Health Actions

CASE STUDY REPORT

AS PART OF THE EVALUATION OF THE TRIPARTITE FRAMEWORK AGREEMENT ON FIRST NATION HEALTH GOVERNANCE

Health Actions Case Study

First Nations Health Authority

Province of British Columbia

Indigenous Services Canada

December 2019

The work represented in this report is carried out on the unceded territories belonging to self-determining First Nations in what is now British Columbia. The Tripartite partners acknowledge and thank those who took the time to share their guidance and wisdom.

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Acronyms

Acronym / Abbreviation	Full Term
BC	British Columbia
BCAAFC	BC Association of Aboriginal Friendship Centres
FNHA	First Nations Health Authority
FNIHB	Health Canada First Nations and Inuit Health Branch
Framework Agreement	*British Columbia Tripartite Framework Agreement on First Nations Health Governance* (2011)
HHH	Hope, Help, Healing
JJCC	Tla'amin Jeh Circle of Care
Joint Project Board	Joint Ministry of Health – First Nations Health Authority Project Board
NGO	Non-Governmental Organization
USLCES	Upper St'at'imc Language Culture and Education Society

Terminology

The Canadian *Constitution Act* specifies that the Aboriginal peoples of Canada include the Indian (First Nations), Inuit and Métis peoples of Canada.[1] Increasingly, the term "Indigenous" is used in place of the term "Aboriginal," with an analogous meaning. In this report, the terms "Indigenous" and "Aboriginal" are used as they are in the source documentation cited.

The term "First Nations" is frequently used within this report. This term includes individuals with and without status under the *Indian Act*.

This report uses a range of data sources, some of which rely on self-identification of ethnicity to identify Indigenous sub-populations and others that are based on deterministic data linkages using the First Nations Client File.

The terms "at-home" and "community-based" are used to refer to geographically based First Nations communities, whether they qualify as "reserves" under the *Indian Act,*[2] or whether the First Nation has signed a modern treaty or holds title to the land. The term "away from home" signifies First Nations individuals who live away from their First Nation community.

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[1] Government of Canada. (n.d.), *Constitution Acts 1867 to 1982*. Retrieved September 9, 2019 from https://laws-lois.justice.gc.ca/eng/Const/page-16.html?txthl=inuit#inc.

[2] An act to amend and consolidate the laws respecting Indians, S.C. 1876, c. 18.

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Executive Summary

This case study on Health Actions was prepared to support the evaluation of the *British Columbia Tripartite Framework Agreement on First Nation Health Governance* (Framework Agreement).

Between 2006 and 2013, funding for Health Actions was provided to the First Nations Health Authority (FNHA) by both federal and provincial governments.

Provincial funding for Health Actions is provided to the FNHA from the BC Ministry of Health to implement the commitments in the 2006 *Transformative Change Accord: First Nations Health Plan*, which established Health Actions to be addressed by First Nations and the Province of British Columbia (BC). The amount was initially identified in Schedule 2 of the Framework Agreement. Flexible in nature, the FNHA has dedicated this funding to projects and activities that advance and align with the First Nations Perspective on Health and Wellness and that advance cultural and wellness-focused practices within a system that is inherently intervention and treatment-focused.

Federal funding for Health Actions was also provided to the FNHA within the context of the 2007 *Tripartite First Nations Health Plan,* which built upon the Health Actions cited in the 2006 *Transformative Change Accord: First Nations Health Plan* and supported regional engagement sessions that underpinned this work. Following the October 2013 transfer of the Health Canada First Nations and Inuit Health Branch[3] regional operations to the FNHA, ongoing federal funding for Health Actions was incorporated and embedded into the global funding amount provided to the FNHA as part of the FNHA's ongoing responsibilities for managing and delivering health programs and services for BC First Nations through the new First Nations health governance structure. This federal funding has primarily been dedicated to the governance and engagement aspects of health plan implementation, including Regional and Sub-Regional Caucus sessions and support capacity; initiatives and priorities of the governance entities, the First Nations Health Council and First Nations Health Directors Association; and, in recent years, activities led by the First Nations Health Council in the social determinants of health.

Both federal and provincial Health Actions funding is currently allocated to two streams: a provincial envelope and a regional allocation. This case study focuses on provincial Health

[3] The references to the Government of Canada's participation in this report is sometimes referred to as "Health Canada" and sometimes as "Indigenous Services Canada." This reflects that the work originated while the First Nations and Inuit Health Branch was within Health Canada, and was then transferred in December 2017 to a newly created federal department called Indigenous Services Canada.

Actions funding[4] and it provides brief examples of the provincial allocation, which is focused on wellness and health promotion, health knowledge and information, as well as investments in Health Human Resources and e-Health. Health Actions funding under the regional allocation can be used for a variety of initiatives supporting wellness and health promotion, traditional wellness, mental wellness and substance use, maternal and child health, and primary care and public health. Importantly, each region distributes their allocated funding in a way consistent with their own regional governance and management processes.

Following a previous evaluation of Health Actions between 2008 and 2013 (see Appendix C), this case study examines how, with a shift towards a more regional focus (due to the development of Regional Health and Wellness Plans, regional funding envelopes and the introduction of FNHA regional teams), Health Actions funding has been used to support projects and activities guided by each region's specific priorities. It also summarizes funding for Health Actions delivered by universities and Indigenous non-governmental organizations (NGOs).

An examination of the categories of initiatives supported by Health Actions funding reveals that this funding has been vital to cover priorities identified by BC First Nations. As well as enabling projects and activities to focus on traditional health and wellness, the main categories align to regional and community priorities, with projects within Mental Wellness and Substance Use, Health Capital and Planning, and Health Human Resources receiving the most funding.

The case study finds that Health Actions funding has had positive impacts on First Nations communities in BC. Its flexibility allows it to support collaborative development, innovation and projects that would not traditionally be funded. Moving forward, challenges remain around the sustainability of the funding stream, as well as issues around staff recruitment and retention, coverage of traditional medicine, community capacity and building awareness. Initial funding was committed through 2019/20. The partners have committed to continued partnership to support service delivery, including building on the strengths of Health Actions and addressing challenges."

[4] Governance and engagement are explored in the evaluation of the *British Columbia Tripartite Framework Agreement on First Nation Health Governance*, including regional engagement and the work of the First Nations Health Council and the First Nations Health Directors Association. See https://www.fnha.ca/about/governance-and-accountability/audits-and-evaluations

Introduction

The Health Actions Case Study was prepared to support the evaluation of the *British Columbia Tripartite Framework Agreement on First Nation Health Governance* (Framework Agreement). The case study provides background information about Health Actions funding, examines how funds were distributed across the province between 2014 and 2018, identifies the types of programming that First Nations communities pursued, and presents examples of community-driven wellness programs that exemplify a shift to a wellness-based health system for BC First Nations. The Health Actions case study set out to answer the following evaluation questions:

- Has the BC First Nations health governance structure enabled innovation?
- How are BC First Nations involved in health decision-making related to planning, design, management and delivery of health services?
- To what extent are health care initiatives, programs, services and policies responsive to the health needs of BC First Nations?
- To what extent are health care initiatives, programs, services and policies reflective of the First Nations Perspective on Health and Wellness?

Background

The 2006 *Transformative Change Accord: First Nations Health Plan,* signed by the First Nations Leadership Council and the Province of BC, established 29 health actions to be addressed jointly between the Province and First Nations. In June 2007, the First Nations Leadership Council, BC and the Government of Canada signed the *Tripartite First Nations Health Plan*,[5] which included an additional 10 Health Actions, bringing the total to 39. These were grouped into 31 Health Actions and eight Governance Actions (see Appendix C). This case study focuses solely on the Health Actions, which are grouped into seven key strategy areas:

- Primary Care and Public Health;
- Mental Wellness and Substance Use;
- Maternal and Child Health;
- Health Human Resources;
- eHealth;
- Health Capital and Planning; and
- Health Knowledge and Information.

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[5] First Nations Leadership Council, Government of Canada, Government of British Columbia. (2007). *Tripartite First Nations Health Plan.* Retrieved from https://www.fnha.ca/Documents/TripartiteFNHealthPlan.pdf.

Between 2007 and 2012, the Tripartite Management Team, composed of senior executives of each of the three signatories, oversaw work related to Health Actions. The team's responsibilities were to:

- Lead and oversee the implementation of Health Actions commitments in the *Tripartite First Nations Health Plan*;
- Identify Health Actions strategic priorities and ensure that these priorities evolved as the needs and aspirations of First Nations communities became clearer through their integral involvement in this work;
- Develop and provide strategic mandate statements and approaches for participants;
- Review progress reports on a quarterly basis;
- Report out on the status of Health Actions work; and
- Coordinate efforts on various Health Action items to ensure that the transition to a new governing body is efficient and comprehensive.

The Tripartite Management Team agreed on three fundamental principles that must underpin the approach to addressing Health Actions from the *Transformative Change Accord: First Nations Health Plan* (2006) and the *Tripartite First Nations Health Plan*:

- The Tripartite Partners will be at the table together to discuss transformation of health services that will benefit the health of First Nations communities in a new collaborative way of working. This requires that the "decision-makers" and those with responsibility and authority on all sides are at the table to inform, plan and make decisions about the system changes that are needed and to monitor the changes as they occur;
- First Nations will be at the table when making plans and decisions for all Health Actions (in whatever form First Nations choose to participate) that reflects increased First Nation decision-making in health at all levels, from strategy and planning to implementation and service delivery; and
- "System transformation" is the goal of all Health Actions work – services need to continue to change, adapt and improve so that they are more appropriate, accessible and effective for First Nations.

To provide strategic leadership, in 2010 the Tripartite Management Team created Tripartite Strategy Councils, with each aligning with one of the Health Actions strategy areas and consisting of senior executives from each Tripartite Partner with responsibility for decision-making in those strategy areas. Planning Committees provided technical planning support to the development of the Strategic Plans and the Health Actions work overall. The

Tripartite Partners and First Nations were represented at all levels of this committee structure and First Nations partners were engaged and kept informed of progress.

Schedule 2 of the Framework Agreement identifies the amount of funding that BC would continue to provide to the FNHA[6] each year to implement the commitments in the *Transformative Change Accord: First Nations Health Plan* and *Tripartite First Nations Health Plan*, as shown in Table 1 below.

Table 1: Schedule 2, Framework Agreement, British Columbia Funding for Health Actions

Fiscal Year	Annual Funding Amount $
2011/2012	4,000,000
2012/2013	6,500,000
2013/2014	8,000,000
2014/2015	10,000,000
2015/2016	11,000,000
2016/2017	11,000,000
2017/2018	11,000,000
2018/2019	11,000,000
2019/2020	11,000,000

On October 1, 2013, Health Canada First Nations and Inuit Health Branch programs and services in BC were successfully transferred to the FNHA. An evaluation of the progress of the Tripartite Partners in fulfilling Health Actions commitments from 2008 to 2013 was completed in 2014 (see Appendix A). This initial evaluation found that the time, effort and resources invested into Health Actions had resulted in notable progress, informed by engagement with BC First Nations and the transformative efforts in provincial and regional health governance structures.

Change to a Regional Focus

In 2014, using the findings from the initial evaluation, the Tripartite Strategy Councils concluded their operations, having successfully established provincial policy and planning strategies intended to enable regional and local planning and implementation. Since 2014, Health Actions work has been advanced through the Regional Partnership Accords, Joint

[6] This was initially provided to the First Nations Health Society.

Ministry of Health – First Nations Health Authority Project Board (Joint Project Board)[7] and efforts to embed the health and wellness of BC First Nations into the provincial health service structure.

In 2014, the FNHA Chief Executive Officer committed to absorb all staffing costs funded from Health Actions (except eHealth), freeing up more Health Actions funding for initiatives. At the same time, the funding approach shifted from being province-wide to incorporate both a provincial and regional focus. A provincial funding envelope has remained, targeted to investments that are provincial in scope or that have a province-wide impact. This has helped strengthen partnerships with organizations such as the First Nations Education Steering Committee and the BC Association of Aboriginal Friendship Centres (BCAAFC), thus allowing for alignment of strategic priorities and identifying areas for collaboration.

Additionally, the FNHA introduced five regional funding envelopes in the 2014/2015 fiscal year, which have generated momentum for implementing Health Actions by involving First Nations Regional Tables and regional health authorities and their new partnerships in the decision-making process. Using First Nations Regional Health and Wellness Plans as well as the Framework Agreement as strategic approaches, each region identifies projects, initiatives and investments within their Health Actions regional allocation. The flexibility of the funding is high and the FNHA continues to distribute Health Actions funding through funding instruments that include grants, contribution agreements and contracts, with funding going directly to communities.

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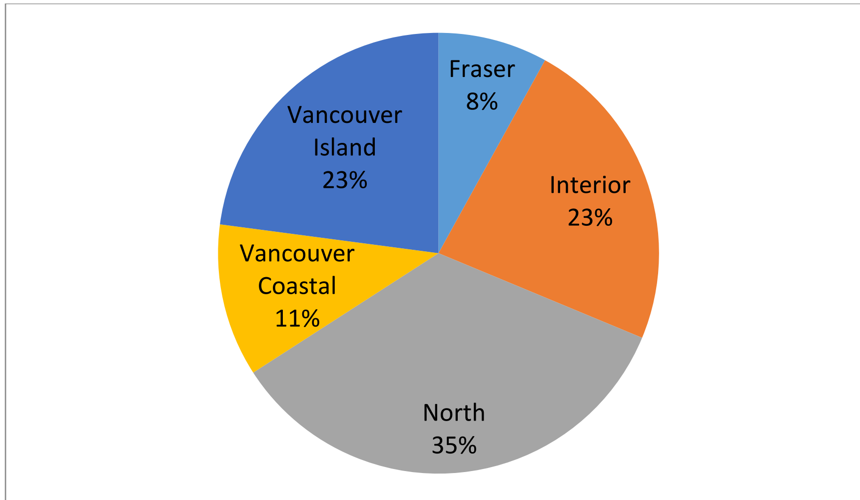
[7] A Joint Project Board was established between the FNHA and the BC Ministry of Health in 2012 to oversee the distribution of funding from the 2012 Agreement In Lieu of Medical Services Plan Premiums. The funding, which supported 27 new projects, needed to align to Regional Health and Wellness Plans, reflect partnership between First Nations and Health Authorities and support First Nations models of health and healing.

Figure 1: Approximate Allocation of Regional Envelope to Each Region



Health Actions funding was set at $10 million for 2014/2015 and $11 million for each subsequent fiscal year until 2019/2020 (see Table 1), divided between provincial and regional envelopes. Approximately 80% of the total funding was allocated to the regional envelope each year. Each region is allocated a proportion of this funding according to a formula that considers factors such as population size (at-home and away from home), percentage of contribution agreements, remoteness and geographic/climate impacts. Figure 1 shows the regional allocations based on this formula.

Initially, regions did not fully use the funding allocation within the fiscal year. However, as regional teams have gained capacity, regions have used the balances from the prior year as well as the funding allocation for each of the last three fiscal years.

At the time of this case study, Health Actions funding allocated to the FNHA as per Schedule 2 of the Framework Agreement was due to expire at the end of the 2019/2020 fiscal year; however, the partners have committed to continued partnership to support service delivery.

Methodology

This study covers all Health Actions funded from 2014 to 2018 and follows a mixed methods approach. Semi-structured interviews were carried out with staff from regional teams (one key informant from each region, except for the Interior, which had two key informants). The key informants were asked to select three to five projects that they considered innovative, community-driven and/or responsive to community needs. The projects could be either fully implemented with early positive change observable or undergoing implementation issues.

The evaluation included an administrative data review of financial records related to all Health Actions funds, including financial and narrative reports, and a document review of relevant, available documents related to Health Actions, including the 2014 evaluation report (see Appendix A) and the FNHA Annual Spending Plans.

Evaluators created an internal database of the financial and document review to allow regional and thematic analysis, with records analyzed and classified by category, sub-category, region, amount and funding date/year. The evaluators selected sub-categories according to either the project's most prominent descriptor or using the project's actual title in cases where the title was a common project type (e.g., Hope, Help and Healing (HHH), Commitment Stick Initiatives, Health Fairs and Community Travel Subsidy).

There are 557 Health Actions-funded initiatives/activities. Of these, 30 Health Actions initiatives/activities received multi-year funding. In these cases, this was specified in the original contribution agreement and is counted as a single Health Action initiative/activity. However, other Health Actions have annual agreements for the same project over multiple years (for example the KUU-US Crisis Line and Response Services, a 24-hour BC toll-free crisis line for Aboriginal people, and Tsow-Tun Le Lum, a helping house program) and these have been counted per agreement.

Finally, although projects are largely divided by region in the following report, a significant proportion of the funds was awarded to universities/NGOs, as well as a small portion to the provincial government (e.g., regional health authorities) and the FNHA itself. These are all included in the regional breakdown below.

Health Actions Funding

Health Actions funding has been allocated to two streams: a provincial envelope and a regional envelope. The 557 Health Actions funded between 2014 and 2018 were included in this case study analysis, amounting to a total funding amount of $32,805,193.42.

Provincial Envelope

Health Actions funding from the provincial envelope is primarily deployed through partnerships with groups such as the New Relationship Trust, First Nations Education Steering Committee, BCAAFC and others (listed in Appendix B), and this funding enables many innovative projects to be undertaken. The ongoing nature of the partnerships allows for deeper collaboration as partners meet regularly to review strategic opportunities and ensure alignment through regional structures.

One example that illustrates the impact of the provincial envelope is the 40th Annual BC Elders Gathering in 2016, organized by the Tletinqox Government. The Gathering was a four-day event with 18 supporting co-host communities and representation from over 200 communities across the province. The main objective of the annual Elders Gathering is to bring Elders together to share culture, attend health and cultural workshops, and enjoy entertainment and feasts together. The Elders Gathering also provides an opportunity for Elders to connect with their friends who live in urban centres.

In another example, the Gathering our Voices Aboriginal Youth Conferences made up three of the Health Actions projects under the Indigenous NGO category. The Aboriginal Youth Conferences are organized by the BCAAFC in partnership with the Provincial Aboriginal Youth Council. These annual four-day conferences welcome Indigenous youth (aged 14 to 24) from across the province. The 2018 event, attended by approximately 1,300 youth, focused on careers, employment and training, leadership, health, language and culture, the environment, education and lifelong learning, as well as sport and recreation. Attesting to its popularity, the event sold out within seven hours of the tickets going on sale and hundreds more youth attended than originally anticipated.

The provincial envelope also supported a set of projects related to the Hope Help Healing Toolkit. The HHH Toolkit was a progenitor of the Health Actions for First Nations and communities to prevent and respond to suicide and it aims to support community health leads and/or Community Champions in preparing for, learning about and navigating the journey towards developing suicide prevention, intervention and post-vention activities.[8]

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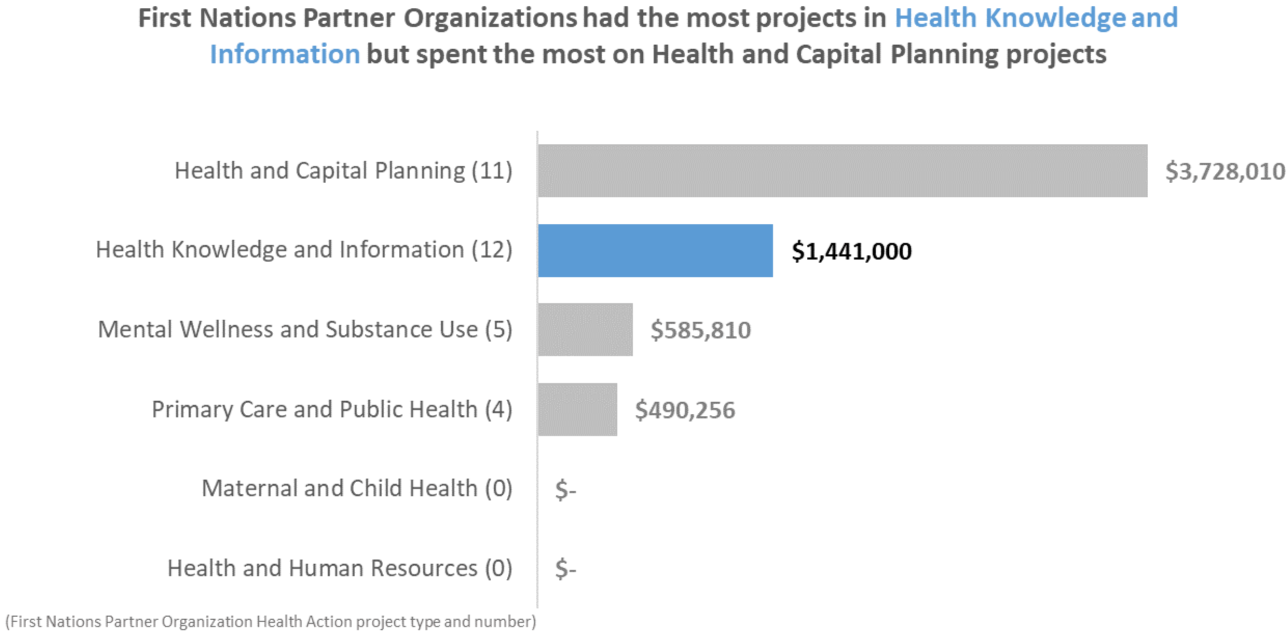
[8] First Nations Health Authority. (2015). *Hope, Help, Healing: A Planning Toolkit for First Nations and Aboriginal Communities to Prevent and Respond to Suicide*. Retrieved December 10, 2019 from https://www.fnha.ca/WellnessSite/WellnessDocuments/FNHA-Hope-Help-and-Healing.pdf.

Thirty HHH Health Action initiatives (11 in the Fraser Salish Region) were developed in partnership with Fraser Health through the Tripartite Working Group on Suicide Prevention, Intervention and Post-vention.

In 2016, Seabird Island received HHH Health Action funding to host a community event to take action against suicide. The event informed the community about the newly formed Community Action for Wellness group and introduced or reintroduced the community to healing, including healing through art and lateral kindness. Over 60 people of all ages attended the event. Following a welcome from the Chief and a song from Seabird Island's youth drummers, people had a chance to learn about drawing, pine needle basket weaving, cedar bark work and stitching a medicine pouch. After sharing a meal, attendees heard from a keynote speaker who addressed the topic of lateral kindness and could then participate in a discussion.

The provincial envelope funded First Nations partner organizations to deliver Health Actions, primarily in the Health and Capital Planning category, although the largest number of Health Action projects delivered by these organizations were for Health Knowledge and Information.

Figure 2: Project Type and Number of Projects Implemented by First Nations Partner Organizations



One First Nations partner organization that has used Health Actions funding for numerous projects is the BC First Nations Education Steering Committee, who in partnership with the First Nations Schools Association accessed multi-year funding for youth and education

projects (2018-2020). This Health Action centered around four projects: the First Nations Health and Science Career Promotion Program, Youth Mental Health Training/Information Workshops, the Circle of Well-being Challenge and the Seventh Generation Club. Project staff shared positive feedback, such as “It is worth more than words can say. The message is getting out there as we witness our students trying harder in the key subjects such as math, science and English,” and “The smiles say it all! Some students chosen for this specific project are at-risk. Seeing them excited about opportunities and eager to ask questions is amazing!” and “Thank you to everyone who makes this possible!”

More specifically, the two-day Youth Mental Health Training/Information Workshop trains educators in how to foster positive mental health and build mental health literacy so as to better understand students’ challenges and offer them appropriate support. Sixty Grade 6-12 educators from First Nations schools across the province participated to better understand potential mental health issues affecting struggling students and to increase their awareness of support options, promoting increased student well-being, school achievement and lifelong coping skills.

The Seventh Generation Club provides fun, engaging opportunities for First Nations students in BC, encouraging them to make healthy choices, participate in sports and community activities and understand the importance of regular school attendance and staying in school. One tool the program uses is Daytimers (daily planners), which are supplied to each youth in the program and include valuable information about how to study and learn and how to plan for post-secondary education and careers, as well as more information about wellness and health careers. Projected outcomes include distributing over 8,500 Seventh Generation Daytimers, as early reports from parents and educators suggest these tools are valued, well-used and represent a source of pride for the youth.

Finally, a well-known Health Action under the First Nations partner organization category is the Moose Hide Campaign. The campaign began as a partnership between the FNHA and the BCAAFC and was part of the BCAAFC’s Ending Violence Action Plan. It calls for Indigenous and non-Indigenous men and boys to wear a small patch of moose hide to signify their commitment to honour, respect and protect the women and children in their lives. The campaign has an educational component as well as a large social media following and internet presence, and it has grown to be well-known in Indigenous and non-Indigenous communities. Over time, the campaign has expanded beyond its initial concept, encouraging people of all genders to demonstrate their commitment. While the Moose

Hide Campaign was once associated with the BCAAFC, it is now its own independent entity.[9]

Regional Envelope

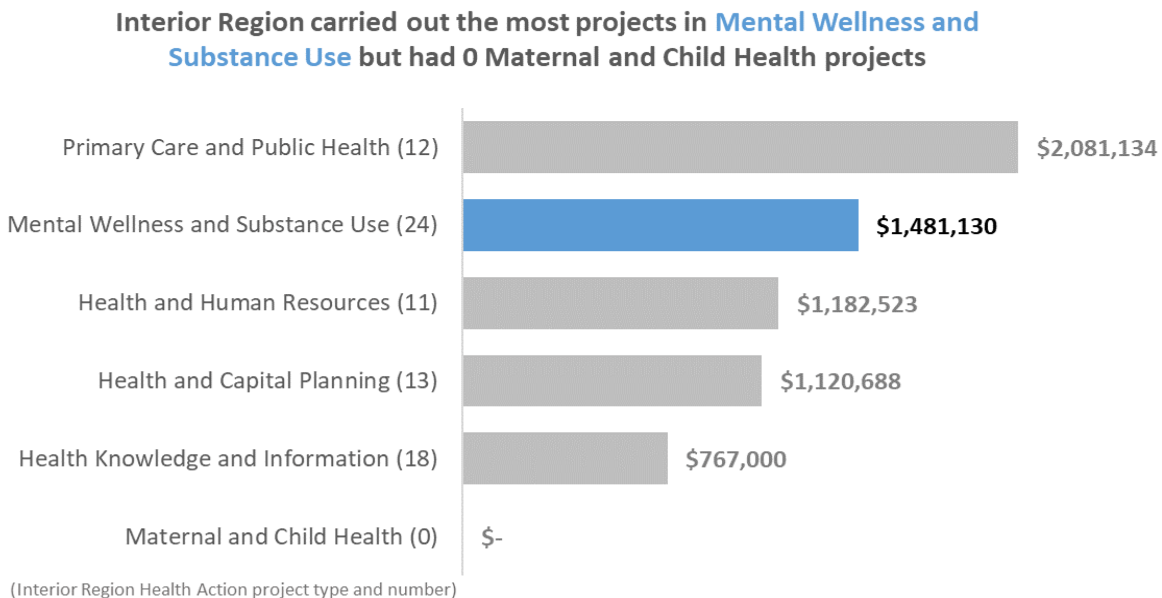
The regional envelope provides an exciting opportunity for new projects and programs to be planned and implemented by First Nations in each of the five regions, in partnership with regional health authorities and in alignment with Health Actions priority areas.

The Northern Region had the highest number of projects, with 227 Health Actions, accounting for 41% of all projects. The Vancouver Island Region and the Interior Region had similar numbers of total projects (85 and 78 respectively) and the Fraser Salish Region and the Vancouver Coastal Region both had 51 Health Action projects.

Interior Region

The Interior Region distributed funding for 78 Health Actions, totaling $6,632,475, with the highest funding category being Primary Care and Public Health. Most projects fell under the categories of Mental Wellness and Substance Use (24) and Health Knowledge and Information (18).

Figure 3: Project Type and Number of Projects Implemented by the Interior Region



[9] Moose Hide Campaign Development Society. (n.d.). "Moose Hide Campaign: Standing up Against Violence." Retrieved December 20, 2019 from https://www.moosehidecampaign.ca/.

Lillooet Tribal Council had the largest amount of Health Actions funding and used the funding to promote wholistic community and traditional wellness activities. With $372,204, the St’at’imc Traditional Wellness Initiatives funding supported six communities in developing monthly community wellness programs, a St’at’imc Language and Traditional Medicines Initiative and a St’at’imc “Walk Your Moccs” Fitbit Challenge, among other activities.

Key informants spoke of the appreciation community members had for the Traditional Wellness Initiatives funding, as it gave them the opportunity to implement projects in ways that were the most meaningful to them. Since each community is very different in terms of its cultural needs, preferences and traditions, activities were often quite varied. For example, one community chose to use the funds toward traditional harvesting and preserving and another chose to build a permanent cultural camp/retreat site; other communities chose to provide traditional teachings (e.g., storytelling, medicine picking, horsemanship, tool making, drum making/singing, dance), as well as healing workshops and events for their people. Each community expressed that the funding made a positive impact on community health and wellness, so much so that the North St’at’imc Leadership has committed to continued funding for community-driven traditional wellness projects.

Funding for the St’at’imc Language and Traditional Medicines Initiative was allocated to the Upper St’at’imc Language Culture and Education Society (USLCES) to enhance language practices and knowledge of traditional medicines and to develop a St’at’imc Research Ethics Guideline to help protect St’at’imc traditional knowledge. This project involved St’at’imc language speakers, Elders and their students from Northern St’at’imc communities. The USLCES was pleased to have the opportunity to expand its existing language program and considered this expansion a very successful component of an ongoing initiative. To enhance the ucwalmicwts (St’at’imc) language, USLCES provided immersion camps and language teacher training, produced and distributed language materials and created an enhanced “First Voices” online language archive accessible to everyone. In order to enhance knowledge exchange of traditional medicines, USLCES held knowledge keeper and apprentice sessions and workshops in each community to share knowledge about medicines and tell stories in the language, after which people could produce their own stories in ucwalmicwts. As one regional representative remarked in seeing the revitalization of traditional wellness and cultural practices, it can be particularly healing for Elders, who have said, “This is how it used to feel.”

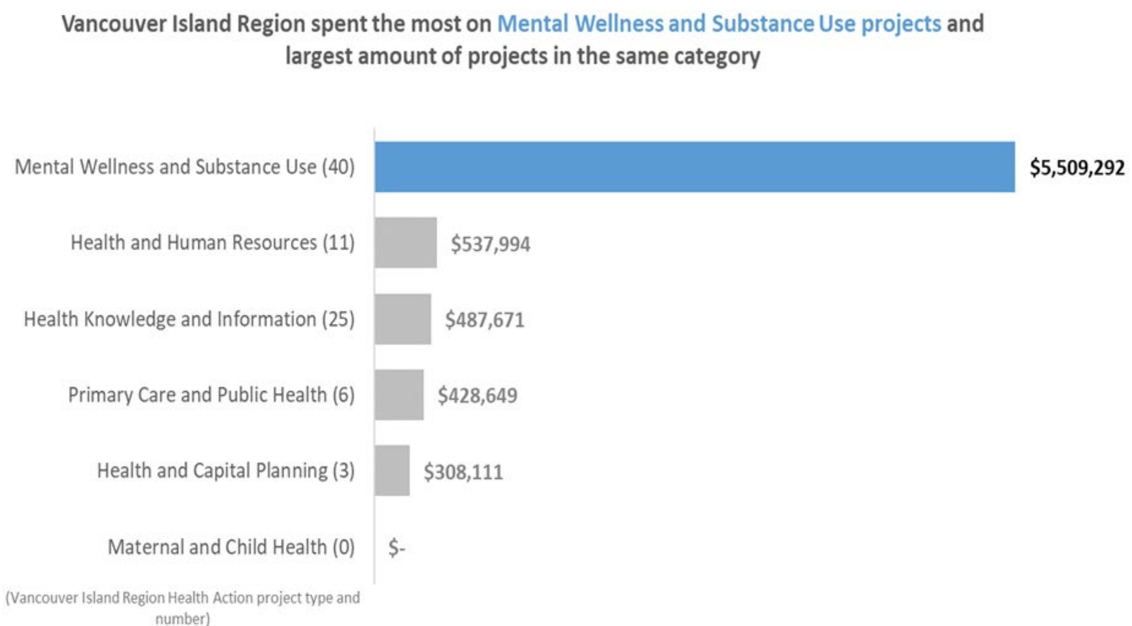
This funding also supported the “Walk Your Moccs” Fitbit Challenge, which many community members credited with motivating them to get out and be more active. Within three months, over 300 members from the different communities had registered and were participating in the challenge. As time went on, organizers successfully built on the interest

in this challenge with other contests and events, such as the selfie contest, a video contest, a Winter Wellness event and a free treadmill draw, so that by the end of the year they had reached over 500 participants.

Vancouver Island Region

Vancouver Island provided 85 Health Actions for a total of $7,271,716. Three-quarters (76 per cent) of the funding was spent on projects/initiatives in the Mental Wellness and Substance Use category, with 40 projects in total. Health Knowledge and Information had the second-largest number of projects (25).

Figure 4: Project Type and Number of Projects Implemented by the Vancouver Island Region



One of the largest Health Actions projects for the Vancouver Island Region was for the Kwunatsustul Trauma Program housed in Tsow-Tun Le Lum, a registered non-profit society that operates a fully accredited treatment centre in Lantzville. The funding, under the Mental Wellness and Substance Use category, allowed the program to be funded between 2017 and 2019. This five-week second-stage residential program addresses the multitude of mental health and complex trauma issues faced in the community. Participants must meet basic criteria such as maintaining a minimum of six months sobriety and identifying a counsellor in the community for aftercare (usually done through referral). The wholistic program includes traditional and contemporary methodologies to address the emotional, mental, physical and spiritual health and well-being of First Nations people. Traditional healers and Elders are involved in ceremonies, and the program provides a range of

education and therapies, including men's and women's groups, clinical counselling, group and individual therapy, daily journalling and physical recreation.

During the second quarter of 2017, 16 people completed the trauma program out of the 17 enrolled, and post-program evaluations indicated that those who completed the program made positive changes during the five weeks. Individuals showed significant improvement in post-traumatic stress disorder, complex trauma and symptoms of anxiety, and a change in negative emotions. Verbal self-reports included comments like: "I feel so much lighter," "I have my power back" and "I feel so good – it's exciting!"

In addition to this program, a secondary two-week residential program called Kwunatsustul Honouring Grief is a healing program that provides an opportunity to embrace any grief and loss that community members may be carrying. Its purpose is to allow the gift of time and the opportunity to process and share feelings in a group setting. Therapeutic sessions include healing circles, cultural ceremony, one-on-one sessions, art therapy and psychoeducation.

Another important Health Action project in the Vancouver Island Region is the KUU-US Crisis Line and Response Services, which provides culturally safe service 24 hours a day, 365 days a year to assist those experiencing a mental health crisis. The service is delivered by staff with crisis intervention training, and crisis response protocols were established for each Nation in BC. Between 2015/2016 and 2016/2017, utilization of this service increased by 50% (11,528 to 23,033). Project staff reported that "It has been very exciting to see the impact and hear about the importance of our service from clients and from Nations and community members. We know we make a difference and save lives, but to be able to provide a service and know that it is helping Nations with limited services or overworked staff goes a long way. We are unique to other crisis lines as we provide a more in-depth service based on the needs of Indigenous people. Between KUU-US and FNHA's commitment to helping those in crisis, there is so much we can do together."

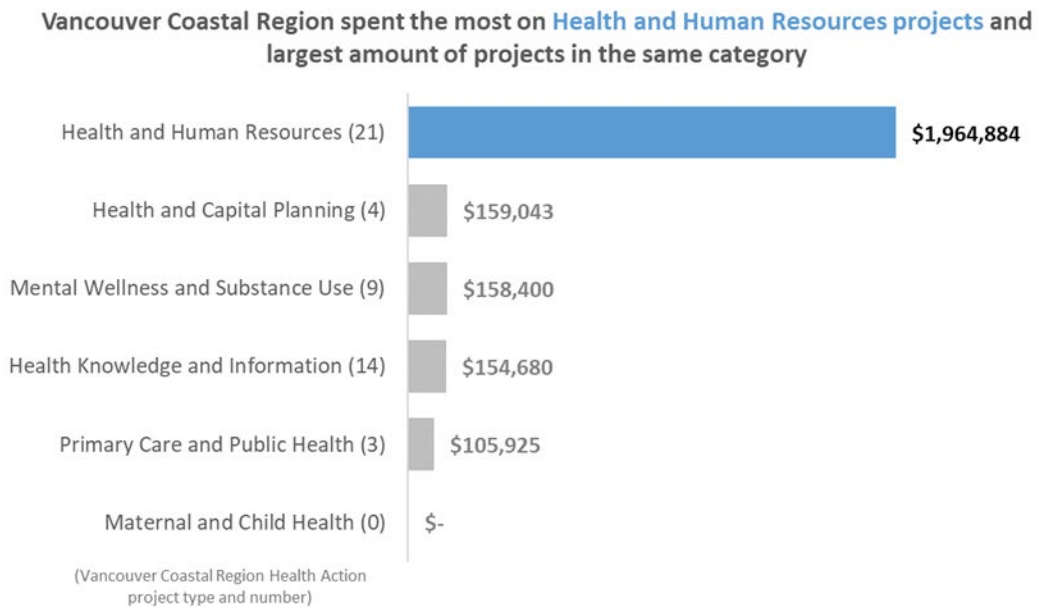
Vancouver Coastal Region

The Vancouver Coastal Region provided Health Actions funding primarily for Health and Human Resources (77 per cent of all funding), which was also the category with the most projects (21 out of 51).

Effective July 2, 2013, Health Canada transferred the funds it had historically used to pay Medical Services Plan premiums on behalf of First Nations residents in BC to the FNHA. A portion of these funds was set aside by the FNHA to support Joint Project Board projects and initiatives related to Medical Services Plan services. Most funding for Health Actions in the Vancouver Coastal Region has been used to supplement Joint Project Board projects. A regional representative identified Health Actions as "Critical in filling the gaps." Health

Action funding is more flexible than Joint Project Board funding and can be combined with Joint Project Board funding for expenses that would otherwise be ineligible.

Figure 5: Project Type and Number of Projects Implemented by the Vancouver Coastal Region



Many of the Joint Project Board projects in the Vancouver Coastal Region include multi-year funding and 10 of the 12 projects supplemented through Health Actions are in the Health Human Resource category. One example is providing necessary resources to fund a social worker for the Urban Clinic Helping House for the Tsleil-Waututh First Nation. The social worker helped community members access services at Helping House and navigate services at nearby hospitals. In the final narrative report, it was noted that the social worker is now a visible member of the health team who helps to reduce stress in navigating health systems, which in turn encourages people to follow through with those services.

Another important project in this region is the Tla'amin Jeh Circle of Care (JJCC), which is also a Joint Project Board-funded project supplemented with Health Actions funding. The JJCC weaves together a comprehensive care program for clients considered to have the highest care needs. Health Actions funding supports two Complex Care Managers and two Wellness Coordinator positions: one for Elders and one for youth. The Tla'Amin Health Centre and the Sechelt Health Centre are the primary care providers for this region, but gaps have been identified in effectively serving clients with complex care needs. These new staff coordinate health promotion/prevention services, particularly for people in vulnerable situations, by focusing on client education, behaviour change support, building support

networks and increasing knowledge of and participation in traditional practices. These staff primarily support clients in the JJCC program as well as other clients accessing the Health Centres.

The Youth Coordinator for JJCC works closely with schools in School District 47. In consultation with principals, the coordinator is assigned to youth and works with them in a variety of ways, including going for walks, tutoring, playing sports, taking them for lunch or transporting them to appointments, depending on the need. The Youth Coordinator developed a strong rapport with the youth and mentored them in making positive decisions. In addition, the Youth Coordinator supported a new program (Ahms Tah Ow) at the community school, working with teachers to support students transitioning to high school.

The project has had a positive impact on the youth it serves. Many of the youth benefited from a positive role model who could help them believe in themselves, assist with behavioural issues and give them the tools to make better choices. As one mother said, "[the coordinator's] visits with [my son] have been very beneficial and successful for him. They lift up his spirit and he looks forward to visits and spending time together. Thanks for allowing [the coordinator] to share time with him, it is wonderful to have the extra assistance he brings to my son's life."

The Elders Wellness Coordinator has had a similar positive impact on community members. This coordinator held many Elder luncheons, initiated an Elder clam dig and organized the Elders' development of Ahms Tah Ow Community Garden, holiday activities, language events, trips and ceremonies.

Another Health Action associated with the Joint Project Board includes funding two full-time Elders Coordinators to support the Lower Stl'atl'imx Chronic Disease Management Wraparound project. These Elders offer transportation to other Elders to get to and from appointments, and each of them drive to approximately 25 appointments every month, sometimes travelling as long as three hours just to get to a paved road. According to the regional representative, the coordinators stay with Elders during their appointments to help them feel safe, demonstrating that these communities "really have their Elders supporting one another."

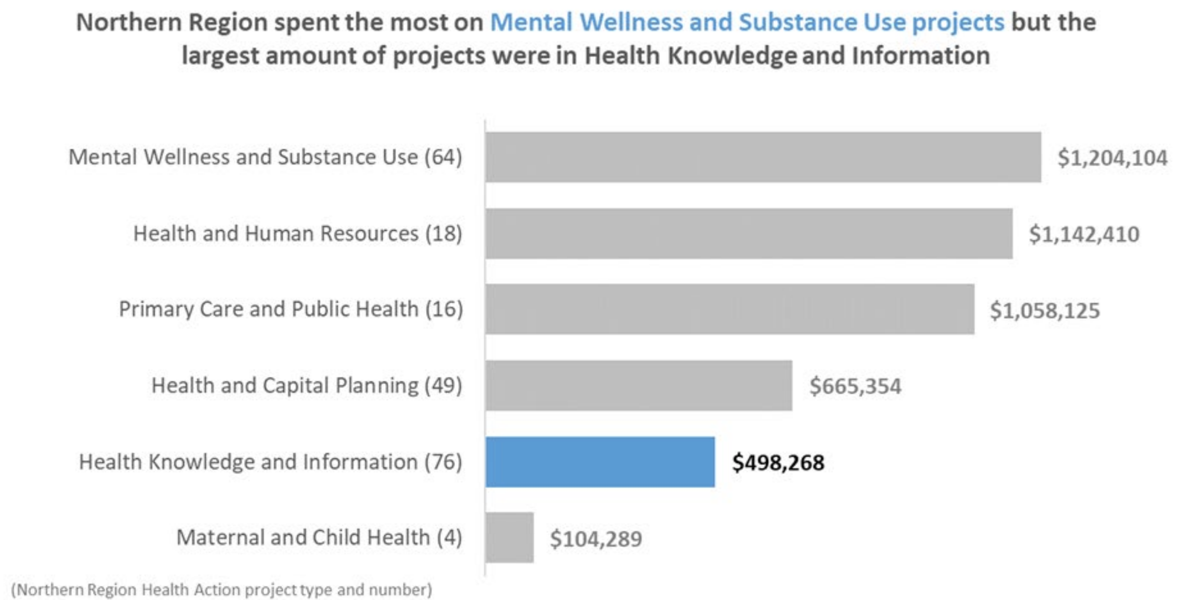
The Walking the Land Together Project is a non-Joint Project Board Health Action for the Vancouver Coastal Region supported by the Lower Stl'atl'imx Tribal Council. This 2014 project grew out of a community desire to learn and practice traditional and preventative approaches to health and wellness by reconnecting with the land, learning what to harvest and when, and where and how to utilize these gifts from the territory. As the final report notes, "It is through walking and connecting with the land and each other … through

practicing our own ways of maintaining health and wellbeing together that we address health and wellness at the collective and active level." Each of the five Lower Stl'atl'imx Tribal Council communities participated and each community organized and facilitated two Walking the Land Together events. Approximately 120 people participated in the community walks, medicine gatherings and preparation sessions. The Walking the Land Together Project budget also contributed to a feast at Stl'atl'imx Days hosted by Xa'xtsa in May 2014, attended by approximately 200 people.

Northern Region

The Northern Region initiated the most Health Actions projects of any region. The primary reason for this discrepancy is that nearly half of the Health Actions projects in the North were for small projects valued at $5,000 or less. Key informants cited that the Northern Region received lump-sum funding, which they opted to deliver in a new way. The funding was distributed to over 50 communities depending on the population and remoteness of the communities, which allowed the communities/Nations to expand the scope of their projects.

Figure 6: Project Type and Number of Projects Implemented by the Northern Region



Most of the region's funding was channeled into the categories of Mental Wellness and Substance Use, Health and Human Resources, and Primary Care and Public Health. The regional representative noted that due to the remoteness of many communities in the North, it is very challenging to provide many health services in community.

An example of a project in the Northern Region in the Mental Wellness and Substance Use category is the Carrier South Traditional Wellness Revitalization Project, developed to strengthen and utilize existing traditional wellness resources and to support mental wellness and substance use by developing new resources identified by the communities.

Within the Primary Care and Public Health category, the Brighter Smiles 2.0 pediatric and dental care program in Gitga'at First Nation is an example of a partnership with the BC Children's Hospital and the UBC Department of Pediatrics to provide access to high-quality, head-to-toe, primary pediatric care. Two pediatric residents visited the community to perform assessments and hold a nutritional uptake meeting with the school breakfast/lunch coordinator, linking in a dietitian from Northern Health. In the first two years, the pediatrician and pediatric residents saw 54 children for individual assessments and made 14 referrals. The pediatric dentist saw 45 children, with eight referrals made to BC Children's Hospital for procedures requiring anesthesia. This program provided much-needed pediatric care to a northern community accessible only by boat or sea plane and gave pediatric residents the opportunity to learn about Gitga'at First Nation perspectives on wellness.

The same program provided funding for two pediatric dentists to visit Gitga'at to see children for treatments and fluoride varnishes. Through this program, the in-school tooth brushing campaign that was part of the original Brighter Smiles initiative was brought back, as teachers and school staff encouraged children to brush at school after breakfast and lunch. Teachers and children kept track of their brushing and every one to two weeks prizes were drawn for kids who brushed regularly.

The success of the Brighter Smiles 2.0 program has encouraged discussions around expanding the pediatric outreach portion of the Brighter Smiles project to the other Coast Tsimshian Hub communities of Gitxaatla and Lax Kw'alaams. The regional representative emphasized the success of this program, noting "It's got sustainability behind it" because the project is in its third year. It's been especially important because "Gitga'at is one of the most remote communities [in the North]" and it has been "really challenging for community members to get that type of service in community… [so] bringing this into the community has really benefitted them overall."

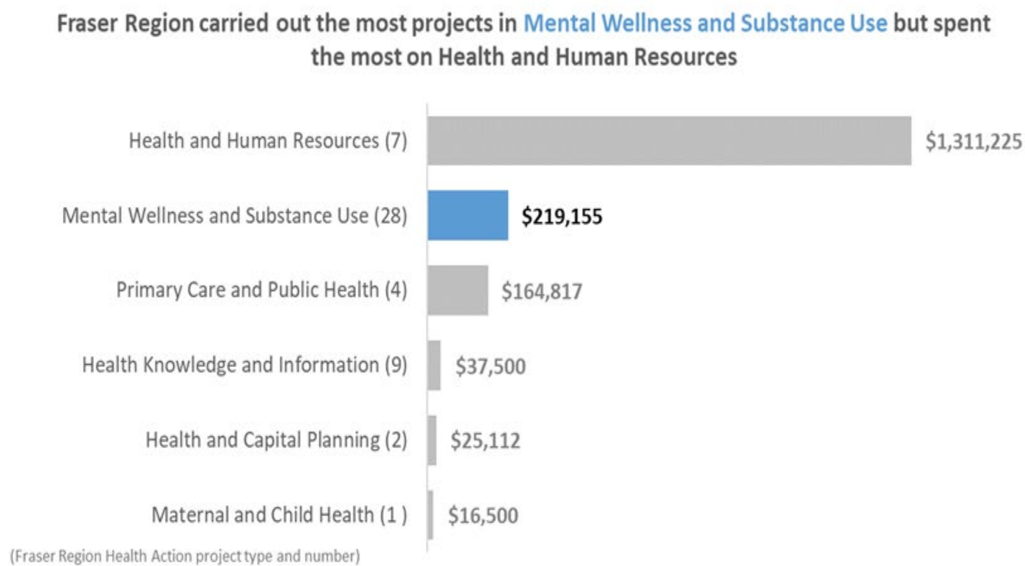
A Northern Region Health Actions initiative under the Health Knowledge and Information category was a two-day workshop held at the Stellat'en First Nation, attended by people between the ages of 20 and 72 years. The workshop included a discussion about barriers to individuals being heard by authorities, and the impacts on families when women went missing or were murdered; the workshop provided the opportunity for participants to share their feelings. An important focus of the workshop was community planning around safety and crisis management. It concluded with a "Letting Go" ceremony where

participants could set free their feelings about what was discussed. Overall, participants expressed a positive response to the workshop.

Fraser Salish Region

The Fraser Salish Region, like the Vancouver Coastal Region, used most of its Health Actions funding for Health and Human Resources.

Figure 7: Project Type and Number of Projects Implemented by the Fraser Salish Region



The largest proportion of Health Actions funding in the Fraser Salish Region went towards hiring a Traditional Parenting Regional Program Coordinator, whose role is to provide ongoing support and leadership to health and wellness staff who work in community-based maternal child health and early child development programs. The coordinator provides services to 32 communities of the Stó:lō Nation with the intent of training members of each community to deliver Stó:lō Nation-specific Traditional Parenting programs. Material was initially compiled through a Traditional Parenting working group. This group, through consultation with communities and Elders, created connections and relationships between service providers and community that would have otherwise not have existed. Elders stated that they felt valued and respected for their teachings, and shared the importance of passing these teachings on to the next generation.

Health Action dollars allowed midwifery services at Seabird Island to be expanded to improve timely care and provide outreach services to the 32 communities in the Fraser

Salish Region and to allow midwifery to become more integrated into the primary health care systems. The Seabird Health midwife is part of both the primary care team and the maternal child health team. She also has an important role in connecting families to the Early Childhood Education program, such as Aboriginal Infant Development. Between January 2014 and February 2017, the midwife delivered 83 babies. The midwife has also become a force in advocating for and educating around culturally safe care, including trauma-informed care and ways to integrate cultural practices. The midwife's successes include integrating culture into birthing care, supporting mothers with addiction and mental health issues, increasing rates of breastfeeding mothers, providing early intervention with newborn complications, empowering women, role modelling in the community, decreasing the number of caesarean sections and operative procedures and enhancing collaborative care.

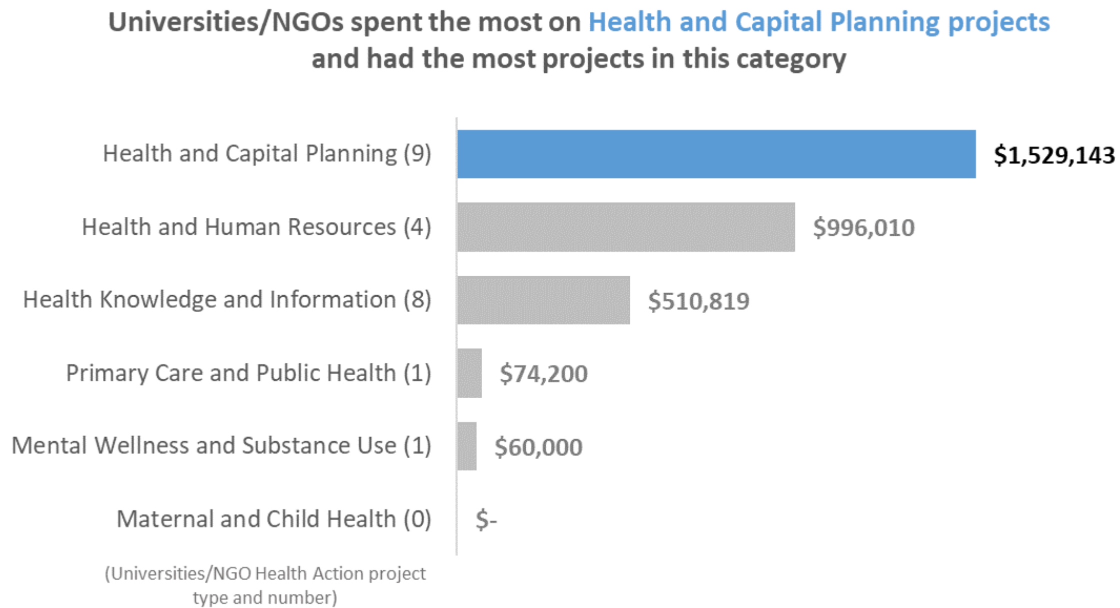
The regional representative had many positive things to say about the successes of the Health Actions funding. Speaking about the Elder-in-Residence program at Chilliwack General Hospital, the representative commented, "It's such a needed service and it's innovative because it hasn't been done before in any of the hospitals in our region. It's been very well-utilized and the response has been great from our communities." They went on to tell a story where the Elder-in-Residence became an advocate for families experiencing unsafe situations where they didn't feel culturally safe. In response, the Elder worked directly with hospital staff to resolve these issues and ensured services would be adjusted so that community members received needed services. The regional representative concluded: "I've heard from other people who have been in the hospital that it is just very comforting to have that presence and to be able to access that service."

Speaking more broadly of Health Actions, the representative shared that "One of the biggest strengths of Health Actions is that it allows communities to access programs and activities that they wouldn't have otherwise," which is especially important because no one is "…dictating how the funding is used and that's so much of how the relationship was in the past…it's pretty amazing to be able to say 'yes' with very little strings attached."

University/Non-Governmental Organizations

While some Health Actions support university-backed research studies or scholarships, most Health Actions funding in this category supported NGOs. This category includes province-wide NGOs with a mandate that includes providing services to Indigenous populations (see Appendix B). The university/NGO category received funding primarily from the provincial envelope, but a small number of projects received regional funding.

Figure 8: Health Actions Funding for Universities/NGOs



The Heart and Stroke Foundation received the most funding for a single Health Action amongst Universities/NGOs (under the provincial envelope), within the Health and Capital Planning category, for the Community Gardens to Support Community Food project. The four-year project began in 2010 and was developed in partnership with the Produce Availability in Remote Communities Initiative as well as 15 First Nations. Its goal was to enhance northern Nations' access to fresh produce by offering small funds for coordination and materials, along with expert onsite support to develop fruit and vegetable gardens and greenhouses. As a result, all participating communities have residents who are trained in produce preservation.

As of 2015, all the communities involved developed or continued working in their gardens and greenhouses. Namgis First Nation, for example, realized several important accomplishments that included reclaiming the ground and surrounding raised beds, having youth involved maintaining yards and clearing sites, cleaning and re-organizing existing greenhouses, planting a demonstration garden outside the Elders' Centre, supporting Elder participation in maintenance and harvest, organizing a variety of mentorship programs, reclaiming home gardens and picking local blackberries to make jam.

Health Actions by Category

In October 2013, key governance milestones were reached with the transfer of services from the Health Canada First Nations and Inuit Health Branch to the FNHA. The FNHA did not use any Health Actions funding for FNHA staffing costs (with the exception of eHealth). The Health Actions approach was refreshed in 2015 to effectively bring the work of both the governance and Health Actions streams back together.

The introduction of regional envelopes provided the opportunity for more local and community-based projects due in part to the development of the Regional Health and Wellness Plans, regional envelopes and the establishment of regional teams. These structures and processes enabled Health Actions planning and implementation to be directly guided by the priorities of each region. As a result, the refreshed approach to Health Actions funding places a larger focus on Traditional Health and Wellness.

Health Knowledge and Information funds are often used for fairs, conferences, publications and speaker events. Examples include the Elders Voice monthly publication, which includes wellness tips for Elders, as well as the BC Elders Gatherings and Aboriginal Youth Conferences.

Health Capital and Planning projects concentrate on health infrastructure, training for future positions and post-secondary scholarships and bursaries. An example of an innovative project under this category is Street-to-Home, which used funding to help create a database that provides a detailed description of each addiction recovery program in the Vancouver area to better match existing services to client needs and preferences, and to optimize service utilization.

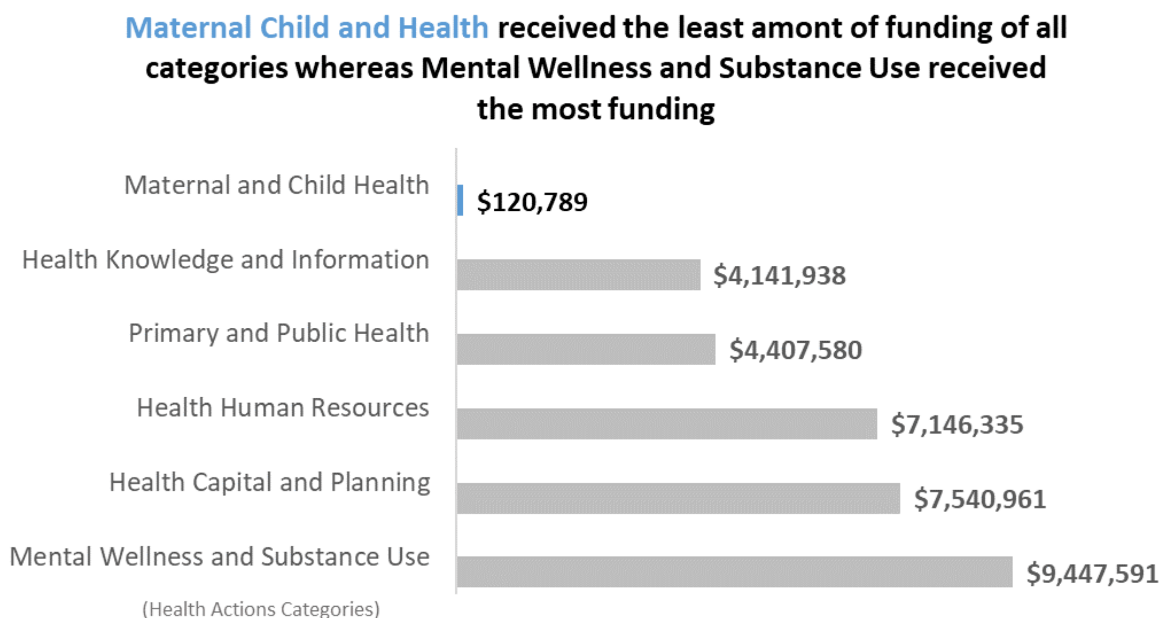
The **Health Human Resource** category includes Health Actions funding used for building capability and capacity within organizations. The largest fund from this category is for the Unlocking the Gates Peer Health Mentor Program. This placed a peer support worker with women and men leaving prison for 72 hours after their release. As part of this program, women and men are invited to identify up to three health goals they would like to achieve during the first 72 hours and the worker connects them to community and health resources based on these goals. Joint Project Board projects were also occasionally supplemented using this funding. Specifically, Health Actions funds have been used alongside Joint Project Board funding to support new primary care and mental health initiatives/activities. Joint Project Board funds regulated health professionals along with paraprofessionals and cultural healers, which all work in an integrated care team(s) across the province.

The category of **Primary Care and Public Health** refers to funding specific to primary care provision and public health surveillance. One example is the Katzie First Nation

Naturopathic Clinic, which was developed in partnership with the Boucher Institute of Naturopathic Medicine to send naturopathic care practitioners to the Katzie First Nation in exchange for learning opportunities. Members with chronic or new health issues were treated on a regular basis in their own community such that there was reportedly a marked decrease in illness and medical leaves from work and happier, healthier people.

Of the six Health Actions initiatives and projects under the **Maternal and Child Health** category, four were in the North. One example is the Heiltsuk Health Centre funding a Maternal Child Health program providing pediatric occupational therapy to identify children with developmental delays and learning difficulties. These assessments were aligned with Heiltsuk traditions and culture and the occupational therapist was considered an excellent resource regarding infant development and learning.

Figure 9: Allocation of Health Actions Funding by Category

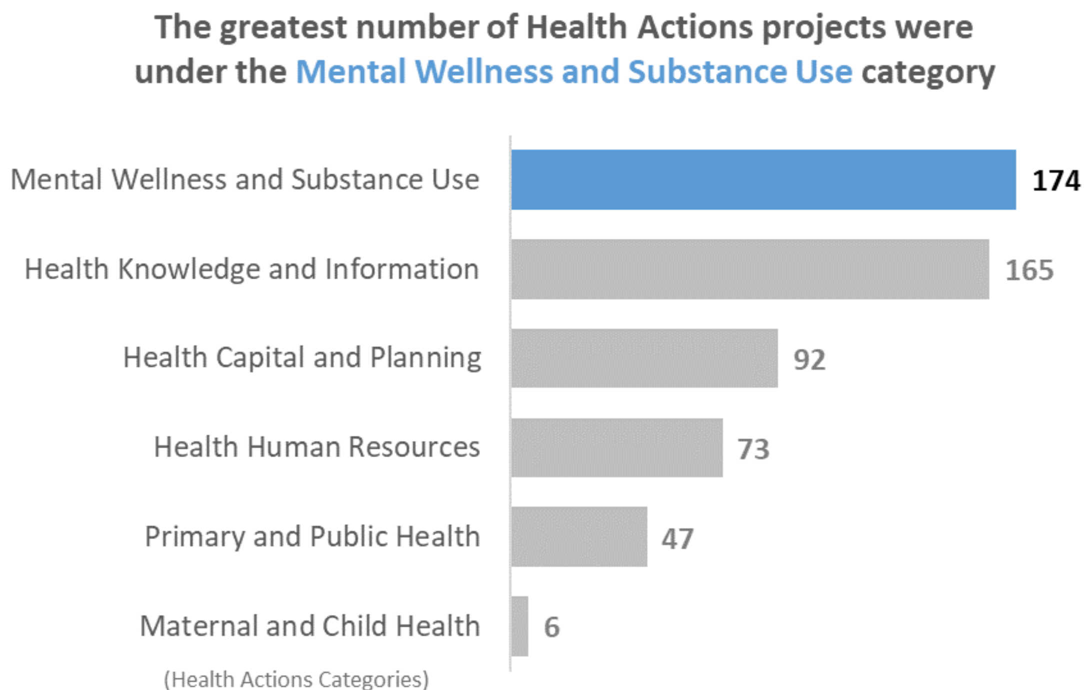


The Mental Wellness and Substance Use category received more than a quarter of total funding, at approximately $9,447,591, and with 174 projects this category had the highest number of projects (see Figure 9). Funding under Mental Wellness and Substance Use was primarily used to pursue community solutions, and nearly early every project in this category identified the First Nations Perspective on Health and Wellness as a foundational paradigm to provide community-driven projects/activities. Almost half had an explicit focus on traditional wellness revitalization, examples of which include helping houses, recovery programs, crisis lines, men's and women's circles and skill development seminars on historical trauma and loss of culture.

Health Capital and Planning had the second highest amount of funding ($7,540,961). The least funded category was Maternal and Child Health at $120,789. Meanwhile Health Knowledge and Information, with 165 projects, had the second highest number of projects, but received only $4,167,311 of funding.

As there were no Health Actions initiatives/activities funded under eHealth, this category is not represented in the report. However, eHealth investments continued in the key human resources needed to advance and initiate projects directly supporting primary care, specialty care, public health and mental wellness, as well as Panorama implementation, tele-health expansion and health connectivity.

Figure 10: Number of Health Action Projects per Category



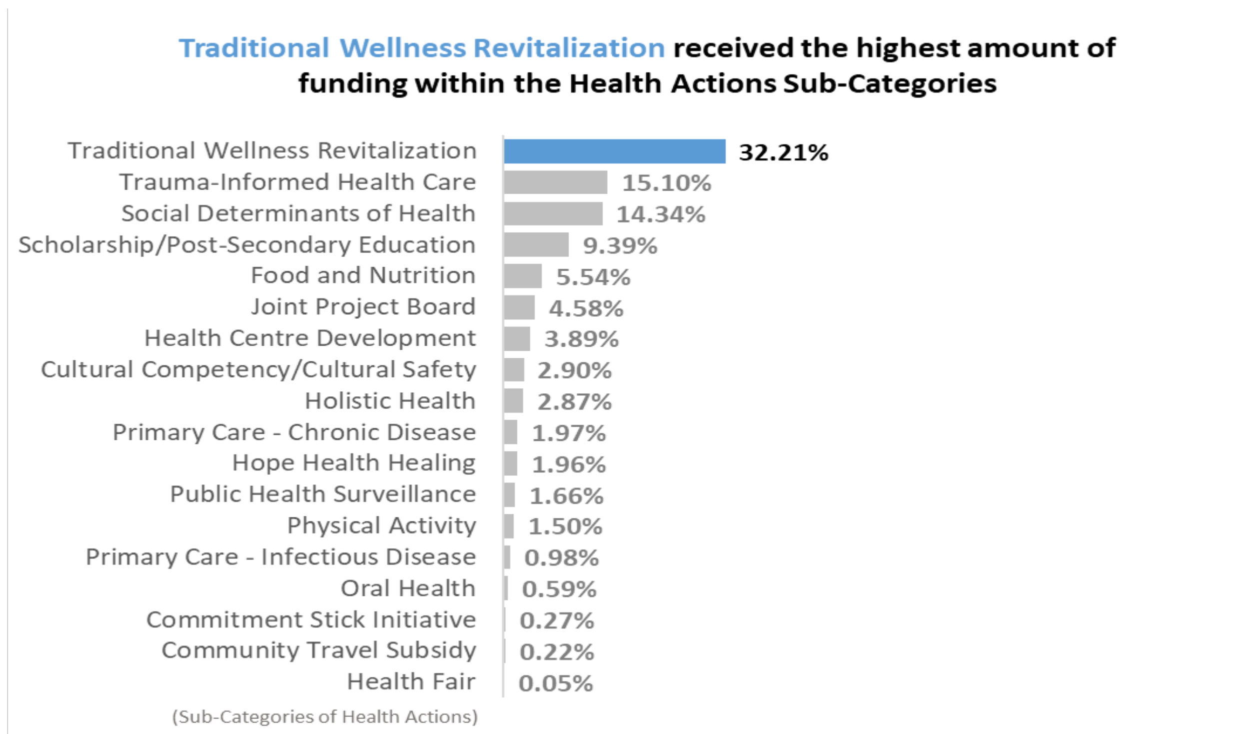
Health Actions by Sub-category

Table 2 (below) shows the sub-categories ascribed to each of the six Health Actions categories with funding. Of these, as shown in Figure 11, Traditional Wellness Revitalization received the highest amount of funding, accounting for 32% of total funding, followed by Trauma-Informed Health Care at 15% and Social Determinants of Health at 14%.

Table 2: Health Action Categories and Their Ascribed Sub-Categories

Health Action Categories and Sub-Categories	
Primary Care and Public Health	Cultural Competency/Cultural Safety Training, Food and Nutrition, Health Centre Development, Wholistic Health, Joint Project Board, Oral Health, Physical Activity, Primary Care - Chronic Disease, Primary Care - Infectious Disease, Public Health Surveillance, Social Determinants of Health, Traditional Wellness Revitalization, Trauma-Informed Health Care
Mental Wellness and Substance Use	Commitment Stick Initiative, Cultural Competency/Cultural Safety Training, Food and Nutrition, Health Centre Development, HHH, Wholistic Health, Physical Activity, Primary Care - Chronic Disease, Social Determinants of Health, Traditional Wellness Revitalization, Trauma-Informed Health Care
Maternal Child Health	Health Centre Development, Wholistic Health, Physical Activity, Scholarship/Post-Secondary Education, Social Determinants of Health
Health Human Resources	Commitment Stick Initiative, Cultural Competency/Cultural Safety Training, Health Centre Development, HHH, Wholistic Health, Joint Project Board, Physical Activity, Social Determinants of Health, Traditional Wellness Revitalization, Trauma-Informed Health Care
EHealth	Investments in eHealth staff, but no initiatives/activities (see above)
Health Capital and Planning	Community Travel Subsidy, Cultural Competency/Cultural Safety Training, Food and Nutrition, Health Centre Development, Health Fair, Joint Project Board, Physical Activity, Scholarship/Post-Secondary Education, Social Determinants of Health, Traditional Wellness Revitalization, Trauma-Informed Health Care
Health, Knowledge and Information	Commitment Stick Initiative, Community Travel Subsidy, Cultural Competency/Cultural Safety Training, Food and Nutrition, Health Fair, Wholistic Health, Physical Activity, Primary Care - Chronic Disease, Scholarship/Post-Secondary Education, Social Determinants of Health, Traditional Wellness Revitalization, Trauma-Informed Health Care

Figure 11: Proportion of Health Actions Funding by Sub-Category of Provincial Envelope



Traditional Wellness Revitalization

The largest amount of funding was allocated to Traditional Wellness Revitalization, which had 150 projects/activities. An example of a Traditional Wellness Revitalization project is the Tides IndigenEYEZ Youth Traditional Wellness Camp, which strives to transform communities through youth empowerment. The project aims to address harmful substance abuse and mental wellness issues by building youth confidence through a focus on traditional-based activities and exercises. Youth experience storytelling from local Elders, traditional foods (including a deer hunt followed by a lesson on skinning, butchering and cooking the meat), rattle making with the deer hides and hooves and a fishing experience with a cultural knowledge-keeper. Through the IndigenEYEZ camp experience, youth learn to embrace their cultural heritage by acquiring new skills and coping mechanisms.

