

## CASE 9

# Achieving Health Equity in Ontario: Increasing Capacity for Relationship Building with Indigenous Communities

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### INTRODUCTION

Paul Green sat down at his desk and stared blankly at the document in front of him. He had been anticipating the arrival of the new *Health Equity Guideline, 2018* (Ministry of Health and Long-Term Care [MOHLTC], 2018a), which was intended to assist boards of health in implementing the requirements established in the modernized *Ontario Public Health Standards' Health Equity Standard* (MOHLTC, 2017). As the newly hired Health Equity Manager at Turtle Creek Public Health (TCPH), Paul knew that it was his responsibility to ensure that the organization complied with the *Health Equity Standard* in its entirety. While he believed that TCPH was already meeting the Standards' requirements in relation to the assessment of population health inequities, Paul was concerned that his organization did not possess the capacity to build meaningful relationships with Indigenous communities. His worries were primarily rooted in the findings of an internal environmental scan that he had conducted just two weeks earlier, which revealed that many TCPH staff members were looking for further direction on how to work with local Indigenous communities.

Having grown up in Northern Ontario and worked as a Public Health Inspector for nearly 20 years at his local public health unit (PHU), Paul had established many close relationships with Indigenous colleagues and clients. While he was confident that he could draw upon his own lived experiences to devise a plausible solution for TCPH, Paul was unsure about how he should proceed. How could he foster organizational capacity for health equity action? What could he do to support his colleagues in the development of meaningful relationships with local Indigenous communities? At next week's strategic planning meeting with executive staff, Paul would need to provide a set of recommendations for organizational action, and he knew that time was of the essence. After taking a sip from his mug of coffee, Paul sighed deeply and logged into his desktop computer. He knew that he had his work cut out for him.

### BACKGROUND

#### Health Equity

As stated in the *Health Equity Guideline, 2018*, "health equity means that all people can reach their full health potential without disadvantage due to social position or other socially determined circumstance, such as ability, age, culture, ethnicity, family status, gender, language, race, religion, sex, social class, or socioeconomic status" (MOHLTC, 2018a, p.5). Health Equity is one of the four Foundational Standards that "underlie and support" all of the Ontario Public Health Standards' *Program Standards* (MOHLTC, 2017, p.15). To comply with the *Health Equity Standard*, boards of health must meet four main requirements. Although the first, second, and fourth requirements relate to the identification of effective local health strategies, orientation of public health interventions, and development of policy, the third requirement of the *Health Equity Standard* necessitates that boards of health "engage in multisectoral collaboration with

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municipalities, Local Health Integration Networks (LHINs), and other relevant stakeholders” to decrease health inequities (MOHLTC, 2018a, p.4). In addition, the third requirement mandates engagement with Indigenous communities and organizations that must include the “fostering and creation of meaningful relationships, starting with engagement through to collaborative partnerships” (MOHLTC, 2018a, p.4).

### **Turtle Creek Public Health (TCPH)**

TCPH is a PHU that delivers public health programs and services in the province of Ontario. It is located along the northern shoreline of Moccasin Lake and serves approximately 100,000 people. While collaborating with primary care providers to facilitate community clinics for immunization, STI screening, and dental services, TCPH also offers educational workshops on prenatal care, breastfeeding, and smoking cessation. In the catchment area served by TCPH, there are many residents of Indigenous heritage. Although some of these individuals live in urban areas, the large majority are habitants of one of the region’s three main Indigenous communities.

### **Community A**

Community A is a rural settlement territory that is populated by just 1,000 residents. It is home to a small recreation facility where Elders and community members participate in traditional ceremonies, hand-drumming circles, and crafting workshops on a monthly basis. Although primary care services are not presently available to residents in the community, Community A recently received federal funding to establish a new Child and Family Health Centre, which will provide Indigenous children, families, and caregivers with access to culturally responsive programming. When completed in 2020, the Centre will offer traditional language education classes, family cooking classes, beading workshops, and other initiatives to support healthy family and child development.

### **Community B**

Community B is a remote territory that is inhabited by nearly 2,000 residents. It is home to a Community Healing and Wellness Centre that offers family-centered health services to both Indigenous and non-Indigenous clients. While delivering holistic health programming that aims to support healthy parenting, early childhood development, chronic disease management, and mental wellness, the Centre also provides community members with access to primary care services via the Ontario Telemedicine Network.

### **Community C**

Community C is a lakeside settlement territory that is populated by approximately 2,400 residents. While home to a community recreation complex, an elementary school, and a collegiate education centre, Community C recently constructed a Community Wellness Centre to address local health disparities. Staffed by an interdisciplinary team of Registered Nurses, Well-Being Counsellors, and Community Support Workers, the Community Wellness Centre delivers a range of culturally appropriate health programs to residents of all ages and abilities. These include a diabetes education program, a family and child development program, and a mental health program that addresses issues such as substance abuse and addiction through one-on-one counseling sessions, peer support groups, fasting camps, sweat lodges, and traditional ceremonies.

## **PUBLIC HEALTH UNIT SURVEY: CURRENT CAPACITY FOR RELATIONSHIP BUILDING WITH INDIGENOUS COMMUNITIES**

In 2017, a Locally Driven Collaborative Project was initiated in Northern Ontario to identify current engagement practices as well as perceived successes and challenges within the context

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of engagement between Ontario PHUs and First Nations communities (Public Health Ontario, 2018). Although it consisted of multiple phases, the second step of the project involved distributing a comprehensive survey to 14 Ontario PHUs whose catchment areas intersect with a First Nations community. The results of the survey revealed that 79% of the respondents did not feel that their PHU possessed the “skills or knowledge to effectively engage with First Nations communities” (Public Health Ontario, 2018, p. 31). In addition, more than 75% of the respondents reported that their PHU required further resources to support First Nations community engagement (Public Health Ontario, 2018).

After a series of questions pertaining to organizational hiring protocols and First Nations representation on boards of health, the participating PHUs were asked to outline any barriers that they had encountered when attempting to foster relationships with First Nations communities. While a number of different challenges were highlighted, the large majority of the respondents indicated that their PHU was grappling with at least one of the issues highlighted below.

### **Jurisdictional Ambiguities**

Ontario PHUs reported that jurisdictional ambiguities prevented them from engaging with First Nations communities. Many respondents expressed that they were unsure if their organization was most responsible or appropriate for the provision of programs and services in First Nations communities, as health service delivery is also a responsibility of the federal government (Public Health Ontario, 2018). Additionally, a number of the respondents indicated that the presence of multiple PHUs in proximity to a given First Nations community led to uncertainty about who should offer to deliver services. These respondents stated that they were hesitant to reach out due to concerns about infringing upon relationship building with a First Nations community whose boundaries intersect with a different health unit.

### **Funding Shortages**

More than 75% of the responding PHUs stated that further resources were required to support engagement with First Nations communities (Public Health Ontario, 2018). Additionally, 100% of the PHUs that indicated the need for additional support checked off the “programming dollars for PHUs” box when prompted by the survey. Moreover, 77% of the respondents indicated that allocating programming dollars to First Nations communities would also be of significant benefit to facilitating the development of meaningful relationships (Public Health Ontario 2018). When asked about how additional funding could be utilized, a number of the PHUs suggested investing in additional human resources and cultural competency training for internal staff (Public Health Ontario, 2018).

### **Absence of Indigenous Health Data**

A number of the PHUs reported that data on Indigenous health was insufficient (Public Health Ontario, 2018). These respondents later added that the absence of data created difficulties with respect to the development and delivery of evidence-based programming in First Nations communities (Public Health Ontario, 2018). While four of the participating PHUs reported that they were in the process of developing a data-sharing agreement with a First Nations community, just one of the PHUs indicated that they actually had a formalized agreement in place (Public Health Ontario, 2018).

## **TWO WEEKS EARLIER: THE ENVIRONMENTAL SCAN**

After hearing about the results of the Northern Ontario PHU survey from his organization’s Medical Officer of Health, Paul decided to conduct an internal environmental scan to explore the nature and quality of existing relationships between TCPH program areas and local Indigenous

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communities. The health unit had hired an MPH student named Riley Woods for the summer, and Paul recruited Riley to join his team and assist with the completion of the environmental scan. To obtain the information needed, Paul sat down for an audio-recorded interview with each of TCPH's six program managers. As anticipated, his conversations revealed variability with respect to levels of engagement between different TCPH program areas and Indigenous community partners. While five of the program managers reported having some contact with service providers in Community C, only three stated that they had reached out to stakeholders in Community B. In addition, just two of the program managers reported that they had engaged with partners in Community A. Surprisingly, three program managers were not aware that Community A and Community B were located within the catchment area of TCPH.

After his interviews with the TCPH program managers, Paul asked Riley to review each of the interview transcripts for the purpose of identifying common themes. Riley quickly pinpointed *engagement type* as a predominant concept and decided to code the interview transcripts in accordance with Arnstein's "Ladder of Citizen Participation" (Exhibit 1). Through coding, Riley determined that the large majority of TCPH's interactions with local Indigenous communities could be characterized as varying degrees of *tokenism*. According to Arnstein (1969, p. 217), tokenism is an engagement approach whereby "citizens may indeed hear and be heard, but under these conditions, lack the power to ensure that their views will be heeded by the powerful". Riley prepared a briefing note to report the key findings to Paul and set up a meeting to discuss the next steps for the organization.

To validate the findings of the environmental scan, Paul asked Riley to carry out a second interview with each program manager, focusing on the existing capacities and unique needs of their respective program areas for the development of meaningful relationships with local Indigenous communities. During the follow-up interviews, many of the program managers spoke about experiencing similar barriers to those reported in the Northern Ontario PHU survey. Others simply stated that their department required further direction on how to work with local Indigenous communities. When prompting each manager to speak about existing knowledge gaps with respect to Indigenous peoples, the majority reported that they did not fully understand how relationships between Indigenous and non-Indigenous peoples came to be so fragile.

### THE HISTORICAL ROOTS OF FRAGMENTED RELATIONSHIPS: COLONIALISM AND ITS IMPACT ON INDIGENOUS PEOPLES IN CANADA

Colonialism is defined as a set of policies and practices where a political power from one territory exerts control or influence over a different territory (Social Sciences and Humanities Research Council of Canada, 2016). It involves the exploitation of a nation's resources and forced assimilation of its people into a dominant culture or group (Czyzewski, 2011). In Canada, colonialism is often cited as an impetus for the fractured relationship that currently exists between Indigenous and non-Indigenous peoples. Over hundreds of years, non-Indigenous settlers forcibly displaced Indigenous peoples from their traditional lands and established colonial policies and systems in an effort to eradicate Indigenous languages and cultures. Some of these policies and systems are outlined in Exhibit 2.

### THE SOCIAL DETERMINANTS OF INDIGENOUS HEALTH

Social determinants of health (SDOH) are the conditions in which people are born, grow, live, work, and age (World Health Organization, 2018). For Canada's Indigenous peoples, SDOH may be further delineated as circumstances, environments, structures, and institutions that influence the development and maintenance of health along a continuum of excellent to poor (National Collaborating Centre for Aboriginal Health [NCCA], 2015). While direct causal relationships are difficult to establish, there is growing evidence to suggest that social

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determinants such as colonialism and self-determination are closely linked to the adverse health issues observed in many Indigenous communities today (Czyzewski, 2011). These social determinants largely stem from colonial policies and historical events, which have fractured relationships between Indigenous and non-Indigenous Canadians. To illustrate the magnitude of their impact on the physical, emotional, mental, and spiritual domains of Indigenous well-being, the NCCAH (2015) categorizes social determinants of Indigenous health as distal, intermediate, or proximal in nature (Exhibit 3).

### DISTAL DETERMINANTS

#### Self-Determination

Self-determination has been cited as the most important determinant of health among Indigenous peoples as it greatly influences other social determinants such as education, housing, safety, and access to health services (MOHLTC, 2018b). In Canada, the persistence of colonial structures, policies, and legislation has resulted in the unequal participation of Indigenous peoples in the political systems under which they are governed (NCCAH, 2015). Under the *Indian Act*, 1985, restrictions are placed upon Indigenous peoples with respect to the lands that they may use for hunting, fishing, and harvesting resources (Mashford-Pringle, 2016). Additionally, the *Indian Act* limits Indigenous governance over community decision-making and constrains the services available to Indigenous peoples on reserves (Mashford-Pringle, 2016). Consequently, the absence of autonomy in relation to decision-making surrounding legal property, economic assets, education systems, and health services has been linked to the manifestation of adverse physical and mental health outcomes among Indigenous peoples (Reading & Wein, 2009). Research conducted by Reading & Wein (2009) links the absence of control or self-determination among Indigenous peoples to low self-esteem, anxiety, depression, and substance use disorders.

