must motivate teams and communities. _ Qualitative indicators must also be established. Although it can be subjective, the perception of individuals is a reliable indicator for wellness and culture. _ How can we quantify wellness? _ We must be mindful of the indicators selected. For example, an indicator may tell us an activity took place even though the population did not take part.	Indicators that make it possible to evaluate the achievement of each objective should be defined to allow activities and services to be assessed for the purpose of continuous improvement.

A RENEWED APPROACH TO GOVERNANCE FOSTERING SELF-DETERMINATION

The health and social services governance process is part of an effort aiming to develop the autonomy of First Nations.

Communities have found that the current health and social services governance model does not meet the needs of the First Nations in Quebec. Therefore, the Chiefs of the Assembly of First Nations Quebec-Labrador entrusted the FNQLHSSC with the mandate to coordinate the development of a governance model that is adapted to the needs and context of the First Nations in Quebec while also being conducive to self-determination. This model is called the health and social services governance process.

The process is guided by the vision that was adopted by the Chiefs of the AFNQL in 2014:
Through our self-determination, a global and concerted approach, individual and collective commitment, we will be healthy people connected to Mother Earth and our physical, mental, emotional and spiritual well-being will be balanced.

For more information, please visit the website at www.cssspnql.com/champs-intervention/gouvernance.

SUMMARY

Given that the new governance model for First Nations health and social services is based on local planning, the regional meeting was an opportunity to look at how health plans are drawn up in communities and how First Nations can get involved in planning their health and wellness. Integration of the new governance model in First Nations culture was also discussed.

CSSSPNQL · FNQLHSSC

FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION