The Development of Our Health Counts Applied Indigenous Epidemiology, Health Information, and Health Services and Program Evaluation Training and Mentorship (OHC-NET) Program

Summary Report of a National Network Environments for Indigenous Health Research (NEIHR) OHC-NET Vision Gathering

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Executive Summary

On June 6-7th 2019, a national NEIHR planning meeting took place in Toronto, Ontario. The gathering developed a vision for the ***Our Health Counts: Applied Indigenous Epidemiology, Health Information, and Health Services and Program Evaluation Training and Mentorship Program (OHC-NET)*** project, co-led by Janet Smylie (Well Living House), Jonathan Dewar (First Nations Information Governance Centre), and Leona Star (Nanaandawewigamig - First Nations Health and Social Secretariat of Manitoba)**.**

The goal of OHC-NET is to train 100 First Nation, Inuit, and Métis (FNIM) epidemiologists/ health information specialists over 10 years through the development and establishment of an accredited applied Indigenous epidemiology program. We envision a 2-year masters level program, in which trainees will be primarily placed at a FNIM or urban Indigenous organizations and take a combination of distance/internet-based courses. Students are expected to meet 3-4 times per year for in-person intensive courses taught by Indigenous leaders, scholars, Elders and Knowledge Keepers and drawing on lived Indigenous experience. This will include a capstone or thesis project. Nation based knowledge, practice, leadership and technical training could be supported by individualized baseline learning assessments, individualized learning plans, and Elder/Knowledge Keeper and technical mentors. This could include additional Indigenous knowledge training/learning activities and practicum placements. Ideally, FNIM sponsors, hosts, and community partners would assist in identifying and recruiting FNIM trainees.

In order to avoid regional competition with other developing NEIHRs, we are asking developing NEIHRs across the country if they would like to collaborate, incorporating the proposed Indigenous epidemiology training and mentorship component into their full NEIHR applications. For the training program to be successful, it is estimated that we would require the collaboration and support of approximately 4 to 6 successful regional NEIHRs. To complement NEIHR funding, we are seeking matching supports from the sponsoring trainee organizations and exploring other avenues for funding.

At the Visioning Gathering, national and international examples of applied epidemiology were presented. Three panelists presented examples of *Building Indigenous Science Competencies and Training Programs* from Canada. This panel identified a number of competencies that would be required to establish an Indigenous epidemiology program, as well as core program courses and gaps in western epidemiology training programs. Further, two Aboriginal scholars from Australia shared their Master of Applied Epidemiology experiences. This training model could be drawn upon in the development of the Indigenous epidemiology program. This was followed by group discussions regarding (1) program competencies, (2) partnerships, (3) governance structure, (4) national network development, (5) curricula, (6) leadership training, and (7) organizational sponsors/practicum placements.

(1) Program competencies can be drawn from the Competencies for Indigenous Public Health, Evaluation, and Research that were developed by an international group of Indigenous public health leaders at University of Hawai'i. Additional recommended competencies included:

- Indigenous leadership and governance.
- Use of Indigenous languages and interpretation.
- Research and data principles and stewardship protocols, including OCAP® and the Inuit Qaujimajatuqangit (IQ) Principles.
- Inclusion of Elders and Indigenous Knowledge.

(2) Partnerships with clearly defined roles and responsibilities of all partners, including contributions (i.e. resources) and clear understanding of program ownership. Recommended partnerships included:

- Regional NEIHRs.
- FNIM organizations, including leadership organizations.
- Universities.
- National organizations in epidemiology and statistics.

(3) Governance structure will be Indigenous-led with a balance of Indigenous community members and academic representation. The recommended governance structure included the following representation:

- Elders, Knowledge Keepers and Grandparents.
- Links to existing FNIM leadership bodies.
- FNIM national and provincial political bodies.
- Provincial and Territory representation.
- Indigenous leaders in the field of epidemiology and statistics, including alumni in due course.

(4) National network development will continue to interface and concentrate efforts on regional NEIHRs who have expressed interest in collaborating. Key recommendations for the national network development include:

- Identifying core funding to sustain resources.
- Resolutions and endorsements from national Indigenous organizations.
- Develop reciprocal relationships with government, institutions, and tribal councils.
- Alignment with United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) and the Truth and Reconciliation Council Calls to Action (TRC).

(5) Curricula development will be undertaken by Indigenous peoples and will draw upon existing curriculum. Key recommendations included:

- Drawing on Indigenous methodologies, including ethical space, relationship building, reciprocity, and accountability, decolonizing statistics, and ethical research.
- Drawing upon FNIM lived experiences, case studies and other examples.
- Balance practical and technical training, including core epidemiology competencies.

- Blending of mixed methodologies.

(6) Leadership training requires FNIM training linkages, and to establish an epi-circle of FNIM mentors for mentorship and coaching. Key recommendations for selecting trainees included:

- Identity and connection to community.
- Demonstrate a willingness to learn and work with Elders and Knowledge Keepers.
- Facilitate/support Elders and Knowledge Keepers participation in the selection process.
- Request in spirit of reciprocity that mentees commit to advocate and lead research, data governance and data sovereignty.

(7) Organizational sponsors/practicum placements. As part of the trainees' placements, trainees will access mentors and communities of practice. Recommended placements included:

- FNIM bodies, including leadership and representative bodies.
- Indigenous community-based placements.
- National leadership organizations in epidemiology and statistics, particularly with a focus on FNIM data.

Next steps and recommendations included:

1. Identify and continue to work with developing NEIHRs and others if they would like to include the proposed Indigenous epidemiology component into their applications.
2. Identify a sustainable funding structure to support the Indigenous epidemiology training program.
3. Develop core curriculum founded on the above-mentioned principles and directions.
4. Establish a trainee selection process based on "leaving no one behind" and including Indigenous community partners were possible.
5. Create mentorship guidelines, principles and establish an "Indigenous Epi-Mentee Network" consisting of FNIM community leaders, Indigenous epidemiologists, Elders and Knowledge Keepers.
6. Identify and recruit host/sponsoring organizations that are the "right fit". This should reflect the established principles, including respect and ethical principles, such as FNIM ownership and IQ Principles.
7. Educate and advance conversations with sponsors, hosts and academic settings and others that students may require flexible funding and tailored curricula to be successful and effectively complete a community-based epidemiology program.

Background

To successfully plan and implement health programs, First Nations, Inuit, Métis (FNIM) and urban Indigenous[1] communities in urban settings need to be able to access relevant, useful and comprehensive population health information and apply it to policies, services and service evaluation. Ensuring that Indigenous peoples lead the planning, governance, implementation and management of their health information is critical for the advancement of both Indigenous rights and health systems effectiveness. In stark contrast to Australia, New Zealand and the United States, there has been a paucity in Canadian investments to advance Indigenous specific human resource development in population health sciences, including applied epidemiology, health information systems and health service evaluation. This contributes to the vast under-representation of Indigenous peoples who can take on the required leadership roles in these fields. Further, in Canada there are striking gaps in information infrastructure in relation to respectful and self-determined mechanisms to accurately and systematically identify FNIM individuals in source data systems across geographies, nation groups, and imposed Indian Act classifications. The result is a discounting of hundreds of thousands of Indigenous peoples and a masking of Indigenous/non-Indigenous health inequities[1]. For example, over the past decade, evidence has demonstrated in three Ontario cities that the Canadian Census is undercounting the size of the Indigenous population by a factor of two to four[2-5]. There is an overreliance on geocoding and sole source linkage to federal registries of "Status Indians" or "Registered Inuit" as a means of identifying Indigenous ethnicity in key administrative datasets and frequent misclassification of Indigenous people as non-Indigenous in vital registration and health surveillance systems. With a few exceptions, there is a paucity of initiatives addressing data system deficiencies[2-5]. Further, in Canada the determination of program funding for Indigenous peoples are often based on national datasets and health information, such as the Census which makes addressing these significant data system deficiencies and limitations of increasing concern[2,6].

With these challenges in mind, Janet Smylie, Jonathan Dewar, and Leona Star partnered to develop the OHC-NET initiative. The overarching goal of OHC-NET is to address a critical Indigenous human resource gap through working in partnership with FNIM and urban Indigenous communities and organizations to develop, implement, and evaluate a national Indigenous training and mentorship network to train and support a cadre of 100+ Indigenous health information specialists, applied epidemiologists, and health service researchers who can lead the required transformation of Indigenous health and social information systems in Canada. Trainees will be equipped to support Indigenous communities and organizations as they assume leadership roles in FNIM health information and health system performance measurement.

The focus of the OHC-NET initiative is to develop Indigenous health and social information personnel and systems. This aligns with the Truth and Reconciliation (TRC) Call to Action #19 to

[1] We humbly acknowledge that Indigenous people are diverse and constitute many nations, language groups and cultures, representing many cultures, perspectives and experiences that brings tremendous vibrancy to our world.

"establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities and publish annual progress reports and assess long term trends" and Articles 11-14 of the United Nations Declaration on the Rights of Indigenous Peoples which recognize our rights to revitalize our cultural traditions, customs, languages, and education.

Janet Smylie, Jonathan Dewar, and Leona Star received a Canadian Institute for Health Research (CIHR) Network Environment for Indigenous Health Research (NEIHR) Developmental Grant to progress this initiative. The developmental grant supported the establishment of a Developmental Circle and national Vision Gathering. The Developmental Circle advises, guides and assists in planning activities for the OHC-NET initiative. Members of the Developmental Circle can be found in *Appendix 1*. The Vision Gathering was held in Toronto, Ontario on June 6-7th and brought together FNIM Elders and Knowledge Keepers, leaders and allies, academic experts, and community partners across Canada to develop a vision for the OHC-NET initiative. The agenda for the two-day vision gathering can be found in *Appendix 2*.

Overview of Vision Gathering

Jan Longboat welcomed participants to the gathering. Master of Ceremony, Jonathan Dewar provided a brief overview of the agenda for the day. This was followed by paired-introductions, where participants partnered with another participant they have never met, and introduced their newly met respective partner to the larger group.

Janet Smylie, one of the Co-Principal Investigators (Co-PI) for the project, acknowledged the work and contributions of the fellow Co-PI's Jonathan Dewar (First Nations Information Governance Centre) and Leona Star (Nanaandawewigamig - First Nations Health and Social Secretariat of Manitoba). Janet identified the objectives for the 2-day Vision Gathering (see Figure 1):

Figure 1 – Vision Gathering Objectives

Janet and Stephanie Sinclair (on behalf of Leona Star) presented an overview and the vision of the OHC-NET project.

Our Health Counts: Applied Indigenous Epidemiology, Health Information, and Health Services and Program Evaluation Training and Mentorship Program (OHC-NET)

The goal of OHC-NET is to ***train 100 First Nation, Inuit, and Métis (FNIM) epidemiologists/ health information specialists*** over 10 years through the development and establishment of an accredited applied Indigenous epidemiology program. The program is envisioned to be a 2-year masters level program. Trainees will be primarily placed at a First Nations, Inuit, Métis or urban Indigenous organizations and take a combination of distance/internet-based courses and meet 3-4 times per year for in-person intensive courses taught by Indigenous leaders, scholars, Elders and Knowledge Keepers. This will include a capstone or thesis project.

Nation based knowledge, practice, leadership and technical training could be supported by individualized baseline learning assessments, individualized learning plans, and Elder/Knowledge Keeper and technical mentors. There could also include additional Indigenous knowledge training/learning activities and practicum placements. Ideally, FNIM sponsors, hosts, and community partners will assist in identifying and recruiting FNIM trainees.

Janet identified that the team is reaching out to FNIM communities prior to reaching out to universities to build this program. Stephanie Sinclair shared the importance of this training program and identified that there is a gap in Indigenous data analysts in Canada who have the skills to analyze and interpret FNIM data.

Janet shared that the team is seeking opportunities for partnerships and collaboration, asking developing NEIHRs across the country if they would like to collaborate and include the proposed Indigenous epidemiology training and mentoring component in their full NEIHR applications. This would help avoid regional competition with other developing NEIHRs. For the training program to be successful, it is estimated that we would require the collaboration and support of approximately four to six successful regional NEIHRs. To complement NEIHR funding our team plans to seek matching supports from the sponsoring trainee organizations.

The presentation slides for Janet and Stephanie's presentation can be found in *Appendix 3*.

Three panelists presented Canadian examples of *Building Indigenous Science Competencies and Training Programs.*

Evan Adams presented Public Health Competencies and shared his experience being involved in the development of Competencies for Indigenous Public Health, Evaluation, and Research

(CIPHER) at University of Hawai'i. The presentation slides for Dr. Adam's presentation can be found in *Appendix 4*.

Vanessa Tait presented Economic Development Training and shared her experience being involved in the development of competencies for the Technician Aboriginal Economic Developer training program offered by Cando. More information about the training program can be found here: http://www.edo.ca/certification/taed-level-certification/11-competencies

Stephanie McConkey presented Experience Completing Master of Science at Western University using Our Health Counts (OHC) Toronto Dataset. Stephanie shared both her positive and negative experiences completing a western-based epidemiology and biostatistics training program, highlighting areas for improvement. The presentation slide for Stephanie's presentation can be found in *Appendix 5*.

This panel identified a number of competencies that would be required to establish an Indigenous epidemiology program, as well as identified core program courses and a number of gaps in western-based epidemiology training programs. Discussants Carol Terry, Adel Panahi and Chyloe Healy then shared their reflections of the panel presentations and led a group discussion.

International examples of applied epidemiology were presented in the next panel. Raglan Maddox shared his experience completing a PhD at the University of Canberra in Australia and shared a video of two Aboriginal scholars from Australia who shared their Master of Applied Epidemiology experiences. The Australian Master of Philosophy (Applied Epidemiology) training model could be drawn upon in the development of the Indigenous epidemiology program.

In the afternoon of day 1 and the morning of day 2, participants broke into small group discussions. The small group discussions included the following topics as identified by the Co-PIs and the Developmental Circle (see Figure 2). On day 1, *program competencies*, *partnerships* and *governance structures* were the priority discussion topics that were discussed simultaneously among small groups. Each smaller group then reported back to the larger group identifying key components of the priority areas. On day 2, *national network development*, *curricula, leadership training*, and *organizational sponsors/practicum placements* were the priority discussion topics that were discussed simultaneously among small groups. Each smaller group reported back to the larger group identifying key components of the priority areas as well as shared key next/steps recommendations for the OHC-NET initiative.

Figure 2 – Priority Discussion Topics

The remainder of the report will focus on sharing the key components and recommendations of each priority areas that were identified and informed by the Vision Gathering participants. The key recommendations and next steps for the overall OCT-NET initiative will then be shared.

At the end of the 2-day Vision Gathering, we celebrated with a feast. Albert Dumont closed the gathering.

Key Components of Applied Indigenous Epidemiology Training Program

Program Competencies

The participants discussed that the program competencies for an applied Indigenous epidemiology training program require strong Indigenous leadership, lived experience and Indigenous governance. Elders and Indigenous Knowledge should guide the development and planning of the program.

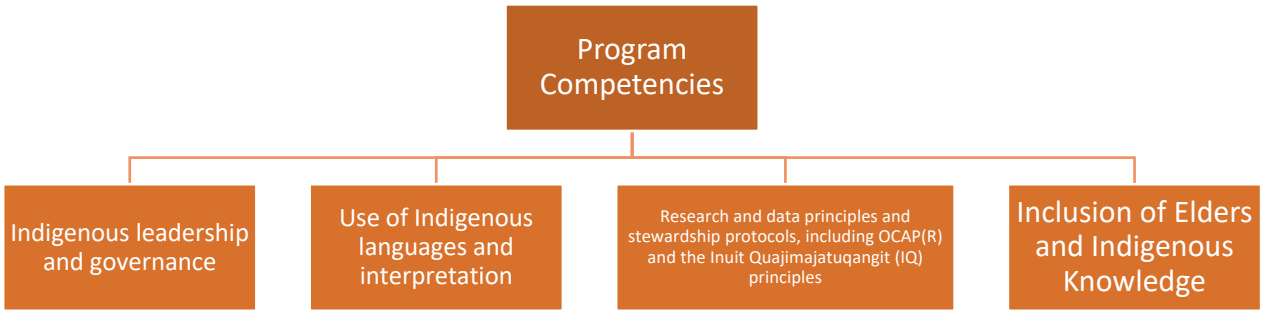
The majority of data analysts in Canada are non-Indigenous. In order to tell our own nation's data stories, it is important that the training program trains Indigenous students and includes Indigenous lived experiences because western science does not reflect Indigenous experiences in epidemiology training and translation of knowledge.

A nations-based approach should be taken to develop program competencies that reflect the ethics and protocols of specific nations and worldviews. This includes training and experiencing nations protocols. Ethical considerations to include OCAP® principles and distinct data stewardship protocols for the respective nations. It is also important that Indigenous knowledge systems, language and ethical practices are embedded in these competencies, including respectful and meaningful interpretation of data.

> *"all data points represent a person and has a spirit"*
> - Bonnie Healy

Program competencies can be drawn for the Competencies for Indigenous Public Health Evaluation and Research (CIPHER) that were developed by an international group of Indigenous public health leaders at University of Hawai'i.

Figure 3 – Recommended Program Competencies



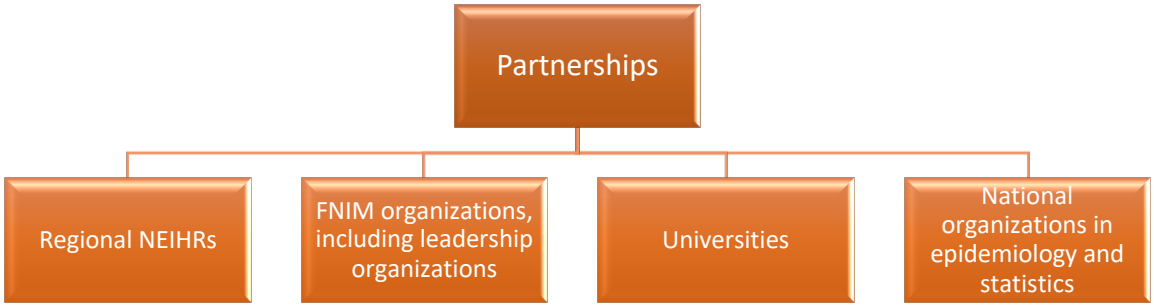
Partnerships

Participants recognized that partnerships are built from trusting and reciprocal relationships. It is important that partnerships are identified and established through partners working towards a common goal and/or objective. Engaging with FNIM communities, program experts and leaders, academic institutions, and government and acknowledging that each partner may provide varying levels of resources and contribute differently based on their expertise is a key function of establishing partnerships.

Partnerships involved in the development of an applied Indigenous epidemiology program need to understand the importance and benefits of the program and be willing to challenge and advance "traditional epidemiology". This is expected to advance Indigenous community-based health knowledge and expertise, meeting and/or exceeding the dual criteria of Indigenous community relevance and scientific excellence.

Partnerships with clearly defined roles and responsibilities of all partners, including contributions (i.e. resources) and clear understanding of program ownership and governance. It is important to identify what partners require to participate and partners are encouraged to share this information.

Figure 4 – Recommended Partnerships



Governance Structure

The participants discussed that the governance structure for the applied Indigenous epidemiology training program should be Indigenous-led and non-hierarchical, including a balance of Indigenous community members, Indigenous academic representation and academic representation, including FNIM Elders, Knowledge Keepers and Grandparents, FNIM leaders, and provincial and territory representation to help represent FNIM diversity. The governance structure should include and link to existing FNIM national and provincial political bodies.

As the training program is established and trainees successfully complete the program, the governance structure should include existing trainee representatives and alumni.

Figure 5 – Recommended Governance Structure

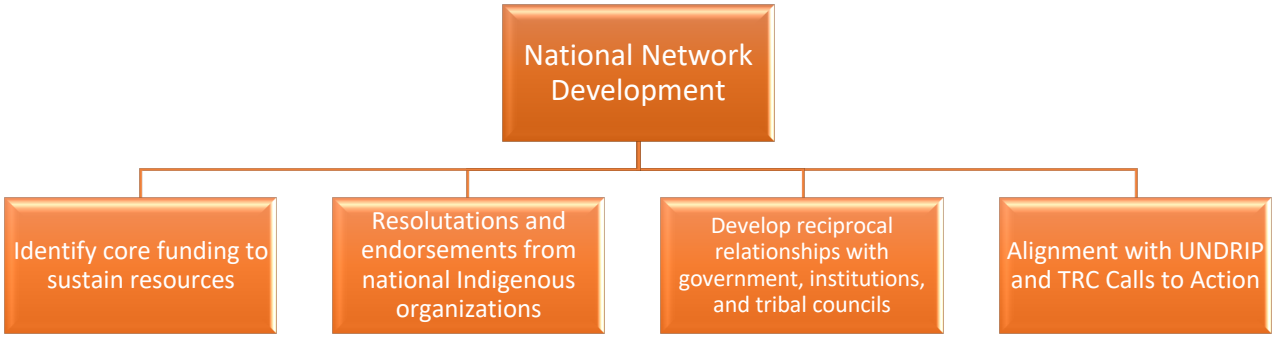
National Network Development

The participants discussed that the national network should include international partners that build on each other's strengths, connections and relationships. The network should include FNIM representation, Indigenous and ally organizations, and universities.

Some regional NEIHRs developing across the country have expressed an interest in the applied Indigenous epidemiology program. It is important to identify how regional NEIHRs can support the development of the epidemiology program and trainees, which may include sharing more information about the program and the direct benefits for communities in their region. National network development will continue to interface and concentrate efforts on regional NEIHRs who have expressed interest in collaborating.

Establishing a national network will require core funding to sustain the program. This may include seeking additional innovation funds at the national, provincial, or regional level. There could also be an opportunity to partner with universities/institutions and leverage them to participate in activities that support the TRC Calls to Action.

Figure 6 – Recommended National Network Development



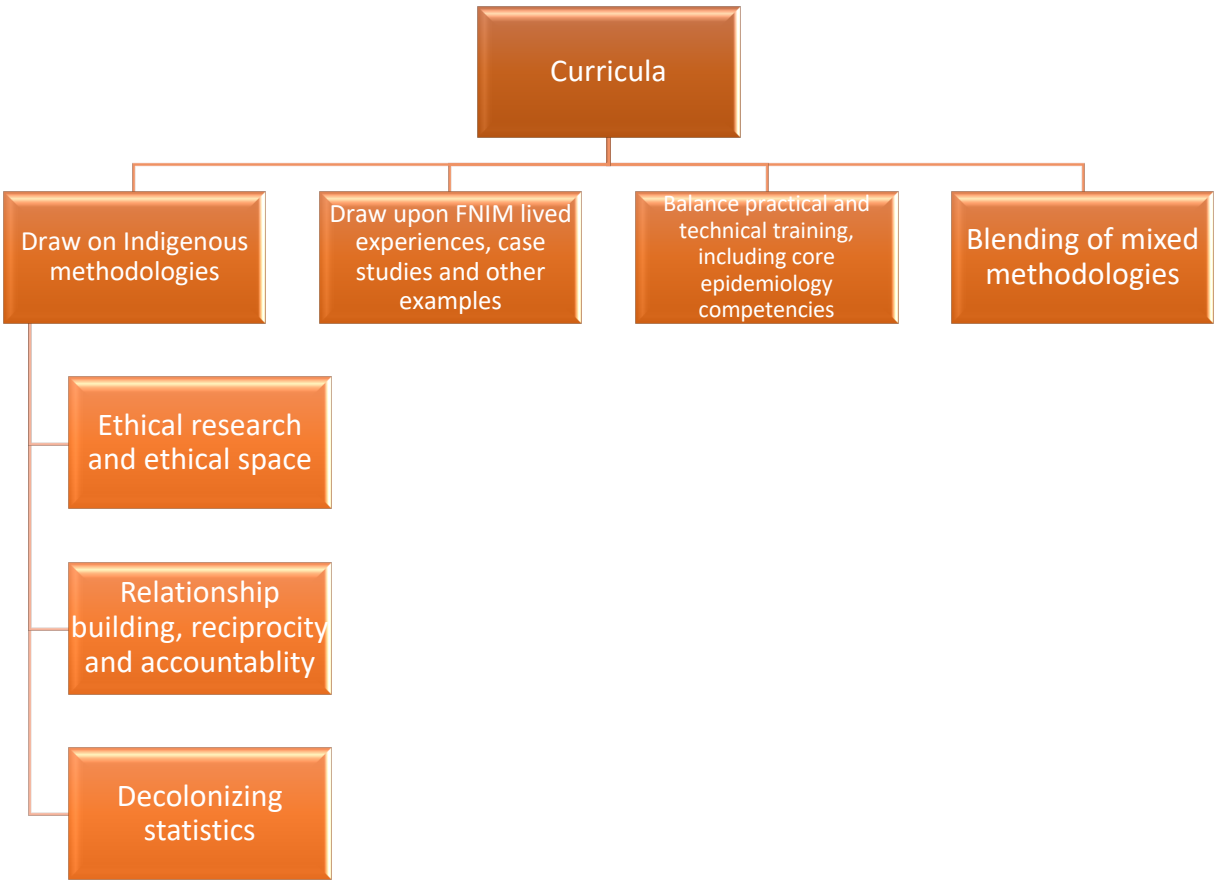
Curricula

Participants discussed that curricula development should be undertaken by Indigenous peoples, including FNIM leaders, epidemiologists, Elders and Knowledge Keepers, building lived experiences and Indigenous Knowledge as the foundation of the curricula.

The Developmental Circle and international Indigenous experts will be involved in the development of the curriculum. It is estimated that the program development will take approximately one year and will require a full-time post-doctorate to lead and coordinate the development of the applied Indigenous epidemiology training program.

The curriculum will draw upon existing curricula, balancing practical and technical skills. This includes identifying core courses and practicum placements as well as blending mixed methodologies. Indigenous research methodologies will be integral to the program and will include key topics including ethical research, ethical space, relationships building, reciprocity and accountability, and decolonizing statistics.

Figure 7 – Recommended Curricula



Leadership Training

The participants discussed that leadership training requires FNIM training linkages and should include establishing a national and international "Indigenous Epi-Network". In addition, networks of Indigenous knowledge holders and language speakers, FNIM leaders, and epidemiologists for trainee mentorship and coaching would be advantageous. Guidelines and leadership principles that are defined by FNIM communities, and Elders and Knowledge Keepers are established. This could include defining and establishing an understanding of "leadership", including defining and establishing an understanding of "leadership" in FNIM languages.

A trainee selection process needs to be established that includes FNIM communities, Elders and Knowledge Keepers based on the principle of "leave no one behind". The selection process should consider ethical conduct, reciprocity, willingness to learn Indigenous languages, as well as to working with Elders and Knowledge Keepers.

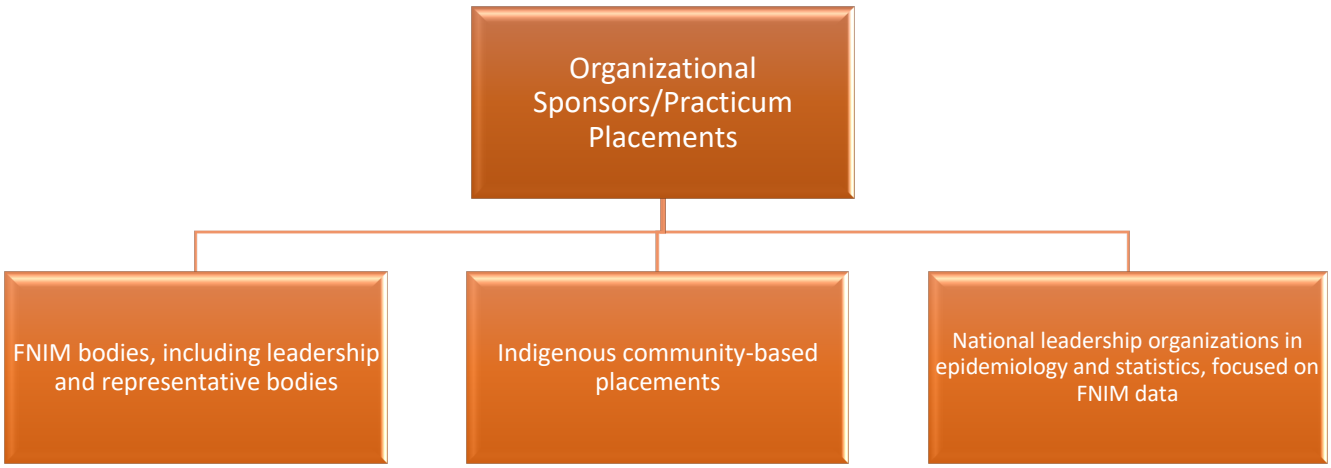
Figure 8 – Recommended Leadership Training

Organizational Sponsors/Practicum Placements

The participants discussed that organizational sponsors/practicum placements could assist to identify and recruit host/sponsoring organizations that are the "right fit" for trainees. Organizational sponsors should include FNIM and ally leadership organizations in epidemiology and statistics. It is important that sponsors and practicum hosts understand principles of Indigenous methodologies and community-based research.

Practicum placements should be community-based and have appropriate technical skill supports to host a trainee. As part of the trainee's placements, trainees will be supported to access mentors and communities of practice.

Figure 9 – Recommended Organizational Sponsors/Practicum Placements



Key Recommendations for Developing an Applied Indigenous Epidemiology Training Program

Based on the small group discussion topics, participants were asked to share 2-3 key recommendations and next steps for progressing the development of an applied Indigenous epidemiology training program. Key recommendations/next steps included:

1. Identify and continue to work with developing NEIHRs across the country if they would like to include the proposed Indigenous epidemiology component into their applications.
2. Identify a sustainable funding structure to support the Indigenous epidemiology training program.
3. Develop core curriculum founded on the above-mentioned principles and directions.
4. Establish a trainee selection process based on "leaving no one behind" and including Indigenous community partners were possible.
5. Create mentorship guidelines, principles and establish an "Indigenous Epi-Mentee Network" consisting of FNIM community leaders, Indigenous epidemiologists, Elders and Knowledge Keepers.
6. Identify and recruit host/sponsoring organizations that are the "right fit". This should reflect the established principles, including respect and ethical principles, such as FNIM ownership and IQ Principles.
7. Educate and advance conversations with sponsors, hosts and academic settings and others that students may require flexible funding and tailored curricula to be successful and effectively complete a community-based epidemiology program

Conclusion

The two-day Vision Gathering brought FNIM Elders and Knowledge Keepers, Indigenous leaders and Indigenous academics, students, allies and accomplices, academic experts, and community partners from across the country to create a shared vision for developing and establishing an applied Indigenous epidemiology training program. Diverse participants brainstormed, shared ideas, and created recommendations for the governance structure, partnerships, competencies, national network development, leadership training, curricula, and organizational sponsors/practicum placements of the Indigenous epidemiology program.

The OHC- NET team is actively pursuing collaboration across the regionally developing NEIHRs and seeking partnerships with FNIM and ally organizations. The Developmental Circle will continue to meet quarterly to assist and guide the development of the applied Indigenous epidemiology training program.

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Appendix 1 – *OHC-NET* Developmental Circle Members

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Well Living House
Network Environments for Indigenous Health Research (NEIHR) Vision Gathering
Spring 2019

June 6th – 7th 2019

Thursday, June 6th 2019 NEIHR Vision Gathering Holiday Inn Toronto Downtown Centre, Wellesley Room (30 Carlton Street, Toronto)		
Time	**Activity**	**Details**
8:00 AM	Breakfast	**Holiday Inn Toronto Downtown Centre, Wellesley Room**
9:00 – 9:15 AM	Welcome to Territory (Jan Longboat) MC (Jonathan Dewar)	NEIHR Vision Gathering **Holiday Inn Toronto Downtown Centre, Wellesley Room**
9:15 AM – 10:00 AM	Paired Introductions Review of Agenda	
10:00 AM – 10:30 AM	Orientation to OHC-NET: Visioning Indigenous Epidemiology (Janet Smylie and Stephanie Sinclair)	
10:30 AM	Health and nutrition break	
10:45 AM – 11:45 AM	Panel: Building Indigenous Science Competencies and	

	Training Programs – Canadian Examples 1. Public Health Competencies (Evan Adams) 2. Economic Development Training (Vanessa Tait) 3. Experience completing M.Sc at Western University using OHC Toronto dataset (Stephanie McConkey)	
11:45 PM – 12:15 PM	Large Group Discussion led by Discussants (Discussants: Carol Terry, Chyloe Healy, and Adel Panahi)	
12:15 PM – 1:00 PM	Lunch	
1:00 PM – 1:30 PM	International Example Video (Australian) (Lead: Raglan Maddox)	
1:30 – 2:15	Focused small group discussions 1. **Governance Structure** (including First Nation, Inuit and Métis organizational roles and leadership) (Leads: Leona Star and Dorothy Myo)	

	2. Competencies (Leads: Vanessa Tait and Bonnie Healy) **3. Partnerships** (NEIHRS; Universities, Federal/provincial governments) (Leads: Margo Greenwood and Philippe Belanger [PHAC])	
2:15 PM – 2:30 PM	Health and nutrition break	
2:30 PM – 3:00 PM	Report Back from Small Groups	
3:00 PM – 4:00 PM	Roundtable End of Day Thoughts and Reflections	

Friday, June 7th 2019
NEIHR Vision Gathering
Native Canadian Centre of Toronto
(16 Spadina Road, Toronto)

Time	Activity	Details
8:00 AM	Breakfast	Native Canadian Centre of Toronto
9:00 AM – 9:30 AM	Welcome to the NCCT Sharing Overnight Thoughts (Jennifer Walker and Raglan Maddox)	Native Canadian Centre of Toronto
9:30 AM – 10:00 AM	International Example Video (New Zealand)	

	Q & A International Exemplars (Facilitator: Raglan Maddox)	
10:00 – 10:45	Focused Small Group Discussions 1. **National network development** (Leads: Janet Smylie and Leona Star) 2. **Curricula** (Coursework - individual/group); Placements; Project/Thesis; Instructors) (Leads: Jennifer Walker and Raglan Maddox) 3. **Leadership Training** (Leads: Bernice Downey and Bonnie Healy) 4. **Organizational Sponsors/Practicum Placements** (Leads: Philippe Belanger [PHAC] and Stephanie McConkey)	
10:45 AM – 11:00 AM	Health and nutrition break	
11:00 AM – 11:30 AM	3 Key Recommendations/Next Steps from each Small Group Discussion	

	(Discussants: Carol Terry, Chyloe Healy, and Adel Panahi)	
11:30 AM – 12:00 PM	Summary of Next Steps (Janet Smylie and Leona Star)	
12:00 PM – 2:00 PM	Feast and Story-telling by Well Living House Grandparents Council	
2:00 PM	Closing	

Appendix 3: *Janet Smylie's* Our Health Counts-NET: Indigenous Health Information, Epidemiology and Evaluation Training and Mentorship Network Presentation

Our Health Counts-NET:

Applied Indigenous Health Information, Epidemiology and Evaluation Training and Mentorship Network

Janet Smylie MD FCFP MPH
Director, Well Living House Action Research Centre, St. Michael's Hospital, Toronto;
Professor, Dalla Lana School of Public Health, University of Toronto
CIHR Applied Public Health Research Chair in Indigenous Health Knowledge and Information

Presentation Overview

- Gathering Objectives
- OHC-NET Orientation
- Visioning Indigenous Epidemiology and Training
- Why do we need this?
- Questions/Discussion

Gathering Objectives

- Visit (Give and take, bridge understanding and build relationships)
- Share, acknowledge and think critically about what is needed (Governance, competencies, curricula, teachers, lodges)
- Prepare for our journey (partnerships, paper)

Our Health Counts NET Orientation

- Developmental Grant
- Organizational Co-Leadership
- Human resources gap –Indigenous health information leaders
- Dual competencies
  - Nation-based knowledge, practice and leadership
  - Quantitative technical information and data skills
- Gaps and challenges in current training environments in Canada
- International models

Our Health Counts NET Orientation

- Graduate level certificate/degree to start
- Program base at FNIM/urban Indigenous organization(s) that will act as primary sponsors
- Trainees sited at FNIM/urban Indigenous organizations
- Combination of distance internet based and face to face (3-4X per year intensive courses) taught by FNIM Indigenous scholars, elders, and knowledge keepers
- Customized nation based Indigenous knowledge/practice/leadership teachers/mentors and activities

Our Health Counts NET Orientation

- Consortium of universities to grant degrees
- Opportunity to build on NEIHR initiative
- Looking for secondary institutional sponsors

Indigenous Epidemiology…..

- We have always relied on our skills of lived observation and precision of accounting
- It is a human right to be counted and our survival depends on responding to observations of change in our lived environment
- Complex inter-relationships between data points as important/more important than the data points themselves
- The worldview that is used to define and interpret our counts is foundational
- Indigenous information and data leadership requires critical thinking, grounded and nation-based understanding of worldview, and precision of skills

Questions?

www.wellllivinghouse.com

Appendix 4 – *Evan Adam's* Public (and Population) Health Competencies Presentation

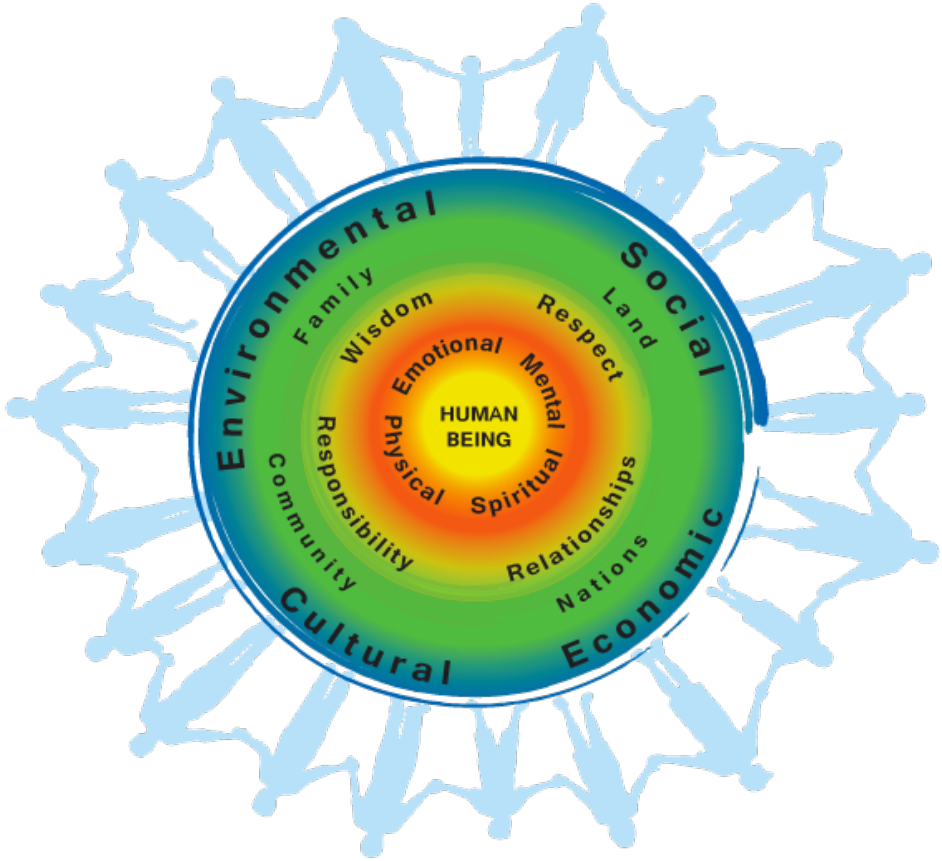
First Nations Health Authority
Health through wellness

Public (& Population) Health Competencies

NEIHR Vision Gathering

Tlesla Il, Evan Adams, MD, MPH
Tla'amin Nation
Chief Medical Officer
BC First Nations Health Authority

Good health interrupted



- Graphic is of the BC First Nations Perspective on Wellness – holistic, with the Individual at the centre
- Our vision of health & wellness comes from the ancestors & **is relational**
- Colonialism interrupted this worldview

At one point, if you drew a circle, the medicine people were Aboriginal, the medicine was Aboriginal, nurses, teachers were Aboriginal. But as colonization evolved and you looked at the circle there were no Aboriginals.

– Chief Robert Joseph

FIRST NATIONS & INUIT HEALTH PROGRAM (FEDERAL)

- Health Canada's role in First Nations & Inuit health goes back to 1945, when Indian health services were transferred from Indian Affairs.
- In 1962, Health Canada provided direct health services to First Nations people on-reserve & Inuit in the north.
- By the mid 1980s, work began to have First Nations & Inuit communities control more health services.

PROVINCIAL ROLE

- Health care services include insured primary health care (such as the services of physicians & some other health professionals) & care in hospitals
- The provinces & territories also provide some services & benefits such as prescription drug coverage, ambulance services, home care, public health, long term care, etc.

PUBLIC HEALTH

- A comprehensive public health system for Indigenous peoples does not exist – instead, there are gaps.
- "At present the legislative framework for the provision of core public health services in BC on First Nations lands is unclear, leading to uncertainties in the provision of services for individuals, communities, service providers, & governments."

AN EXAMPLE

From CBC News, September 24, 2008

"Upset parents are asking a band council in BC to stop allowing smoking at bingo games held in a community hall that adjoins the band's elementary school."

Smoking is banned in all public places by provincial law (the Tobacco Act does have exemptions for smoking in 'relation to a traditional Aboriginal cultural activity – this not include bingo).

PUBLIC HEALTH SERVICES ON FIRST NATIONS LANDS

… are currently provided by a hodgepodge of workers:

- RMOs
- FN-EHOs (FNIH)
- PHNs
- CHRs
- MHOs
- EHOs
- Various HA workers

CIPHER

What if the Indigenous perspective were applied to public health core competencies? This question has been raised by 12 Indigenous scholars from Australia, New Zealand, the US, & Canada, initiating the idea for an international program to establish Competencies for Indigenous Public Health, Evaluation & Research (CIPHER).

In July 2011 the group convened at the University of Hawaii in Honolulu & agreed by consensus that Indigenous health could be improved by promoting culturally safe public health practices through the development & implementation of core competencies for Indigenous public health.

CIPHER – KEY CONCEPT: CORE COMPETENCIES

Core competencies for public health represent a set of skills, knowledge & attitudes necessary for providing effective health services. Competencies also inform education, training, research & governance. The core competencies have the potential to:

- inform curriculum, standards & accreditation for public health education
- guide community research
- inform Indigenous health policy & legislation
- promote a culturally competent workforce
- create career ladders for Indigenous public health professionals
- expand Indigenous public health capacity
- improve health outcomes
- inform the development of Indigenous health research & Indigenous cultural safety training modules.

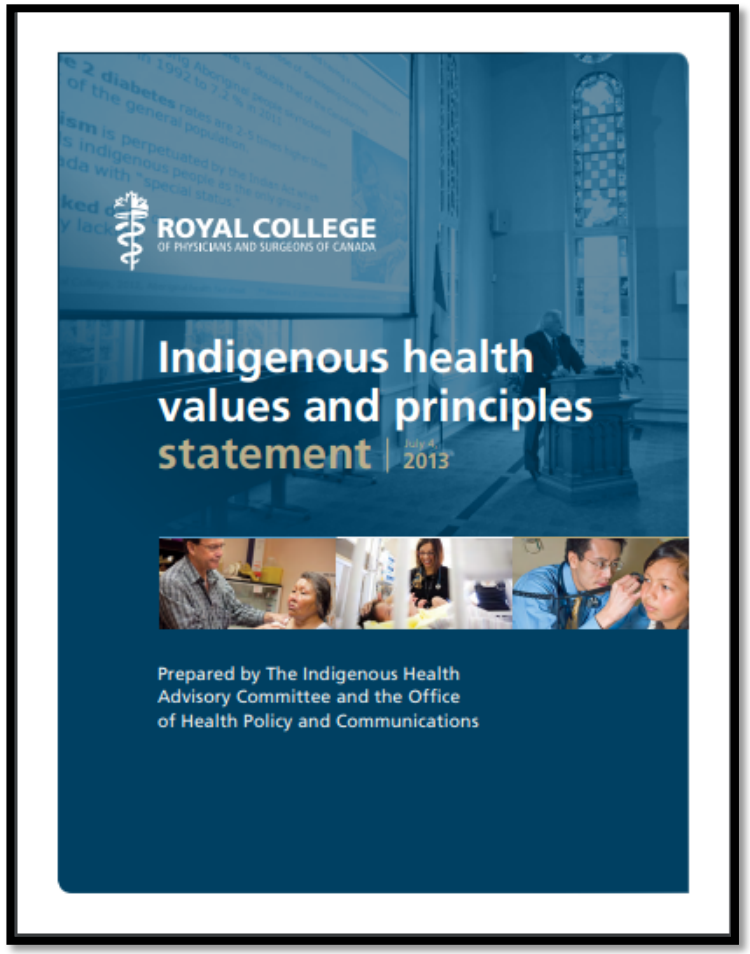
CIPHER

The CIPHER strategy is aimed at improving the cultural safety of Indigenous health services, through standardized training of public health practitioners & formal integration of Indigenous health perspectives into public health education, practice, & governance. The result will be a higher quality of Indigenous health services & reduced Indigenous health disparities. Given the plurality of Indigenous populations, the core competencies must balance unique community approaches with a consensus on what constitutes a core set of knowledge, skills, & values for the transnational workforce in Indigenous public health.

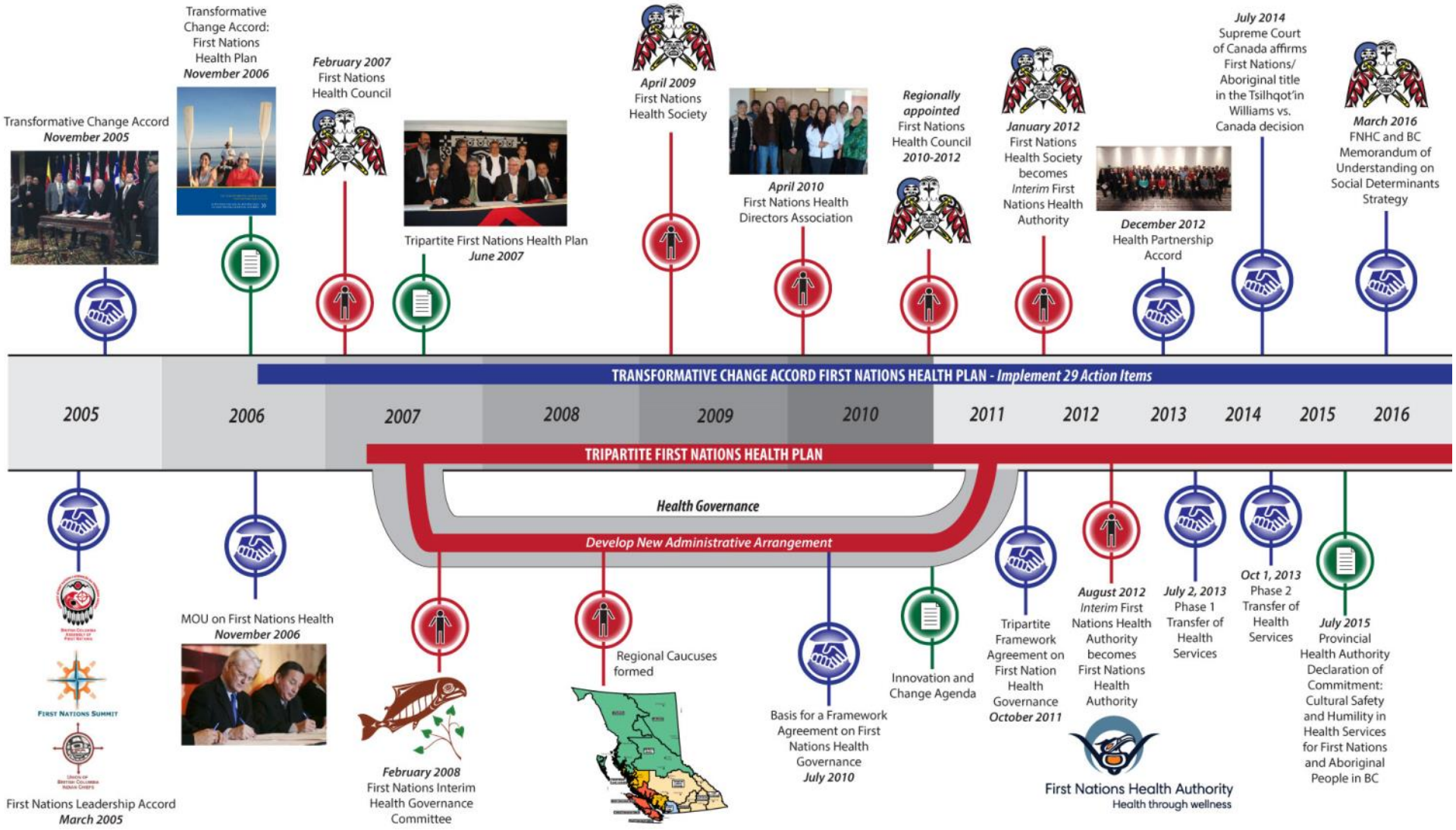
ROYAL COLLEGE OF PHYSICIANS & SURGEONS OF CANADA

- A landmark decision to make Indigenous health a mandatory component of postgraduate medical education.

- A focus on improved health and health care of Indigenous Peoples



BC First Nations Health Authority



Who We Are

- **The First Nations Health Authority (FNHA)** is the first province-wide health authority of its kind in Canada
- In 2013, the FNHA assumed the programs, services & responsibilities formerly handled by Health Canada's First Nations Inuit Health Branch - Pacific Region
- We aim to reform the way health care is delivered to BC First Nations to close gaps in health disparities & improve health & wellbeing

Our Vision

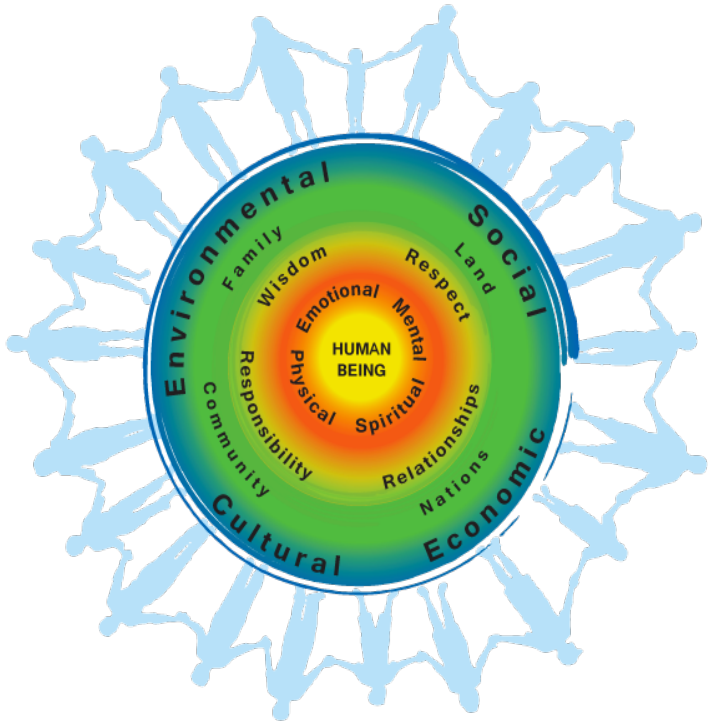
Healthy, self-determining & vibrant, BC First Nations children, families & communities

Our Values

Respect, Discipline, Relationships, Culture, Excellence & Fairness

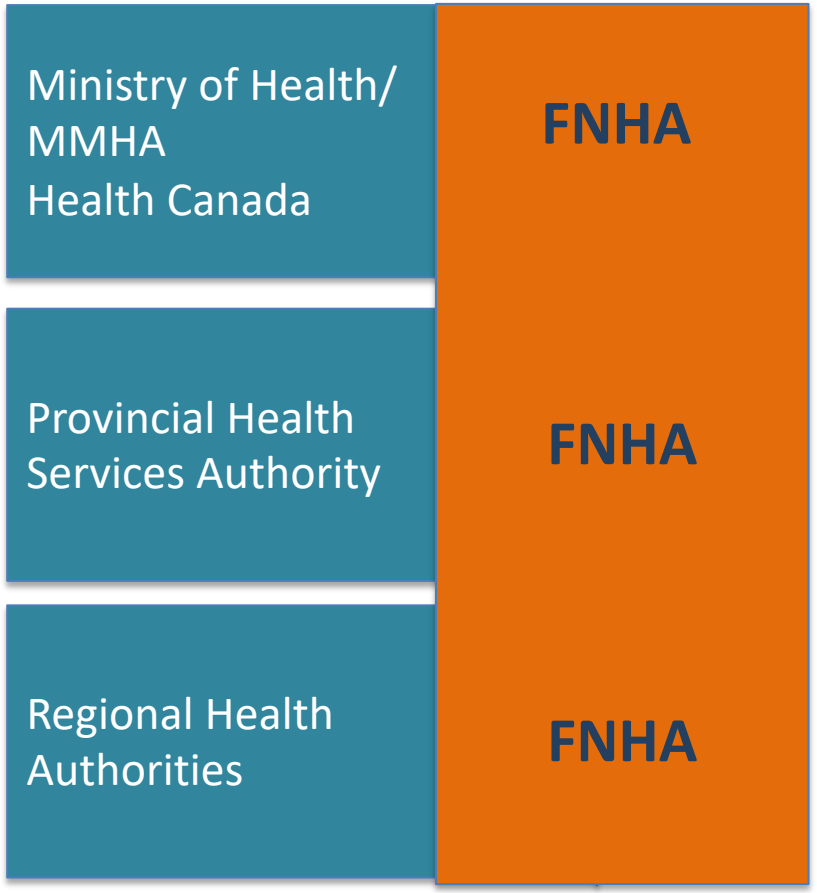
Our Directives

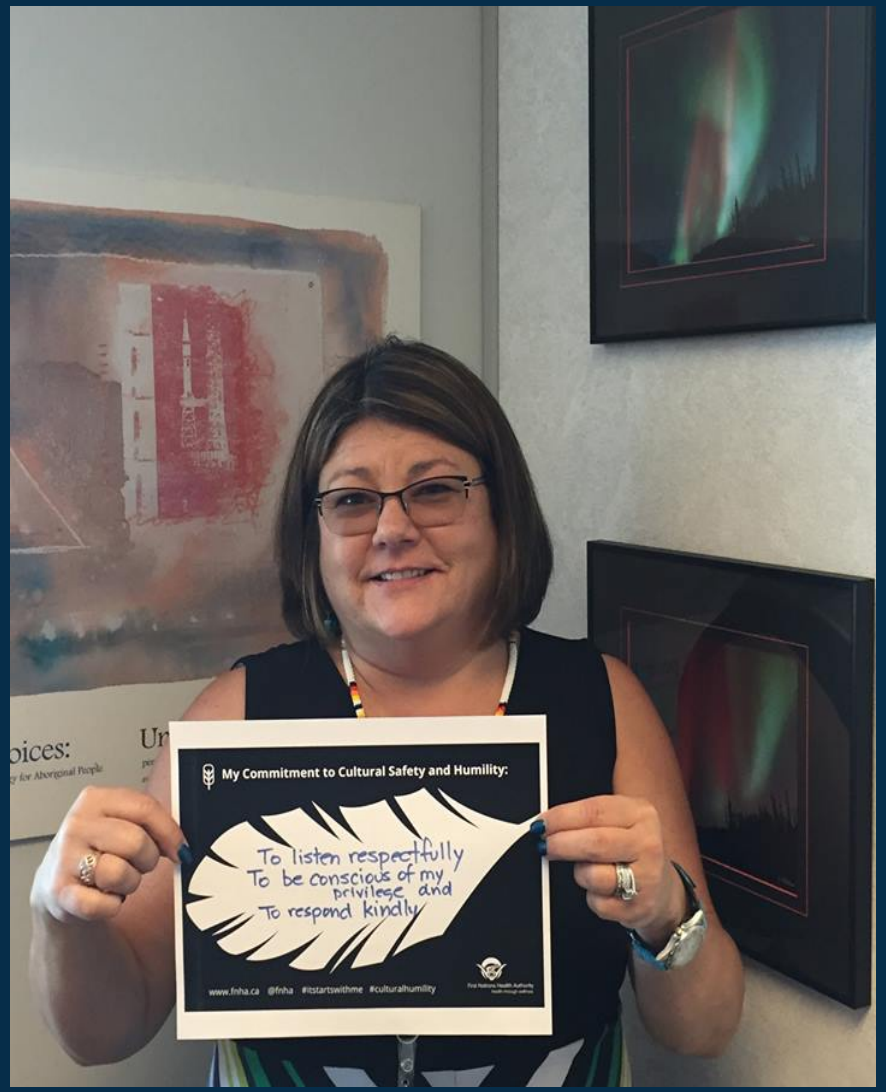
1. Community Driven, Nation Based
2. Increase First Nations Decision-Making
3. Improve Services
4. Foster Meaningful Collaboration & Partnerships
5. Develop Human & Economic Capacity
6. Be without Prejudice to First Nations Interests
7. Function at a High Operational Standard



Approach of the FNHA: First Nations Decision-Making

- **"Nothing for us without us"**
- FNHA created by First Nations for First Nations to advance a holistic First Nations Perspective on Health & Wellness
- Empowering individuals, families, & communities to be self-determining
- BC's 7th Health Authority. Non-profit society under the BC Society Act. FNHA's authority comes from the **inherent right** of First Nations people to be self-determining
- Working at all levels of the health system simultaneously
- Articulating First Nations views about health & wellness & develop policy that works for First Nations





First Nations Health Authority Services:

- Primary Health Care
- Children, Youth & Maternal Health
- Mental Health & Wellness
- Communicable Disease Control
- Environmental Health & Research
- First Nations Health Benefits
- eHealth & Telehealth
- Health & Wellness Planning
- Health Infrastructure & Human Resources

Photo: Dr. Shannon McDonald, FNHA Senior Medical Officer – Vancouver Island Region

Photo: Dr. Shannon McDonald, FNHA Deputy

HEALING & MOVING FORWARD WITH SELF-DETERMINATION

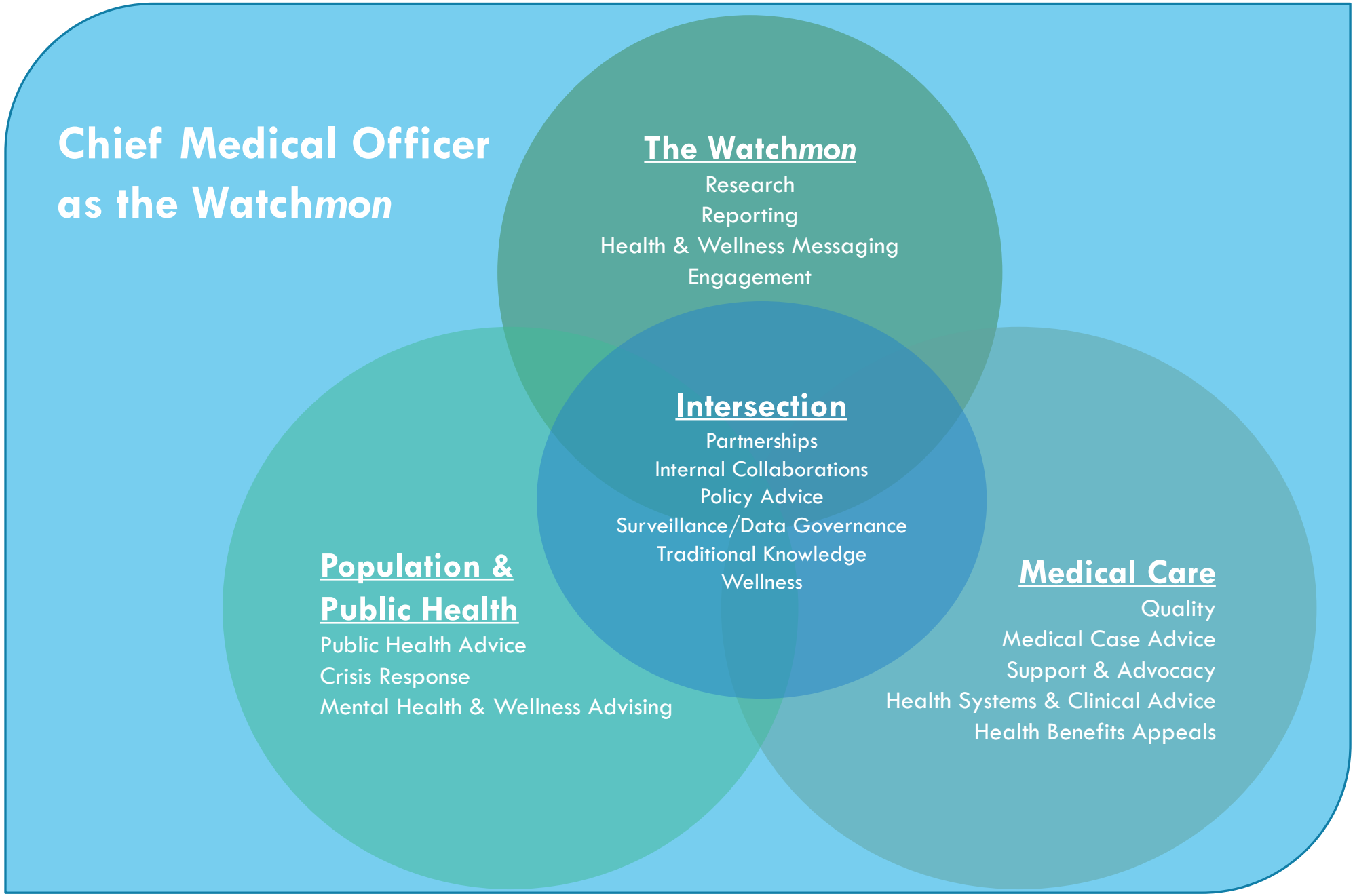
Image: "The Three Watchmen" by Haida artist Chief James Hart