### INTERMEDIATE DETERMINANTS

#### Health Care Systems

Early Western health care systems were underpinned by an agenda that sought to sustain Canada's colonial legacy, with the ratification of the *Indian Act* leading to the enforcement of regulations that permitted the sanitation of Indigenous reserves (Kelm, 1998). During the 20th century, thousands of Indigenous peoples were forcibly removed from their homes and admitted to Indian hospitals for treatment of diseases such as whooping cough and tuberculosis, with the large majority never returning to their communities (Lux, 2010). These historical events are the premise of long-held apprehensions among many Indigenous peoples with respect to accessing health care services from Western institutions today. At present, many Indigenous peoples have yet to obtain appropriate physical, political, and social access to the Canadian health care system, and this prevents them from achieving their fullest health potential (NCCAH, 2015). While insufficient access to health services on reserves remains the most pressing health inequity experienced by Indigenous peoples, the fragmentation of the federal system for health care delivery has resulted in a large number of individuals who have unmet health needs (NCCAH, 2015). Furthermore, the existing structure of the health care system significantly impacts the health outcomes of many Indigenous peoples, who are often unable to pursue educational opportunities, obtain employment, or maintain social support networks due to the damaging repercussions of chronic health conditions (NCCAH, 2015).

### PROXIMAL DETERMINANTS

#### Physical Environments

Physical environments that are detrimental to the health of Indigenous peoples have been imposed through the historic dispossession of traditional territory (NCCAH, 2015). Following the introduction of the Indian reserve system, many Indigenous peoples in Canada lost access to

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lands that were once available for hunting, fishing, and trapping, which has subsequently created issues related to food insecurity and poverty (Kelm, 1998). In addition, thousands of Indigenous families do not have adequate housing and are unable to access safe drinking water on reserves, as their ancestors were forced to settle on small tracts of land scattered across rural and remote regions of the country (NCCAH, 2015). On many Indigenous reserves, inadequate housing has caused overcrowding to become commonplace, with multiple families often residing under the same roof. These living conditions place many Indigenous peoples at an increased risk of developing adverse health conditions (NCCAH, 2015). In addition to creating situations of overcrowding, the loss of traditional lands through colonization has also reduced opportunities for Indigenous peoples to engage in traditional practices, resulting in the loss of cultural identity (NCCAH, 2015). According to Wexler (2009), the loss of cultural identity has been linked to high rates of suicide among Indigenous peoples, with cultural connection cited as an integral component of Indigenous well-being.

### APPROACHING SOCIAL DETERMINANTS OF INDIGENOUS HEALTH AT TCPH

To develop recommendations for his organization's next steps, Paul would need to consider the social determinants of Indigenous health and their impact on Indigenous peoples residing within the catchment area of TCPH. While understanding that Indigenous communities in Canada are being disproportionately burdened by many of the proximal, intermediate, and distal determinants of Indigenous health, he was unsure about the magnitude of their impact within the three local Indigenous communities. He was also unsure about whether the scope of his work at TCPH would allow him to address all of the issues that stemmed from these determinants. He didn't believe that his organization could effectively tackle social determinants like self-determination without the assistance of Indigenous community partners, and realized that meaningful progress could not be made without establishing meaningful relationships.

### FOUNDATIONAL PRINCIPLES FOR RELATIONSHIP BUILDING

In 2017, a literature review was conducted by an interdisciplinary project team from Northern Ontario in collaboration with Public Health Ontario to identify mutually beneficial, respectful, and effective principles and practices for engagement between First Nations communities and Ontario PHUs (Public Health Ontario, 2017). Through a comprehensive analysis of both grey and published literature, four foundational principles emerged. These include the following:

#### Trust

Trust is the foundation to building respectful and mutually empowering long-term relationships with Indigenous peoples (Public Health Ontario, 2017). When attempting to cultivate relationships with members of Indigenous communities, it is imperative to acknowledge the historical events and colonial policies that have contributed to feelings of mistrust internalized by many Indigenous peoples today (Public Health Ontario, 2017). It is also important that organizations and agencies reach out to Indigenous communities that they wish to partner with and initiate early dialogue, as fostering trust requires a significant amount of time and should not be rushed (Public Health Ontario, 2017). Finally, it is essential that non-Indigenous peoples and organizations connect with Elders and spiritual leaders in the Indigenous communities that they hope to engage, as these individuals often play an integral role in building bridges between Western organizations/agencies and members of their community (Public Health Ontario, 2017).