Food and Nutrition

Projects within this sub-category include community gardens, a BC School Fruit and Vegetable Nutritional program and the Gathering of Indigenous Food Trading Wild Salmon Caravan. The Wild Salmon Caravan project invited community members to learn and engage in traditional cultural practices and protocols around trading and sharing Indigenous foods. The event revitalized inter-tribal fisheries relationships and affirmed the

social and ceremonial value of wild salmon fisheries in the observation of cultural and spiritual protocols in salmon ceremonies, songs, feasts and offerings that were made to the salmon, the river and the peoples.

Wholistic Health

Projects in this sub-category include those that combine physical, mental, emotional and spiritual health and culture. Wholistic Health also referred to projects related to naturopathy, a wholistic approach to health. One such project provided continued support for a Traditional Chinese Medicine Practitioner for Snuneymuxw. Community members showed strong interest and demand in the continuation of this project after experiencing relief from this practice.

The four Stl'at'imx communities identified that their Elders are facing a burden of isolation and remoteness, which creates barriers for Elders with chronic conditions to access care. A key concern is that Elders cannot physically attend healthcare appointments because their family members do not have access to vehicles. The Southern St'atl'imc Health Society has hired two Elders to provide transportation to other Elders to attend appointments. The project provides Elders with support, as the two Elders stay with those they are transporting throughout their appointment.

Trauma-Informed Health Care

This sub-category refers to projects that address day-to-day trauma in a culturally appropriate way. An example is the Haida Health and Skidegate Health Centre trauma training program. This project provided members of two communities with greater access to trauma services in areas of maternal and child health, home and community care, drug and alcohol counselling and overall mental health. Now, all health centre employees are trained to help a person deal with trauma in a non-invasive manner.

Commitment Stick

Commitment Stick and its resulting initiatives are a symbol of a personal commitment to live violence free and to actively stop violence against Indigenous women and girls.[10] The idea of the Commitment Stick started with Alkali Lake (Esk'etemc) Elder, Fred Johnson Sr., with the support of Chief Charlene Belleau in the Interior. Commitment Sticks are a gift from the Esk'etemc community, who are honoured to have Hereditary Chiefs, Chiefs and frontline workers take up this commitment. Commitment Stick initiatives can now be found throughout the province, including 27 in the Northern Region.

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[10] First Nations Health Authority. (n.d). *#ViolenceStopsWithMe Commitment Stick Initiative to End Violence Against Women*. Retrieved from https://www.fnha.ca/Documents/FNHA-Commitment-Stick-Initiative-Event-Promotion-Guide.pdf

Summary

What is Working Well?

Key informants described various strengths attributable to Health Actions funding and projects that have had a positive impact on Indigenous communities/Nations. All key informants iterated that the Health Actions funding was used in part or entirely for traditional wellness.

Supporting Collaborative Development

Health Actions funding is foundational in providing opportunities to support collaborative development and support a new way of working with First Nations communities/Nations. Health Actions support a First Nations Perspective on Health and Wellness by taking a community-driven approach, allowing communities/Nations to identify their own needs and the ways that they would like to address them. The inclusion of the First Nations Perspective on Health and Wellness illustrates how the relationship between Indigenous communities/Nations and the healthcare system has changed.

> *"It's because the same people are coming back as health professionals... [community members] walk in and see a familiar face that they know is very patient, understanding and thorough with them." - Key Informant*

Key informants highlighted the strength of supporting the continuity of staff going into communities to deliver Health Actions projects/activities. Building interpersonal relationships between staff employed under Heath Actions and communities facilitates participation in Health Actions projects/activities.

Innovation

A central strength of Health Actions funding highlighted by key informants is its flexibility and low barrier restrictions, which allows for innovation by removing the need for communities/Nations to develop in-depth proposals, statistics or literature reviews, which can be difficult to do when there is a lack of capacity to take on such detailed work. Additionally, communities/Nations can pilot a program for one year, evaluate whether it is successful and then apply again for funding if the community/Nation finds that the program is a success.

Gap-filling

Key informants described Health Actions as essential for filling gaps; projects that do not fit into other budgets due to funding restrictions can be funded by Health Actions; Joint Project Board projects can be combined with Health Actions funding; and the funding allows communities/Nations to use the funds for recruitment.

Many of the projects offered through Health Actions do not fit under other funding streams. Therefore, without Health Actions funding, communities/Nations would not have access to the programs and services that they need.

What is Needed Moving Forward?

The major challenges for Health Actions outlined by key informants include project sustainability and issues related to recruitment and retention, coverage of traditional medicines, project/activity awareness and community capacity.

Project Sustainability

All key informants raised concerns about the ending of Health Actions funding in the 2019/2020 fiscal year, particularly since other funding streams are considered less flexible and do not support some of the projects/activities operating under Health Actions funding.

> *"Other funding streams can potentially pick up some of the projects…but under those streams there's not a lot of flexibility compared to what we have with [Health Actions], and so that's where I think we might have some concern in terms of sustainability for projects that may not fit those funding streams." – Key Informant*

A concern is that projects may have to change to fit more rigid funding guidelines, which would be difficult to explain to communities, and that the community-driven nature of the projects could be lost. For example, a key informant explained that under Health Actions "We largely fulfil requests as identified by community since we are a community-driven, Nation-based organization in principle." There is concern among key informants that Health Actions funding has created a need by providing funding opportunities, but lacks sustainability to continue meeting these needs in the future. A consequence of ending Health Actions funding is the loss of community-driven projects because projects/activities will be required to conform to other funding guidelines that are not as flexible as the Health Actions.

Moving forward, communities/Nations would benefit from clarification on the status of Health Actions funding renewal so they can arrange alternative ways to fund projects/activities. Following the conclusion of the fieldwork for this case study, the Tripartite Partners committed to ongoing partnership to support continued service delivery.

Recruitment and Retention

Many of the projects that key informants highlighted faced staffing issues. In some cases, communities/Nations were unable to "find the right person to fill the position," whereas others were concerned about staff burnout. Issues related to recruitment include finding

individuals who are culturally aware and can perform their work with cultural safety and humility. A lack of qualified professionals is also a concern.

Conversely, staff retention due to burnout is another issue that key informants highlighted during interviews. Key informants felt that the Health Actions work is very needed and innovative, but are cognizant of overstretching staff. For example, the Elder-in-Residence Services project created space for and the hiring of a full-time Indigenous Elder to provide cultural services to patients and staff at the Chilliwack General Hospital and Fraser Canyon Hospital. However, there are many requests for the Elder's support, and a challenge is "making sure the Elder isn't spread too thin." High turnover of staff/leadership creates barriers to project/activity success.

Increased funding for recruitment and retention would be helpful in the future to find the right person for positions and to prevent staff burnout.

Funding for Cultural Healing

All key informants outlined the importance of cultural and traditional activities to advance the First Nations Perspective on Health and Wellness. One example is the Wholistic Health Practitioner project at Seabird Island, which aims to enhance community members' access to traditional and wholistic practices and provides the services of traditional and wholistic health practitioners who work together on an interdisciplinary team. The team's approach is to provide a person-centered, wholistic, integrated and accessible experience. One barrier for clients was the cost of treatments prescribed by the naturopath, since many of the recommended traditional medicines were not covered by non-insured health benefits.

Project/Activity Awareness

Concerns around the lack of awareness of Health Actions projects/activities in communities was a challenge discussed by key informants. Promotional posters are often used to promote activities. However, this strategy is not engaging as the posters are distributed on bulletin boards or public spaces, which many people do not look at. A key informant shared that a useful strategy for bringing community awareness to a project/activity was to hire a youth to distribute posters door-to-door.

Increasing project/activity awareness is essential to ensure a project's positive impact. Strategies for developing project/activity awareness can be implemented through creative thinking and networking.

Community Capacity

Most Health Actions projects/activities from communities/Nations were approved, but those that were not approved or stalled lacked community capacity to carry out the project/activity. The main cause of a project/activity not being approved was the absence of

an individual to lead the work. FNHA regional teams were able to work with communities/Nations who had stalled projects/activities to prepare for the implementation phase.

FNHA regional teams are instrumental in supporting and providing guidance to communities/Nations with stalled projects. This relationship fosters the development of community capacity when preparing for the implementation of a project/activity. The interface between FNHA regional staff and communities/Nations is needed moving forward, particularly with the uncertainty that communities/Nations feel around funding sustainability.

Conclusion

This Health Actions Case Study demonstrates ways in which Health Actions have provided significant opportunities for First Nations communities across the province. The evaluation provides information around the types of funding that have been allocated and how the different regions are using it within their own context and to meet their specific needs.

Health Actions has provided funding for a range of project types, including projects that are often innovative in nature and that build upon the First Nations Perspective of Health and Wellness. Flexibility is vital to the funding, which has allowed communities/Nations the opportunity to develop and deliver projects suitable for their own community's needs. This opportunity for self-determination is often absent from traditional funding, which is reliant on structured and strict guidelines.

Many projects/activities have been successfully completed, providing confirmation that the availability of Health Actions funding has positively impacted communities/Nations, a sentiment that was reiterated by key informants.

Moving forward, the partners have committed to continued partnership to support service delivery, including building on the strengths of Health Actions and addressing challenges.

Appendix A: Health Actions and Governance Actions

SUMMARY OF TCA:FNHP AND TFNHP ACTIONS (highlighting 'clusters' of linked activity)

TCA: FNHP & TRIPARTITE FIRST NATIONS HEALTH PLAN – REFERENCES (Action # & Description)			
GOVERNANCE ACTIONS		**MATERNAL AND CHILD HEALTH**	
1	Establish a new First Nations Health Council	10	Improve childhood Vision, Hearing, and Dental Screening for First Nations children
2	Appoint an Aboriginal Physician in the Provincial Health Officer's Office	11	Follow up on 2005 Child Death Review Report with the BC Coroner's Office
3	Each Health Authority to develop an Aboriginal Health Plan	14	Introduce Campaign to raise awareness on Seatbelt Use and Safe Driving
4	Establish a First Nations Health Advisory Committee	21	Improving Access to Maternity Services
5	Establish a Province-Wide Health Partners Group	**HEALTH HUMAN RESOURCES**	
6	Develop a Reciprocal Accountability Framework to address gaps in health services for FNs	18	Dedicate Post-Secondary Seats for Aboriginal Health professions
TFNHP	Establish a First Nations Health Directors Association	19	Develop a Curriculum for Cultural Competency for Health Authorities
TFNHP	Establish a First Nations Health Governance Body (FN Health Authority)	20	Designate Senior Staff in Health Authorities Responsible for Aboriginal Health
HEALTH ACTIONS		24	Develop role of Nurse Practitioners & Physician participation in Ab. Health & healing centers
PRIMARY CARE AND PUBLIC HEALTH		25	Increase the number of professional and skilled trades First Nations in health professions
7	Lead the development of a specific Aboriginal ActNow BC Program	26	Increase the number of Aboriginal Hospital Patient Liaisons/Navigators
12	Improve Primary Care Services on reserve to match or exceed off-reserve services	**EHEALTH**	
13	Improve the First Responder Program in Rural and Remote Communities	23	Create a fully integrated clinical Tele-health network
17	Implement a Northern Region Chronic Disease Prevention and Management Pilot	**HEALTH PLANNING & CAPITAL**	
22	Introduce Integrated Primary Health Services and Self-Management Programs for Chronic Health Conditions	TFNHP	Develop a Multi-Jurisdictional Planning Framework
TFNHP	Develop and Implement an Injury Prevention Strategy	16	Develop a new Health Centre at Lytton
NEW1	Develop and Implement an HIV / AIDs Strategy (new 2008)	TFNHP	Ensuring and supporting First Nations in developing Community Health Plans
NEW2	Pandemic Planning and H1N1 (New 2009)	TFNHP	Support the process of developing Capital Infrastructure with First Nations
NEW3	Traditional Medicines and Practices (new 2009)	**RESEARCH & SURVEILLANCE**	
MENTAL HEALTH AND ADDICTIONS		27	Issue Provincial Health Officer's Report on Aboriginal Health every 5 years
8	Develop and implement a Mental Health and Addictions Plan	28	Renew the Tripartite Agreement to ensure First Nations information is shared
9	Host a forum to support and encourage cultural learning and to develop models for Youth Suicide Prevention	29	Expand the Community Health survey to include First Nations
15	Develop new culturally appropriate Addiction Beds for Aboriginal Peoples	TFNHP	Develop Indicators to complement the 7 existing indicators

Appendix B: University/NGO and Indigenous NGO Breakdown

University/NGOs

BC Agriculture in the Classroom Foundation
Diabetes Canada
College of New Caledonia
Heart and Stroke Foundation of Canada
Justice Institute of BC
McCreary Centre Society
Northern Lights College Foundation
Coast Mountain College
SportMedBC
Streettohome
Tides Canada
University of British Columbia
University of Northern BC

Indigenous NGOs

Indigenous Awakening
BC Association of Aboriginal Friendship Centres
BC Elders Communication Center Society
First Nations Education Steering Committee
Inter Tribal Health Authority
New Relationship Trust

Appendix C: Evaluation of Health Actions, 2008-2013

Evaluation of the BC Tripartite Health Actions

2014

PREPARED FOR: **FIRST NATIONS HEALTH AUTHORITY**

PREPARED BY: **MNP LLP**

Updated: **June 2014**

BACKGROUND

On November 27, 2006, BC First Nations, represented by the First Nations Leadership Council, and the Province of British Columbia, signed the ten-year Transformative Change Accord: First Nations Health Plan (TCA:FNHP), which established twenty-nine (29) actions intended to close the gaps in health status between First Nations people and other British Columbians. In June 2007, BC First Nations, the Government of Canada and the Province of British Columbia signed the Tripartite First Nations Health Plan (TFNHP), which brought federal support to the table and added new health actions relating to governance.

Since these tripartite agreements were signed, the Tripartite Partners (Province of British Columbia, government of Canada and BC First Nations) have been taking active steps to fulfill the now thirty-nine (39) health actions (See Appendix A for a listing of the 39 health actions). The Tripartite Partners grouped the 39 health actions into two streams of work: Governance (eight action items); and, Health Actions (thirty one action items). The thirty-one action items in the Health Actions stream of work were grouped into the following seven Strategy Areas:

1. Primary Care and Public Health
2. Maternal and Child Health
3. Mental Wellness and Substance Use
4. Health Human Resources
5. E-Health
6. Health Knowledge and Information
7. Health Planning and Capital

The Governance stream of health actions has been advanced since 2008 through an evolving structure (a separate evaluation was conducted on the work in governance by the Institute on Governance). The Health Actions stream of work was advanced since 2008 through a Tripartite Management Team (TMT) established by the Tripartite Partners to lead the implementation of the health actions commitments made in the tripartite agreements. Comprised of representatives from the Federal and Provincial Governments and what is now the First Nations Health Authority, TMT took a lead role in advancing the health actions work until 2013. TMT's main functions were to:

- Lead and oversee the implementation of Health Actions commitments in the TFNHP;
- Identify Health Actions strategic priorities, and ensure that these priorities evolve as the needs and aspirations of First Nations communities become clearer through their integral involvement in this work;
- Develop and provide strategic mandate statements and approaches for participants;

- Review progress reports on a quarterly basis;
- Report out on the status of Health Actions work; and,
- Coordinate efforts on various health action items to ensure transition into a new governing body, is efficient and comprehensive.

In accordance with the seven Health Actions Strategy Areas, Strategy Tables were created to provide strategic leadership to the health actions work, and in particular to help lead the creation of Strategic Plans for each Strategy Area. These Strategy Tables were supported by Planning Committees, which provided technical planning support to the development of the Strategic Plans and the health actions work overall. The Tripartite Partners and First Nations were represented at all levels of this committee structure, and First Nations and Aboriginal stakeholders were engaged and kept informed of progress in a variety of different ways, including through the Gathering Wisdom forums, Regional Caucus meetings, online forums, surveys, Community Engagement Hubs and many other forums.

Through the hard work and commitment of the Tripartite Partners, many achievements were made in health actions. These achievements can be attributed in large part to the commitment of the Tripartite Partners, but they are also in many ways a result of the collaborative efforts of the First Nations communities and partners who shared in supporting the health actions work. Over the past two years, significant shifts in the governance stream of health actions has created a different landscape for health actions, and this evaluation is intended to inform a renewed approach to ensure ongoing forward momentum and progress in health actions implementation.

1.0 **EVALUATION** OVERVIEW

1.1 Evaluation Purpose and Focus

This Health Actions Evaluation was conducted to assess the progress of the Tripartite Partners in fulfilling the health actions commitments made in the tripartite agreements, and to consider potential improvements in the health actions work going forward. It takes into consideration the activities and accomplishments in health actions, and the effectiveness of the structures that were established to support the health actions work. As well as assessing outcomes in each of the seven health actions strategy areas, this evaluation considers the success of partnerships, processes, structures and procedures and identifies recommendations to help guide future efforts in health actions.

While this evaluation considers all aspects of the health actions dating back to 2007, the main focus of this evaluation is on the overall progress made in health actions. Further while the 'governance' stream of health actions is considered, the primary focus of this evaluation is on the 'health actions' stream. Note that an independent evaluation of the progress made in governance has been conducted and is documented in a separate report.

1.2 Evaluation Approach

This evaluation was initiated by the TMT in July of 2013 and completed in January 2014. Three main methods for gathering information were utilized to complete this report: a review of existing documents relating to health actions (see Appendix B), a series of interviews and a focus group session. These methods are described in further detail below.

Two main entities were involved in conducting this evaluation:

1. The Evaluation Steering Committee, which was set up by and included representatives from the Tripartite Partners to guide the evaluation toward its stated goals; and,
2. The Evaluation Team (MNP Consulting), which gathered information for this evaluation and prepared a summary of the evaluation results contained within this report.

This evaluation utilized mainly a qualitative approach to gathering information. This is in large part due to systemic barriers to comprehensive data collection about BC First Nations peoples – a matter that the Health Knowledge & Information strategy area of the health actions is working to address. Additionally, effort sof the Tripartite Partners have been focused mainly on relationship building and on establishing the structures and mechanisms to be able to move this work forward, which renders most of the progress achieved in health actions qualitative in nature. This being said, there is some quantitative information available. A key commitment of the health plans and agreements has been a leadership role of the Provincial Health Officer in reporting on the 7 core indicators outlined in

those health plans and agreements in 2006 and 2007. The Provincial Health Officer issues reports on First Nations health outcomes every five years.

An "Inventory of Health Actions Deliverables/Outcomes to inform the Health Actions Evaluation" was developed as a means of providing secondary data to support this evaluation (see Appendix C). It should be noted that the inventory does not represent an exhaustive list of the initiatives that have been undertaken, but simply a sampling of those initiatives for the purposes of this evaluation. Further, many of the initiatives in the inventory have considerable crossover (i.e., they support multiple health actions), so the information provided in the inventory cannot be used as a standalone evaluation of progress. As well, the number of initiatives supporting any Health Action or Health Action area is not necessarily indicative of effort, budget, or efficiency, and should not be considered in isolation when evaluating the progress against various Health Actions.

1.2.1 Document Review

A number of documents and sources of information were identified to help inform this evaluation (see Appendix B). These documents and information sources include the tripartite agreements noted above, a number of health actions documents that were produced by the Tripartite Partners to support the implementation work, and a number of other sources that were identified by the Evaluation Steering Committee as important to consider in conducting this evaluation.

1.2.2 Interviews and Focus Group Session

Early in the evaluation, the Evaluation Team worked with the Evaluation Steering Committee to develop a questionnaire (see Appendix D) and a list of interview participants. The main intent of the questionnaire was to gather information from a variety of stakeholders about the progress of health actions. It was utilized to conduct the interviews as well as the focus group session. The main mechanism was through one-on-one interviews although one small focus group of FNHC and FNHDA members and staff was held. Interview and Focus Group Participants included representatives from each of the Tripartite Partners and from other entities that were involved in supporting health actions. The following Table provides a breakdown of the number of individuals that participated in the interviews and focus group session from each stakeholder group.

Table 1: Interview Participants

Stakeholder Group	Number of Interviews Conducted
Health Authorities	3
Ministry of Health	11

Ministry of Children and Family Development	1
FNHA	5
First Nations Health Council	2
First Nations Health Director's Association	2
First Nations Inuit Health Branch	3

2.0 EVALUATION FINDINGS

2.1 Health Actions Progress

The Tripartite Partners invested a considerable amount of time, effort and resources into the health actions implementation commitments, and these investments resulted in significant progress. This progress has been grouped into three theme areas: health actions implementation structure; health actions engagement; and, health actions outcomes. A synopsis of the progress made in each of these areas is provided below.

It should be noted that while these developments were taking place in health actions, the Tripartite Partners ultimately investing the majority of their time, strategic attention, and investment in fulfilling the governance commitments of the tripartite agreements.

2.1.1 Health Actions Implementation Structure

Shortly after the TCA: FNHP and the TFNHP were signed, TMT was established to lead the implementation of the health actions commitments. Through the structure established, TMT did successfully reach a number of its stated goals, the most important of these being the establishment and coordination of the Strategy Tables and Planning Committees and the development of a number of Strategic Approaches or Plans. Interviewees and focus group participants reported some success, particularly in the early years of its existence, in regard to the structure that was established to move the work forward, and in the management of this structure.

2.1.2 Health Actions Relationships

A fundamental principle underpinning the health actions implementation work has always been the participation of all partners, including First Nations, Aboriginal partners, and the Tripartite Partners. Interviewees reported that the effort undertaken by the TMT to maintain successful partnerships with all of these stakeholders has been a key achievement, and quite possibly the greatest achievement in the health actions work overall.

With respect to the relationships between the Tripartite Partners, interviewees felt that the Health Actions implementation structure nurtured effective working partnerships and relationships that enabled significant progress both on shared priorities as well as in each Partner's respective work. For instance, MoH interviewees noted that through the Health Actions work, they gained greater

awareness of First Nations, the First Nations Perspective on Wellness, and other important developments in First Nations health, which they integrated into their work.

With respect to engagement with First Nations communities, a key component of this evaluation was to assess the level of involvement by First Nations in the health actions implementation process. Many respondents noted that the use of social media, such as the FNHA website, email, annual reports and quarterly newsletters, have had much success in communicating progress and in creating awareness of the health actions work. Throughout the process, First Nations participated in ways that they felt they could best contribute; at times there were challenges in obtaining full participation at all tables for a variety of reasons; nonetheless First Nations representation and input was strong at all levels. Overall, interviewees reported that the various engagement processes and activities that were utilized helped to build greater awareness about the health actions work. Extensive engagement and relationship building took place through forums such as Gathering Wisdom for a Shared Journey and other engagement processes - including a significant round of regional sessions to inform planning in the area of Mental Wellness and Substance Use.

Finally, a sense of excitement exists in terms of relationship building moving forward, particularly with the creation and implementation of the Regional Partnership Accords and with the emphasis on regional planning. Interviewees indicated that the regional work provides an opportunity to strengthen the health actions planning and implementation work. The past five years has been a time of transition and setting the stage for First Nations health transformation through relationship building and strategic planning. Now is the time to build on this foundation and bring health actions even closer to the community level through the community and regional planning efforts.