FNHA **Chief Medical Officer** as the Watch*mon*

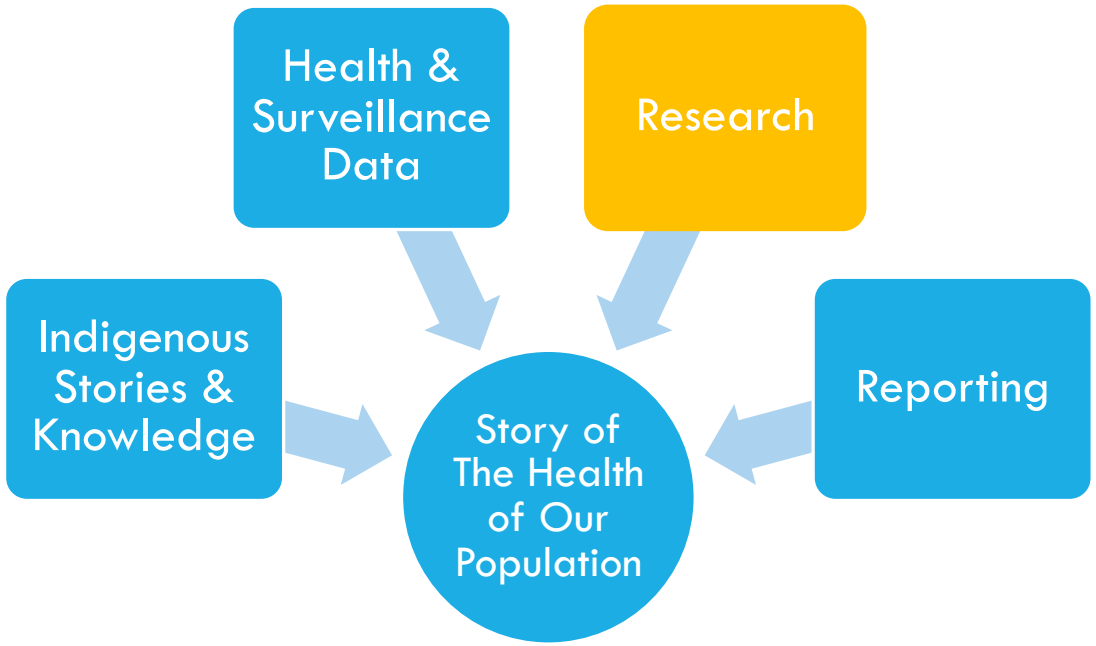
Mandate:

Establish & implement the "watchman" role as the keeper of the story of the health of our population, that integrates Indigenous stories, knowledge, & health data to monitor & identify priorities & report on First Nations health & wellness; responsive to community needs, leading to the best health & wellness outcomes for First Nations in BC

Chief Medical Officer as the Watch*mon*



WATCH*MON*: KEEPER OF THE STORY…



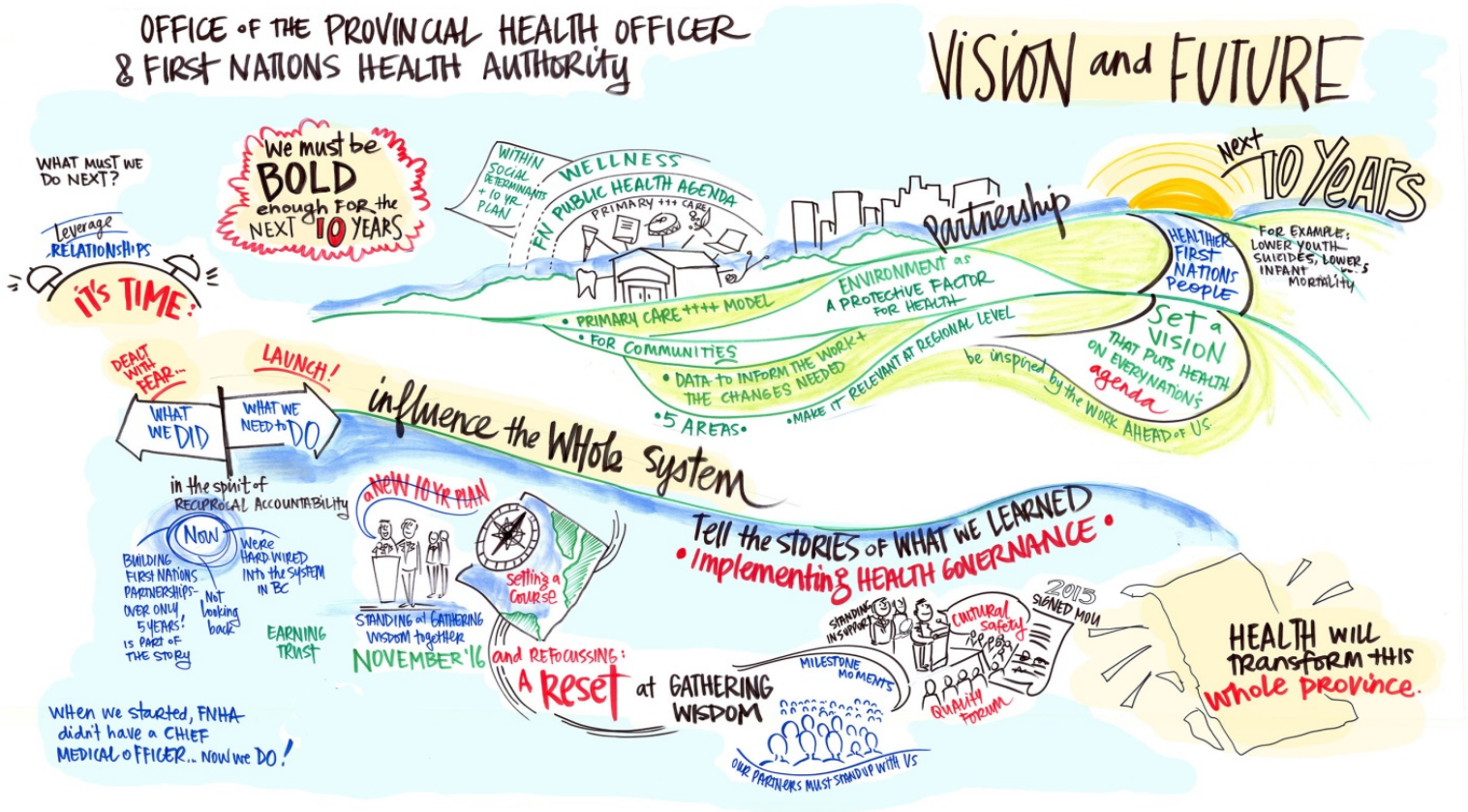
SHIFTING THE PARADIGM: SICKNESS TO WELLNESS, DEFICITS TO STRENGTHS

- Many First Nations have especially good health outcomes, we want to celebrate their sources of strength & resilience; build, share & spread those successes.
- Focus on wellness outcomes, not only “health” or disease, illness outcomes.





FIRST NATIONS POPULATION HEALTH & WELLNESS AGENDA: THE NEXT 10 YEARS



- **Standing together:** PHO & FNHA CMO
- A **renewed set of indicators** to be measured & reported on for the next 10 years
- Supporting **FNHA's vision** for *Healthy, Self-Determining, & Vibrant BC First Nations Children, Families, & Communities*

SOCIAL CULTURAL ECONOMIC ENVIRONMENTAL	HEALTH SYSTEMS	LAND FAMILY NATIONS COMMUNITY	MENTAL PHYSICAL SPIRITUAL EMOTIONAL	HEALTH AND WELLNESS OUTCOMES	TRANSFORMATIVE CHANGE ACCORD FN HEALTH PLAN
EDUCATION	EXPERIENCE OF CULTURAL SAFETY & HUMILITY IN RECEIVING HEALTH SERVICES	COMMUNITY STRENGTH AND RESILIENCE	LEVEL OF PHYSICAL ACTIVITY	INFANTS BORN AT A HEALTHY BIRTH WEIGHT	INFANT MORTALITY
FOOD INSECURITY	AVOIDABLE HOSPITALIZATIONS	ECOLOGICAL HEALTH	NUMBER OF CHILDREN WITH HEALTHY TEETH (no cavities)	ALCOHOL-ATTRIBUTABLE DEATHS	CHILDREN WITH HEALTHY BODY MASS INDEX (BMI)
ADEQUACY OF HOUSING			SMOKING RATES OF COMMERCIAL TOBACCO	SERIOUS INJURIES REQUIRING HOSPITALIZATION	YOUTH SUICIDE
CULTURAL WELLNESS • Exposure to traditional language • Knowledge of/access to traditional foods • Access to traditional medicine/healing • Sense of community belonging • Importance of traditional spirituality				SELF-REPORTED MENTAL AND EMOTIONAL WELL-BEING	DIABETES PREVALENCE AND INCIDENCE AGE-STANDARDIZED MORTALITY RATE LIFE EXPECTANCY NUMBER OF PRACTICING, CERTIFIED FIRST NATIONS HEALTH CARE PROVIDERS

WHAT WE'VE LEARNED

- Indigenizing practice
- Self-determination as central
- Data governance
- Relationships
- Indigenous public health is a continuation of our ancestors' work

DECOLONIZING

"Kaipo, you're Hawaiian. What do you think of Hawaiian issues?"