#### Respect

Respect is a rudimentary principle that encompasses traditional practices such as honouring, knowing, and understanding (Public Health Ontario, 2017). It delineates the need for non-Indigenous peoples to acknowledge and appreciate both the history and current context of Indigenous peoples in Canada (Public Health Ontario, 2017). This includes recognizing cultural

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practices, traditions, protocols, values, and views while acknowledging the existence and impact of assimilationist, colonizing, oppressive, and suppressive policies and actions within legal, political, social, economic, and health-related contexts (Public Health Ontario, 2017). When aiming to cultivate relationships with Indigenous communities, it is imperative that non-Indigenous peoples actively seek to enhance their cultural competency, pursuing opportunities for personal growth through educational training or community mentorship (Public Health Ontario, 2017).

### **Self-Determination**

Self-determination is the inherent right of Indigenous peoples to freely choose their own pathways and to make decisions about all aspects of their communities and livelihoods (Public Health Ontario, 2017). It supports cultural preservation and ensures that sovereignty is respected in a way that provides clear benefits to Indigenous peoples and communities. To honour the principle of self-determination, those working with Indigenous peoples must strive to establish partnerships that are Indigenous-driven and strengths-based, building upon the capacities and assets that Indigenous communities possess (Public Health Ontario, 2017). Additionally, those engaging with Indigenous peoples are more likely to be successful if they operate within a framework where self-determination is consistently acknowledged, understood, and honoured (Public Health Ontario, 2017).

### **Commitment**

Commitment is a principle that supports prosperous engagement if appropriate practices are in place (Public Health Ontario, 2017). These practices include exploring ways to work in a more culturally appropriate manner and the prioritization of Indigenous self-determination. In accordance with the principle of commitment, relationship building with Indigenous peoples must be viewed as a long-term process, as it requires time, patience, and meaningful dialogue. The process of engagement with Indigenous communities must also be deliberate and adaptive, while facilitated by people who are fully committed to Indigenous empowerment, priority setting, and decision-making (Public Health Ontario, 2017). To cultivate meaningful partnerships with Indigenous peoples, organizations and agencies must aim to establish an authentic presence in the communities they are working with, attending community events when invited and supporting community-led initiatives. In addition, non-Indigenous peoples may strengthen relationships with their Indigenous counterparts by routinely engaging in the practice of self-reflection, acknowledging the balance of power within a partnership while identifying opportunities for personal growth (Public Health Ontario, 2017).

### **INTERNALIZING PRINCIPLES FOR RELATIONSHIP BUILDING AT TCPH**

To develop an appropriate set of recommendations for TCPH, Paul would also need to be cognizant of the foundational principles for relationship building with First Nations communities. While confident that his approach should be guided by trust, respect, self-determination, and commitment, he was unsure about how he could encourage staff within his organization to internalize and employ these principles when engaging and working with Indigenous peoples. He was also unsure about what each of the aforementioned principles meant to those residing within the three Indigenous communities located in TCPH's catchment area, and understood that this knowledge could only be obtained by cultivating meaningful partnerships.

### **A WORD OF ADVICE**

After a counterproductive morning of brainstorming possible recommendations for organizational action, Paul dejectedly retreated to the lunchroom. As his plastic container of chicken and veggies sizzled in the microwave, he was approached by Jen Girard, TCPH's new Community Engagement Liaison. Over lunch, the pair engaged in a spirited conversation, with

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Paul explaining his dilemma and expressing that he needed assistance. Having collaborated with an Indigenous community on a health promotion initiative at her previous place of employment, Jen recommended that Paul consider the development of an Indigenous Relationship Building Strategy for TCPH. She expressed that meaningful relationships with local Indigenous communities could not be established if TCPH staff did not first develop an understanding of each community's unique history, current context, and preferences for engagement. After taking a moment to reflect upon Jen's remarks, Paul began to wonder about how he might obtain the information required to educate his staff and develop an organizational strategy. At a recent conference, Paul had learned about a new planning tool developed by Public Health Ontario called a *Situational Assessment*, and wondered if he could utilize this approach to assist TCPH in developing a preliminary understanding of how to effectively, appropriately, and meaningfully build relationships with local Indigenous communities.