2.1.3 Health Actions Outcomes

Over the past several years, a number of key outcomes have been achieved as a result of the emphasis that was placed on health actions by the Tripartite Partners (see Appendix C). In addition to providing direct financial support to communities, the Tripartite Partners achieved the following key outcomes:

- Strategic Approaches, Plans and Frameworks in a number of the strategy areas, including but not limited to: Maternal and Child Health; Mental Wellness and Substance Use; Oral Health; Traditional Wellness; Health Human Resources; Health Knowledge & Information; and, eHealth.
- Child Seat Safety Guide
- An environmental scan relating to mental wellness and substance use was conducted to inform the development of a gap analysis
- A document feedback survey of the 10 Year Mental Wellness and Substance Use Plan
- An environmental scan of Maternal Child Health
- An Aboriginal Doula Initiative, which has enabled doulas to achieve certification to support Aboriginal women throughout BC

- A Vision Screening Initiative, which included development of a vision screening manual and a number of training, vision screening surveys and reports to support these efforts
- Scan of childhood oral health preventative services for First Nations and Aboriginal children in BC
- Collection of childhood oral health resources to support families and service providers
- First Nations and Aboriginal Childhood Oral Health Strategy
- Completion and distribution of the Family Path brochure
- Completion and distribution of 'Your Child's Hearing' video
- Safe Sleep Initiative, which included the development of safe sleep discussion cards and a facilitator's guide
- Ongoing health career promotion activities, which include financial support for and participation in the annual BC Gathering Voices Youth conference, and attending numerous events to promote health careers for First Nations and Aboriginal peoples
- Environmental Scan of BC Post-secondary Health Programs: A contributing report for the BC Aboriginal Health and Human Resources Initiative Environmental Scan
- Established the New Relationship Trust Scholarship/Bursary program for First Nations students, providing awards to over 80 students in 2012/13 and 2013/14.
- Regional Profiles of BC First Nations communities, which helped inform the Regional Health and Wellness Plans
- Tripartite Evaluation of the H1N1 Tripartite Pandemic Response
- Completion of the Tripartite Data Quality and Sharing Agreement (TDQSA) and implementation of a number of commitments articulated in the TDQSA
- Development of the First Nations Client File (FNCF) and processes to support access to the FNCF
- Development of an Information Privacy and Security Framework
- Development of an EpiCentre business plan
- Literature review of health indicators
- Contributed to PHO Reports on Aboriginal Health and other provincial and federal documents relating to First Nations health
- Partner with UNBC on Closing the Gap Research Project
- Administered the Regional Health Survey (RHS)
- Implementation stage of the First Nations Regional Early Childhood, Education and Employment Survey (FNREEES)
- Secured funding for and is leading a three year project funded by the Canadian Partnership Against Cancer (CPAC) that aims through partnership with the BC Cancer Agency and Provincial Health Services Authority to advance improvements in the continuity of cancer care in a culturally responsive and safe way for First Nations, Inuit and Metis cancer patients in BC.
- Supported and mentored a number of students, through practicum placements, to work at the FNHA as a strategy to increase the number of First Nations in the health workforce
- Support for a number of Best or Better Practices in First Nations communities

- Creation and launch of the First Nations Perspective on Wellness, which is being used throughout the organization as a foundation for many of the projects and initiatives that are underway
- Establishment the Traditional Healers Advisory Committee (THAC) (established 2013).
- Traditional Healers' Advisory Committee Terms of Reference (Final Draft Version 2013)
- Traditional Wellness Survey, which was used to inform the development of the Traditional Wellness Strategic Framework
- Traditional Models of Wellness Environmental Scan in BC
- Paper on Models of Traditional Wellness: Canadian, American and International Practices
- Development of a number of other resources for communities that provide a traditional holistic perspective, including the Health and Wellness Diary, Corporate Wellness Calendar, Community Toolkit and Facilitator Guide, ADI Resources Booklet, Traditional Approaches Poster; and First Nations Traditional Foods Fact Sheets.

2.2 Issues

Through the interviews and focus group session, it became evident that there were also a number of issues and concerns regarding the health actions implementation work that was carried out. The following provides a summary of the main concerns put forward by interviewees:

- There is much diversity in terms of the capacities, backgrounds and expectations that people bring to the table (which may also be seen as a key strength). This sometimes made it difficult to achieve progress and navigate through the work and to obtain consensus. At times, information did not get shared between the different tables and this made it hard to coordinate efforts.

- The ability to engage all stakeholders at all levels was not always possible, especially given the number of entities and people involved. The cost of travel made it a challenge to bring individuals in from remote communities, and even the opportunity to engage communities through technology was at times challenging given the lack of IT capacity in some communities. Some communities had concerns about being over-engaged, given all of the different areas that they were asked to provide feedback on. Conversely, there were also concerns expressed that the work in health actions was not informed by engagement and driven by BC First Nations. At minimum, there has been a lack of clarity about how the fairly extensive engagement conducted has translated into and informed the work at TMT and the Strategy Tables.

- The 'Health Actions' themselves are diverse, and this made it challenging to assess progress. Many of the Health Actions can be identified as strategic objectives, while others are more specific in intention. Some of the Health Actions can be "checked off" as completed – for example, "Health Action #16: the development of a new Health Centre at Lytton". Other Health Actions will never actually be done, as they are ongoing objectives to achieve within a larger health transformation over a significant period of time – for example, "Health Action #21: Improving Access to Maternity Services.

- Existing measurement and reporting tools do not provide a complete and accurate depiction of progress in health actions (limitations in obtaining data have been noted as an issue); reporting methods have been inconsistent. While health indicators have been identified in the context of First Nations health overall, specific health indicators have not been identified and fully described within each of the health actions. Two categories of Health Actions exist: those that are short- term and finite, and those that are much more long-term in nature and broad, requiring a range of leading (i.e. representing factors contributing to a change) and lagging (i.e. that reflect change) outcome indicators to assess if they have been successful or not. The indicators that do currently exist tend to be more lagging (for example, mortality rates, for which there are many contributing factors). As a result of this, it was difficult to identify key measurable successes within each of the Health Actions.
- TMT did not have the authority to make decisions or commit resources, and this made it difficult to move forward on certain issues. This may be why work was sometimes put on hold at the strategy and planning levels, and why it was difficult to determine where investments should be made, and how those investments could be assessed to determine their effectiveness.
- Within many of the health actions areas, there are a number of systemic barriers that impact not just First Nations but all BC residents. Immediate change is not always possible, as the issues are often systemic in nature, and this likely contributes to why progress is often slow and difficult to measure.

3.0 RECOMMENDATIONS

This section of the report provides a list of key recommendations for improving the health actions work and building on the successes that have been achieved to date. These recommendations were developed based on the feedback received in the interviews and focus group session, and as well on an overall assessment of the progress in health actions based on the health actions documents that were reviewed.

3.1 Health Actions Implementation Structure

It is recommended that the Tripartite Partners:

- Continue to align the health actions implementation work with the regional planning work.
- Identify an entity that can oversee the Health Actions implementation work. This entity should have the authority to make decisions and apply funding where necessary. Interviews suggest this entity may be the Joint Project Board, which includes BCMOH ADMs and FNHA VPs.
- Identify a secretariat to provide coordination and communication functions and to help create standardized tools and processes to support the work.

- Discuss and clarify how the Tripartite Partners, First Nations, Regional Health Authorities, Aboriginal organizations, and all other stakeholders will continue to be involved in supporting health actions. This is a crucial time for a renewed discussion on the health actions, given the many changes and developments that have recently occurred. FNHA is now participating in various other provincial structures as a service delivery and strategic policy organization, and this will need to be considered.
- Identify qualifications of key roles within the health actions implementation structure and opportunities to participate in health actions so that participation can align with the capacities, interests and backgrounds of the people that are qualified and committed to the health actions work.

3.2 Health Actions Relationships

It is recommended that the Tripartite Partners:

- Develop a strategy for connecting with other relevant service providers in BC. Interview respondents noted the importance of connecting with other ministries and networks, such as the Ministry of Child and Family Development, the Ministry of Education and the Ministry of Justice.
- Continue to build on the important work in wellness and on incorporating a holistic approach in the health actions, as this will not only bring greater depth to the work but it will also help to strengthen relationships.
- Establish and maintain a conflict resolution process to help address issues that arise in health actions.
- Continue to increase awareness of the Health Actions among key groups, particularly First Nations, the Province of BC, partner organizations, and the public.
- Continue to utilize ways to bring health actions closer to First Nations through community and regional planning. A key opportunity exists with the recent emergence of the regional structures and the increased emphasis on regional planning, where health actions can inform regional planning and in turn the priorities identified by communities in their regional plans can also feed into the health actions work. As communities develop their community and regional health and wellness plans, they will be able to recommend, through these plans, how health actions can be achieved more effectively at a community and regional level. Moreover, regional investments can be made that focus on health actions implementation.
- Build communication strategies around plans for health actions implementation, and around the community and regional planning processes that are underway. Develop communication strategies that are relevant to each stakeholder group. Developing standard communication processes and tracking mechanisms may help to better connect communities where issues and developments are cross-cutting.

- Strengthen opportunities for collaboration by utilizing different kinds of engagement methods and by continuing to support efforts to increase access through improved technology, particularly in rural and remote communities
- Reciprocal accountability should continue to be strengthened at all levels, from the ground level to the strategic planning level.

3.3 Health Actions Outcomes

It is recommended that the Tripartite Partners:

- Update the Health Actions to reflect current realities and evolving expectations, i.e. Action 11 "Follow up on 2005 Child Death Review Report with the BC Coroner's Office" may be updated to reflect the current collaboration between the Tripartite Partners and the BC Coroner's Office relating to First Nations children.
- As part of broader ongoing efforts to develop wellness indicators and develop a tripartite evaluation plan, create indicators and performance measures for health actions that are both leading (logically connected indicators of upcoming changes) and lagging (demonstrations of effectiveness following interventions). Measures of performance should be based on areas of existing information and available data, to reduce the requirements for additional data gathering. Tools to guide the development of appropriate indicators of success and measures of performance should be developed and shared to build knowledge and capacity.
- There are areas where best practices are emerging, such as with the development of logic models to identify actions and intended outcomes, and these new developments should be shared across the various regions and teams involved. It may be helpful to also create standardized tools and frameworks to help create more structure to the health actions implementation work, while at the same time create space for the Regions to prioritize health actions commitments according to their own unique needs and priorities.
- Put more emphasis on creating change more broadly within the system; continue to work with key partners to see where opportunities to collaborate on these systemic change efforts can occur, and continue to raise awareness about developments in health actions more broadly so that this work can help influence systemic change.

4.0 IN CLOSING

Since 2008, through the Health Actions implementation structure established by the Tripartite Partners, notable progress in health actions has been achieved, informed by engagement with BC First Nations.

Simultaneously, intensive and transformative efforts were taking place in the Governance stream of the Tripartite Partners' shared agenda. Over the past several years in particular, significant changes have resulted in governance - including the establishment of a new First Nations health governance

structure, new forums and processes for bilateral and tripartite decision-making, and emerging regional governance structures and planning.

Overall, it is now timely to bring these two agendas together, and refresh the priorities and processes for health actions through utilizing the new governance structure at provincial and regional levels, and linking health actions to new approaches being taken around tripartite evaluation and in regional investment. While much has been accomplished, much more progress can be achieved in the next stage of the Tripartite Partners' shared journey.

APPENDIX CA – HEALTH ACTIONS

SUMMARY OF TCA:FNHP AND TFNHP ACTIONS (highlighting 'clusters' of linked activity)

TCA: FNHP & TRIPARTITE FIRST NATIONS HEALTH PLAN – REFERENCES (Action # & Description)			
GOVERNANCE ACTIONS		**MATERNAL AND CHILD HEALTH**	
1	Establish a new First Nations Health Council	10	Improve childhood Vision, Hearing, and Dental Screening for First Nations children
2	Appoint an Aboriginal Physician in the Provincial Health Officer's Office	11	Follow up on 2005 Child Death Review Report with the BC Coroner's Office
3	Each Health Authority to develop an Aboriginal Health Plan	14	Introduce Campaign to raise awareness on Seatbelt Use and Safe Driving
4	Establish a First Nations Health Advisory Committee	21	Improving Access to Maternity Services
5	Establish a Province-Wide Health Partners Group	**HEALTH HUMAN RESOURCES**	
6	Develop a Reciprocal Accountability Framework to address gaps in health services for FNs	18	Dedicate Post-Secondary Seats for Aboriginal Health professions
TFNHP	Establish a First Nations Health Directors Association	19	Develop a Curriculum for Cultural Competency for Health Authorities
TFNHP	Establish a First Nations Health Governance Body (FN Health Authority)	20	Designate Senior Staff in Health Authorities Responsible for Aboriginal Health
HEALTH ACTIONS		24	Develop role of Nurse Practitioners & Physician participation in Ab. Health & healing centers
PRIMARY CARE AND PUBLIC HEALTH		25	Increase the number of professional and skilled trades First Nations in health professions
7	Lead the development of a specific Aboriginal ActNow BC Program	26	Increase the number of Aboriginal Hospital Patient Liaisons/Navigators
12	Improve Primary Care Services on reserve to match or exceed off-reserve services	**EHEALTH**	
13	Improve the First Responder Program in Rural and Remote Communities	23	Create a fully integrated clinical Tele-health network
17	Implement a Northern Region Chronic Disease Prevention and Management Pilot	**HEALTH PLANNING & CAPITAL**	
22	Introduce Integrated Primary Health Services and Self-Management Programs for Chronic Health Conditions	TFNHP	Develop a Multi-Jurisdictional Planning Framework
TFNHP	Develop and Implement an Injury Prevention Strategy	16	Develop a new Health Centre at Lytton
NEW1	Develop and Implement an HIV / AIDs Strategy (new 2008)	TFNHP	Ensuring and supporting First Nations in developing Community Health Plans
NEW2	Pandemic Planning and H1N1 (New 2009)	TFNHP	Support the process of developing Capital Infrastructure with First Nations
NEW3	Traditional Medicines and Practices (new 2009)	**RESEARCH & SURVEILLANCE**	
MENTAL HEALTH AND ADDICTIONS		27	Issue Provincial Health Officer's Report on Aboriginal Health every 5 years
8	Develop and implement a Mental Health and Addictions Plan	28	Renew the Tripartite Agreement to ensure First Nations information is shared
9	Host a forum to support and encourage cultural learning and to develop models for Youth Suicide Prevention	29	Expand the Community Health survey to include First Nations
15	Develop new culturally appropriate Addiction Beds for Aboriginal Peoples	TFNHP	Develop Indicators to complement the 7 existing indicators

APPENDIX CB – LINKS AND RESOURCES

- Aboriginal Health Plan 2007 – 2010. Aboriginal Health Services, Fraser Health, December 2006.
- Aboriginal Health Year in Review Report 2011 – 2012, Fraser Health; First Nations Health Authority.
- First Nations eHealth Tripartite Strategy Council, Status Report for TMT. Quarterly Update, September 2012.
- First Nations eHealth Tripartite Strategy Table, Status Report for TMT. Quarterly Update, January 2013.
- First Nations Health Council, http://www.fnhc.ca/
- First Nations Health Plan, Memorandum of Understanding, between The First Nations Leadership Council Representing The BC Assembly of First Nations, The First Nations Summit and The Union of BC Indian Chiefs; Government of Canada; and Government of British Columbia. (Executed) November 27, 2006.
- Fraser Partnership Accord, First Nations Health Council: Fraser Salish Regional Caucus and Fraser Health Authority, Version 4.0, December 12, 2011.
- Governance Evaluation, First Nations Health Authority, September 2013. Institute on Governance.
- Health Human Resources Tripartite Strategy Council, Status Report for TMT. Quarterly Update, January 2012.
- Health Human Resources Tripartite Strategy Council, Status Report for TMT. Quarterly Update, September 2012.
- Health Knowledge and Information (HKI) Strategic Approach, Finalized August 2, 2013.
- Health Knowledge and Information Tripartite Strategy Council, Status Report for TMT. Quarterly Update, June 2012.
- Health Knowledge and Information Tripartite Strategy Table, Status Report for TMT. Quarterly Update, January 2013.
- Health Partnership Accord, First Nations Health Council; the British Columbia Ministry of Health; and Health Canada, December 17, 2012.
- Maternal and Child Health Tripartite Strategy Council, Status Report for TMT. Quarterly Update, September 2012.
- Maternal and Child Health Tripartite Strategy Table, Status Report for TMT. Quarterly Update, December 2012.
- Mental Wellness & Substance Use Tripartite Strategy Council, Status Report for TMT. Quarterly Update, September 19, 2012.
- Mental Wellness & Substance Use Tripartite Strategy Table, Status Report for TMT. Quarterly Update, January 2013.
- Primary Care & Public Health Tripartite Strategy Council, Status Report for TMT. Quarterly Update, September 2012.
- Primary Care & Public Health Tripartite Strategy Table, Status Report for TMT. Quarterly Update, January 2013.
- Rockandel & Associates, Meeting Summary, July 19, 2012.
- Snow, Beth. Evaluation Report for the Aboriginal Health Program. Fraser Health, August 2010.
- Structure of Health Actions Strategy Areas, updated April 26, 2012.
- Terms of Reference: Tripartite Management & Oversight, Tripartite Management Team Committee, updated October 2010.
- TFNHP Health Actions Strategy Council Operating Protocols, Version 2.0, February 22, 2011.

- The Transformative Change Accord: First Nations Health Plan
- TMT‟s Overarching Strategic Vision. TMT‟s Overarching Role.
- Transformative Change Accord, between Government of British Columbia; Government of Canada; and The Leadership Council Representing the First Nations of British Columbia. (Signed) November 25, 2005.
- Tripartite „Health Actions‟ Implementation Approach, Revision No.2, Approved by TMT 21 January 2011.
- Tripartite First Nations Health Plan, between The First Nations Leadership Council Representing The BC Assembly of First Nations, The First Nations Summit and The Union of BC Indian Chiefs; Government of Canada; and Government of British Columbia. (Signed) June 11, 2007.

APPENDIX CC: EVALUATION QUESTIONNAIRE

Tripartite Management Team Evaluation Focus Areas	Critical Evaluation Questions
Governance Structure and Function	• What are the: o Strengths of the tripartite governance over Health Actions, in terms of structure and how it operates, as well as in membership (i.e., sharing of experience, skill sets, decision-making authorities)? o Challenges, if any, associated with the current tripartite governance structure? o Improvements that could be made moving
State of Collaboration	• To what extent is collaboration and relationship building occurring at a strategic level, and how might this be improved? • To what extent is participation and resourcing at a strategic level contributing to the successes and/or challenges of the First Nations Health Authority (FNHA)? • Are the authorities in place to facilitate decision-making at a strategic level? • What other opportunities are there to enhance decision making at a strategic level? • What should the role of the federal government be, if any, in

Level of First Nation Engagement	•In what ways are First Nations engaged in the planning and implementation of Health Actions and is this consistent with expectations? •What, if any, barriers are there to engagement? •What should the role of the federal government be, if any, in furthering the engagement of First Nations in planning and implementation?

Health Action Leads (Regional and Provincial) Evaluation Objectives	Critical Evaluation Questions
Progress on Delivery of the Health Actions	1. How do governance and accountability processes support or inhibit progress on the Health Actions, as well as communication of results? 2. What, if anything, has changed since the development of the Health Actions, and looking forward, what are the implications for the Health Actions? 3. Is the state of progress in delivery of the Health Actions as intended? a. What barriers, if any, have prevented delivery of the Health Actions as intended? b. What opportunities exist to enhance delivery on Health
Realization and Sustainability of Results	•To what extent, and in what ways, have the Health Actions achieved the intended results? •What, if any, unintended results have been achieved? •In what ways is the achievement of results associated with Health Actions being measured and reported? •What have been the barriers or challenges in the realization of results and what strategies would best address these challenges? •What strategies are there, if any, to ensure the best use of capacity and expertise at a provincial and regional level? •What do the experiences with both larger, systemic projects and with smaller projects suggest for the future priorities and delivery of Health Actions? Are the current Health Actions still relevant?

APPENDIX CD – INTERVIEW GUIDE

Health Actions Evaluation – Interview Guide

The First Nations Health Authority has engaged MNP LLP to conduct an evaluation to assess progress made to date on the Tripartite First Nations Health Actions, and to consider potential improvements that can be made to both the governance structure and associated practices of the Tripartite Management Team (TMT). As a member of the_______organization, you have a unique perspective on the goals and intentions, program administration and delivery, as well as achievement of intended results associated with the program. Through your responses to the following open-ended questions, we hope to gain insight into your perspective on the Health Actions and the Tripartite Management governance structure in their current form, as well as an understanding of possible future directions.

Your participation is completely voluntary and the information you provide is for the purpose of this evaluation project only.

CONTACT INFORMATION:

Name:	
Title/Role:	
Organization:	
Region:	
Date:	

ORGANIZATIONAL PROFILE:

Are you a member of (check all that apply):

- The Tripartite Executive or Management
- One or more Health Action Teams
- Other Stakeholder organization or group

Please describe your primary organization (i.e. service offerings, objectives, mandate, etc.)

Please describe your primary role and responsibilities at this organization.

Please describe your past and current history and involvement with the Health Actions.

OPEN ENDED QUESTIONS

As a member of the Tripartite Executive or Management Governance Structure and Function

What do you believe the strengths and challenges to be of the current tripartite governance structure over Health Actions? This may include consideration of membership, participation, use of delegates, etc.

- What improvements could be made to the structure?

State of Collaboration

Which organizations and individuals have you observed collaborating or building relationships through the First Nations Health Authority?

What are the most common ways of collaborating? This may include working together to deliver certain tasks, sharing resources, formal partnerships, etc.

Are there opportunities to increase collaboration and strengthen these relationships?

What types of resources or knowledge is being leveraged through participation at the strategic level (the TMT)? What is the impact of participation and resourcing at a strategic level (the TMT) on the First Nations Health Authority and associated Health Actions?

What, if anything, could be done to improve participation and resourcing?

What types of collaborative decisions are being made at the strategic level (the TMT)?

What are the impacts of those collaborative decisions on the Health Actions and/or progress of the FNHA?

What opportunities exist to improve decision making at a strategic level (the TMT)? This may include adjusting authorities to further facilitate decision making.

What do you believe the role of the federal government should be in decision making at a strategic level (the TMT)?

OPEN-ENDED QUESTIONS:

As a member of one or more Health Action Teams or other Stakeholder Level of First Nation Engagement

How have First Nations engaged in the planning of Health Actions associated with the FNHA?

How have First Nations been engaged in the implementation of the resulting Health Actions?

Do you think this aligns with the expectations First Nations have of their level of engagement for both planning and implementation?

Are there barriers to First Nations engagement in planning and implementation of the Health Actions? If so, what are they?

What do you think the role of the federal government should be, if any, in furthering First Nations engagement in planning and implementation of the Health Actions?

Progress on the Delivery of Health Actions

Does the current oversight or management of the Health Actions support or inhibit the intended progress and results?

How are results of the Health Actions communicated? Are there opportunities for better reporting on results?

What, if anything, has changed since the development of the Health Actions? This may include social issues, economic environments, technology developments or health information, etc.