© Pam Mullins/solent © Solent News & Photo Agency

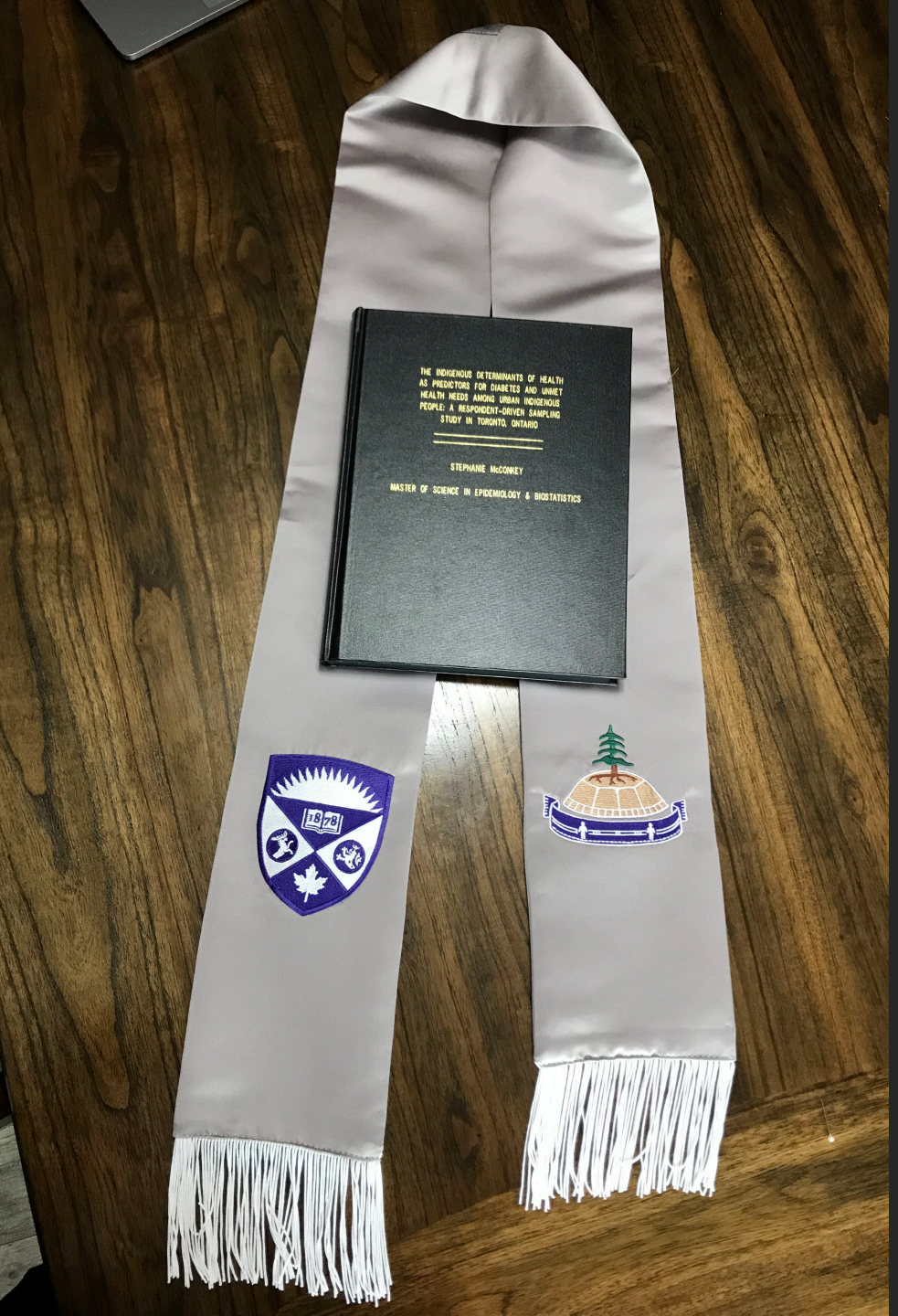
ʔIMOT (THANK YOU IN TLA'AMIN)

Dr. Evan Adams
Evan.Adams@fnha.ca | P: 604-693-6523
501–100 Park Royal South, West Vancouver, BC
www. fnha.ca

Artistic Credit: Daphne Odjig, "Pow Wow at Wikwemikong"

Appendix 5 – *Stephanie McConkey's* Master of Science in Epidemiology and Biostatistics at Western University using OHC Toronto Dataset: Reflecting on my Experience

Presentation



M. Sc in Epidemiology & Biostatistics at Western University using OHC Toronto dataset: Reflecting on my Experience

Stephanie McConkey, M. Sc, MPH

Community Research Manager

Southwestern Ontario Aboriginal Health Access Centre c/o Well Living House

Acknowledgements

Community Partners: **Seventh Generation Midwives Toronto** (SGMT)
Community Representative: **Sara Wolfe**, SGMT
Primary Supervisor: **Dr. Lloy Wylie,** Schulich School of Medicine & Dentistry
Co-Supervisor: **Dr. Greta Bauer,** Schulich School of Medicine & Dentistry
Advisory Committee: **Dr. Janet Smylie**, Well Living House
Advisory Committee: **Dr. Michelle Firestone**, Well Living House
Advisory Committee: **Dr. Ava John-Baptiste**, Schulich School of Medicine & Dentistry

Why Epidemiology ?

- Always had an interest in research methods
- Introduced to Epidemiology & Biostatistics Courses in MPH program
- Interested in Indigenous health research
- Originally planned to fast-track to PhD program
- Wanted to challenge ”traditional” epidemiology

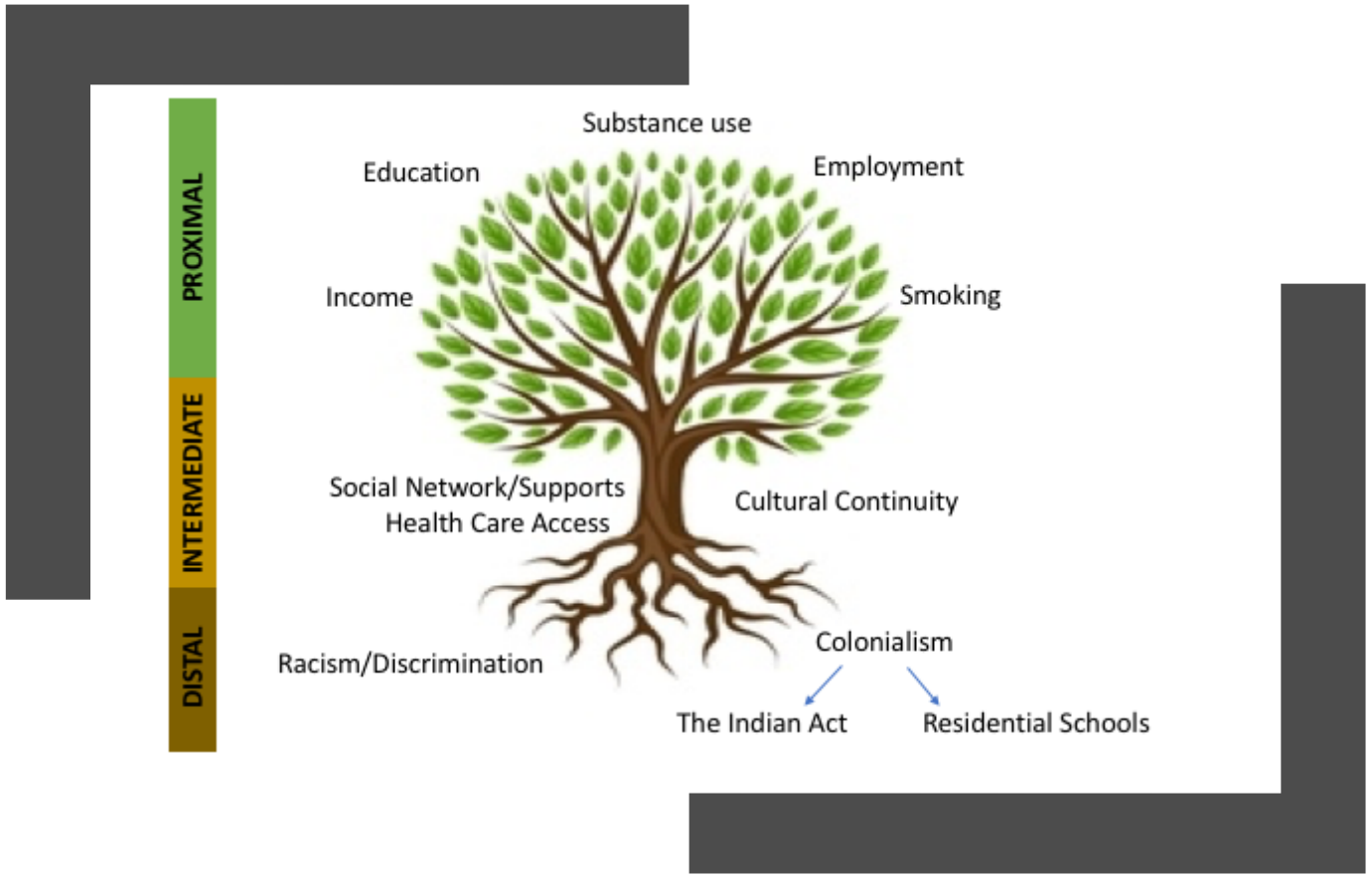
Western University - M. Sc Epidemiology & Biostatistics

- Core Courses
  - Principles of biostatistics
  - Multivariable methods in biostatistics
  - Foundations of epidemiology
  - Analytic epidemiology
  - Clinical epidemiology

- Electives (choose 2)
  - Questionnaire Design and Survey Implementation
  - Sampling Methods
  - Health Economics (x2)
  - Methods and Issues in Program and Policy Evaluation in Health Human Services
  - Health Services Research Methods
  - Population health
  - Causal Modelling
  - Grant Writing and Peer Review
  - Randomized Trials (x2)
  - Systematic Reviews
  - Meta-analysis
  - Measurement in Epidemiology

Schulich
MEDICINE & DENTISTRY

SOCIAL DETERMINANTS OF HEALTH AS PREDICTORS FOR DIABETES AND UNMET HEALTH NEEDS AMONG URBAN INDIGNEOUS PEOPLE: A RESPONDENT-DRIVEN SAMPLING STUDY IN TORONTO, ONTARIO



- Community-based research
- Relationship building
- Secondary Data Analysis using OHC Toronto data
- Analysis guided by Indigenous framework
- OCAP® Principles

What I would like to see…

- The program to be supportive of community-based research
- The program to include Indigenous content (developed by and for Indigenous students)
  - Indigenous methodologies course
  - OCAP® Training
- Practical skills learned through field placement/thesis project with Indigenous community, organization, etc.
- A network of Indigenous mentors with epi training
- Availability of program (multiple sites across Canada, online)

Yaw^ko (Thank you)

Stephanie McConkey, M. Sc, MPH

Community Research Manager

Southwestern Ontario Aboriginal Health Access Centre / Well Living House

McConkeyS@smh.ca