### SITUATIONAL ASSESSMENT

A situational assessment is a systematic process to gather, analyze, synthesize, and communicate data to inform planning decisions [(Public Health Ontario (PHO), 2015)]. It is the second step of PHO's six-step model for planning a health promotion program (PHO, 2015). While often used to gather information that can inform decisions regarding strategies or frameworks, a situational assessment may be carried out to learn more about a population of interest and identify the wants, needs, and assets of a community (PHO, 2015). According to PHO (2015), a situational assessment must consist of the following steps:

1. Identify key questions to be answered
2. Develop a data-gathering plan
3. Gather the data
4. Organize, synthesize, and summarize the data
5. Communicate the information
6. Consider how to proceed with planning

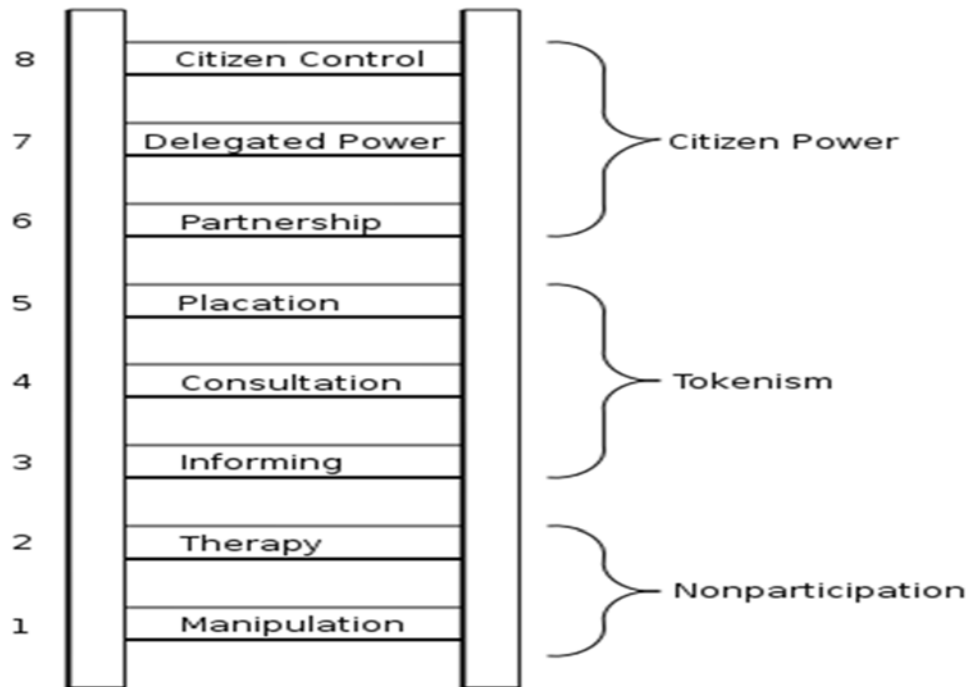
### PAUL'S NEXT STEPS

After mulling over his colleague's advice for the remainder of the afternoon, Paul decided that conducting a situational assessment using PHO's six strategic steps would be crucial to inform the development of an Indigenous Relationship Building Strategy for TCPH. While allowing him to identify the assets and opportunities that could be leveraged in local Indigenous communities to support the development of meaningful relationships, an organizational strategy could provide his colleagues with the guidance they had requested. In addition, an Indigenous Relationship Building Strategy could foster organizational capacity for health equity action, and assist TCPH in meeting each of the requirements outlined in the *Health Equity Standard*.

With time remaining in Riley's placement at TCPH, Paul wanted to get him started on the situational assessment right away. However, Paul was unsure about where to begin. What questions should be asked? What important considerations needed to be made? After pausing to reflect, Paul collected himself and prepared to face the many challenges ahead. With the support of his team at TCPH, he was confident that meaningful relationships could be developed with Indigenous peoples and communities for generations to come.

EXHIBIT 1

Arnstein's Ladder of Citizen Participation



Source: Arnstein, 1969. © The American Planning Association, [www.planning.org](http://www.planning.org), reprinted by permission of Taylor & Francis Ltd, <http://www.tandfonline.com> on behalf of The American Planning Association.