What adjustments, if any, could be made to the Health Actions moving forward to accommodate those changes?

What barriers have prevented the delivery of the Health Actions? What opportunities exist to enhance delivery of the Health Actions moving forward?

Realization and Sustainability of Results

How have the Health Actions achieved their intended results? Are there any unintended results that have been achieved?

Can the achievement of these results that are associated with the Health Actions be measured and reported on? If so, is this happening?

What barriers or challenges have gotten in the way of achieving the Health Actions? Looking forward, what strategies could best address these challenges?

How might capacity and expertise be better used to support the achievement of Health Actions? For example, are there possible synergies at the provincial and regional level? Are there differences between capacity and expertise within projects of different sizes?

Do you have anything else to add that should be considered for future priorities related to Health Actions?

APPENDIX CE – SEVEN DIRECTIVES

Since 2008, BC First Nations have been involved in an unprecedented process of community engagement to guide the work in First Nations health governance. Through more than 120 regional and sub-regional caucus meetings, and more than 250 Health Partnership Workbooks, First Nations in BC have developed the following directives. These directives describe the fundamental standards and instructions for the new health governance relationship.

Directive #1: Community-Driven, Nation-Based

- The Community-Driven, Nation-Based principle is overarching and foundational to the entire health governance arrangement.
- Program, service and policy development must be informed and driven by the grassroots level.
- First Nations community health agreements and programs must be protected and enhanced.
- Autonomy and authority of First Nations will not be compromised.

Directive #2: Increase First Nations Decision-Making and Control

- Increase First Nations influence in health program and service philosophy, design and delivery at the local, regional, provincial, national and international levels.
- Develop a wellness approach to health including prioritizing health promotion and disease and injury prevention.
- Implement greater local control over community-level health services.
- Involve First Nations in federal and provincial decision-making about health services for First Nations at the highest levels.
- Increase community-level flexibility in spending decisions to meet their own needs and priorities.
- Implement the OCAP (ownership, control, access and possession) principle regarding First Nations health data, including leading First Nations health reporting.
- Recognize the authority of individual BC First Nations in their governance of health services in their communities and devolve the delivery of programs to local and regional levels as much as possible and when appropriate and feasible.

Directive #3: Improve Services

- Protect, incorporate and promote First Nations knowledge, beliefs, values, practices, medicines and models of health and healing into all health programs and services that serve BC First Nations.
- Improve and revitalize the Non-Insured Benefits program.
- Increase access to primary care, physicians, nurses, dental care and other allied health care by First Nations communities.

- Through the creation of a First Nations Health Authority and supporting a First Nations population health approach, First Nations will work collectively to improve all health services accessed by First Nations.
- Support health and wellness planning and the development of health program and service delivery models at local and regional levels.

Directive #4: Foster Meaningful Collaboration and Partnership

- Collaborate with other First Nations and non-First Nations organization and governments to address social and environmental determinants of First Nations health (e.g. poverty, water quality, housing, etc.).
- Partnerships are critical to our collective success. First Nations will create opportunities through working collaboratively with federal, provincial, and regional partners.
- Foster collaboration in research and reporting at all levels.
- Support community engagement hubs.
- Enable relationship-building between First Nations and the regional health authorities and the First Nations Health Authority with the goal of aligning health care with First Nations priorities and community health plans where applicable.

Directive #5: Develop Human and Economic Capacity

- Develop current and future health professionals at all levels through a variety of education and training methods and opportunities.
- Result in opportunities to leverage additional funding and investment and services from federal and provincial sources for First Nations in BC.
- Result in economic opportunities to generate additional resources for First Nations health programs.

Directive #6: Be Without Prejudice to First Nations Interests

- Not impact on Aboriginal Title and Rights or the treaty rights of First Nations, and be without prejudice to any self-government agreements or court proceedings.
- Not impact on the fiduciary duty of the Crown.
- Not impact on existing federal funding agreement with individual First Nations, unless First Nations want the agreements to change.

Directive #7: Function at a High Operational Standard

- Be accountable, including through clear, regular and transparent reporting.
- Make best and prudent use of available resources.
- Implement appropriate competencies for key roles and responsibilities at all levels.
- Operate with clear governance documents, policies, and procedures, including for conflict of interest and dispute resolution.

APPENDIX CF – INVENTORY OF HEALTH ACTIONS DELIVERABLES/OUTCOMES

Governance

Name	Type	HA Strategy Area	Health Action Item	FNHA Partner(s)	Date	Brief Description	What made it a success?	Key lessons learned
Establishment of the First Nations Health Council	Governance - organizational establishment		1	BC First Nation communities political relationship	2007-Present	Established to provide a forum for appointees selected by each of three political bodies (BC Assembly of First Nations, Union of BC Indian Chiefs & the First Nations Summit) to focus on delivery of the TCA:FNHP and TFNHP. In 2010 the council was restructure to its current format of having three representatives from each region and supporting the FNHA through leadership and governance support.		
Establishment of the First Nations Health Directors Association	Organizational establishment	All	TFNHP	BC First Nation health leaders/managers	2010	This is a key action from the TFNHP. FNHDA role is to focus on improved technical capacity, providing a technical advisory function to the FNHA governance structure as a whole, as well as to provide professional development to its membership. Full and associate memberships are supported; founding Board had 12 members (spread across 5 regions); fy1314 Board had 15 members representing the 5 regions (with regionally designed representation processes- ie consensus, vote, appointment, etc..)	Became an independent, established organizational entity (registered as a non-profit in Canada with annual reporting obligations to its membership). Helps to ensure TFNHP implementation grounded in community based, health technical knowledge.	

Establishment of First Nations Health Society and its subsequent evolution into the First Nations Health Authority	Organizational establishment	All	TFNHP	BC First Nation communities	2009-Present	Established as the technical team for addressing all of the actions in the TCA:FNHP and TFNHP. AT Gathering Wisdom IV it was voted that the FNHS should be evolved into the FNHA.	Formal organizational evolutionary process from non-profit to incorporation and organizational maturity.	
Creation of Regional Caucuses & Regional Tables	Governance infrastructure	All		BC First Nation community leadership and health leads/managers	2008 to present	Governance structure composition evolved from engagement structure established in early days; one regional caucus for each region is comprised of regionally appointed political leadership; each caucus in turn elects three representatives to the FNHC. Annually to date, more than 100 caucus sessions occur e.g. in 2011 there were 120 regional and sub- regional meetings. Since inception, there has been close to 300 caucus and sub-regional meetings in total to date.	Early Health Actions funds enabled this precedent setting infrastructure to be established to engage on community health issues and ensure community based nation driven directive realized	
Creation and implementation of 25 Community Engagement Hubs (representing 160 communities)	Infrastructure	All	All	BC First Nation community health organizations	2009 to present	Created to provide a mechanism for health organizations to come together to collaborate, plan and communicate around improving services and TCFNP implementation in their communities. In total, 25 community engagement hubs have been operational annually, with 160 communities participating in them.	By 2010 there were 25 hubs involving 160 communities engaged in planning, collaborating, and communicating	Capacity support instrumental to successful efforts; self-governance key

Guiding Documents for Leadership Engagement & Decision-Making (Including the Consensus Paper leading to the 7 Directives, the Engagement & Approvals Pathway, and the Guidebook processes)	Process	All	All	BC First Nations Communities	2009 to present	The Engagement & Approvals Pathway is our process for engaging First Nations leadership in key governance-level decisions. Through following that pathway on key issues in each of 2011, 2012, and 2013, the result was Consensus Paper 2011 and Consensus Paper 2012 ("Consensus Paper 2012: Navigating the Currents of Change- Transitioning to a New First Nations Health Governance Structure"), establishing the governance structures, standards, and processes agreed-upon by BC First Nations which guide our work today and moving forward.	First organization of this size in health to execute upon and hold steadfast to their accountability body- BC First Nations political leadership. Precedent setting community driven, nation based cycle utilized to engage on complex health issues and build consensus.	
Tripartite Committee on First Nations Health (TCFNH)	Political and technical oversight	All	All, 4	British Columbia, Canada, BC First Nations leadership (signatories to Framework Agreement 2011)	2009	Development of effective political and technical working relationships where none had been before	Political support at highest levels of each system; legislative mandate by way of the Framework Agreement	All parties committing resources to shared vision advanced the vision

Partnership Accords-regionalizing of Health Actions (one for each region: Fraser-Salish, Vancouver Coastal, Vancouver Island, North, Interior)	Document	All/TBD	All/TBD, 3, TFNHP New	Regional Health Authorities, regional caucus tables, Ministry of Health		2012/13 formal tripartite recognition of the need to and shift towards regionalizing health strategies by way of the Partnership Accords: one per region.	The formalizing and establishment of Regional Health Authority relationships with BC First Nations to, *for the first time in history,* strategize and plan to improve BC First Nation and Aboriginal health outcomes; efforts necessarily bring health actions planning to communities at the Regional Health Authority service delivery level for systems 'hardwiring' of shared agendas	
Gathering Wisdom (I-VI)	Event	All	All	BC First Nations communities	Since 2007	Support towards this critical and precedent setting conference intended to uniquely bring together BC First Nation political and health leads to dialogue and plan for community health (with limited and restricted invitations for health service delivery partners). The forums have been expanding in size over the years (312 people attended GW II in 2008, 400 people from 130 attended GW III, and over 900 people attended the last GW VI in 2013).	Created opportunity to dialogue and build consensus towards a shared health and wellness vision enabling an eventual transfer of federal health services--NEVER accomplished before in any other field in BC, or provincial jurisdiction in Canada (with a culturally and geographically diverse population base); target breakout sessions engaging on how to advance health actions strategic objectives (e.g. primary care services, eHealth initiatives, etc.)	Guidebook process and engagement pathway utilization key for ensuring mutual understanding of health issues and for decision making on health issues (governance). Facilitated breakout sessions an important opportunity for retrieving technical feedback on health action approaches and work.

Joint Project Board establishment	Political and technical oversight	eHealth, PCPH	23, new	Ministry of Health	2012	Established through the "MSP In Lieu" agreement to advance primary care and eHealth initiatives as priority community health issues ($15.5 m from fy1314-fy1516)	Bilateral, provincial scale commitment to expedite key projects to resolve BC First Nation defined health issues/gaps	TBD
Kelowna Accord	Event/ document	Prior to	Prior to	BC Government		Shifting from an Ottawa driven system to BC based system-- Premier's early involvement and commitment to write a bilateral plan (2006) and declaration that it would serve *anyone* in the province regardless of where they live (ie if they are on-reserve)--- this resolved the jurisdictional responsibility question (RHAs were mandated to deliver services)	BC Premier and First Nations leadership commitment to develop a bilateral action plan to address health	Change in government cannot destabilize BC First Nations political will
Reciprocal Accountability Framework and realization	Document	All	All, 6	Ministry of Health		Mutual agreement and understanding towards partner role accountabilities and commitment to action and overcome divergence	Individual level commitment to define and advance shared priorities	
Tripartite Communications Steering Committee and working group	Working Group	All	All	Ministry of Health, FNIH BC Region, FNIH Ottawa		To jointly communicate on shared obligations with tripartite communication protocol signed off at ADM level- never been done before;	Tripartite communications strategy was developed and strengthened working relationships, understanding	shifted order of precedence by having it loosely defined and not hierarchically driven by federal system e.g. elder could speak first rather than federal Minister
First Nations Health Directors Association-engagement	Engagement	All	All	FNHDA	Since 2011	Direct engagement for guidance/feedback on health action tripartite strategy table and working group strategies and plans	FNHA and tripartite facilitated feedback sessions	FNHDA Board preference to design sessions in partnership

FNHC-FNHA-FNHDA Relationship Agreement	Agreement	All	All	FNHC, FNHDA, FNHA	2012	Outline of the three parties commitment to each other and to a shared vision, set of six values (respect, discipline, excellence, culture, and fairness), and a series of reciprocal accountabilities and processes to support the effective functioning & upholding of roles and responsibilities amongst the First Nations components of the health governance structure	Supported strong working relationships; shared dedication to vision and values	TBD

Relationships

Name	Type (Process, Relationship, Document, Event, etc.)	HA Strategy Area	Health Action Item	FNHA Partner(s)	Date	Brief Description	What made it a success?	Key lessons learned
Appointment of Deputy Provincial Health Officer for Aboriginal Health	Position and Relationship	All	All, 2	Province of BC	2012	On April 1, 2012, the Government of BC appointed Dr. Evan Adams as Deputy PHO - the first Aboriginal Physician to be appointed to this role with legislative enforcement authority. Dr. Adams has specific responsibilities for monitoring and reporting on the health of First Nations and Aboriginal people in BC, and for tracking the progress of seven performance indicators laid out in the Transformative Change Accord: First Nations Health Plan	First Aboriginal physician in BC with legislative enforcement authority- provides leadership to BC First Nations communities and informs culturally appropriate practices in a government setting	
Provincial Health Officer's Special Report: The Health and Well-being of the Aboriginal Population, Interim Update 2012	Report	Health, Knowledge and Information	27	Office of the Provincial Health Officer	2012	This report provides an interim update on progress made to close the gaps in health between First Nations and other British Columbians, in accordance with targets and indicators set out in the Transformative Change Accord and Tripartite First Nations Health Plan.	It delivers on the TCA: FNHP commitment of issuing Aboriginal health status reports every five years, with interim updates every two years.	There are persistent gaps in health outcomes between First Nations and other residents in BC. Despite these gaps, improvements have been made that reflect progress in the five indicators for which data are currently available

Political and Technical tripartite working relationships (bilateral since Oct 1/13 transfer)	Decision making and working groups	All	All	Ministry of Health, Ministry of Advanced Education, Ministry for Children and Family Development, Ministry of Aboriginal Relations and Reconciliation, Ministry of Education, FNIH BC Region, FNIH (Ottawa)	Since 2005	Development of effective political and technical working relationships where none had been before	Political support at highest levels of each system; legislative mandate by way of the Framework Agreement	
Tripartite/bilateral working relationship building capacity development for enhanced collaboration	Working Groups	All	All	Ministry of Health, Ministry of Advanced Education, Ministry for Children and Family Development, Ministry of Aboriginal Relations and Reconciliation, Ministry of Education, FNIH BC Region, FNIH (Ottawa)	Since 2009	Depth and understanding of mutual interests and pathways to advance them in solidarity; leveraging of each system's capacity	Vision, dedication and commitment of individuals, table infrastructure and resourcing with funds and in -kind	

Partnership Tables	Implementatio n partner table	All	TBD	Regional health authorities and regional caucuses (BC First Nations political and technical leadership)	2013-present	Partnership table formed to implement Partnership Accords to work collaboratively to leverage systems and advance regional priorities	The formalizing and establishment of Regional Health Authority relationships with BC First Nations to, *for the first time in history,* strategize and plan to improve BC First Nation and Aboriginal health outcomes; efforts necessarily bring health actions planning to communities at the Regional Health Authority service delivery level for systems 'hardwiring' of shared agendas	
Tripartite Management Team	Oversight table	All	All	FNIH BC Region, Ministry of Health	2010- 2013	Executive level oversight and accountability to implement health action items in Health Plans with reporting obligations to the Tripartite Committee on First Nations Health	Subject to the outcomes of this evaluation	Decision makers with budget and strategic accountabilities must represent

Tripartite Strategy Tables for the following population health and enabling areas: 1) primary care and public health, 2) maternal and child health, 3) mental wellness and substance use, 4) health knowledge and information, 5) eHealth, and 6) health human resources	Strategic and Implementatio n Tables	All	All	FNIH BC Region, Ministry of Health	2011-2013/4	Brought key technical and policy personnel together to strategize for, plan, and implement health action commitments in the 2006 First Nations Health Plan and 2007 Tripartite First Nation Health Plan	Precedent setting responsive structures designed to advance the work, and commence community dialogue towards their achievement; reporting mechanisms established via scorecard, dashboards, and quarterly tripartite table reports up to TMT and the TCFNH; shared communication approaches for first time (e.g. tripartite logo, H1N1 pandemic response)	Evidenced through various research and Approach document guidance which now guide the regional implementation work
FNHA and Ministry of Health Joint Project Board establishment	Oversight table	eHealth, PCPH	TBD	Ministry of Health	2012	Established through the "MSP In Lieu" agreement to advance primary care and eHealth initiatives as priority community health issues ($15.5 m from fy1314-fy1516)	Bilateral, provincial scale commitment to expedite key projects to resolve BC First Nation defined health issues/gaps	TBD
Ministry of Health and Regional Health Authority recognition of jurisdictional responsibilities to serve BC First Nations in health	Event (Premier's announcement)	All	All	Ministry of Health, BC government, Regional Health Authorities, FNIH BC Region	2005-present	MoH executive understanding of accountabilities since 2005 Premier declaration that all Regional Health Authorities have jurisdictional responsibility for BC First Nations health service delivery	Aboriginal Healthy Living Branch commitment and collaboration	Enhanced, repetitive, continuous communication clarifies jurisdictional responsibilities across all service delivery arms

Tripartite Committee on First Nations Health (TCFNH) Annual Report – Together in Wellness 2011/2012 and 2012/13	Annual Report	All	All	Tripartite	2012 and 2013	Annual Tripartite report on the progress of the integration and the improvement of health services for First Nations in British Columbia following the signing of the BC Tripartite Framework Agreement on First Nation Health Governance - key activities and successes	It delivers on the British Columbia Tripartite Framework Agreement on First Nation Health Governance commitment to produce an annual Tripartite report.	The report highlights the progress in partnerships and actions being made in the regions and at the provincial level.
Michael Smith Foundation for Health Research	Relationship	HKI			2011 to Present	1) Two Science Policy Fellowships for FNHA supported by MSFHR and CIHR, 2) Developing a Research Agenda for First Nations health in BC, incl. Blue Sky Workshop (with other partners)		
Nike N7	Relationship			Nike	2012 to Present	The FNHA has partnered with Nike in the past two GW forums and are working to formalize this relationship with a Statement of Partnership that will describe how we will work together in promoting sport and physical activity aligned with the FNHA's wellness perspective & plan.	Strategic alignment and synergies	TBD
Ministry of Health	Relationship	All	All	Ministry of Health- various departments within as well as their Ministry counterparts (Ministry of Aboriginal Relations and Reconciliation, Ministry of Children and Family Development, Housing, etc…)	Since 2005	At the most recent GWVI (Oct/14) the MOH made the following commitments to this ongoing relationship: 1. direct working partnership between Deputy Minister of Health and CEO of the FNHA; 2. the FNHA and MOH Executive team working relationships through Joint Project Board to address health issues and priorities; 3. ongoing alignment with regional planning processes; 4. FNHA and MOH Executive Team to undertake joint regional and community engagements; and 5. continued commitment to address health action commitments in TFNHP.	See entire workbook this cell is within	Hardwiring and overlaying of strategic missions onto key planning documents/efforts is key to maximizing system advantages and joint strategic goals

Health Canada	Relationship	All	All	Federal headquarters as well as BC Region	Since 2005	At most recent GWVI (Oct/13), Health Canada committed to an ongoing relationship with the FNHA, including the following: 1. working together to ensure future new programs, funding or technology developed and delivered by HC; 2. a direct working partnership between the CEO FNHA and the ADM FNIHB Health Canada to address operational matters; 3. a working relationship between Executive team of FNHA and FNIHB Health Canada; and, 4. continued commitment to address health action commitments in TFNHP.	Oct 1/13 successful transfer of FNIH BC Regional operations and management to FNHA; see workbook this cell is within	TBD
Memorandum of Understanding: FNHA and First Nations Schools Association (FNSA)	Partnership			FNSA		The parties will work through collaborative discussions towards topics of mutual interest (service/program barriers; action plan).		
Memorandum of Understanding: FNHA and BC Aboriginal Network on Disabilities Society (BCANDS)	Partnership			BCANDS		MOU re: information-sharing and holding discussions on items of mutual interest.		
Memorandum of Understanding: FNHA and Vancouver Native Health Society (VNHS)	Partnership			VNHS	2010	To collaborate and undertake joint efforts in the development of strategies and initiatives intended to support urban First Nations people in BC in accessing quality and culturally appropriate health service and to improve their health status and well-being.		
Opening of the Lytton Health Centre	Service	PCPH	16	FNIH BC Region, Ministry of Health, Interior Health Authority	2009	Partner effort to open community health centre		

Memorandum of Understanding: FNHA and BC Association Aboriginal Friendship Centres (BCAAFC)	Partnership			BCAAFC		To formalize a working partnership between the respective Parties in order to utilize the existing infrastructure, resources, and networks of the Parties to deliver services, information, and policy positions that will contribute to improving the health status of urban First Nations Peoples in BC.		
Aboriginal Youth Internship Program participation	Program	All	All	BC Public Service Agency	Since 2008	Well over a dozen youth recruited into the FNHA through this program, many still serving in leadership roles	Selecting 'right fit' candidates	Internal succession planning and career development
FNHC-FNHA-FNHDA Relationship Agreement	Agreement	All	All	FNHC, FNHDA, FNHA	2012	Outline of the three parties commitment to each other and to a shared vision, set of six values (respect, discipline, excellence, culture, and fairness), and a series of reciprocal accountabilities and processes to support the effective functioning & upholding of roles and responsibilities amongst the First Nations components of the	Supported strong working relationships; shared dedication to vision and values	TBD

Wellness

Name	Type (Process, Relationship, Document, Event, etc)	HA Strategy Area	Health Action Item	FNHA Partner(s)	Date	Brief Description	What made it a success?	Key lessons learned
Community Health & Wellness Initiatives Program	Funding	All		BC First Nation communities or community-serving organizations in health and wellness	2012-present	fy1213pprox $1.25m invested into community designed and delivered health and wellness initiatives to address community defined gaps; fy1314 investment is TBD	Community based, nation driven, straight forward process; leading to a more refined FNHA-community 'partnership' process; supported initiatives across the health spectrum as they pertain to BC First nations and Aboriginal health and wellness needs	Process ease key for communities; partnership in practice with communities; FNHA asked to shift away from conventional 'government funding' model whereby communities may perceive they are competing for funds
Elders Gathering Conference	Funding	All		Elders Gathering conference organizers		fy1213 $100K invested to support a wellness approach in partnership with this key annual BC First Nations and Aboriginal elders gathering	Providing health and wellness services to community based Elders gathering conference; FNHA visibility as partner. MoH attends each year (both Aboriginal Health and Seniors Branches), and provides information and health and wellness resources	FNHA culturally grounded health service presence a welcome inclusion

BC School, Fruit and Vegetable Nutrition Program in BC First Nation community schools	Funding	All		BC Agriculture in the Classroom Foundation		Over $150K invested over several years to expand the delivery of fresh produce to remote and rural BC First Nations schools to supplement student nutrition. In 2011/12 56 First Nation schools participated in the program, with 76 FN schools participating in 2012/13, and the goal to continue increasing this number in subsequent years.	Nutritional supplementation to vulnerable population (by remoteness and childhood age); over 70 community schools involved with a target to reach close to 100, and/or all of BC First Nation community schools	Continued expansion across BC First Nation communities continues
Gathering Our Voices: BC Aboriginal Friendship Centre hosted Youth Conference	Funding	All	9	BCAAFC		This annual conference supports the health and wellness component of the key annual BC First nations and Aboriginal youth conference which builds youth resiliency and inspires strong Indigenous identity. 2011 conference had a theme of: "A Vision of Our Future" with over 1000 youth delegates in attendance (engaged and empowered youth by building on youth leadership, self-esteem, relationships and other opportunities). 2012 theme was "A Generation on the Move' which saw 1600 BC First Nation and Aboriginal youth participants from around the province with growing numbers annually. 2013 theme was on health.	Event well planned, well organized, and relevant for youth. AHD has encouraged and enabled our Aboriginal Youth Interns to participate, and to facilitate workshops	BCAAFC very open to aligning their conference planning with Tripartite health goals for First Nations people; good value for funding
BC Aboriginal Friendship Centre Partnership	Funding	All		BCAAFC		General working partnership with BCAFC to advance shared priorities (youth conference, maternal and child health tripartite work, mental wellness and substance use tripartite work, etc...)		

Best or Better Practises Program	Funding	All		8 BC First Nation communities	2012	1. 3 Year initiative which identified 8 community designed and led programs spanning across health priority areas of primary mental wellness, chronic disease management, and maternal and child health to showcase best or better practices within BC First nation communities ($300k per year per community program) with ultimate goal to share out lessons learned. 4 emerged: 1. begin small, remain flexible, remind yourselves of developmental process, communication, build internal capacity and infrastructure to support programming use a continuous improvement approach to evaluation, as it allows for changes and learning without abandoning the services, involve stakeholders within the planning process from the start, 2. request feedback through evaluation forms from participants, 4. Follow up, post evaluation questionnaire and	Community defined, lead, and sharing of community success stories e.g. Xeni-gwetin MWSU program won national accolades	Inherent community wisdom in community based program design leads to improved health outcome and culturally competent service delivery

FNHA Perspective on Wellness	Document and Narrative	All		BC FNs communities	Jul-05	Development of a visual depiction with narrative to capture the holistic perspective of wellness traditional to BC First Nations, engaged BC First Nations with it 2012and it was supported	Ever-evolving, capturing a broad based and interconnected philosophy on health far beyond the narrow mainstream cultural perspective on 'health'; critical tool for community based and FNHA dialogue towards building shared system understanding; partner embracing of and adaption of model to implementation efforts	Engaged on, ever-evolving
Inaugural Beefy Chiefs Challenge	Funding	All		BC First Nation Chiefs/ community	2013	First Annual First Nations Health Council health and wellness leadership challenge	Direct weight loss challenge to communities to increase healthy eating and activity levels with the potential of winning $40,000 in prizes	
Development of FNHA Wellness Streams	Document	All			2013	4 Streams of Wellness for FNHA to Champion: 1. being active 2. healthy eating 3. nurturing spirit, and 4. respecting tobacco	Unique wellness approach capturing key elements relevant to BC First Nations that may serve to lend holistic approaches to other public health systems	

Inaugural Jun 21st Aboriginal Day Wellness Event	Funding	All			2012	FNHA partnered with communities and organizations around the province to deliver a run/walk or cultural program on June 21st, 2013 (the AFN created Aboriginal Day being celebrated across the country). In 2013 almost 75K was distributed in small grants to communities and/or community serving organizations for this purpose. In 2014, 140 applications were received for this purpose (assessment underway at the time of writing this).	FNHA partnered with and supported 20 communities across the 5 regions to deliver events in their communities; as well as hosted a Trout Lake run/walk 5km event in Vancouver	Ease of process, targeted communication, community based, nation driven
Canadian Red Cross First Responders Training funding support	Funding	All	13	Red Cross	2013	Funded Canadian Red Cross to pilot a First Responders project based in Nuu-Chah-Nulth territory	Pilot program delivering emergency response training to close the gap in emergency response services reaching some remote and isolated communities	
BC Elders Communication Society funding support	Funding	All		BC Elders Communication Society	2009-present	Annual funding of this small non-profit group to support newsletter writing which targets BC First Nations elders for improved wellness	Newsletter written by elders for elders with elders related content	
BC Elders Gathering	Funding	All		BC Elders Gathering	2012-present	Funding and partnership support to this well regarded annual event, the only one of its kind, which gathers BC First Nation elders from across the province	Health service team presence at the Elders Gathering in the event care was/is needed	

Aboriginal Sport, Recreation and Physical Activity Partners Council	Funding	All	7	Ministry of Health, BCAAFC, Metis Nation BC	2009-present	Funding to enhance programs and number of Aboriginal and BC First Nation communities and individuals served. 2012 funding of $150K supported much needed core capacity for the organization to deliver an array of 12 community based programs and services centered on sports, recreation, and physical activity capacity (involving 291 separate events and/or activities, a total of 10,430 Aboriginal people across BC).	Group took over from the Aboriginal Sport and Recreation Association of BC and formed a strong partnership to support with a plan to regionalize	Partnerships; regionalization
First Nations Education Steering Committee	Funding	All		FNESC	2009-present	Funding support to promote science and technology programs in the classroom (later life student recruitment to health)	Community school based and driven	
Sharing our Strength Grants	Funding	All		BC First Nation communities	2008	$5K grant per interested community for community based wellness activities that promote wellness through FN history, culture, and tradition (total of $885,000 distributed to 177 communities). Approximately 30% of the grants supported community expression of culture and identity.	First time communities had an opportunity to decide how to utilize money in a self-determined way- significantly used for cultural and/or traditional purposes/ceremony.	FNHC learned that to provide grants with minimal reporting burden enabled communities to address immediate issues for themselves; issues determined within their own communities
Physical Activity Cards	Funding	All						
Exercise Program for Frequent Travelers	Funding	All						
Aboriginal Diabetes Publication	Funding	All						
Aboriginal Diabetes Conference 4 years	Funding	All	22, New 2009		2009-present	$100K or $150K annually to bring together BC FN program coordinators and community members to improve self-management approaches and overall health outcomes		
Child Yoga DVD	Funding	All				DVD for family wellness activity sent to BC First Nation communities		

Wellness stream magnets creation and distribution	Funding	All			2012	Fridge/other magnets for highly visible reminders of wellness activities one can implement daily		
PHSA Patient Navigators/Patient Liaison	Funding	All			2009	Program established with annual conference and training; program to establish FN and Aboriginal patient support in a hospital setting within each region	Program established as a response to community requests; community members welcomed this program and asked for program to be expanded; Regional Health Authorities took on program	Program needed to be expanded with many more navigators/liaisons to be available one to one to meet patient demand; RHA budget restraints limits program expansion despite continued community demand and need
Traditional Foods Study	Funding	All			2009	Traditional foods environmental scan		
Spirit Magazine	Publication	All	New 2009		2012-Present	Magazine to communication First Nations health best practices and share wellness stories.	community based, nation driven vehicle can address health actions within a community based lens	
Healthy Food Guidelines - For First Nations Communities	Publication	All	New 2009		2009	A book providing healthy food guidelines. Focus on making recipes healthier, promoting healthy eating in Children, serving health meals at meetings and conferences, serving traditional foods, improving local food security and recipes for large groups.	Captured community based food security and subsistence context	
First Nations Traditional Food Fact Sheets	Publication	All	New 2009	ActNow	2009 (updated 2013)	A series of 14 fact sheets focusing on traditional foods in BC. Fact sheets focus on historical use, nutritional value and modern harvesting and use.	Captured community based food security and subsistence context	
First Nations Approaches to Traditional Medicine	Publication		New 2009		2009-10	Environmental scan of Traditional Models of Wellness. Key messages include: advocating for recognition and funding of traditional medicines and practices.		

Closing the Gap	Research Project	PCPH		UNBC	2011 to Present	The purpose of this study is to answer the question: What is the optimal complement of on-reserve primary healthcare services that can best meet the needs of First Nations accessing care on-reserve? This study used hospitalization data for Ambulatory Care Sensitive Conditions to indicate where investments in British Columbia's on-reserve primary healthcare services might be particularly effective. This project is currently in the data analysis phase.	TBD	TBD
Aboriginal Mothers Center Society	Funding	All	New 2009	Aboriginal Mother Centre Society	2011	Funding to Transformational Housing Program to provide a culturally based traditional wellness program based on intergenerational models of care for mothers and children at risk of homelessness or child welfare intervention who are based in City of Vancouver-primarily in Downtown Eastside (but from around the province).	Program supports traditional healing and reunification to help mothers whose kids are in care to become a family again; program complements safety and onsite delivery of necessary primary care and other public health supports.	Targets one of most at-risk and marginalized demographics in Canada: single Aboriginal mothers
Tla'amin Community Meetings for Intergenerational Healing	In Kind funding	All	New 2009	Tla'Amin Community Health and neighboring Nations	2012	Tla'Amin Community Health Services Society, in partnership with neighboring nations, hosted 4 community hub sessions to share on the intergenerational effects of residential school to spur dialogue and further healing-- providing a positive sharing and healing model that can be used by other FNs (with a local touch). Over 80 community members participated.	Community based nation driven identified and empowering path towards healing (identification of next steps)	
Emergency or Crisis Funding Program	Funding	All		Various BC First Nation communities	Since 2006	Annual funding, of various denominations dependent upon year, set aside for the purposes of assisting community based efforts towards crisis resolution. Examples include support for cluster suicide response, or fire.	Supplemental to community based efforts and honoring of community based choices; relief where other relief monies are not made available	Small budget amount annual to ensure adequate crisis response critical to support community wellness in times of crisis/emergency

Traditional Foods Conference- Island Nations	In Kind	PCPH		Kwakuitl District Council Health (host), Vancouver Island Health Authority, Cape Mudge Band, Campbell River Band, Vancouver Island Indigenous Foods Network	2008-present	More than 400 delegates in regular attendance for this 2 day conference from throughout Vancouver Island. Conference is an opportunity for information sharing between island and coastal communities on traditional foods, cooking techniques, and traditional nutrition. Key outcome is the establishment of knowledge keepers' networks.	Network, sharing and preservation of traditional wisdom as it relates to traditional foods, nation-driven	Network establishment and sharing continuous past conference days.
Telmexw Awtexw (Medicine House)	Funding	MWSU	15	Sts'ailes First Nation	2012-13	Culturally relevant 1-6 month long residential treatment to downtown eastside residents in this 9 bed facility.	Unique traditional community owned and managed program with strong success, and excess demand.	Economic benefits to Sts'ailes FN

Maternal & Child Health

Name	Type (Process, Relationship, Document, Event, etc)	HA Strategy Area	Health Action Item	FNHA Partner(s)	Date	Brief Description	What made it a success?	Key lessons learned
Your Child's Hearing DVD + Family Path Brochure	Video + Brochure	MCH	10	Penelakut Tribe & BC Early Hearing Program (BCEHP)	Spring 2013	Family Path Brochure and Your Child's Hearing Video (DVD) illustrating the care path for infants and families from early hearing screening, assessment and early communication services and support. 1000 Family Path brochures and 750 DVDs were distributed in 2012/13-- 1000 DVDs and brochures were reprinted in 2013/14. In 2012/13, 96.8% of all births received newborn hearing screening. Of the infants screened for hearing, 1.4% were referred for further diagnostic audiological assessment.	BCEHP program leads worked collaboratively with the Tripartite First Nations and Aboriginal Maternal-Child strategy area representatives on the development of the Family Path brochure and DVD. The Penelakut Tribe members were active participants during the project and provided input, advice, and acted on the DVD . While the BCEHP provided program and content expertise First Nations families provided the cultural lens.	This partnership supported greater awareness about other areas for future collaboration. The BCEHP is continuing to work with First Nations and Aboriginal representatives on resource development and service coordination to improve access to supports and services for First Nations families, particularly those in rural and remote areas.

Telehealth support for early hearing therapy	Telehealth – improving access	MCH	10	FNHA telehealth & BCEHP (An agency of PHSA)	2013-14	Steps towards establishing tele health support for speech and language services through remote technologies for children who are deaf and hard of hearing in remote areas in BC	Project is underway. BCEHP is working collaboratively with PHSA tele health, FNHA tele health. To support the successful use of tele health in remote communities (e.g. Bella Bella and Niahmiah Valley) relationships have been developed between health service providers, First Nations families, community services and the BCEHP.	In progress Community engagement and involvement is critical for the successful delivery of programs.
First Nations and Aboriginal Oral Health Strategy	Strategic Document	MCH	10	Tripartite Maternal Child and Family Health Planning Committee (Inclusive of FNHA, MoH, Perinatal Services BC, etc.), IHA, Island Health, Aboriginal Doula Initiative working group	March, 2014	Communities and regions can use this strategy to help plan, act on and measure oral health projects and programs that best meet their needs. In 2012/13, 3427 children self-identified as Aboriginal participated in the kindergarten dental survey (89.7%) of Aboriginal children enrolled in all participating schools). Of the Aboriginal children surveyed: 43.3% were caries free (no broken enamel), 31.9% had treated caries (no visible decay but existing restorations), and 24.8% had evidence of visible decay.	First Nations Communities, service providers, health authorities and federal partners worked together to develop the First Nations and Aboriginal Oral Health Strategy. The First Nations and Aboriginal Maternal-Child Health committee provided input and supported connections with First Nations Communities.	The importance of including stories from First Nations communities and dental health providers in the Strategy document. Communities are critical sources of information and need to be involved in planning and development.

Aboriginal Doula Training Initiative	Pilot Project	MCH	21	Tripartite Maternal Child and Family Health Planning Committee (Inclusive of FNHA, MoH, Perinatal Services BC, RHAs, etc.), COHI Program reps, FN Health Directors, Regional Health Authority reps, etc.	Dec. 31, 2013	This demonstration project trained and supported a total of 31 Aboriginal women across Vancouver Island (n=18)and the Interior (n=12) of BC to train and practice as Doulas in their local communities. Two 0.5 FTE doula liaisons were employed to support this program. At the end of fy1213, over 35 FNs and Aboriginal women had been supported by the doulas. 4 training events took place over the course of the pilot including the 5 day training, additional breast feeding training and sexual abuse recognition training, with curriculum created by a working group led by PSBC.	Final evaluation pending release April 2014	The attrition rate for both regions was more than half of the Aboriginal Doula trainees. A sustainability working group has been established to focus on understanding women's needs for doula services and improvements pertaining to increasing awareness, funding, collaboration, and community readiness/ ownership of the program.
Promising Practices Working Group	Literature review + recommendations for future MCH programming investment and action	MCH	21	Tripartite Maternal Child and Family Health Planning Committee (Inclusive of FNHA, MoH, Perinatal Services BC, RHAs, etc.), COHI Program reps, FN Health Directors, Regional Health Authority reps, etc., FNHA funded MCH program coordinators, working group members	Ongoing	Working on reviewing current FNHA funded MCH programming on-reserve and summarizing existing culturally safe and respectful approaches to provider-family partnership models that support expectant women and new mothers. 25 interviews completed with Health Directors, health system and community stakeholders.	Understanding processes for effectively engaging FN communities, and having a facilitator who can do that; involving and giving voice to FN women re their needs (FN women already have programming they like, and identify the parts they think are critical components of any MCH program on-reserve)	Necessary to engage Communities before assuming a provincial-level program – NFP – will work on-reserve. Communities are critical sources of information.

CPT1a Genetic Variant - Medical guidelines and family brochure	Medical guidelines and family information brochure	MCH	21	Tripartite Maternal Child and Family Health planning committee (Inclusive of FNHA, MoH, Perinatal Services BC, RHAs, etc.), BC Women's and Children's Hospital, Island Health	April, 2014	Medical guidelines in development for health practitioners to better understand and support testing and care related to CPT1a genetic variance with FN and Aboriginal infants and children (and will be email distributed). 5000 Family information brochures were printed (not yet distributed) to increase awareness about this genetic variance and how parents can ensure that infants are feeding and have high enough glucose levels prior to necessary surgery or dental procedures.	Support of clinical research to inform medical guidelines and family path brochure. Review of materials by working group members to make sure that the information is in plain language for families.	Necessity to get group consensus in the completion and potential printing of documents.
Honouring Our Babies: Aboriginal Safe Sleep Practice Cards & Facilitator's Guide	Health provider and family tool	MCH	21	Perinatal Services BC (PSBC) & working group		Tool to improve knowledge surrounding safe sleep practices. They can be used by health providers with First Nations and Aboriginal families. 1500 hardcopy toolkits were distributed, waitlist developed and 1000 toolkit reprints are currently on order. Accessed online >800 times from Oct/13-Mar14.	First Nations Safe Sleep took kit was developed with input and advice of First Nations communities and care providers. The resource was focus tested and evaluated by First Nations families and providers and changes made based on recommendations and feedback.	Communities are critical sources of information.

Tripartite Maternal, Child and Family Health Strategic Approach	Strategic Document	MCH	10, 21	Tripartite partners, PHSA, RHAs, PHAC, First Nations community members, BCAAFC, MNBC (invited), MCFD	Oct-13	This approach is intended to start discussions within the regions around strategic directions and actions in Maternal child and family health to support and complement the existing maternal, child and family oriented work currently happening at local, regional and provincial levels in BC. It is not meant to be prescriptive. It is recognized that First Nations and Aboriginal community contexts, priorities and needs are different, and that partners will look to this document and use it in different ways that will support and complement work already in place. It aims to ensure that First Nations and Aboriginal mothers, children and families are supported to reach and maintain excellent physical, mental, emotional and spiritual health and wellness outcomes.	Tripartite partners worked collaboratively, with content experts fully engaged. Secretariat support was key to success.	It was important to communicate effectively with everyone involved, ensuring changing contexts were fully understood (in this case, the context was a shift over a period of years from creation of a strategic document to guide the strategy table itself, to a document suggesting strategic approaches communities could use to plan their MCH component)
Returning Home Demonstration Project	Pilot Project	MCH		Child Health BC, Island Health	Ongoing	Aims to improve discharge planning and well-connected care for infants and children with serious and complex health care needs through linkages between hopital and community services providers.	Pilot project lead is approachable and collaborative and has experienced what it is to be a parent of a child with complex health needs.	Necessary to have clear means of communicating out about a pilot's focus with a variety of partners.
Parents as First Teachers	Publication	MCH	21	NCCAH	2013	A resource booklet about how children learn. Focus on how children learn, teaching and guiding your child and how to support learning.	Culturally grounded tool for community based programming celebrating traditional and strong child raising practices	Importance of contracted support to complete booklet content.

Growing Up Healthy	Publication	MCH		NCCAH	2013	A resource booklet about healthy children. Focus on traditional foods, healthy food on a budget and active families.	Culturally grounded tool for community based programming celebrating traditional and strong child raising practices	Importance of contracted support to complete booklet content.
Family Connections	Publication	MCH		NCCAH	2013	A resource booklet for bonding with your child. Focus on bonding with your child, forming a secure attachment and connections with family and community.	Culturally grounded tool for community based teachings celebrating and empowering the importance of family- particularly important following intergenerational family breakdown resulting from residential schools	Importance of contracted support to complete booklet content.
Fatherhood is Forever	Publication	MCH		NCCAH	2013	A resource booklet about fathering. Focus on why fathers are important, learning how to be a father and different approaches to different situations.	Culturally grounded tool for community based approaches to celebrate and empower this key family role- connected to wellness and foundational to anti-violence work	Importance of contracted support to complete booklet content.
Child Death Review Report	Document	MCH	11	BC Coroners Office	2006- 2014	FNHA contribution to how the Coroners do business, particularly as it relates to children within a cultural context- cultural competency piece	Increased awareness with Coroner office changing how they do business	Pathologist resistance showed continual education, awareness, and relationship building is a critical success factor to the work
Optometry equipment purchase and loan program	Equipment	MCH	10		2009-present	FNHA purchase of optometry equipment for community based loaning	Relationship with community health providers	Community, and family based assurance of OCAP

Vision screening	Service	MCH	10	FNs Schools Association, Tripartite First Nations and Aboriginal MCH Planning Committee and Provincial Screening Services	2007- 2014	FNHC assisted Regional Health Authorities develop relationships with FNs communities to ensure vision screening access. FNHC ensured OCAP-based process to ensure screening activities and related data collection occurred in culturally safe manner. In 2012/13, 86.6% of Aboriginal children received kindergarten vision screening. Of the children screened, 23.6% were referred to an eye doctor.	OCAP principles, FNHC as bridge builder between Health Authorities and communities; tools and templates, partnership roll out; FNHC played a key issues resolution role	OCAP principled approach key; partnerships key; FNHC commitment to issues resolution= trust for communities which enabled the program
Best or Better Practise: Cowichan Tribes Iron Deficiency Campaign	Funding	MCH		Ts'ewulhtun Health Centre	2008-10	Focusing on an iron deficiency campaign to improve the high rates of anemia without their community. Involved development of posters, resources and workshops aimed at education and behaviour change to ensure women had healthy pregnancies and babies were not born with iron deficiencies.	Addressed maternal and fetal iron deficiency issues which were disproportionate	community based initiative
Child and Family Wellness Booklets	MCH	MCH		MCH Tripartite Committee, National Collaborating Centre for Aboriginal Health (NCCAH)	2012/13	4 booklets developed collaboratively with NCCAH: *Family Connections, Parents as Teachers, Growing up Healthy, Fatherhood Forever*. In 2012/13, 8000 booklets were distributed in total, 2000 of each title. An additional 8000 booklets have been reprinted for 2013/14 distribution.	Multi-partner commitment and collaboration	

Primary Care & Public Health

Name	Type (Process, Relationship, Document, Event, etc)	HA Strategy Area	Health Action Item	FNHA Partner(s)	Date	Brief Description	What made it a success?	Key lessons learned
Aboriginal Healthy Living Activities	Initiative	PCPH	7	ASRPAPC, MoH, FNHA, BCAAFC, MNBC, SportMedBC	Ongoing	Aboriginal Healthy Living Activities are funded by MoH and delivered by Aboriginal Sport, Physical Activity and Recreation Partners Council, including First Nations Health Authority, Métis Nation BC and BC Association of Aboriginal Friendship Centres. Grants supported approx 6000 FN and Aboriginal people in BC in 2012/13. In 2012/13 there were 1600 participants in the Aboriginal run/walk, 2300 participants in Aboriginal Healthy Living Projects, 155 grants to communities for community based projects. In 2013/14, 217 participants attended the AHLA training sessions. The two day sessions were held in: Terrace, Prince George, Kamloops, Nanaimo and Chilliwack in Oct and Nov, 2013.	Program has expanded and builds on early program day work of the "Honor Your Health Challenge"; Partners Council has regionalized this program; new team leaders are being trained annually (building community capacity)	Regionalization supports a closer to the ground effort; reaching new people annually for participation