**EXHIBIT 2**

**The Historical Roots of Fragmented Relationships**

**Early Land Treaties**

Following the conclusion of the Seven Years' War in 1763, King George III established the *Royal Proclamation*, a foundational document that set guidelines for European settlement on Indigenous lands (Government of Canada, 2016). While explicitly stating that the lands of North America are to be considered the "hunting grounds" of Indigenous peoples, the document declares that any territory occupied by Indigenous peoples cannot be ceded unless the Crown purchases the land and sells it on their behalf (Government of Canada, 2016). Between 1871 and 1921, 11 land surrender treaties were signed between Indigenous leaders and the Crown, which allowed thousands of European colonists to settle upon Indigenous lands (Usher et al., 1992). In recent years, the federal government has fielded a number of complaints in relation to the legitimacy of the land surrender treaties. Several Indigenous groups have voiced their belief in the notion that the treaties were rushed, fraudulent, incomplete, and in many cases, breached by governing bodies (Government of Canada, 2011).

**The Indian Act**

The *Indian Act, 1876* is a statute through which the federal government may determine who can and cannot legally be considered a "Status Indian" (Allan & Smylie, 2015). It is largely responsible for the relocation of Indigenous peoples to Indian reserves from their traditional lands. In the establishment of the Indian reserve system, the federal government appointed Indian Agents for each community and granted them the authority to restrict the movement of residents on and off reserves using a written pass system (Allan & Smylie, 2015). Under the *Indian Act*, "Indian" identity was once rooted in male lineage, and legal status was stripped away from any woman who chose to marry a partner who did not meet the federally imposed definition of Indian (Mikkonen & Raphael, 2010). Although it has undergone a number of amendments since it was passed in 1876, the *Indian Act* remains in place today and largely retains its original form.

**Residential School System**

In the late 1880s, the federal government sponsored religious organizations to operate residential schools with the intention of "kill[ing] the Indian in the child" and forcing Indigenous youth to assimilate into dominant Canadian culture (Bombay et al., 2014; Smith et al., 2005). Over a period of nearly 100 years, it is estimated that nearly 150,000 Indigenous children were removed from the care of their families for the purpose of attending a residential schooling institution (Bombay et al., 2014). Under the instruction of religious missionaries and government officials, students of Indigenous heritage were taught to be ashamed of their languages, cultures, and beliefs. At residential schools, thousands of Indigenous children became the subjects of unethical experiments and endured various forms of physical, mental, and sexual abuse, with many eventually losing their lives (Bombay et al., 2014). Although the last institution closed down in the mid-1990s, residential schools have had "rippling, multigenerational effects on survivors, negatively impacting the health of their children, grandchildren, and great-grandchildren" (Allan & Smylie, 2015, p. 7).

**EXHIBIT 3**

**Social Determinants of Indigenous Health**

**DISTAL DETERMINANTS**

**Colonialism**

There is increasing consensus that the oppressive and colonial structure within which Indigenous peoples live produces social, political, and economic inequities that prevent many individuals from maintaining a connection to their Indigenous heritage (Waldram, Herring, & Young, 2006; NCCAH, 2015). Primary examples of this are the traumatic experiences of Indigenous children who attended residential schools. While stripping many Survivors of their cultural identities, residential schools have also been cited as an impetus for the manifestation of physical and mental health disparities among Indigenous peoples (Waldram, Herring, & Young, 2006). Butler-Jones (2008) stated that “diminished life expectancy, disproportional burden of chronic disease, communicable illness, addictions, and social violence have all been linked to an overarching colonial structure”. In short, these adverse health outcomes may subsequently influence educational achievement, likelihood of employment, socioeconomic status, and living conditions of Indigenous peoples (Czyzewski, 2011). As such, the aforementioned consequences of diminished health may subsequently cycle into future generations of Indigenous families if those affected are unable to access the supports they desire to heal from unresolved trauma (NCCAH, 2015).

**INTERMEDIATE DETERMINANTS**

**Education Systems**

Although the number of Indigenous children pursuing an education continues to trend upwards, there is limited Indigenous involvement in the development of school curricula in Canada (Neegan, 2005). Across the nation, culturally appropriate education continues to be denied to Indigenous children and youth, as mainstream education systems pay little attention to the social determinants that place Indigenous students at a disadvantage in relation to their non-Indigenous peers (NCCAH, 2015). Existing curricula are largely devoid of Indigenous-specific content and fail to acknowledge the intergenerational impacts of residential schools and other colonial events that have shaped the current contexts of Indigenous communities in Canada (Neegan, 2005). These glaring oversights may subsequently have profound consequences for many Indigenous youth, impeding the acquisition of knowledge and skills that are needed to pursue higher education, obtain stable employment, and secure adequate housing (NCCAH, 2015). According to Statistics Canada (2010), approximately 22% of Indigenous youth in Canada drop out or are “pushed out” of high schools in comparison to just 8.5% of non-Indigenous youth.