From Hope to Health: Towards an AIDS-free Generation	Report	PCPH	22, New 2008	MoH, RHAs	Dec. 2012	a framework for implementation to guide the regional health authorities to incorporate the HIV "Treatment as Prevention" approach. This framework articulates the need for health authorities to meaningfully engage with FNHA and other Aboriginal organizations to implement successes from the STOP HIV/AIDS pilot		
First Nations and Aboriginal-focused NP4BC projects	Initiative	PCPH	12, 24	Ministry of Health	2012/13 - ongoing	Funding for basic salary and benefits for First Nations and Aboriginal-focused NP4BC projects, within the MoH-funded NP4BC Program, with 24 approved in rounds 1 (2012/13) and 2 (2013/14)	Improved primary care access to some remote and rural communities	Improved tripartite collaboration can leverage program reach
Aboriginal Intentional Injury Review	Report	PCPH	TFNHP new	MWSU Strategy table	2013	An internal working document: Initial literature review on epidemiology, surveillance, prevention, and frameworks for intentional injury prevention, with a subsequent expansion to cover additional areas of intentional injury, to inform a future Injury Prevention Strategy	Necessary background to an informed Injury prevention strategy	Needed more Tripartite collaboration in defining scope, content and approach.
Secwepemc Surveillance Program	Program	PCPH	TFNHP new	Ministry of Health	early 2000s	to work with partners to find better community based solutions to improve injury outcomes. Funded over many years by various parties (FNIH BC Region, Ministry of Health, Interior Health Authority)supporting a community based Secwepemc Surveillance project was great - locally driven, multiple communities, multiple partnerships with Health players (e.g. local Emerg Depts) - took info and turned it into injury prevention Falls Prevention strategy which put action in community, based on data, fostering local and sustainable solutions	Community initiated, informs Interior Health Authority planning and work, scalable community driven surveillance model; found community based solutions for key health issues without having to put significant dollars	Community driven supports a trusting atmosphere for information reporting and therefore innovative community based solutions to the issues

Aboriginal Unintentional Injury Review	Report	PCPH	TFNHP new	MWSU Strategy table	2013	An internal working document to inform strategic planning: Literature review on epidemiology, surveillance, prevention, and frameworks for unintentional injury prevention, to inform a future Injury Prevention Strategy	Necessary background to an informed unintentional injury prevention strategy	needed more Tripartite collaboration in defining scope, content and approach. The driver for this work wasn't 'policy for injury prevention' - it was surveillance-focused - who is getting injured by what and where - and therefore a lost opportunity for an Aboriginal Injury Prevention strategy
Report for the Tripartite Partners: Healthy Lifestyles and Wellness Project	Report	PCPH	22	MoH, FNIH BC Region	2013	An internal working document: a high level scan of healthy lifestyles and wellness programs and services in BC, including approaches across the lifespan addressing healthy eating, healthy activity, tobacco cessation, healthy pregnancy, and social determinants of health, to inform a future Health Promotion Strategy		originally supposed to be the 'state of play' of healthy lifestyles and wellness promotion re chronic disease risk factors; needed more Tripartite collaboration in defining scope, content and approach, and in coordinating input
British Columbia First Nations Child Passenger Safety Strategic Framework	Strategic Document	PCPH	14	MoH, FNIH BC Region	2012	Recommendations designed to enable FN communities to take responsibility of the guidance needed to protect children through increasing child passenger safety practices	contracting with experts in passenger safety	Moving forward, there needs to be a plan to share this document

Child Passenger Safety Education and Child Seat Loaning Programs within First Nations Communities in BC	Report	PCPH	14	MoH, FNIH BC Region	2012	Environmental scan of the current state of child passenger safety (CPS) programs in FN communities, to provide the foundation for developing a CPS Strategy for FN communities. Resulted in this tripartite project whereby 33 communities participated with a total of 372 child car seats.	contracting with experts in passenger safety	Moving forward, there needs to be a plan to share this document
First Nations Child Seat Share Co-operative (CSSC) Guide	Tool	PCPH	14	BC First Nation communities	2012	To support program above and provides FN communities with an overview of what a CSSC program is, and how to develop and operate one. It is posted on the FNHA website.	contracting with experts in passenger safety	Moving forward, there needs to be a plan to share this document

ActNow	Service	PCPH	7	Ministry of Health, BCAAFC, MNBC, National Collaborating Centre	2007- 2010	$3M invested in various activities and resource development; opportunity for Aboriginal approach with partners and get feedback from end user and what works for them and what didn't e.g. wellness diaries were fantastic; bear DVD, FN Schools Association wellness program on nutrition/physical activity, etc. . There were 17 community initiatives focused on health promotion. Distribution of 10,000 2009/2010 day-timers; 500 First Nation role model posters distributed; 14 traditional foods fact sheets produced; 500 nutrition guides distributed; Active Spirit, Active History legacy book; 5 community toolkit training sessions and two additional presentations of the toolkit; Student day-timers distributed to 138 Seventh Generation Clubs; Hooping program delivered to 24 schools and 1150 children; Kidsport delivered in 3 communities reaching 89 community members; 20,000 copies of the Path of the Warrior comic book distributed throughout province; 4 day Gathering Our Voices conference had 1000 youth and 200 adult chaperones and volunteers; 1000 corporate calendars were printed and distributed to each First Nation; 19 Chief and Council members participated in Leadership Challenge. There was also a Pedometer program, Bear DVD, Fitness knowledge course. An evaluation was completed with feedback from over 1,215 community participants including children, youth, adults, and Elders.	Learned what worked for communities; program evaluation process with community lessons learned,	

HIV Renewing Our Response	Working Group	PCPH	22, New 2008	PHSA	2009	Tripartite report on community-centric approaches with recommendations	Tripartite report	Lack of community engagement; Coordination effort among partners and service providers to develop recommendations strong but implementation efforts required additional support (with community partnership to execute)
Aboriginal Review Committee- STOP HIV	Working Group	PCPH	22, New 2008	PHSA	2010-present	Ensures any documentation or process developed for Stop HIV is reviewed by an FNHA working group to create an informed feedback loop to provincial efforts		Community engagement at inception of service design and delivery is critical for program success
H1N1 pandemic response	Service	PCPH	New 2009	Ministry of Health, FNIH BC Region	Oct-09	Precedent setting multi-jurisdictional tripartite response to H1N1 pandemic crisis involving Ministry of Health and Medical Health Officers, Regional Health Authorities, federal Community Health Nursing teams, as well as the FNHA to this high profile global pandemic crisis requiring immediate action. H1N1 trainings were offered in approximately 18 central venues across BC.	Tripartite collaboration across multiple jurisdictions	strong tripartite technical collaboration and commitment to resources and action
Primary Care Integration Report	Document	PCPH	12	MoH, FNIH BC Region		Evaluation of six primary care integration projects	Increased knowledge of best practices and lessons learned in primary care integration	

Sacred Breath chronic disease management report	Document	PCPH	22	MoH, FNIH BC Region		Environmental scan on First Nation and Aboriginal programs relating to chronic disease programs and services	Increased knowledge of chronic disease programs and best practices to inform planning; early attempt at gathering information with partners on current landscape in chronic disease programming	
HIV/AIDS document scan and literature review	Document	PCPH	22, New 2008	MoH, FNIH BC Region		HIV/AIDS literature review and scan of existing HIV/AIDS strategies	Increased knowledge of HIV/AIDS best practices and strategies	
Aboriginal Diabetes Conference participation	Initiative	PCPH	22	Ministry of Health (early days), Regional Health Authorities, FNIH BC Region	2006-present	Annual diabetes conference with goals to increase awareness and knowledge for health promotion, disease prevention, and complications associated with diabetes. 2012 conference had over 400 participants from around province (Chiefs, elders, community health workers, community members, and educators). 2013 conference had 371 participants, 37 professional development participants and 40+ volunteers, facilitators and sponsors.	Professional development, sharing best practices, developing connections	Community designed and delivered
Care North Evaluation Report	Report on initiative	PCPH		NHA, MoH, FNIH BC Region		Evaluation of the implementation of Northern Health's Care -North Aboriginal health Collaborative	Increased knowledge of best practices and lessons learned in primary care integration	
Tripartite quantitative and qualitative evaluations of the H1N1 pandemic response	Report on initiative	PCPH	New 2009	MoH, FNIH BC Region		Evaluation of the response to the H1N1 pandemic	Early test tripartite collaboration on evaluation	Lessons learned from the H1N1 pandemic response and recommendations for areas to build improvements

Chronic Disease Prevention and management environmental scan	Document	PCPH	22	MoH, FNIH BC Region	2013	The chronic disease prevention and management environmental scan was completed in April 2013.	Tripartite collaboration across multiple jurisdictions	
Document Scan and Literature Review: HIV/AIDS: First Nations and Aboriginal People in British Columbia	Document	PCPH	New 2008	MoH, FNIH BC Region	2013	Report completed - providing HIV/AIDS strategy environmental scan.	Tripartite collaboration across multiple jurisdictions	
Best or Better Practise: Seabird Island Health Information and Support Project	Funding	PCPH	2008	Seabird Island	2008-10	Program to provide a fully integrated culturally appropriate chronic disease prevention and management program (on reserve services to over 3000 members). Aimed at using emerging communication technologies to disseminate information on best practices in chronic disease management to communities (including the creation of a website and toll free information line). This project included the creation of the diabetes centre for excellence.	Community and culturally driven innovative program; with potential of sharing of lessons learned	Holistic wellness, health promotion and continuity of care integral.
Best or Better Practice: Strong Medicine	Funding	PCPH		Tla'Amin Community Health Services		A Chronic Disease Management program based on the Spiritual, Mental, Emotional and Physical components of the Medicine Wheel	Community and culturally driven innovative program; with potential of sharing of lessons learned	
Injury Prevention Environmental Scan	Document	PCPH	TFNHP new	MoH, FNIH BC Region	2012	An environmental scan of injury prevention programs in BC	Increased knowledge of injury prevention programs in the province	Limited, fragmented data

Mental Wellness and Substance Use

Name	Type (Process, Relationship, Document, Event, etc)	HA Strategy Area	Health Action Item	FNHA Partner(s)	Date	Brief Description	What made it a success?	Key lessons learned
A Path Forward: Mental Wellness and Substance Use 10 Plan	Strategic Document	MWSU	8	BC Ministry of Health, HC FNIHB, BC Ministry of Children and Family Development, BC Association of Aboriginal Friendship Centres, Metis Nation BC and BC Mental Health and Addiction Services, Regional Health Authorities	Mar-13	Over a two year period, this document was created utilizing the broad technical expertise of health system partners at all levels for a provincial scale approach to facilitate regional and local planning and action on this priority area. To date approximately 3500 copies have been printed and distributed to every BC First Nation community (203) as well as mental health service providers across BC. Over 100 stakeholders were engaged in joint 2 days engagement sessions held with BCAAFC, MNBC, MoH, BC FN communities and community serving organizations in Nanaimo, Vancouver, Prince George, and Kamloops to design planning forums.	Engagement of FN people and communities and other Aboriginal people for input, advice and guidance at various developmental stages. Also a strong Tripartite-structured planning team, expanded to include representatives of other Aboriginal groups. Builds on the mainstream MHSU plan in order to focus on issues and concerns specific to FN/Aboriginal people, but accounting for what is happening/available through mainstream activities. Follow-up re-engagement of community/regional reps to identify planning priorities.	Focused, motivated and effective leadership required to complete plans of this scope in a timely way, but ample opportunities for feedback/input from communities also need to be built in and accommodated.

Regional MWSU Forums	Event	MWSU	8	Ministry of Health, Ministry of Children and Families, Regional Health Authorities, and others as requested by communities- partnership varied by forum	2013- 2014	Forums held regionally and sub-regionally to discuss and plan for how best to actualize the 10Year MWSU Strategic Approach in each region (involving communities, and service delivery providers at the community level where there was community support for inclusion). There have been three regional forums (participant total #s as follows are North: n=120 participants, 16 planning committee members, Fraser: n=86 participants, 10 planning committee members, Vancouver Coastal: n=70 participants, 11 planning committee members), 3 sub-regional forums on Vancouver Island(n=200 participants) and 7 Nation-based forms in the Interior (n=TBD).	The regional forums were community driven and reflected a strong partnership between FNHA and other partner organizations, which demonstrated linkages, opportunities for collaboration, and a desire to coordinate MWSU planning efforts.	Inclusive broad based, multi-jurisdictional service delivery planning is possible reflecting our unique BC First Nations health landscape
Suicide Prevention Intervention and Postvention Planning Toolkit	Tool	MWSU	9	Ministry of Health & FNHDA	Since 2012	Driven at the distinct request of the TCFNH, this planning toolkit for community planners and service providers is to address suicide prevention, intervention, and post-vention needs. Toolkits will distributed to each community and implementation forums held. Printed toolkit #'s to be determined at the time of writing this.	Tripartite developed culturally safe and competent tool to address this key priority area for communities. Five FN communities engaged to pilot draft toolkit and offer advice on revisions. Builds on both mainstream PIP work and other Aboriginal/FN-specific resources.	Tripartite working group structure very effective in supporting development of this resource. Engagement of pilot communities to 'try it out' was critical to the success of the project and the quality of the product.
Best or Better Practise: Indian Residential School Survivors Society regional gathering	Funding	MWSU		Indian Residential School Survivors Society	2008	Regional gathering to review the Indian Residential School Support System and the Truth and Reconciliation Commission's Role. Objectives were to provide background information for the commission and share practical tools with communities. There were 390 participants from across BC.	Engagement forum provided for BC First Nations on this highly politically driven process and commission	

Best or Better Practise: H'ulh-etun Health Society - Warriors Wellness Group	Funding	MWSU		H'ulh-etun Health Society	2008-10	The initiative was aimed at improving the emotional wellbeing of men through open forums, one on one sessions, resource sharing, collaboration between communities and developing programs tailored to men.	Community and culturally driven innovative program; with potential of sharing of lessons learned	Organizational turnover and challenges limited successful program delivery
Best or Better Practise: Xeni Gwet'in First Nation Project	Funding	MWSU		Xeni Gwet'in First Nation	2008-10	National, award winning, traditionally based mental health initiative looking at issues with family breakdown, relationship, self-esteem, depression, apathy and emotional volatility. Combined traditional healing methods with western-based mental health services and focused on looking at the whole family rather than the individual.	Community and culturally driven innovative program; with potential of sharing of lessons learned	
Best or Better Practise: Development of Our Nation Voice and the Okanagan Nation Youth Response Team	Funding	MWSU		Okanagan Nation Alliance	2008-10	Strengthened the linkages between the two programs and developed a handbook to be shared with other Nations. Activities included a variety of initiatives, curriculum review, provision of training and 10 youth workshops.	Community and culturally driven innovative program; with potential of sharing of lessons learned	
Best or Better Practise: Inter-Tribal Health Authority ASCRIT Mentors	Funding	MWSU		Inter-Tribal Health Authority	2008-10	Developed two suicide response team mentors that engaged with the ITHA's 29 member nations to support communities in the development of their community-based response teams.	Community and culturally driven innovative program; with potential of sharing of lessons learned	
Best or Better Practise: Aboriginal Family Wellness Healing Program	Funding	MWSU		Chehalis Indian Band	2008-10	The project included 5 residential beds for an effective and secure in-patient residential addictions treatment for young Aboriginal men residing in Vancouver's Downtown Eastside.	Community and culturally driven innovative program; with potential of sharing of lessons learned	

eHealth

Name	Type (Process, Relationship, Document, Event, etc)	HA Strategy Area	Health Action Item	FNHA Partner(s)	Date	Brief Description	What made it a success?	Key lessons learned
FN Panorama Implementation	Provincial eHealth Project	eHealth		Ministry of Heatlh (MoH), Regional Health Authorities (RHAs), Provincial Health Services Authority (PHSA)	2013	Successful implementation to five First Nations Health Service Organizations in 2013 and continued work in progress with additional communities (28 early-adopter FNs health service delivery organizations have been identified) and FNHA Nursing.	Implementation with 5 communities and more to come as a multi-phase project; ultimately improves service delivery to patients at community level	Communities were engaged early on regarding project design
FN TeleHealth Expansion Project	Provincial eHealth Project	eHealth	23	MoH/RHAs/Canad a Health Infoway	2011-13	Initiation of Tele Health Expansion Project, pursuant to "Action item #23". Engagement with 64 communities in Phase 1 of assessment and planning.	Remote and isolated community access to primary care via tele health services	TBD
Provincial iScheduler - Telehealth Connect	Provincial eHealth Project	eHealth		MoH/RHAs/PHSA	2013	Collaboration with the Ministry of Health and PHSA to plan co-implementation of I Scheduler within FN TEP communities	Based on community readiness and interest; UBC Learning Circle sessions hosted 9 health and wellness related sessions to BC First Nations.	
Identity Management - AADS and BC Services Card	Provincial eHealth Project	eHealth		MoH/RHAs	2013	Working with the FNHC and the Ministry of Health to collect and harmonize business requirements to accompany overarching Project Charter	TBD	TBD
Health Connectivity - Health Network	Provincial eHealth Project	eHealth		MoH/RHAs/PHSA/ ANTCO	2013	Proof of concept completed in Bella Bella using tele health over PPN. ANTCO proposal submitted for Health Connectivity charter and funding.		

Electronic Medical Record (EMR/cEMR)	Provincial eHealth Project	eHealth		RHAs and FN HSOs	2013	Creating standards and integration strategy for continued implementation of EMR/cEMRs within First Nations. Part of this project included delivery of WAN to enable Carrier Sekani (test community) to manage health information safely for their 15,000 members.	Interoperability built into project as critical success factor.	
eMR Video	Video	eHealth				$15,000 PSA on the importance of eMR in community; with Elder Leonard, Evan Adams	Used to spur an important dialogue; raised awareness from a FNs perspective on why and how FNs need to hold own info- which leads to better health outcomes	

Health Knowledge & Information

Name	Type (Process, Relationship, Document, Event, etc)	HA Strategy Area	Health Action Item	FNHA Partner(s)	Date	Brief Description	What made it a success?	Key lessons learned
Tripartite Data Quality and Sharing Agreement (TDQSA)	Agreement	HKI	28	Ministry of Health, FNIH BC Region	2010	Agreement has three objectives: to improve the quality of FN data, facilitate data sharing, and ensure that federally and provincially held information on FN is properly used and shared	Agreement established trilaterally through partner commitment	Commitment of executive level execution for annual refreshing required; resource limitations are a constraint

First Nations Client File (FNCF)	Ministry held database	HKI	28	Ministry of Health	2011	Data file, or cohort of Status Indians, and their unregistered children for whom entitlement-to-register can be determined. Prior to the FNCF, data were abstracted from the Indian Registrar and the Status Verification File. The FNCF is not an independent database, but is the product of a record linkage between an extract of the Aboriginal Affairs and Northern Development Canada Indian Registry and the BC Ministry of Health Client Registry and subsequent probabilistic matching. The Personal Health Number contained in the FNCF enables linking to other administrative databases	Still in progress	
Tripartite Data Quality and Sharing Agreement (TDQSA) 2012 Annual Report	Report	HKI (now RAKM)	28	Ministry of Health, FNIH BC Region		This document reports out on implementation of the TDQSA, which was established to create the First Nations Client File	Tripartite collaboration	Annual refreshing required; resource limitations are a constraint
Building a Health Knowledge and Information Centre (Epi Centre) for FNHA	HSIF Project	HKI	TFNHP New (as related to indicator development)	Ministry of Health, FNIH BC Region	2012-present	3 positions engaged by the FNHA 1) Data and Information Co-ordinators; 2) Qualitative Analyst; 3) Research Analyst	3 positions initially on contract are now permanent FTEs at the FNHA to expand FNHA capacity to manage data	
Practicum Student development	Program	HKI		UBC, SFU	2012- 2014	HKI has hosted 6 students from UBC.	Champions within HKI who've driven the process	Organization-wide policies are key to facilitate hosting students with high potential internal succession. Also further relationship building with other academic institutions

Health Human Resources

Name	Type (Process, Relationship, Document, Event, etc)	HA Strategy Area	Health Action Item	FNHA Partner(s)	Date	Brief Description	What made it a success?	Key lessons learned
Health Careers Guidebook	Publication	HHR			2013	A comprehensive guidebook on health careers containing descriptions, average earnings, job growth and training requirements for the various health careers listed.	Culturally grounded tool for community based health careers promotion (health and school)	Follow up outreach to communities key success factor
Scholarships & Bursaries	Funding	HHR	25	New Relationship Trust Foundation	2012	In fy1213 a total of 40 health scholarships and bursaries for BC First Nations and Aboriginal students were funded in total valued at $160,000 with $110K for scholarships ($50K undergrad, $20K masters, $40K doctorate levels) and $50K for bursaries; in fy1314 a total 83 scholarships and bursaries were additionally provided from FNHA supported (in addition to NRT's regular funding programming)- $160K total scholarships with $60K at undergrad level, $40K for masters level, $60K at doctorate level; $48K total bursaries	Partnership with NRT to leverage their core business	Despite FNHA supplemental funding, there is still a significant shortfall of funds for the demand ie fy1213 64% scholarship applications unfunded

Health Human Resources Tripartite Strategic Approach		HHR	25		2013	A resource that communities can use for their own HHR planning, and for regional planning, as the HHR strategies are being developed	Re development of the document: Planning committees were very well organized and facilitated, using an inclusive process with Tripartite and external partners.	Status of this document, and the next steps from here, are unclear to MoH: has it been approved - it hasn't come back to MoH for final sign-off; what are the next steps for putting the document into action (e.g. an inventory of First Nations and Aboriginal health practitioners)?
Indigenous Cultural Competency training	Training	HHR	19	MoH, PHSA, RHAs	Ongoing	500 seats of cultural competency training is available to each health authority and MoH annually with continuous ongoing enrollment. Training is a compulsory requirement of all BC Government health workers at the Ministry of Health and Regional Health Authorities.	Culturally grounded and sensitive course to enhance health service provider cultural competency, government mandating attendance as requirement	
First Nations and Aboriginal-focused NP4BC projects	Initiative	PCPH, HHR	24		2012/13 - ongoing	Funding for basic salary and benefits for First Nations and Aboriginal-focused NP4BC projects, within the MoH-funded NP4BC Program, with 24 approved in rounds 1 (2012/13) and 2 (2013/14)	Primary care in BC First Nation communities (including remote and rural access)	TBD
Health Careers Recruitment Outreach	Program	HHR	25	BC First Nations communities	2009	2009 Health careers travelling roadshow targeting greater than 50 communities a year by First Nations for First Nations	Built a large inventory of students interested in health careers- foundational to current health careers work; established a network of young people interested in health careers	Community based outreach always in demand for this area

Gathering Our Voices: BC Aboriginal Friendship Centre hosted Youth Conference	Funding	All		BCAAFC	Since 200	This annual conference supports the health and wellness component of the key annual BC First nations and Aboriginal youth conference which builds youth resiliency and inspires strong Indigenous identity. 2012 theme was "A Generation on the Move' which saw 1600 BC First Nation and Aboriginal youth participants from around the province with growing numbers annually. 2013 theme was on health.	Event well planned, well organized, and relevant for youth. AHD has encouraged and enabled our Aboriginal Youth Interns to participate, and to facilitate workshops	BCAAFC very open to aligning their conference planning with Tripartite health goals for First Nations people; good value for funding
HHR Database Project-Phase 1	Project	HHR	18,20,25,26	Ministry of Health, Ministry of Advanced Education, Ministry of Education	2012/13	Phase 1 feasibility study for large scale, dynamic HR database capturing First Nations and Aboriginal workers in the health field for planning and management purposes	Phase 1 foundational work complete for precedent setting comprehensive database re: Aboriginal and FN health workers for planning and management	
First Nations Education Steering Committee	Relationship	HHR		FNESC		Funding support to promote science and technology programs in the classroom (later life student recruitment to health)	BC First Nation school uptake; foundational for future health career options	Partnership is key