**PROXIMAL DETERMINANTS**

**Health Behaviours**

Intergenerational trauma stemming from colonialism and historical oppression has greatly shaped the health behaviours of Indigenous peoples in Canada (NCCAH, 2015). High rates of alcohol consumption, drug use, and smoking are observed among many Indigenous Canadians, which significantly increases their likelihood of suffering from heart disease or lung cancer, and increases their risk of all-cause mortality (NCCAH, 2015). With respect to Indigenous populations, adverse health behaviours are often adopted as a means through which to cope with injury, illness, stress, or pain associated with unfavourable social conditions or traumatic events (Frohlich, Ross, & Richmond, 2006). According to Physicians for a Smoke-Free Canada (2013), the smoking rate among Canada’s Indigenous population is nearly twice that of non-Indigenous Canadians (39% compared with 20.5%). Upon further analysis of population subgroups, the disparity between Indigenous and non-Indigenous smoking rates increases significantly, with the prevalence of smoking estimated to be three times higher for Indigenous youth than it is for non-Indigenous youth (Jetty, 2017).

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## INSTRUCTOR GUIDANCE

# Achieving Health Equity in Ontario: Increasing Capacity for Relationship Building with Indigenous Communities

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### BACKGROUND

Paul Green is concerned that his organization is not meeting the requirements of the modernized *Ontario Public Health Standards' Health Equity Standard* after his colleagues ask for direction on working with local Indigenous communities. Under the third requirement of the new *Health Equity Standard*, all boards of health must engage with Indigenous communities and organizations, which must include the “fostering and creation of meaningful relationships”. As the new Health Equity Manager at Turtle Creek Public Health (TCPH), Paul is tasked with developing a set of recommendations for organizational action. After receiving advice from a colleague, Paul decides that the next step for his organization is to conduct a situational assessment to explore how it may effectively, appropriately, and meaningfully build relationships with local Indigenous communities. However, Paul is unsure about where to begin. What questions should be asked? What important considerations need to be made? By developing an understanding of community histories, current contexts, colonial policies, historical events, social determinants of Indigenous health, and the foundational principles for relationship building with First Nations communities, meaningful partnerships may be cultivated with stakeholders and organizations in Indigenous communities across the province.

### OBJECTIVES

1. Identify existing barriers to relationship building with Indigenous communities from the perspective of public health units in the province of Ontario.
2. Discuss the means by which historical events and colonial policies undermine Indigenous health and create challenges to achieving health equity at organizational, community, and societal levels.
3. Identify and differentiate between the proximal, intermediate, and distal determinants of health that affect Indigenous peoples in Canada.
4. Develop an understanding of what a meaningful relationship might look like and how a meaningful relationship may be cultivated with Indigenous peoples.
5. Develop a context-specific situational assessment plan for a public health unit wanting to create an Indigenous Relationship Building Strategy.

### DISCUSSION QUESTIONS

1. What were some of the barriers encountered by Ontario public health units when attempting to build relationships with Indigenous communities?
  - Have you ever encountered any of these barriers during a volunteer or work experience? Were you able to overcome this barrier? If so, how?
2. List the social determinants of health that are present in the case.
  - In which categories do each of these determinants fit?
3. Explain the link between the social determinants of Indigenous health and the colonial policies and historical events outlined in the Case Note/required readings.

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4. Define each of the four foundational principles to relationship building with First Nations communities.
5. What is a meaningful relationship? What might a meaningful relationship look like? How might a meaningful relationship be fostered?
6. What is a situational assessment? Why might a situational assessment be conducted? How might a situational assessment support engagement and the development of meaningful relationships?
7. Can a situational assessment plan that is developed for working with a particular Indigenous community be utilized to work with another Indigenous community? Why or why not?
8. Some Indigenous peoples are hesitant to participate in research initiatives due to the mistreatment of their ancestors and family members in previous studies. How could you appropriately and respectfully engage Indigenous communities to encourage their participation?
9. Describe the achievements or challenges that your learning team experienced during the situational assessment planning activity.
10. Highlight a key aspect of another learning team's situational assessment plan that your learning team did not consider during the activity. How might this aspect or element have strengthened your learning team's plan?

### KEYWORDS

Health equity; Indigenous communities; relationship building; social determinants of health; situational assessment